Health Care Reform Update
January 2012
Disclaimer

This presentation is for educational purposes only. It is not a complete analysis of the material contained herein. Before taking any action on the issues featured in this presentation, we recommend that you review them more fully and consult with your counsel as needed.
Many Health Reform Changes were Immediate

- Drug Manufacturer Annual Fee (1/1/2011)
- Part D Coverage Gap Discounts (1/1/2011)
- Transparency requirements (April 1 of each year beginning 2012)
- Imaging Utilization Assumption Change (1/1/2011)
- Part D Coverage Gap Closing Begins (1/1/2011)
- MA Regionally-Adjusted Benchmarks Phase-In Begins (1/1/2012)
- MA Payments Frozen (1/1/2011)
- MA Quality Payments Begin (1/1/2012)
- Exchanges Begin Operations; Premium and Cost Sharing Subsidies (1/1/2014)
- Independent Payment Advisory Board Recommendations Effective (1/1/2015)
- Medicaid Expansion (1/1/2014)
- Exchanges Begin Operations; Premium and Cost Sharing Subsidies (1/1/2014)
- Independent Payment Advisory Board Recommendations Effective (1/1/2015)

2010 | 2011 | 2012 | 2013 | 2014 | 2015
--- | --- | --- | --- | --- | ---
Agenda

- Insurance Reform and Expansion
  - Market Reform
  - Medicaid Expansion
  - State Health Insurance Exchanges
  - Medicare Changes

- Payment Reform
  - Accountable Care Organizations
  - Medicare Star Rating System
Insurance Reform and Expansion
Insurance Market Reforms Will Have Significant Impact on Health Plans

- Establishes 3:1 age rating requirements, which will reduce the variation in premiums by charging more for healthier members and less for sicker enrollees
- Requires minimum medical loss ratios (MLR) to ensure plans use a specified percentage of premium dollars on medical care
  - Beginning 2011, 85 percent MLR required for large groups and 80 percent required for small and non-group plans
- Requires coverage of dependents up to age 26
- Prohibits annual or lifetime limits and pre-existing condition exclusions
- Prohibits “grandfathered” plans from applying excessive waiting periods or rescinding coverage
Medicaid and Insurance Exchanges are the Primary Sources of New Coverage Under Health Reform

Expected Sources of Primary Insurance Coverage, in Millions of Persons

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid/CHIP</th>
<th>Medicare</th>
<th>Employer</th>
<th>Exchanges/ Nongroup</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>25</td>
<td>155</td>
<td>37</td>
<td>31</td>
<td>52</td>
</tr>
<tr>
<td>2016</td>
<td>48</td>
<td>162</td>
<td>56</td>
<td>51</td>
<td>21</td>
</tr>
</tbody>
</table>

Sources of Coverage Expansion

- Expands Medicaid to 133% FPL
- Reauthorizes and expands CHIP
- Requires employers to provide affordable coverage or pay a penalty; workers without coverage may enroll in plans in the exchange
- Establishes state-based insurance exchanges for individuals not eligible to participate in public programs; separate exchanges for businesses with up to 100 employees
- Imposes financial penalties on individuals who remain uninsured


CHIP=Children’s Health Insurance Program.
Health Reform Broadens Medicaid Eligibility Substantially

- *Requires* states, beginning in 2014, to cover all individuals who are under 65, do not receive Medicare, and have income below 133% of the Federal Poverty Level (FPL)
  - *Allows* states to cover some or all of this population immediately
  - Equivalent to $29,000 for a family of four
  - Expansion will largely affect parents and childless adults who are not disabled
    - Most states only cover parents at much lower income levels, and very few states cover any childless adults unless they are disabled
- *Allows* states to cover individuals with incomes >133% FPL who are not otherwise Medicaid eligible, beginning in 2014
- States must keep current eligibility levels in place until exchanges are operational
  - States may then end or restrict eligibility for individuals above 133% FPL
  - States must also count income in the same manner as the new exchanges to ensure coordination of coverage between the two
Coverage Gap Discount Program
The Affordable Care Act Requires Manufacturers to Offer a Discount for Brand-Name Drugs in the Coverage Gap

