12th Annual Spring Symposium 2014: Facilitator Guide

Today's case concerns Frank and Sally LaVallee, both in their 50's, from Thomaston, Maine. Frank is a sternman on a lobster boat and Sally owns a family day care. They have two adult children living out of state. Frank's mother, Giselle, 78, lives with the couple. Lobster fishing is hard work that has taken a toll on Frank's body. Sally was recently diagnosed with Type 2 Diabetes and Hypertension. Neither Frank nor Sally has health insurance.

Today's interactive sessions will ask you the following:

Session I: Which insurance and health reforms of the ACA can benefit this family?
Session II: In light of changes stimulated by the ACA, what provider/systems changes would you suggest in Maine's healthcare systems to improve quality of care, patient satisfaction and cost benefits?

Begin the facilitation session by introducing yourself to the students, then share the rules of group etiquette listed below (~3 minutes): **IF YOU CAN DO THIS BEFORE THE KEYNOTE IS INTRODUCED, THAT WOULD BE IDEAL!**

SCHEDULE

7:00 - Buses depart
8:00-8:25 - Continental Breakfast
8:25-8:30 - Introductions
8:30-9:00 - Keynote
9:00-9:10 - Patient Impact Video
9:10-9:50 - Facilitated discussion
9:50-10:00 – Report out
10:00-10:15 - Break
10:15-10:25 – Team/ System Video
10:25-11:15 - Facilitated discussion
11:15-11:30 - Wrap up, report out
11:30 - Symposium concludes
11:45 - Buses depart

GROUP ETTIQUETTE

- Listen attentively—contribute to a learning atmosphere of equality, trust and respect.
- Create a climate receptive to the sharing of thoughts, feelings, and experiences.
- Support the expression of multiple perspectives, even if you may not agree.
- Risk sharing your own perspective, even if you think others may not agree.
- Create space in the conversation for less vocal participants to speak.
- Use discretion in regard to any personal information that is shared.

FACILITATOR ROLE

- Promote thinking and respectful problem-solving
- Encourage interaction – do not lecture or impose your views
- Show enthusiasm for process
- Make sure students stay on task
- Encourage students to ask questions of each other or other tables.
- Facilitate a summarizing session; try to get everyone to participate.

12th Annual Spring Symposium 2014: Facilitator Guide

Session 1: Following the ~7-minute video: **ACA impact on Patients**

1. Students introduce themselves to the others in their group and choose a note taker to report out to the larger group (~7 minutes). **Students and facilitators need to place their devices in "Airplane Mode" or turn them off – if too many people are connecting to the Wi-Fi, no one will be able to get online. ONE person at the table can act as a researcher and keep their device linked to the web for the purposes of looking up potential answers.**

2. Review the case with the students if necessary, they all received the case via email, but not all will have read it. (~3 minutes)

3. Students will discuss the case and ask each other questions about their perspectives on Frank and Sally's situation (~10 minutes).

4. Students will then be directed to Exercise I. Students will begin discussion the following questions (~15 minutes):

    1. Which insurance and health reforms of the ACA can benefit this family?
    2. Now that health reform is fully realized you as a health care manager for a health insurer are in the position of determining how reimbursement dollars are spent. Payments to your company will increase substantially if their health improves. You can spend the $1,000 for each of them in any way that will improve their health. How would you spend it over the first 3 months? You can answer with dollars amounts or approximate proportions of the $1,000.

    Prompts for discussion:

    - How will you prioritize what you reimburse for?
    - What data do you want to see in order to track your progress?
    - How do you hope the funding breakdown will change in one year?
    - What health changes do you expect to see in Frank and Sally? Why?

    Hint: Costs should be in categories such as health care provider visits (and which types of providers), diagnostic tests, treatment, preventive and educational services, behavioral health and social services, and any creative/alternative health interventions strategies.

5. Facilitators will then bring the whole group back together to share their thoughts and observations. (~5 minutes).

6. At ~9:50AM there will be an opportunity for a few tables to report out to the entire room. After that, thank students for their participation and remind them to be back promptly from break in 15 minutes.

Session II: Following the ~9-minute video: **ACA impact on Providers & Systems**

Now having familiarized themselves with Frank and Sally and their individual needs, students will focus on practice and systems changes. The first group task asks students to consider the environment in which integrated primary/behavioral/and oral health care will be delivered. **Please choose ONE of the following questions for the students at your table to respond to.** [Remind students that their responses are speculative. There are no right or wrong answers and that all views deserve respectful hearings.]

1. On a piece of paper, sketch out the floor plan for an outpatient health center that would best serve patients/clients comprehensively. Health homes are still a fairly new concept, and requirements that qualify a practice as a health home are evolving. What changes would you make to the attributes and supports listed above for patient-centered medical homes? (20 minutes – we will have drawing implements and paper on the tables).

