California Rheumatology Alliance Meeting

The ACA and California Rheumatologists

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Disclosure

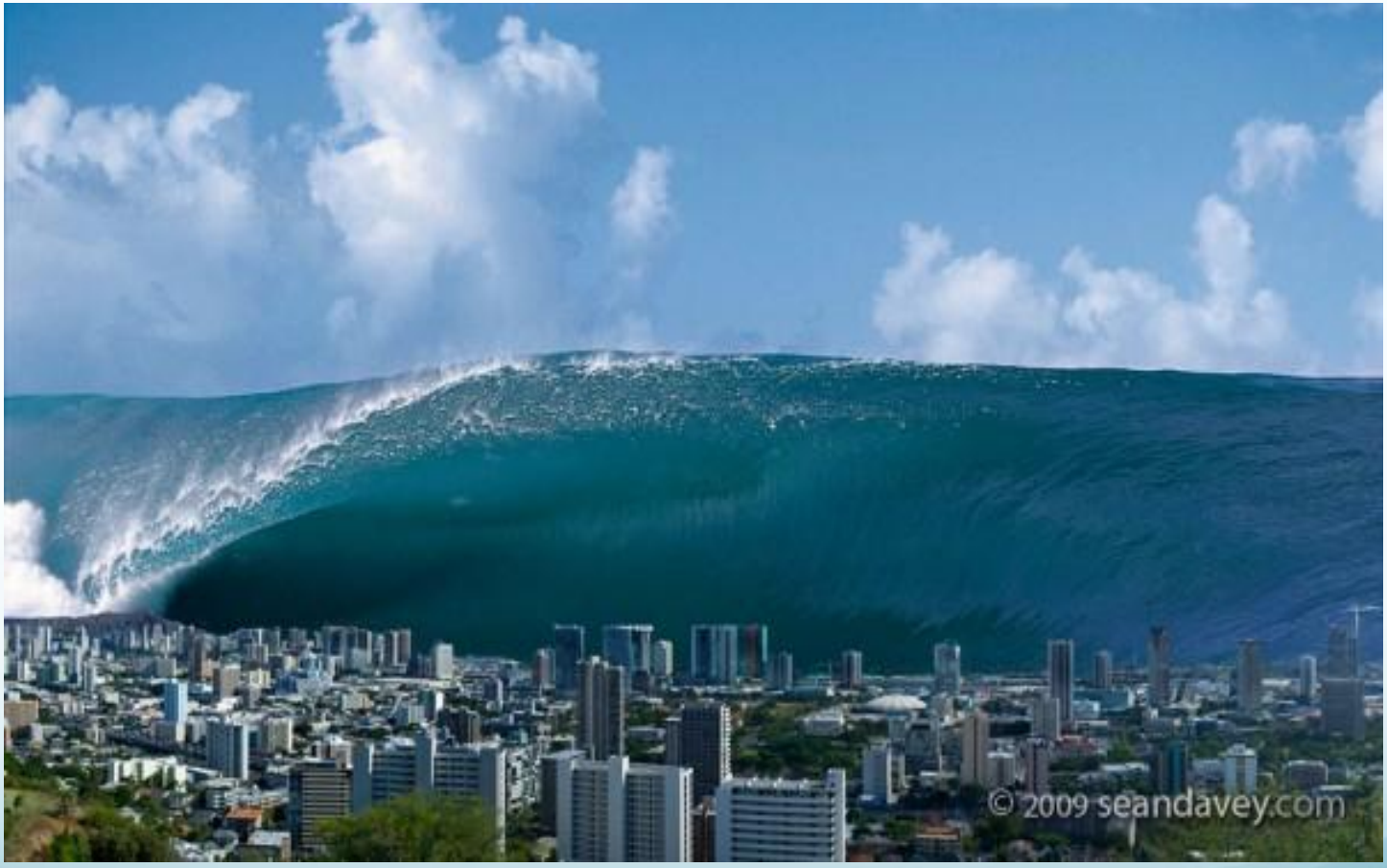
In order to assure the highest quality of CME programming, the CRA requires that all faculty and planning committee members disclose any relationships or affiliations with commercial companies whose products or services are discussed in educational presentations.

My disclosure is as follows:

- I have nothing to disclose.

