Impact of the Affordable Care Act on Primary Care Delivery & PCHC
New Developments in Reform Implementation

- **Marketplace Updates – Insurance Reforms**
Health Insurance Reform

- Essential Health Benefits
- Ambulatory Services Emergency Services
- Hospitalization Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision care

- Plans offered on Maryland Health Connection will include:
  - Medical Only Plans
  - Medical Plans with Embedded Dental
  - Stand-Alone Dental Plans

- Carriers are required to obtain approval from the MIA on plans before they can be certified by Maryland Health Benefits Exch.

- Carrier applications indicate that they intend to offer PPO, HMO, EPO, POS products.

- Additionally, carriers have noted that they intend to offer plans across all metal tiers for the Individual and SHOP marketplaces.
Authorized Carriers

Maryland has adopted a strategy for 2014-2015 that allows any willing carrier to offer qualified health plans on Maryland Health Connection as long as they meet federal and state requirements. This approach will foster competition in the marketplace and help to build stability for Maryland Health Connection.

**Medical**
- Aetna
- CareFirst
- Coventry
- Evergreen (CO-OP)
- Kaiser
- United HealthCare

**Stand-Alone Dental**
- Aetna Dental
- BEST Life
- CareFirst
- Coventry
- Delta Dental
- DentaQuest
- Dominion Dental
- Guardian
- Metropolitan Life
- United Concordia

*List reflects names of carriers by parent company name.*
Uninsured and Currently Insured – Projections for Tax Credit Eligibility on the HBE

The Hilltop Institute has projected that 3 out of 4 Marylanders newly purchasing coverage through Maryland Health Connection (101,312 of 138,764 people) will be eligible for tax credits that will allow them to pay less than the approved rate for coverage.

In 2012, according to the Maryland Insurance Administration, there were 146,078 Marylanders in the individual market. DHHS has estimated that approximately 40% of participants in the individual market nationally using 2011 data, had incomes that could make them eligible for tax credits.

If this is true, another 58,431 Marylanders who are currently insured might qualify for tax credits. This means it is possible that as many as 4 out of 5 purchasers of coverage through the Maryland Health Connection could be eligible for tax credits, representing about half of the total number of Marylanders in the state’s individual market (both inside and outside of the Maryland Health Connection).
# Insurance Reform – HBE- Subsidies for Uninsured and Enrollee’s Estimated share of premium

<table>
<thead>
<tr>
<th>Single Person FPL %</th>
<th>Annual Income</th>
<th>Maximum Premium (as % of Income)</th>
<th>Enrollee Monthly Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>133% FPL</td>
<td>$ 14,856.10</td>
<td>2.00%</td>
<td>$ 24.76</td>
</tr>
<tr>
<td>150% FPL</td>
<td>$ 16,755.00</td>
<td>4.00%</td>
<td>$ 55.85</td>
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<tr>
<td>200% FPL</td>
<td>$ 22,340.00</td>
<td>6.30%</td>
<td>$ 117.29</td>
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<tr>
<td>250% FPL</td>
<td>$ 27,925.00</td>
<td>8.05%</td>
<td>$ 187.33</td>
</tr>
<tr>
<td>300% FPL</td>
<td>$ 33,510.00</td>
<td>9.50%</td>
<td>$ 265.29</td>
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<tr>
<td>350% FPL</td>
<td>$ 39,095.00</td>
<td>9.50%</td>
<td>$ 309.50</td>
</tr>
<tr>
<td>400% FPL</td>
<td>$ 44,680.00</td>
<td>9.50%</td>
<td>$ 353.72</td>
</tr>
</tbody>
</table>
Projected New Enrollment

- New Medicaid
- Individuals/Families on Maryland Health Connection

Yearly Enrollment:
- 2014: 248,918
- 2015: 305,238
- 2016: 336,258
- 2017: 375,291
- 2018: 409,715
- 2019: 439,825
- 2020: 471,019
Navigator Entities Selected

- **HealthCare Access Maryland (Central Region)**, serving Baltimore City and Baltimore and Anne Arundel counties

- **Seedco, Inc. (Upper Eastern Shore Region)**, serving Harford, Cecil, Kent, Queen Anne’s, Caroline, Talbot and Dorchester counties

- **Worcester County Health Department (Lower Eastern Shore Region)**, serving Worcester, Wicomico and Somerset counties

- **Montgomery County Department of Health (Capital Region)**, serving Montgomery and Prince George’s counties

- **Calvert Health Solutions (Southern Region)**, serving Calvert, Charles and St. Mary’s Counties