2. Some health care experts say it's difficult to control healthcare costs since it is difficult to control patient/client behaviors. Given the emphasis on prevention and health education in the ACA, should payment reform include incentives for patients/clients to improve their health status? Should payment reform include benefits to patients/clients when their health is improved, and not just financial benefits to the providers and insurers? What happens if a patient is unable to improve their behavior for reasons beyond their control? (20 minutes).

3. In Maine, there have been deliberate outreach efforts to engage people like Frank who work in the fishing and lobstering communities to enroll in a health insurance plan in order to avoid tax penalties. One such organization, the Fishing Partnership, provides such services in Maine. What is the value of such outreach programs and how should providers and systems engage with other types of programs in Maine help people navigate the health insurance market and enroll? (15 minutes).

- Facilitators will then bring the whole group back together to share their thoughts and observations. (Approximately 10 minutes).
- Wrap up with whole group. **Please remind students that evaluation forms will be in their email, as a link to Survey Monkey. Encourage them to complete the evaluation!**

Thank you!

Profile:

Name: Frank LaVallee; Sarah "Sally" LaVallee

Age: 57 (born 1957); 56 (born 1958)

Occupation: Lobsterman; Family Day care Provider

Marital Status/Family: Married (son: Marc, 34; daughter: Elisa, 33)

Living Arrangement/City: Thomaston, Maine – The LaVallees live in their own home, which they purchased in 1986. They have two ten-year mortgages, which are paid monthly.

Patient/Client Background:

Frank LaVallee is a sternman on a lobster boat owned by his uncle. Lobster fishing is hard and rigorous work that has taken a toll on Frank's body. He grew up and still lives in Thomaston, Maine where he met his wife, Sally, in high school. Sally runs a home-based family day care, which she started when their youngest child was 3-years-old. Frank has a high school diploma and Sally has an associate's degree in childcare from Kennebec Valley Community College Their first child, Marc, was born in 1980. Their second child, Elisa, was born in 1981. Both adult children are married with children of their own and live in New Hampshire and Massachusetts respectively. Mr. LaVallee's 78-year-old mother Giselle has lived with the couple for the last 5 years following the death of her second husband. The LaVallee's also have a 29 year-old nephew, Nick, who began living with them at age 9 after the death of his mother.

Patient and Family Concerns:

Frank LaVallee: Frank believes in the values of hard work, self-sufficiency, and family. He has always been a good provider and at the same time, appreciates Sally's contributions to the household finances. He is self-contained – a man of few words. He loves his family but could be described as uncomfortable with displays of affection. His marriage to Sally is strong but not without its hardships especially perpetual financial worries, concerns about his mother's health, and conflicts with his nephew Nick.

Sally LaVallee: Sally is an efficient woman who derives pleasure and satisfaction from managing her home and business. She is pleased to have raised her children well and enjoys caring for others' youngsters. Unlike her own mother who stayed at home raising 9 children, Sally places great value on her economic contributions to the family. Like Frank, she is fiercely independent and does not always agree with her husband's views on family matters and social issues. For the most part, she avoids marital conflict focusing instead on managing their household. Sally has become increasingly concerned about Frank's health in the last 4 years, and has repeatedly found herself unsuccessfully trying to encourage him to seek medical help. She is also quietly worried about her own health. Since Elisa was born Sally has steadily gained weight.

She's at her highest weight now since quitting smoking 18 months ago. At her last yearly check-up, Sally learned that she has diabetes and high blood pressure.

Socioeconomic Status:

The LaVallee's have never depended on social services, but they have always struggled with finances. They own their home in Thomaston, but because both are self-employed and income is unpredictable, they've had to make difficult choices about which bills to pay. They have never carried health insurance for themselves because other expenses were prioritized. Both Frank and Sally are concerned that their physical symptoms could cause them to slow down and/or retire early. They have no savings, life insurance or retirement plan. Should they be unable to work, Social Security will be their only income.

Patients' Medical Histories

Family History

Frank's family has a history of lung and heart disease. He has no knowledge of his paternal medical history. His maternal uncle Jack, 77, has Chronic Obstructive Pulmonary Disease (COPD) and diabetes and lives in a nursing home. His mother Giselle, 78, is relatively healthy with mild dementia.