Catherine I. Hanson

It’s a brave new world…



Today's Presentation

- Affordable Care Act (ACA) Overview
- Healthcare Exchanges
- ACOs

ACA timeline- 2010

- Young adults on parents' health plans up to age 26
- Preexisting Condition Insurance Plan available to people who have been uninsured for at least six months and who have a preexisting condition
- Employer early retiree health benefits reinsurance available to employers from June 2010-January 2014
- Ban on preexisting condition exclusions for children
- Ban on rescissions except for fraud or intentional misrepresentation of material fact.
- Ban on lifetime coverage limits
- Ban on annual coverage limits phased in by 2013
- Recommended preventive care and immunizations covered without cost-sharing in private plans and Medicare
- Medical loss ratio and annual premium rate review

ACA timeline- 2011

- Value of Employer Benefits must be reported on W-2
- Tax on Nonmedical Distributions from Health Savings Accounts (HSAs) increased to 20%
- FSA reimbursement for OTC drug costs only if prescribed by a doctor
- “Doughnut hole” in Medicare Part D elimination phased in by 2020 – starting with 50 percent discount on brand-name drugs

ACA timeline – 2012

- Increased health plan quality improvement reporting requirements
- Medicare Hospital Value-Based Purchasing Program - percentage of hospital payment tied to hospital performance on quality measures
- Medicare Data for Performance Measurement to "qualified entities" available to evaluate the performance of providers and suppliers on measures of quality, efficiency, effectiveness, and resource use.
- Understanding Health Disparities: Data Collection and Analysis
- Independence at Home Medicare Demonstration Program
- National diabetes report card

ACA timeline – 2013

- Enhanced electronic eligibility information, including patient financial responsibility, available at or prior to the point of care
- States must pay Medicaid providers at least equal to Medicare payment rates for primary care services.
- National Pilot Program on Medicare Payment Bundling
- Hospice program payment methodology revised
- Reduction of DSH payments

ACA timeline – 2013 tax changes

- $2,500 cap on FSA contributions a year
- Threshold for deduction unreimbursed medical expenses increased from 7.5 to 10% of adjusted gross income
- 0.9% Medicare tax on every taxpayer with wages or self-employment income over $200,000 ($250,000 couple)
- 3.8% tax will apply to "unearned" income (e.g. capital gains, rents, dividends, and interest) for "high-income" taxpayers
- Employer Part D subsidy repealed
- 2.3% medical device tax
- $500,000 cap on deductibility of compensation for health insurance executives if at least 25% of the insurance provider's gross premium income from health business is derived from plans that meet the minimum essential coverage requirements

ACA timeline – 2014

- Ban on preexisting condition exclusions
- Ban on medical underwriting - health status, medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, etc.
- Employers may adopt wellness programs linking premium discounts, rebates, or rewards to enrollees meeting a health status standard if certain conditions are met
- Waiting periods limited to 90 days maximum
- Individuals participating in clinical trials can not be dropped or denied coverage for routine, covered care

ACA timeline – 2014 Exchanges

- Each state required to establish an American Health Benefit Exchange, and a Small Business Health Options Program (SHOP) Exchange for individuals and small employers with up to 50 employees.
- Exchanges must offer "qualified health plans;" covering the the essential benefits package
- Plans offered on exchanges or individual or small group market must guarantee availability and renewability of coverage
- Monitoring of premium increases inside and outside the exchanges and justification for any "unreasonable" increase required prior to implementation

ACA timeline – 2014 Subsidies

- **Premium Credits.** Refundable premium tax credits for QHPs purchased through the exchange available on a sliding scale for individuals and families earning between 133 percent ($29,327 for a family of four) and 400 percent ($88,200 for a family of four) of the federal poverty level (FPL)
- The reference premium for determining premiums is the second-lowest cost silver plan available in the market area where the individual resides
- Those with incomes up to 133 percent of FPL will become eligible for Medicaid

Healthcare Exchanges- what physicians should know before they contract

- HIX – online "shopping mall" for the purchase of health insurance by individuals and small businesses
- Purpose – inject more competition into the health insurance marketplace by creating a venue for people to compare standardized product offerings and buy what they believe to be the best product for their needs.
- Goal – transparency and choice will transform health insurance from an unduly expensive and opaque offering to a regular consumer product, directly accountable to the needs of the individuals it serves