- Starting January 1, 2011, manufacturers must make discounts available at the point of sale to “applicable beneficiaries” receiving “applicable covered Part D drugs” while in the coverage gap
  - Discounts are 50 percent of the negotiated price which includes the drug’s ingredient cost, sales tax and vaccine administration fees but excludes dispensing fees
- Manufacturers must sign a “Model Agreement” with CMS in order for their drugs to be eligible for coverage under Part D
  - Manufacturers also must enter into a contract with CMS’s third party administrator
Payment Reform
The Medicare Shared Savings Program (MSSP) as an Organizing Principle for High-Value Health Care

An ACO is an entity and a related set of providers that agree jointly to be held accountable for the cost and quality of care delivered to a defined patient population.

Voluntary Provider Participation

Local Provider Accountability for Efficiency and Quality

Payment Incentives to Improve Care and Slow Cost Growth

Performance Measurement to Ensure Optimum Care Delivery

Beneficiary Assignment, but Not Enrollment*

*Note: The MSSP requires beneficiary assignment, however private payer conceptions of ACOs may require beneficiary enrollment
ACOs Can Take Multiple Configurations

**Different Structures**

- **ACO Model 1**
  - IPA or Primary Care Physician Groups
  - Specialty Groups
  - Hospital

- **ACO Model 2**
  - Multi-Specialty Group
  - Hospital

- **ACO Model 3**
  - Hospital Medical Staff Organization (MSO) or Physician Hospital Organization (PHO)

- **ACO Model 4**
  - Integrated Delivery System

**Different Actors**

**Public Programs**
- Medicare Shared Savings Program (MSSP)
- Medicaid Pediatric ACO
- CMS Innovation Center Pioneer ACO
- Physician Group Practice Demonstrations*

**Private Programs**
- Payer-led Accountable Care Networks
- IPA-led ACOs
- Hospitals/Health Systems in partnership with affiliated physicians

**ACO Collaboratives**
- Brookings/Dartmouth pilots
- Premier launched two ACO groups in 2010

*Physician group practice demonstration projects are well positioned to serve as early ACOs
CMS: Centers for Medicare & Medicaid
IPA: Independent Practice Association
Everything Old Is New Again – with Some Key Differences

How do ACOs differ from health maintenance organizations (HMOs)?

<table>
<thead>
<tr>
<th></th>
<th>HMO</th>
<th>ACO</th>
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<tbody>
<tr>
<td>Accountability</td>
<td>Payers</td>
<td>Providers</td>
</tr>
<tr>
<td>Patient Enrollment</td>
<td>Network Lock In</td>
<td>Open access</td>
</tr>
<tr>
<td>Payment</td>
<td>Mostly capitation</td>
<td>Fee-for-service + shared savings</td>
</tr>
<tr>
<td>Quality Incentives</td>
<td>P4P</td>
<td>Shared savings hinge on clinical performance</td>
</tr>
</tbody>
</table>
For ACOs to be successful, they will need...

- Aligned Incentives
- Better Data to Drive Decisions
- Care Coordination
The ACA Establishes ACOs in Medicare and Medicaid

ACO Provisions in the ACA

Medicare
- Requires the Secretary to establish a shared savings (i.e., ACO) program that promotes accountability for a patient population and coordinates services under Medicare Parts A and B starting January 1, 2012
  - An ACO is defined as a group of providers (regardless of specialty) and suppliers that voluntarily meet certain quality benchmarks and achieve spending targets to be eligible for shared savings payments
- Secretary may use multiple payment models such as partial capitation, in which an ACO is at financial risk for some, but not all, of the services furnished
  - Secretary can limit this payment model to ACOs in an integrated delivery systems
- Requires Secretary to set minimum threshold of savings relative to a benchmark that an ACO must achieve to be eligible to share in savings
- On October 20, 2011, CMS released a final rule implementing the Medicare Shared Savings Program (MSSP)