Lifestyle

Frank has a 60-pack year tobacco addiction (1 ½ packs per day x 40 years). He describes an unremitting cough and increasingly feeling breathless. He considers himself a moderate drinker (1-3 beers a night and occasionally more when watching sports with friends) and has never used illegal drugs. Frank's work has always been very physical, he is lean (Body Mass Index, BMI = 20), and views himself as very active. He leaves work exhausted every day and has recently taken unpaid sick days as a result of fatigue and increasing body pain. He suffers with chronic neck and mid- to lower back pain, which he attributes to the repetitive motions of hoisting and hauling heavy ropes and traps. He consumes mostly meat, fish, and potatoes and stays away from soda and sweets. He drinks 5-6 cups of coffee a day and recently added high-energy drinks (e. g. Red Bull) to manage his fatigue. He takes 2 – 4 OTC (over the counter) Ibuprofen 200mg daily and sometimes a No-Doz tablet in the morning or afternoon. He does not believe in taking vitamins. His leisure activities include watching sports, darts, and ice and smelt fishing.

Sally's family history is significant for diabetes, depression, and domestic violence. Her mother and sister take insulin injections daily. Sally assumed getting diabetes was inevitable so her recent diagnosis of Type II diabetes came as no surprise. Sally does not drink alcohol and gave up smoking 18 months ago (with a 20-pack year addiction, 40 years x 1/2 pack per day). She is a self-described stress eater and drinks diet Pepsi throughout the day. She is approximately 30 pounds overweight for her height of 5'4" (BMI = 32). She considers her work running around

after the children in her daycare and cleaning the house her form of exercise. Sally takes Metformin for diabetes, occasional Xanax for stress, OTC Ibuprofen for headaches, and a daily multivitamin for women. She enjoys knitting, cross-stitching, card playing, cooking, cleaning the house, visiting with her children and grandchildren, and baking.

Current Situation

Frank has had an increasingly complex set of health problems, which started in his early 50s. He did not have a primary care doctor (PCP) or medical home where he could receive regular check-ups or health care, largely because he didn't have health insurance did not perceive it at the time as necessary. In the last year Frank has missed 15 days of work because of increasing neck and back pain. He assumes the pain is muscular-skeletal, though it may emanate from other sources. His cough has worsened and keeps him up at night. He's also experiencing tooth pain for which he takes OTC aspirin. In the last month Sally has lobbied for him to go to the community health center for a comprehensive check-up. Frank has agreed it's time especially given the lost days at work and the impact his health is having on their finances.

Like Frank, since turning 50 Sally's health has become more complicated. The migraines, night sweats, anxiety and frequent urination that she previously exclusively attributed to menopause she learned from the physician assistant in her yearly check-up were in fact symptoms of diabetes and hypertension (BP = 160/88). The PA suggested that Sally lose 30 lbs. and join nutrition and exercise programs offered at the community center for people with diabetes. Sally also confided to the PA who she's known for years that her anxiety and feelings of depression are worsening. She describes using sleep as a method to escape from stress.

The LaVallee family seems to have reached a significant turning point in thinking about healthcare. Frank's condition isn't getting any better and there are plenty of young people in line for his job. The LaVallee's know they need insurance coverage but worry if their pre-existing conditions and limited finances might make health coverage beyond their reach. Additionally, both Frank and Sally worry about how much longer they can care for Giselle. They do not believe in putting elder family members in nursing facilities – it goes against their cultural and intergenerational customs.

The family does not know what to do, and are struggling with the question: "What is it that we really want?" What do they need?

The U.S. health care system is distinguished by three overarching challenges. First, it is by far the **costliest in the world**. Health care in the U.S. costs about $8,000 per capita (for every person) every year. In the second most expensive country in the world, health care costs about half of this. Health care expenditures in the U.S. also supersede spending on other goods and services, such as on education, transportation, and housing. For example, health care costs in the U.S. represent about 18% of GDP (Gross Domestic Product, which is the market value of all officially recognized final goods and services produced within a country in a year). The country with the second highest proportion spends just over 10% of their GDP on health. With so much of our economy focused on purchasing health care, we are unable to buy many other goods and services.