Healthcare Exchanges-HIX

- Two Exchange programs
  - American Health Benefit Exchange for individuals
  - Small Business Health Options Program (SHOP”) for small business with up to 100 employees (50 for the first 2 years)
- These Exchanges, which may be merged, will offer “qualified health plans”
  - standardized set of “essential health benefits”
  - four standardized coverage levels, based on an enrollee’s average annual out-of-pocket cost for the covered benefits:
    - Bronze – 60%
    - Silver – 70%
    - Gold – 80%
    - Platinum – 90%

Healthcare Exchanges-HIX

- Depending on their communities and patient populations, most physicians will likely end up with patients who are covered by HIX plans.
- Uninsured people throughout the country will be looking for affordable coverage, and many who currently pay high rates for health insurance in the individual and small group markets may also look to the Exchanges for more affordable options.
- According to the May 2013 estimates from the Congressional Budget office, 24 million people are likely to be covered by HIX plans by 2023.
  - www.cbo.gov/publication/44215

HIX plan physician contracts

- Managed care contract considerations +
- Compensation
  - Reimbursement levels
  - Patient financial liability
  - Grace-period
  - Risk profile
- HIX plan obligations
  - Federal mandates
  - Reporting requirements
  - Network restrictions
  - State specific requirements

HIX plan physician contracts

- **Compensation**
- ***Reimbursement levels likely to be lower***
  - These plans will be competing head to head in an electronic marketplace where the price of competing offerings will be easily accessible and comparable - health plans will likely seek deep discounts so they can offer the best price.
  - Physicians should evaluate the proposed fee-schedule or other payment system in the context of their practice costs and their current collection rate for the individuals who are likely to obtain coverage on the Exchange, that is, patients who are currently uninsured, covered in the individual health insurance market, or potentially, covered by a small employer.

HIX plan physician contracts

- **Compensation**
- ***Cost-sharing requirements are much greater***
- These plans have significant cost-sharing requirements, far in excess of the deductibles and copayments included in traditional health plans
- Physicians will need to ensure their systems are set up to maximize the likelihood they collect these payments if they are to maintain the solvency of their practices
- Cost-sharing subsidies will be available on a sliding scale for patients who make up to 250% of the federal poverty level ($22,340 - 27,925 for individuals; $38,180 - $47,725 for a family of 3)

HIX plan physician contracts

Covered California cost-sharing requirements

KEY BENEFITS	**Silver** (Lower Cost Sharing Available on Sliding Scale)	Bronze
Preventative Care Copay	No Cost – at least 1 yearly visit	No Cost – at least 1 yearly visit
Primary Care Visit Copay	$45	$60 – 3 visits per year
Specialty Care Visit Copay	$65	$70
Generic Medication Copay	$25	$25
Lab Testing Copay	$45	30%
Brand medications may be subject to Annual Drug Deductible before copay	$250 deductible then pay the copay amount	$50-$75 after meeting deductible
Preferred brand copay after Drug Deductible (if any)	$50	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$6,400	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$12,800	$12,800

HIX plan physician contracts

- ***3-month grace period for non-payment of premiums***
- Health plans are required to give enrollees of HIX plans a 3-month grace period before they terminate them for failure to pay premiums.
- **These health plans can shift the risk of loss for the second two months to the physicians** and other health care providers who provide services to these patients during this period
- Physicians should make every effort to protect themselves from absorbing this potentially extensive liability
  - Ensure HIX contracts require clear notification whenever an enrollee's premium payments are late
  - Negotiate for indemnification of the services provided during the grace period.

HIX plan physician contracts

- ***Higher risk-profile***
- Risk-based payment – consider both:
  - specific benefits for which risk is assumed, an
  - likely risk profile of HIX enrollees
- Kaiser Family Foundation analysis of initial HIX enrollees concludes they will likely be in fair to poor health. Many of those eligible to enroll have not had a recent check-up, and nearly a third have had no contact with the health care system in the last year.
- Negotiate for a minimum payment guarantee, appropriate stop-loss insurance or other protections from undue risk exposure.