- **Healthy Howard (Western Region)**, serving Howard, Carroll, Frederick, Washington, Allegany and Garrett counties.
Insurance Reform

Greater Accessibility to Insurance

- Applicants will be able to apply online, by phone, mail, or in-person at existing and new locations such as community health centers.
- Data from the IRS, Social Security Administration, and other state and federal data sources will be available; no paper verification will be necessary when the information is already available.
- The State of Maryland had its data systems tested by the federal government for connectivity to all these federal data sources for income verification, etc. and all systems passed as of July, 2013.
ACA – Recent delays

- Due to the suspension of "out of pocket" limits for those purchasing on the Exchange, and
- Due to the delay of employer mandates for one year,
- It is anticipated that a substantial number of low income people will opt to pay the annual penalty instead of a monthly premium.
- Those who choose a "low-metal" plan will have pharmacy co-pays and deductibles, thus impacting clinical outcomes, treatment adherence & improved health.
- Crowd out has started at major corporations such as IBM and UPS, local small businesses, too..
New Developments in Reform Implementation

- Health Care Delivery System Reforms
CMS Innovations Grant Award

Community-Integrated Medical Home
• Integration of a multi-payer medical home model with community health resources

• 4 pillars:
  1) Primary care
  2) Community health
  3) Strategic use of new data
  4) Workforce development

• Goal is for CIMH to be an umbrella program with certain programmatic standards that allows for innovations across payers

• Six month planning grant just ended August 31, 2013. Implementation grant will cover the next 4 years.
Health Care Delivery Reform

- Payer and Provider Engagement Process
  - Payer & Provider aligned in outcomes goals

- Develop a governance structure for CIMH program

- Establish a *public utility* to administer payment and quality analytics processes

- Set programmatic standards, such as
  - Criteria for *practice inclusion*
  - Quality metrics
  - Analytics
  - Shared savings methodology
Health Care Delivery Reform

- Local Health Improvement Coalition (LHIC) Engagement Process

  - Complement medical care by linking high-need patients with wrap-around community-based health services

  - Capacity of LHICs will be strengthened
    - Develop new models to carry out population health activities (e.g., 501(c)3, integration with LHD, etc.)

- Community Health Worker role
  - Define responsibilities and required skills/education for CHWs
  - Develop pathways through which they will be connected to practices

- Use new data and mapping resources to "hot-spot" high utilizers and bring them into CIMH
Local Health Improvement Coalitions – Intersection of Public Health and Private Industry in defined geographic areas

The Governor adopted, with strong legislative support, provision for State support to Local Health Improvement Coalitions in the FY 2012 budget. The Maryland Hospital Association provided start-up funds in order to help form local health improvement coalitions and begin planning efforts across Maryland's 24 local public health jurisdictions. County Health Officers and Health Department Commissioners led the Coalition formation, start-up and maintenance of effort.

The State has identified 39 critical health measures, which is a small subset of the CDC’s Healthy People 2020 objectives.

The first measure, "Increase life expectancy" encompasses all of the State Health Improvement Plan’s six vision areas:

(1) Healthy Babies;
(2) Healthy Social Environments;
(3) Safe Physical Environments;
(4) Infectious Disease;
(5) Chronic Disease; and
(6) Health Care Access.
Health Delivery Reform

New Data Resources

- CRISP developing mapping tools for “hot spotting”
  - Real-time hospital admissions data
  - CHWs and care managers could use to reach out to high utilizers in the community
  - LHICs and local health departments can use to monitor population health and develop targeted interventions
  - Monitor progress on community-based interventions
- DHMH will expand Virtual Data Unit
  - Warehouse of social and economic determinants, population health, outcomes, and other data
  - Will help LHICs with CIMH work as well as SHIP measures
- Maryland Health Care Commission to assess and plan expansion of All-Payer Claims Database
  - Envision APCD as supporting provider measurement on cost and quality and clinical decision-making.
Health Care Delivery Reform

CRISP can produce visualizations of hospital utilization data in near real time. Community Integrated Medical Home can leverage geographic data to better understand localized use of services and opportunities for the most efficient / targeted interventions.
CRISP Background and Status
CRISP is Maryland’s State Designated Entity for Health Information Exchange