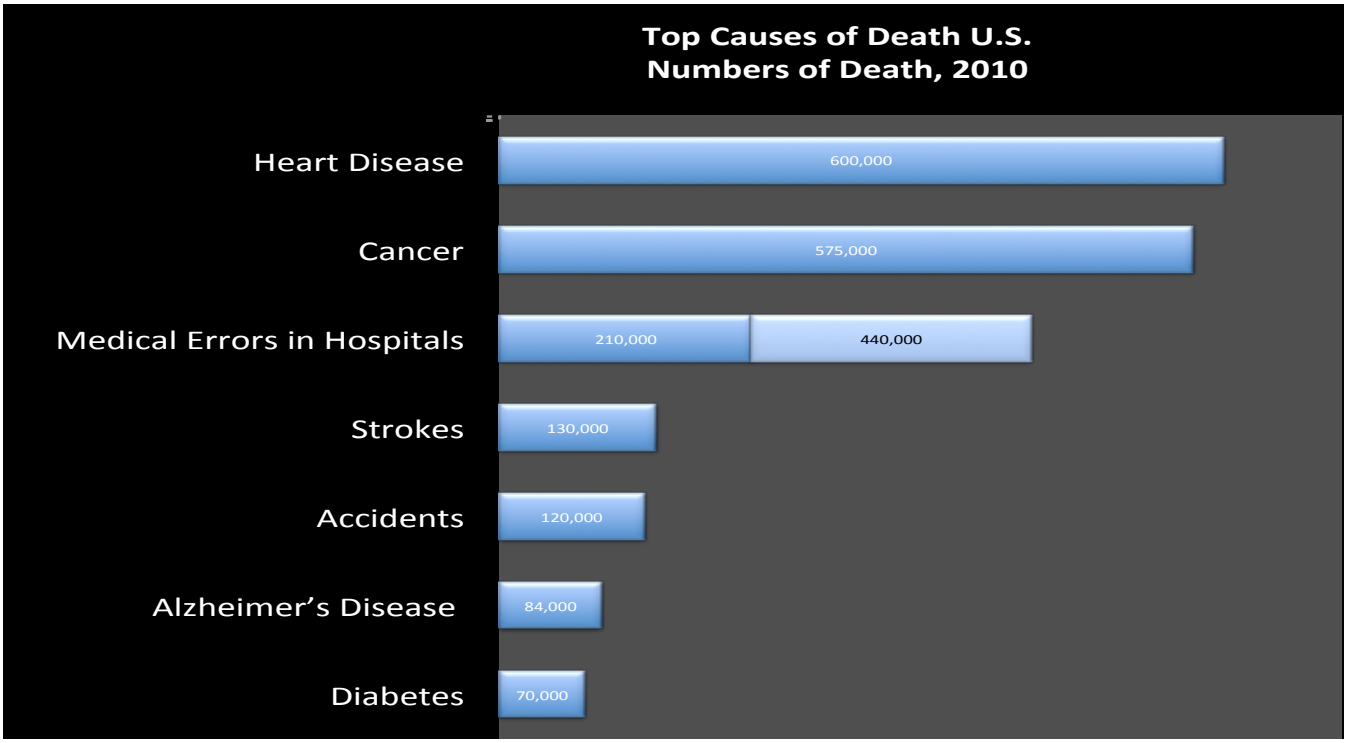
Second, despite the high costs of health care in the U.S., **health outcomes are poor**. The U.S. ranks 56 for infant mortality (the death of an infant before his/her first birthday), considered the most sensitive indicator of overall societal health. The U.S. ranks 42nd in life expectancy (CIA World Fact Book).

One of the driving forces behind this relatively low life expectancy is the high prevalence of preventable chronic diseases. 7 out of 10 deaths in the U.S. are due to one of four diseases - cancer, cardiovascular disease, diabetes, or chronic lung disease. The majority of cases of these diseases are preventable, with the main underlying causes of tobacco addiction, poor nutrition, physical inactivity, and obesity. Behavioral health problems are inter-related to these chronic diseases. For instance, people with a diagnosis of one of these chronic diseases are significantly more likely to be diagnosed with a mental health disorder such as depression. People with a serious and persistent mental illness have a life expectancy that is 25 years younger then the population as a whole, and their most common causes of death are these four chronic diseases. Chronic diseases also account for the major causes of disability, and contribute to low disability-adjusted life expectancy in the U.S. (which is a measure of overall disease burden, expressed as the cumulative number of years lost due to ill health, disability, or early death).

1900 Top Causes of Death
Infectious diseases such as tuberculosis, waterborne diarrhea, and vaccine-preventable diseases (polio, measles, smallpox, etc.) as well as childbirth

2014 Top Causes of Death
Chronic diseases such as cardiovascular disease (heart disease and stroke) and cancer

Additionally, many people encountering the health care system are harmed by that encounter. The Institute of Medicine published a landmark report in 1999 called “To Err Is Human” which estimated up to 98,000 deaths every year from medical errors in U.S. hospitals. Several subsequent and more comprehensive studies estimate this number to be 180,000 among Medicare hospitalized patients (2010, U.S DHHS study), and 210,000 – 440,000 among all hospitalized patients (2013, John T. James), making hospital medical errors in line with the 3rd highest cause of death in the U.S.



Subsequent reports by the Institute of Medicine (e.g. Crossing the Quality Chasm, 2001) provide a number of recommendations for the health care system to improve patient safety. One featured recommendation is for improvements in team skills among health professionals through such strategies as interprofessional education (IPE). Indeed, when root cause analyses of medical errors have been conducted, 80% are due to poor communication (60%), coordination, and/or collaboration, i.e. poor teamwork.