HIX plan physician contracts

- Sicker likely to sign up first:
  - Higher risk individuals with pre-existing conditions will now be guaranteed coverage
  - Coverage will not be rated for individual medical risk – only age and smoking status can be factored in setting the premium
  - Age variation will be a relatively small 3:1.
  - Kaiser Family Foundation, “A profile of health insurance exchange enrollees,” March 2011
- Younger, healthier individuals may delay
  - Penalty for those who fail to buy insurance in first 2 years is relatively low (the greater of $95 or 1% of gross income in 2014; the greater of $325 or 2% of gross income in 2015)

HIX plan physician contracts

- **HIX plan obligations - *Federal mandates***
- Host of federal laws prohibiting discrimination and imposing affirmative burdens:
  - Americans with Disabilities Act (ADA), including the obligation to provide ASL interpreters
  - Federal Civil Rights Act and Executive Order 13166, mandating the provision of foreign language interpreters
- Ask for a complete list of these obligations
- Negotiate for plan's assumption of the associated cost:
  - direct provision of the services, or
  - reimbursement of the amounts incurred providing these services

HIX plan physician contracts

- **HIX plan obligations - Reporting requirements**
- HIX plans are also subject to a number of reporting mandates.
- Ask for a list
  - What information will you need to report?
  - How will you need to report it – what format?
  - How often will you need to report it?
- Consider the consequences and their costs
  - Will you need to implement a new or enhanced health information system?
  - Will you need new or additionally trained staff?

HIX plan physician contracts

- **HIX plan obligations - Network restrictions**
- HIX plans will likely provide little or no coverage for out-of-network services except that mandated for:
  - Emergency services
  - Preventive services that cannot be provided in-network
- Consider network adequacy
  - Will the physicians, hospitals and other health facilities that you generally work with be participating?
  - Negotiate for protection if you rely on an erroneous entry in the HIX plan's provider directory or when there is no in-network resource available to meet a patient's needs

HIX plan physician contracts

- **HIX plan obligations – State Specific requirements**
- As of October 2013, 16 states and DC operating their own Exchange, 8 operating an Exchange in partnership with the federal government, and 26 had decided to let the federal government operate the Exchange in their state.
- The government's website, http://www.healthcare.gov/marketplace/about/state-marketplace/index.html, provides helpful links to each of the state Exchange websites.

HIX plan physician contracts

- **HIX plan obligations – State Specific requirements**
- State Exchanges, like California's, that are "active purchasers" in the health insurance marketplace are more likely to impose additional obligations
- The California Exchange, Covered California, requires HIX plans to comply with numerous quality, network management and delivery system standards, all of which are likely to trickle down to impose significant obligations on physicians.
- Model QHP contract, www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf

Medicine's victories

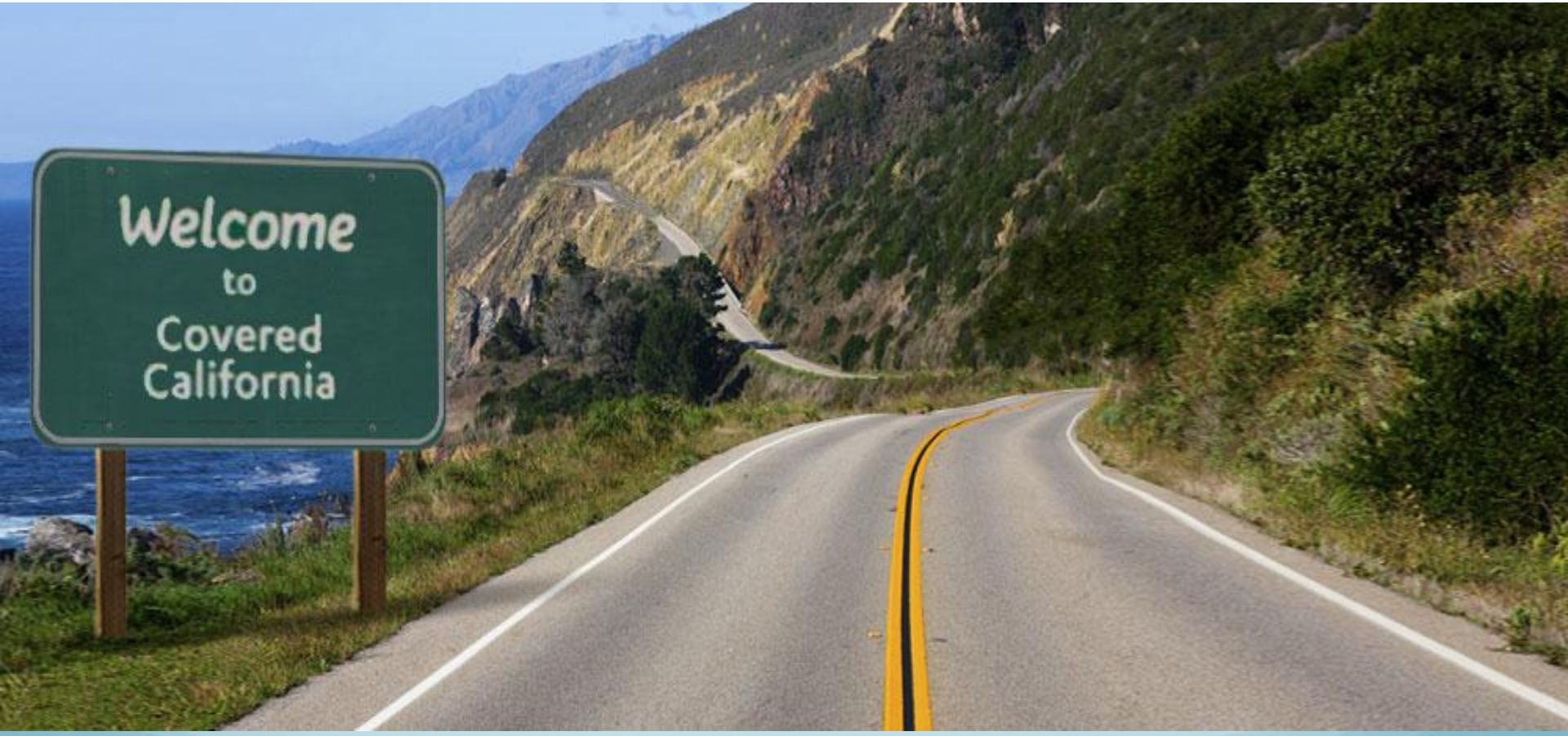
- Notification at least 15 calendar days prior to a patient entering the federal claims pend and deny period (days 31-90)
- Deletion of deleterious definitions of "medically necessary" and "medically appropriate.
- More accurate provider directory, and safe-harbor for physicians who rely on directory for referrals
- Deletion of MFN clause
- Clarification that 5-day reporting requirement for protected health information (PHI) "security incidents" did not apply to physicians.
- A substantial reduction in the scope of quality reporting and other data collection requirements on plans and providers in the first two years of Exchange operation.