Medicaid
- Authorizes the Secretary to create a Pediatric Accountable Care Organization Demonstration based on a shared savings model. Demonstration to begin on January 1, 2012, and end on December 31, 2016
  - Participating states must work with the Secretary to determine the annual minimal level of savings in expenditures for items and services covered under Medicaid and CHIP
  - Secretary to establish incentive payments for participating ACOs
- CMS has yet to release guidance for the Pediatric ACO demo

ACA: Affordable Care Act
CHIP: Children's Health Insurance Program
CMS: Centers for Medicare & Medicaid Services
The Innovation Center Pioneer ACO Model

Medicare

- On May 17, 2011, CMS and the Centers for Medicare and Medicaid Innovation (the Innovation Center) released a request for application (RFA) for the Pioneer ACO Model, which is designed for healthcare organizations and providers that are already experienced in coordinating care for patients across care settings.
- The model will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP.
- The model will work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients.
- Under the Pioneer model, providers are eligible for shared savings in the first two years of the program; in the third year, they may be eligible for a partial population-based payment.
- Applicant ACOs must serve at least 15,000 beneficiaries (5,000 in rural areas).
- Implementation of the Pioneer models is currently in progress.
- CMS has accepted applications for up to 30 qualified organizations.
- As of December 2011, CMS had yet to release the list of participants in the Pioneer model.

MSSP: Medicare Shared Savings Program

Sources:
1) The Innovation Center, Pioneer ACO Model, Available at http://innovations.cms.gov/initiatives/aco/pioneer/
Medicare Advantage Star Rating System
ACA Will Significantly Reduce MA Plan Payments

<table>
<thead>
<tr>
<th>New Payment System</th>
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<tbody>
<tr>
<td><strong>MA Payment Benchmark Aligned with FFS Spending</strong></td>
</tr>
<tr>
<td>▸ The ACA sets MA benchmarks equal to county-level FFS costs multiplied by specific percentages</td>
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<tr>
<td>» Counties ranked into quartiles according to FFS spending with percentage multipliers for each quartile:</td>
</tr>
<tr>
<td>– Quartile 1: 95%</td>
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<tr>
<td>– Quartile 2: 100%</td>
</tr>
<tr>
<td>– Quartile 3: 107.5%</td>
</tr>
<tr>
<td>– Quartile 4: 115%</td>
</tr>
<tr>
<td>▸ Transition to new benchmarks starts in 2012</td>
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<tr>
<th>Impact of Star Ratings</th>
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<tbody>
<tr>
<td>▸ Increases benchmarks for plans with a quality rating of 4 stars or higher beginning in 2012</td>
</tr>
<tr>
<td>▸ Reduces rebates to all plans beginning in 2012, and sets rebates according to quality rating of the plan</td>
</tr>
<tr>
<td>» 70 percent for plans with at least 4.5 stars, 65 percent for plans with 3.5 or 4 stars, and 50 percent for plans with fewer than 3.5 stars</td>
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<td>▸ Phases in new rebate amounts with a blend of current and new methodology until 2014</td>
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Each year CMS releases quality ratings for all Medicare Advantage (MA) plans
- Ratings for all plans are displayed on [www.medicare.gov](http://www.medicare.gov)
Ratings range from 1 star (poorest quality) to 5 stars (highest quality)
Current ratings based on assessment of clinical performance, patient experience, enrollee complaints, customer services, etc.

Draws measures from nationally standardized quality measures (e.g., HEDIS®)
- Measures focus on clinical outcomes (e.g., plan members with high blood pressure who got treatment and were able to maintain a healthy pressure), beneficiary experience (e.g., how many complaints Medicare received about the health plan), and operational metrics (e.g., timely responses when making an appeal)
- Most measures are scored based on thresholds for performance; plans know what score is necessary to receive 5 stars on a measure
- Most measures grade plans relative to others

Plans are rated at the contract level
- Different plan types, especially SNPs and non-SNPs, are often aggregated under one rating

HEDIS = Healthcare Effectiveness Data and Information Set.
SNP = Special Needs Plan
Calculating Overall Plan Ratings