The third main distinguishing feature of the U.S. health care system is that so many people **lack access** to it. Although access to health care is determined by a number of factors, including physical proximity, transportation, and entry to a health facility as well as language and cultural factors, health insurance is a major ticket to enter the U.S. health care system. The U.S. is the only developed country that does not provide universal coverage, and as a result, 47 million, or about 1 in 6 Americans do not have health insurance.

The Patient Protection and Affordable Care Act, also known as ACA (as this paper calls it) or PPACA or "Obamacare", was signed into law in March of 2010, and is considered the most significant overhaul of the U.S. health system since the 1965 passage of Medicare and Medicaid.

The ACA seeks to address these overall challenges in the U.S. health system, specifically the needs to:

- Increase access to health care through an expansion of health insurance **coverage**;
- Reduce health care **costs**; and
- Improve **care**, including the quality and patient/client satisfaction of care.

The ACA addresses these challenges through both insurance and health system reforms. Below are some of these reform strategies.

- What is the difference between **Medicaid** and **Medicare**? Both are forms of public health insurance.

Medicaid covers those with low income. Funded by both federal and state governments, it is administered by state governments, which have broad authority to determine who is eligible.

Medicare covers Americans 65 and older as well as younger people with disabilities and end stage renal disease. Is administered by the federal government.

Insurance Reforms

Increased Access to Health Insurance:

- Medicaid expansion;
- Insurance exchanges (marketplaces) for people to learn about their insurance options and purchase coverage;
- Coverage of young adults < 26 on their parents' insurance;
- Guaranteed issue (no one denied coverage due to pre-existing conditions); and
- Individual mandate to purchase health insurance (with tax penalties for non-compliance).

More Benefits and Protections:

- Insurance plans must include minimum health benefits (i.e. a minimum set of services covered);
- Effective preventive services are covered;
- Some insurance rate controls (inability of insurers to charge more based on gender and health status);
- No lifetime or annual coverage limits on essential benefits; and
- Uniform summaries (consumer friendly summaries of benefits).

Lower Costs:

- Subsidies or tax credits to individuals and small businesses buying insurance on the exchanges/marketplace;
- Medical loss ratio (MLR) requirements that insurers must spent at least 80-85% of premium dollars on health care;

- Premium rate increases to be reviewed and approved; and
- Medicare reforms to lower costs to seniors.

Health System Reforms

Quality and Efficiency Reforms:

- ACOs (Accountable Care Organizations);
- Health homes (patient centered medical homes, behavioral health homes);
- Providers (hospitals and clinicians) monitored with quality measures that include patient-driven measures;
- Provider reimbursements increasingly based on quality, not on number of patients/clients seen in person; and
- Coordination of care for people who are Medicare – Medicaid dually eligible.

Stronger Workforce and Infrastructure

- Funding for community health centers and school-based health centers;
- Medicaid primary provider reimbursements increased to align more with Medicare;
- Student loans for providers serving in underserved areas; and
- Funds for public health and preventive medicine training.

Public Health and Prevention

- Funding for public health such as the Community Transformation Grants (CTG) and Prevention and Public Health Fund (PPHF);
- Public health education campaigns (tobacco, nutrition, etc.);
- Community Health Needs Assessments (required of non-profit hospitals); and
- Nutrition labeling (chain restaurants).

PCMHs and ACOs are two major strategies that are changing the way health care is delivered.

Patient-Centered Medical Homes (PCMHs)

The PCMH model holds promise as a way to improve health care by transforming how primary care is organized and delivered. Behavioral health homes are similar to PCMHs, and include the same concepts, but are geared toward serving those with serious mental illness or substance abuse who are currently served by mental health and/or behavioral health centers. Both types of health homes are supported by the ACA through Medicaid and/or Medicare payments to providers.

The PCMH encompasses five functions and attributes:

Comprehensive Care	The PCMH is designed to meet the majority of a patient's physical and mental health care needs through a team-based approach to care.
Patient-Centered Care	Delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.
Coordinated Care	The PCMH coordinates patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions.
Accessible Services	The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email.
Quality & Safety	The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management. Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.

The PCMH model is built upon three foundational supports:

Health IT	Health IT can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes. Health IT can also support communication, clinical decisionmaking, and patient self-management.
Workforce	A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.
Finance	Current fee for service payment policies are inadequate to fully achieve PCMH goals. Providers are not routinely compensated for care coordination or enhanced access, contributions of the full team are often not reimbursed, and there is no incentive to reduce duplication of services across the care continuum. Payment reform is needed to achieve the full potential.

http://pcmh.ahrq.gov/page/tools-resources

Accountable Care Organizations (ACOs)
An ACO is a network of providers and hospitals that shares responsibility for providing coordinated care to patients/clients in hopes of limiting unnecessary spending. ACOs are sort of a health care neighborhood that health homes reside in. At the core of each patient's/client's care is a primary care provider, preferably one who is part of a health home. Although the ACA initially rolls out ACOs through Medicare, ACOs are being expanded through Medicaid and even a number of private insurers.