<table>
<thead>
<tr>
<th>Progress Metric</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Hospitals</td>
<td>47 (includes All Acute Hospitals)</td>
</tr>
<tr>
<td>Live Labs and Radiology Centers (Non-Hospitals)</td>
<td>7</td>
</tr>
<tr>
<td>Live Hospital Clinical Data Feeds</td>
<td>100 (lab, radiology, clinical document feeds)</td>
</tr>
<tr>
<td>Identities in MPI</td>
<td>~5M</td>
</tr>
<tr>
<td>Patient Searches (past 30 days)</td>
<td>~12,000</td>
</tr>
<tr>
<td>Encounter Alerts Sent</td>
<td>~15,000/month</td>
</tr>
<tr>
<td>Lab Results Available</td>
<td>~23M</td>
</tr>
<tr>
<td>Radiology Report Available</td>
<td>~6M</td>
</tr>
<tr>
<td>Clinical Documents Available</td>
<td>~3M</td>
</tr>
</tbody>
</table>
All Payer Claims Database
EXPANSION PLAN SUMMARY

Creation of a Master Patient Index (MPI)

Private carriers and Medicaid will submit demographic information on enrollees (fully-insured and self-insured) to CRISP, the HIE, which will assign each enrollee an MPI.

To enable matching of self-insured employer plan enrollees’ pharmacy and behavioral health claims with the enrollees’ claims for professional and institutional care.

To enable claims for any enrollee who changes private plans during the year to be combined.

Add the four-digit zip code extension to information submitted by carriers for summarization at sub-zip code level & targeted interventions when needed.
Health Care Delivery Reform

All Payer Claims Database EXPANSION PLAN SUMMARY

• Define and create annual summary utilization records for
  • Enrollees in private insurance (including self-insured) by insurance characteristics
  • Enrollees in Medicaid MCOs

• Define and create summary annual utilization data for sub-zip code areas by summing the per enrollee records (across all payers)

• Will enable identification of neighborhoods with high utilization levels but protect the privacy of individuals

• Will permit sharing of data among State agencies.
PURPOSE OF MEASUREMENT PROJECT

Produce consistent information available to providers, payers, and patients on practitioner performance in:
- Quality, Cost (resource use), Efficiency
- To promote transparency in practitioner performance measurement
- Better informed practitioner selection
- To promote performance improvement in the provision of health care services
HEALTH CARE PRACTITIONER PERFORMANCE MEASUREMENT PROJECT – Delivery Reform

- OPERATIONAL OUTLINE
  - Combine claims data from public & private insurers
  - Accelerate & fully standardize private carriers submissions
  - Obtain & fully standardize Medicaid MCO claims
  - Integrate Medicare claims
  - Quality: National Quality Forum-endorsed measures
  - Alternative Measures: cost/resource use; efficiency
  - Risk adjustment for patient mix
  - Specialty-specific measure sets
  - Start with a limited set of performance measures which expand over time
  - Make reports available to the other providers and payers
  - Make reports available to the public – abbreviated system
  - Use outcome as criterion for practice inclusion
Subtitle 09 MEDICAL CARE PROGRAMS
10.09.36 General Medical Assistance Provider Participation Criteria
Authority: Health-General Article, §§2-104(b), 15-103, and 15-105, Annotated Code of Maryland
Notice of Proposed Action 13-224-P
The Secretary of Health and Mental Hygiene proposes to amend Regulation .03 under COMAR 10.09.36
General Medical Assistance Provider Participation Criteria.
Statement of Purpose The purpose of this action is to allow the Medical Assistance Program to conduct on-site visits of any and all provider locations.
Comparison to Federal Standards
There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.
Estimate of Economic Impact The proposed action has no economic impact.
Economic Impact on Small Businesses The proposed action has minimal or no economic impact on small businesses.
Impact on Individuals with Disabilities The proposed action has no impact on individuals with disabilities.
Opportunity for Public Comment Comment period has ended. A public hearing has not been scheduled.
.03 Conditions for Participation.
A. To participate in the Program, the provider shall comply with the following criteria:

Allow the Department or its agents to conduct an unannounced on-site visit of any and all provider locations to verify compliance with State and federal statutes and regulations
[(17)] [(18) (text unchanged)]
B. — E. (text unchanged)
Safety Net System - Overview
Federally Qualified Health Centers (FQHCs)

A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 3, 2016.

Note: Alaska and Hawaii not shown to scale
Maryland’s Safety Net

- Facility types: Federally Qualified Health Centers and look alikes, Local Health Departments, Hospital Based Clinics, Behavioral Health providers, Ryan White grantees, Charitable/Free Clinics, Mobile Clinics, Homeless Services, STD Clinics, Family Planning providers

- Safety net facilities served 671,745 approximately patients during calendar 2012 in Maryland.

- Of the patients served, 65% (436,634 patients) had Medicaid or were without health insurance.