- CMS will calculate a summary rating for Part C and D scores by taking an average of the measure level stars
  - For the first time, CMS will differentially weight measures, emphasizing outcomes-based measures over process measures using the following weights:
    - Outcomes measures – counted 3 times Process measures
    - Intermediate outcomes measures (quasi-outcomes measures) – counted 3 times Process measures
    - Patient Experience and Access - counted 1.5 times Process measures
    - Process – only counted 1 time
- The overall summary plan rating for MA –PD plan contracts is calculated by taking the weighted average of the Part C and D measure level stars and combining this with the integration factor
- If a contract does not have a summary rating for Part C or a summary rating for Part D, the overall MA-PD summary rating is not calculated
- CMS will calculate a score based on the information reported from the measure sets
  - For example, CMS will rely on data from HEDIS and CAHPS for most measures within the Part C Staying Healthy Domain

Scores in Five Different Domain Categories Based on Plan Quality of Care and Service for MA Plans

<table>
<thead>
<tr>
<th>Domain Category</th>
<th>Examples of Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying Healthy: Screening, Tests, Vaccines</td>
<td>– Screening for breast cancer, colorectal cancer, cholesterol, and glaucoma</td>
</tr>
<tr>
<td></td>
<td>– Annual flu and pneumonia vaccine</td>
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<td></td>
<td>– At least one primary care visit annually</td>
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<tr>
<td>Managing Chronic Conditions</td>
<td>– Reducing the Risk of Falling</td>
</tr>
<tr>
<td></td>
<td>– Ensuring proper and appropriate diabetes care</td>
</tr>
<tr>
<td>Ratings of Health Plan Responsiveness and Care</td>
<td>– Ease of getting needed care and seeing specialists</td>
</tr>
<tr>
<td></td>
<td>– Getting appointments and care quickly</td>
</tr>
<tr>
<td></td>
<td>– Overall rating of health plan quality</td>
</tr>
<tr>
<td>Health Plan Member Complaints and Leaving the Plan</td>
<td>– Complaints about the health plan</td>
</tr>
<tr>
<td></td>
<td>– Beneficiary access and performance problems</td>
</tr>
<tr>
<td></td>
<td>– Members choosing to leave the plan</td>
</tr>
<tr>
<td>Health Plan’s Customer Service</td>
<td>– Reviewing appeals decisions</td>
</tr>
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<td></td>
<td>– Plan making timely decisions about appeals</td>
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</tbody>
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Please see Appendix A for full list of measures
http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp
## Scores in Four Different Domain Categories Based on Plan Quality of Care and Service for Part D Plans

<table>
<thead>
<tr>
<th>Domain Category</th>
<th>Examples of Performance Measures</th>
</tr>
</thead>
</table>
| **Part D Plan Member Complaints and Leaving the Plan** | – Complaints about the Part D plan  
– Members choosing to leave the plan                                                                                                                                 |
| **Customer Service**                         | – Time on hold when pharmacist calls the Part D plan  
– Drug plan making timely decisions about appeals  
– Availability of TTY/TDD & foreign language interpretation services when members call the drug plan                                                  |
| **Member Experience**                        | – Provides information or assistance when member needs it  
– Member’s overall rating of Part D plan  
– Member's ability to have prescriptions filled easily                                                                                               |
| **Drug Pricing and Patient Safety**          | – Accurate pricing information on plan website and Plan Finder tool  
– Members taking high risk drugs when safer alternatives existed  
– Proper blood pressure medication for patients with diabetes                                                                                   |
Similar to 2011, Most Enrollees are in MA-PD Plans with 3-star or Higher Ratings

Source: CMS Fact Sheet “2012 Part C and D Plan Ratings” available at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage

* These ratings summarize all Part C and Part D measures combined.
While CMS will likely continue to maintain a mix of process and enrollee experience measures, the agency has hinted that it will adopt more outcomes-based measures for future benefit years.

CMS will consider the following principles when updating the measures for future years:

- Maintaining a mix of standards, process, outcomes and patient experience measures;
- Recognizing differences in payment system maturity and statutory authority, align measures across Medicare’s and Medicaid’s public reporting and payment systems;
- Collecting information that minimizes a burden on providers to the extent possible; and
- Using measures that are nationally endorsed by a multi-stakeholder organization to the extent possible.

Questions