ACOs make providers jointly accountable for the health of their patients/clients, giving them financial incentives to cooperate and save money by avoiding unnecessary tests and procedures. For ACOs to work, they have to seamlessly share information. Those that save money while also meeting quality targets keep a portion of the savings. ACOs can choose to be at risk of losing money if they want to aim for a bigger reward, or they can enter the program with no risk at all.

ACOs may sound a lot like health maintenance organizations (HMOs). There are some similarities in that both are networks of providers. However, there are some critical differences – notably, an ACO patient/client is not required to stay in the network. In addition, unlike HMOs, the ACOs must meet a long list of quality measures to ensure they are not saving money by cutting necessary care.

http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx

2-page summary of ACA: http://www.apha.org/NR/rdonlyres/26831F24-882A-4FF7-A0A9-6F49DFBF6D3F/0/ACAOverview_Aug2012.pdf

UNE Library Resources about the ACA: http://bit.ly/1dKjcf5

What Patients May See:

- Easier access to health insurance – more options, more affordable, fewer barriers to obtaining insurance
    - Because of Medicaid expansions, insurance exchanges (marketplaces), requirements that young adults <26 be covered by parents' insurance, no one denied coverage due to pre-existing conditions, Medical Loss Ratios (MLRs) requiring insurers to spend at least 80-85% on health care
- Easier access to preventive services (vaccines, cholesterol testing, cancer screenings, etc)
    - Because of requirements that such services be covered and because of payment reform that emphasizes paying for quality, not quantity
- Care is more coordinated
    - Because of payment reform focusing on quality rather than quantity and because of health homes and ACOs (which together, form medical neighborhoods)
- There are sufficient primary care providers
    - Because of loans for providers in underserved areas, funds for education of primary providers, funding for community health centers and school-based health centers
- Will have easier access to one-stop shopping
    - Because of funding for community health centers with primary care, behavioral health, and oral health, funding for behavioral health homes (behavior health centers to add primary care), and payment reform (for quality outcomes that include behavioral health and primary care)
- More children and youth will be able to get health care while at school
    - Because of funding for school-based health centers and because of payment reform, including ACOs, that promote paying for care that is effective and efficient, and not longer confined to traditional models
- More awareness of and access to prevention - tobacco cessation, nutrition
    - Because of insurance regulations that require preventive services to be covered and because of funding for public health initiatives

What Clinicians May See:

- Fewer patients uninsured, so no longer need to struggle making decisions between what the patient needs versus what they can afford
    - Because of Medicaid expansions, insurance exchanges (marketplaces), requirements that young adults <26 be covered by parents' insurance, no one denied coverage due to pre-existing conditions, Medical Loss Ratios (MLRs) requiring insurers to spend at least 80-85% on health care
- Clinicians will more likely work in a team-based setting with primary care, oral health, and behavioral health
    - Because of payment reform, including ACOs and federal funds to support community health centers to include comprehensive care, funds for patient-centered medical homes and behavioral health homes

- More job opportunities in underserved areas, school-based health centers, community health centers, ACOs
    - Because of funding for all of these
- Providers will receive routine feedback on quality measures (readmissions, immunization rates, etc), and increasingly will be getting paid based on these quality measures. These quality measures will also include patient satisfaction!
    - Because of requirements for quality measures to be reported by providers, including meaningful use measures and patient satisfaction measures
- More public health presence in the community
    - Because of funding for public health, required community health needs assessments by non-profit hospitals, nutrition labeling
- They will know the health status of their patient panel as a population as well as that of the community, which means, for instance, they will know what the immunization rate is of their patient panel as well as that of the community. And they will have some responsibility to address the appropriate health status measures of their patient panel, and their employer (esp if a non-profit) will likely have some responsibilities for contributing to the health of the community.
    - Because of community health needs assessment requirements, provider reporting of meaningful use data and patient satisfaction data, and because of payment reform that pays for quality

What the System May See:

- There will actually be a system!
- There will be more of a health system, and not the illness system we have now. There will be more emphasis on prevention and keeping people well, rather than just figuring out how to take care of people's illnesses.
- Health system will be throughout a community, not just confined to brick buildings – it will be in schools, in pharmacies, in community centers
- Rather than focused on satisfying payers, it will be focused on satisfying patients
- Rather than being built to satisfy providers, it will be built to satisfy patients
- Prevention will be a major focus
- Patient safety will be a major focus
- More efficiencies and better effectiveness, and hopefully paying less attention to how not to cover someone's illness