Remaining concerns

- Financial risk of 60 days of unpaid claims (notification limited to providers who have seen the patient within the prior two months or who are the patient's assigned PCP)
- Obligation to notify patients prior to use or referral to out-of-network provider or facility
- Potential physicians will have to disclose rates to Exchange
- Lack of clarity on enrollees' insurance identification cards
- Plans' ability to force participation through all products clauses
- Potential for unduly burdensome new data collection and reporting provisions (e.g., more than 70 reports required of plans)
- Potential low Exchange rates may be leased

Your destination for affordable health care

https://www.coveredca.com



Covered California contracting plans

- Alameda Alliance for Health
- Anthem Blue Cross
- Blue Shield of California (also SHOP)
- Chinese Community Health Plan (also SHOP)
- Contra Costa Health Plan
- Health Net (also SHOP)
- Kaiser Permanente (also SHOP)
- L.A. Care Health Plan
- Molina Healthcare
- Sharp Health Plan (also SHOP)
- Valley Health Plan
- Western Health Advantage (also SHOP)

Covered California statistics

- Conservative enrollment estimates are between 490,000 and 1.38 million covered lives as of January, 2015 and between 1.24 million and 2.3 million as of January, 2017
- Covered California estimates enrollment in 2014 to run between 150,000-400,000. By 2016, they estimate anywhere from 850,000-1,890,000 enrollees.
- The Health Plan Booklet on the Covered California website does, however, provide information on the number of subsidized enrollees eligible for coverage by county.

Health Plan Booklet

Pricing Region 19

San Diego

Number of subsidy-eligible individuals:
193,000

Health Insurance Plans available:

- **Anthem** – EPO, HMO
- **Blue Shield** – PPO
- **Health Net** – PPO, HMO
- **Kaiser Permanente** – HMO
- **Molina Healthcare** – HMO
- **Sharp Health Plan** – HMO (copay), HMO (coinsurance)

Covered California statistics (*cont.*)

Enrollment Assistance Program	Certified or Authorized to Enroll	Certification** in Progress
Enrollment Entities	272	237
Enrollment Counselors	390	4,165
Insurance Agents	2,074	21,746
County Eligibility Workers*	10,275	
Total	**13,011**	**26,148**

*Trained by Covered California and authorized to use agency's enrollment system.