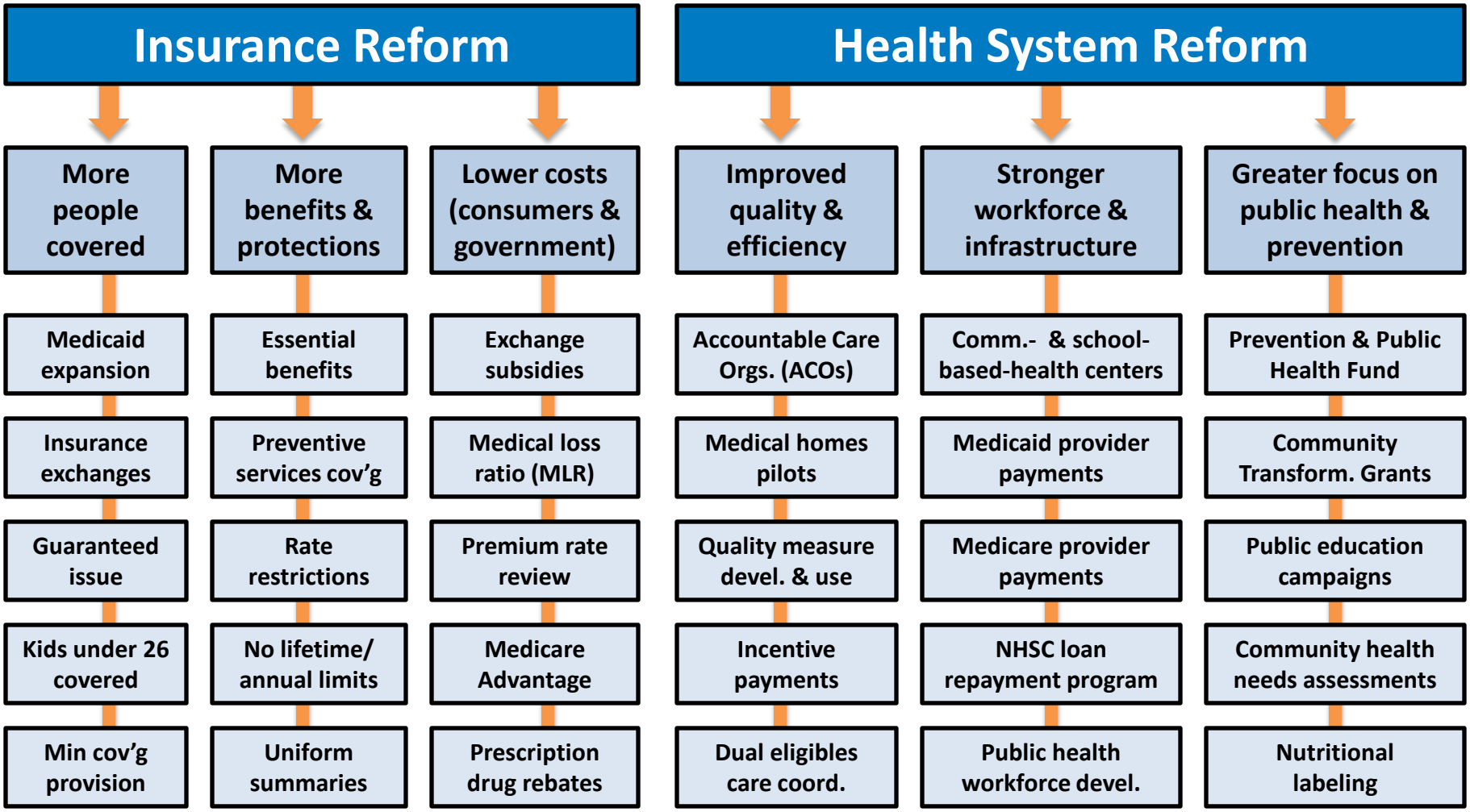
Affordable Care Act Overview

Selected Provisions

August 2012

American Public Health Association

This chart provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. See next page for brief explanations of these provisions. Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit http://www.apha.org/advocacy/Health+Reform/ for more ACA resources.



Adapted from Dr. Donald Berwick's presentation "The Triple Aim: Health, Care, and Cost: Public Health and the Health Care Transition," given June 2012 at APHA's mid-year meeting. Find this document at http://www.apha.org/advocacy/Health+Reform/ACAbasics/.

Affordable Care Act Overview

Summaries of Selected Provisions

August 2012

American Public Health Association

The chart on the previous page provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. This table provides a brief explanation of the provisions in the chart, and the year each is effective (in parentheses). Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit http://www.apha.org/advocacy/Health+Reform/ for more ACA resources.

Insurance: More people covered	**Insurance:** More benefits & protections	**Insurance:** Lower costs for consumers, gov't	**System:** Improved quality & efficiency	**System:** Stronger workforce, infrastructure	**System:** greater focus on public health, prevention
Medicaid expansion: Nearly all Americans under 65 with incomes under 133% of the federal poverty line will now be eligible, in states that choose to expand. *(2014)*	**Essential health benefits:** In order for a plan to qualify to be sold through the exchanges, it will have to offer a minimum set of benefits. *(2014)*	**Exchange subsidies:** Many individuals and small businesses buying exchange plans will receive subsidies or tax credits to help them afford coverage. *(2014)*	**Accountable Care Orgs. (ACOs):** Medicare incentives to providers to work together to coordinate care, improve quality of care, and reduce costs. *(pilot 2012)*	**Community- & school-based-health center funding:** New funding for community health centers (CHCs) and school-based health centers (SBHCs). *(2010)*	**Prevention & Public Health Fund (PPHF):** New funding for state and local prevention efforts, bolstering public health capacity, & prevention research and tracking. *(2010)*
Insurance exchanges: New virtual marketplaces will help consumers and small businesses comparison-shop for insurance. Also see "exchange subsidies." *(2014)*	**Preventive service coverage:** Insurers must cover certain preventive services at no cost to enrollees. *(2010 most services; 2012 additional women's services)*	**Medical loss ratio (MLR):** Insurers must spend at least 80-85% of premium dollars on health care (instead of profits, marketing costs, etc), or refund enrollees. *(2011)*	**Medical homes:** New options under Medicaid to test and implement medical home models of coordinating care and integrating community-based services (*2010, 2011*)	**Medicaid provider payments:** Medicaid primary care provider payments are increased so they are equal to Medicare provider payments. *(2013 -2014)*	**Community Transformation Grants (CTG):** PPHF funding (see above) focused on community-level efforts to address preventable chronic conditions. *(2010)*
Guaranteed issue: Insurers can no longer deny coverage due to pre-existing conditions. Until it's effective for adults in 2014, there is a temporary Pre-Existing Condition Plan for adults. *(kids 2010; adults 2014)*	**Rate restrictions:** Insurers can't charge higher premiums based on gender or health status; other limitations also apply. *(2014)*	**Premium rate review:** Insurers must justify proposed premium increases of 10% or more; states or the federal government will review and publish the info for the public. *(2011)*	**Quality measure devel. & use:** New quality measures for M'care/M'caid providers, incl. patient-centeredness, health disparities, meaningful use of electronic records, and more. *(2011)*	**Medicare provider payments:** 10% bonus payments for Medicare primary care services, and for general surgeons serving communities in need. *(2011-2015)*	**Public education campaigns:** New funding for large-scale outreach activities focused on nutrition and exercise, tobacco cessation, oral health, and more. *(2010)*
Kids under 26 covered: Young adults can stay on their parents' plans until age 26. *(2010)*	**No lifetime/annual limits:** Insurers are banned or restricted from imposing lifetime or annual coverage limits on essential benefits. *(2010; 2014)*	**Medicare Advantage reform:** Excessive payments to insurers via this program will be curbed, to lower government and consumer costs. *(2011)*	**Incentive payments:** M'care payments will be based on quality measures, not number of patients served. Payments reduced for hosp.-acquired infections or excessive readmissions. *(2012, 2014)*	**Loan repayments:** The National Health Service Corps program (loan repayments while serving communities in need) is permanently authorized, and funding is increased. *(2010)*	**Community health needs assessments (CHNAs):** Tax-exempt hospitals must assess and address community needs, and include public health stakeholders in the process. *(2012)*
Minimum coverage provision ("individual mandate")**:** Most Americans will have to obtain coverage or pay a small penalty, in order to keep the system balanced. *(2014)*	**Uniform summaries:** Insurers must provide standardized summaries of benefits and coverage so consumers can easily understand and compare plans. *(2012)*	**Prescription drug rebates:** Medicare enrollees who reach the drug coverage "donut hole" get rebates while the hole is slowly closed. *(2011)*	**Dual eligibles care:** New efforts to coordinate care for Medicare/Medicaid dual eligibles, often the sickest and most costly enrollees. *(2010)*	**Public health workforce development:** PPHF funding (see above) for graduate and post-graduate training in public health and preventive medicine. *(2010)*	**Nutritional labeling:** Chain restaurants & vending machines must display nutritional info. *(2011 , but implementation delayed)*

Sources: healthcare.gov; Kaiser Family Foundation. Find this document at http://www.apha.org/advocacy/Health+Reform/ACAbasics/.