**The majority of certifications currently in progress are expected to be completed in November

Covered California statistics
Initial enrollment activity

Weekly Report	Week of Oct. 13	Since Oct. 1
Unique visits to CoveredCA.com	486,678	2,232,091
Total call volume	45,110	156,779
Average wait time	00:45	04:32
Average handling time	15:11	15:47

What benefits will HIX plans cover?

HIX plans must cover the “essential health benefits, including at least the following 10 categories, equal in scope to benefits offered by a “typical employer plan” (CA benchmark plan - Kaiser Small Group HMO)

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

What benefits will HIX plans cover?

Drug benefit

- At least the greater of:
  - 1) one drug in every category and class of the United States Pharmacopia (USP); or
  - 2) the same number of drugs in each category and class as the EHB-benchmark plan.

- Drugs are only counted separately if they are chemically distinct under the USP (e.g., different dosage forms or strengths and brand name drugs and their generic equivalents are not considered separate drugs for EHB purposes)

- (45 C.F.R § 156.122)

Must HIX plans accept any willing provider?

- No. HIX plans are prohibited from "discriminat[ing] with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law."
- Center for Consumer Information & Insurance Oversight (CCIIO):
  - "does not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer,"
  - "does not require plans or issuers to accept all types of providers into a network" and also
  - "does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations."

HIX plan contracting tips

- Review all managed care contracts − including HIX plan contracts − carefully before signing them. Bad contracts can create significant financial hardship for a practice
- Dramatic changes in the health care marketplace will likely lead third party payers to amend their contracts significantly over the course of the next few years
- In response to increasing cost-consciousness and consumerism by both employers and individuals seeking to purchase health insurance, payers may well attempt to reduce payments, increase risk-sharing and increase data gathering and reporting obligations.
- HIX plans offer the beneficial prospect of coverage for numerous patients who were previously uninsured, but also raise new challenges that physicians will need to consider.

One Size Does Not Fit All — You have choices

- Payment reform will necessitate delivery reform
- Every practice is unique
- There are more than one integration options
- Physicians must educate themselves as much as possible

Choosing an ACO

12 factors to think about

1. Employment vs independent contractor?

Independent contractor - more practice autonomy and potentially easier exit strategy (but beware covenants not-to-compete)

Employment – fewer management headaches and potentially better hours (but how much control will you cede with respect to clinical matters, administrative issues, practice assets and support services)

Choosing an ACO

2. Exclusivity?

- Medicare Shared Savings Program (MSSP) ACOs require PCPs (internal medicine, general practice, family practice, and geriatric medicine) to be exclusive
- Exclusivity is also required for non-primary care specialists if it is possible they could have a Medicare patient attributed to them – if they bill any of the following CPT codes:
  - 99201-99215
  - 99304-99340
  - 99341 through 99350
  - G0402
  - G0438
  - G0439

Choosing an ACO (cont.)

3. **Competence of leadership?**

   Who are the ACO's leaders? Do you know them personally or are they corporate transplants? Do the leaders have an established track record of managerial competence in the health care field? In managing physician practices?

4. **Will your voice be heard?**

   What role if any will you have with respect to ACO governance? What happens if there is a deadlock between physician interests and those of others participating in the ACO, e.g., hospitals? Will management work with physicians in a collaborative way, or as a dictatorship? If management is physician friendly now, what protections, if any, are in place to ensure that the physician will be protected if new, less amicable ACO leadership comes on board?

Choosing an ACO (cont.)

5. **What are other physicians in your community saying or doing?**

   What are other physicians are doing, or saying about the ACOs in your market? Are respected colleagues signing up with one ACO vs. other ACOs? If you have colleagues who are already participating in an ACO, ask them about the ACO's working and political environment and their general level of professional and financial satisfaction. Ask staff at your county or state medical association to see what they have heard about the ACOs in your market.

6. **Quality of facilities involved.**

   Are the best hospitals and other facilities contracting with a particular ACO and not another? Participating with the ACO with the best-performing facilities may indicate an opportunity for greater financial reward for you.

Choosing an ACO (cont.)

7. Existing referral relationships/staff privileges

If you are a specialist and the primary care physicians from whom you receive many of your referrals have decided to contract with ACO A, then not also participating with ACO A may have a detrimental financial and professional impact on your practice. Similarly what will happen to your staff privileges at Hospital 1 if it decides to participate with ACO A and you do not?

8. Technological capacity

Does the ACO have the systems and medical expertise in place to give you timely feedback on your quality and efficiency performance? Much of an ACO's success will ultimately depend on its ability to collect and organize data concerning the quality and efficiency of its participants' services, and its ability to disseminate in real time that information in a way that participants can readily use to evaluate and improve performance and consequently maximize financial awards

Choosing an ACO (cont.)

9. Will the ACO be transparent with essential data?

Your success (financial and professional) in an ACO will depend on how well you perform on quality and cost-effectiveness metrics. Will the ACO provide you with clear complete information describing how your performance will be evaluated? Will the ACO will be able to provide you with timely feedback concerning your quality and cost-effectiveness performance—as a solo or small group physician, it is likely that you will not be generating this data yourself.

10. Risk assumption

How much "upside risk" will you have? How much "downside risk" will you be asked to assume? Will the amount of potential upside reward be commensurate with the amount of downside risk you will shoulder (it should)? Will you be protected from losses beyond a specific threshold? Can you ease into risk assumption, or will you have to quickly assume an amount of risk that is beyond your comfort level?

Choosing an ACO

11. Can you compare contracts?

Attempt to obtain offers and proposed contracts from all of the ACOs in the area. This will enable you to compare the terms on which they expect to do business with you.

12. Where is your patient base?

Right now you are likely receiving most of your patients from the health insurers with whom you contract. But if one or more of your health insurer contract partners enters into major contracts with an ACO in your community, you may need to consider joining that ACO as a way of maximizing access to your existing patient base.

ACO "shared savings" compensation

Key questions to ask:

1. How much of the savings will the ACO retain?

   MSSP ACOs taking only "upside" risk may share up to 50% of any savings with the Medicare program, and ACOs assuming both "upside" and "downside" risk may share up to 60% of such savings.

2. How will ACO "savings" be distributed to ACO participants?
   a) How much of the pool will be distributed and when?
   b) How will your patient population be determined?
   c) How will shared savings and losses be calculated?

ACO "shared savings" compensation

How will shared savings and losses be calculated?

1. How were the quality targets and utilization budgets determined? Are they attainable?
2. What metrics will be used to evaluate your quality and resource-utilization performance, e.g., quality standards developed by national medical specialty societies;
3. To what extent will your performance be risk adjusted based on your attributed patient population; etc.

Access to accurate, comprehensive data is increasingly key

- Only way to manage new payment models
  - economic results depend on the variation between projected and actual experience, rather than on maximizing volume
- Only way to respond effectively to profiling
  - to ensure publicly reported practice profiles are accurate,
  - to use the data to improve practice quality and efficiency
- Only way to eliminate the currently inexplicable variation in treatment patterns

Do I have to make a decision now?

Not necessarily.

While CMS has stated that *during* the MSSP ACO application process, as a practical matter, it will be difficult to add ACO participants, there is no practical barrier to adding or removing participants once the application is granted.

Any barriers placed on an ACO adding physicians would likely be based on lack of need, or a matter of contract, e.g., if an ACO had an exclusive contract with a certain specialty group that prohibited the ACO contracting with a competing physician organization.

Can I quit if I am unhappy?

- **No legal mandate -** MSSP doesn't require physicians to be locked into contract with ACOs for the initial three year term.
- **Likely will be contractual requirement**
  - **ACOs must contract with a sufficient number of primary care physicians and specialists in order to obtain MSSP certification.**
  - **ACOs must also report to CMS any changes (add/drops) of ACO participants during the three-year term.**
  - **ACOs will not want to risk losing their certification due to an exodus of initial participants - anyone expending the resources to develop an ACO will likely protect that investment by securing at least a three-year commitment from all ACO participants.**
- **Likely necessary to obtain shared savings payments**
  - **Achievement of quality and cost-effectiveness goals will likely require altering existing practice patterns, which takes time.**
- **Negotiate escape rights if you want them**
  - Access to patient lists and records, right to compete

Succeeding in the evolving marketplace will require change

- **Standardizing care** through the use of accepted guidelines, policies and procedures
- **Facilitating better coordination** and interaction among all parties involved with the care, including the patient
- **Automating both administrative and clinical activities** through HIT adoption
- **Developing and analyzing data** to change behavior, produce better outcomes, and provide care more efficiently
- **New payment models**

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