- Based on the analysis of patient/provider ratios for PCP, Mental Health, and Dental services, safety net providers are a critical resource to meet demand and provide care continuity for those newly insured through Health Care Reform (and those who toggle between both systems due to changes in eligibility).
Maryland Health Access Assessment Tool
Survey Results – Safety Net Facilities

Total Safety Net Facilities by County

Source: Maryland Health Access Assessment Tool,
Primary Care - Pre and Post

- People's Community Health Center – *Brief History*

- Current Responses to Primary Health Care Delivery and Payment Reforms.
Since 1970, People's Community Health Center has provided quality, comprehensive clinical services to all who seek it, regardless of patients' income, ability to pay, or insurance status.
Greenmount Ave Now
The Services We Provide

- Primary Care- Adults Internal Medicine
- Women’s Health (OB/GYN)
- Pediatrics
- Infectious disease Medicine (HIV/AIDS)
- Oral Health and Dentistry
- Mental Health/Case Management
- Substance Abuse Treatment & Counseling
- Discount Pharmacy services

- We work hard to keep our patients out of hospital emergency departments.
- We revitalize our neighborhoods and contribute to the local economy
We have expanded to 7 Primary Care Locations

**Baltimore City**
Greenmount Avenue
Washington Boulevard
Maryland Avenue
York Road

**Anne Arundel County**
Ritchie Highway
Odenton Road
Reece Road (Ground-up Construction Project-Replacing Pioneer City site)
The Joint Commission, the gold standard for the healthcare industry, has again issued People's its full accreditation for Ambulatory Care and Behavioral Health.
PCHC Patient Mix

Self Pays and Non-Billable Services Account for 51% of Patient Visits.

# of Visits by Payer Category

- Medicaid, 34%
- Private Insurance, 10%
- Medicare, 5%
- Other - Non-Billable, 12%
- Self-Pay, 39%
PCHC’s Patient Base

Patient Demographics:
- 70% Age 18-64  20% over age 65
- 65% Female  35% Male
- 50% African American  40% Caucasian  10% Latino

Predominant Health Conditions:
- Diabetes / hypertension ~45% of adult patients;
- Asthma ~25% of adult and pediatric population
- Co-occurring substance misuse/mental health diagnosis ~68% of adult patients
- Cardiovascular disease ~ 30% of adult population
- HIV/AIDS ~ 5% of patient population
Primary Care in the midst of reform

- Impact of the Maryland Implementation of Health Reform
- Primary Care Delivery
Toto, I don’t think we are in Kansas anymore!!!
HRSA helped prepare us for Reform:

- PCHC was supported with federal funds to fully implement Electronic Patient Record in 2011. A chronic disease management/patient registry software has been added so that panel management is possible at a provider level, site level, or corporate-wide level.

- PCHC was supported with funds to develop infrastructure and apply for Patient Centered Medical Home in 2013.

- PCHC was supported with federal funds in 2013 to hire Certified Application Counselors that the State must train and certify.
Primary Care - Transitions

Staff Impact

- Rigorous standards and a high level of transparency cause us as primary care providers to focus on clinical outcomes. New regulatory oversight creates 3 agendas in the exam room – the patient’s, the provider’s and the regulators.

- Changing provider behavior is a major initiative being “pushed” by DHHS through CMS-Delmarva initiative, Medicare STAR targets, Medicaid HEDIS targets, NIH-participatory based research models, and HRSA-BPHC-UDS. Kaiser All-Phase Project is as much about providers prescribing patterns as it is about patients’ self-care and prevention emphasis. Changing patient behavior to focus on prevention and wellness is the ultimate goal.

- Our Trade Association – also funded by HRSA – has been provided with additional support to assist all the community health centers and their staff through this transition.
Innovative Approaches Through Partnership

GE Foundation

West Baltimore Primary Care Access Collaborative
*Working in Partnership for a Healthier Community*

Delmarva Foundation
Improving Health in the Communities We Serve

Million Hearts®

Kaiser Permanente

PHASE
*Prevent Heart Attacks and Strokes Everyday*

Worklife

The Johns Hopkins Neighborhood Fund

Sojourner-Douglass College
Staff Impact-All Phase Program

ALL / PHASE
Reduce Risk of heart attack and stroke among diabetics

Aspirin, Lisinopril and a Lipid-lowering medication

Preventing Heart Attacks and Strokes Everyday
Health Enterprise Zone
West Baltimore
Primary Care Access Collaborative
Working in Partnership for a Healthier Community

- Health Delivery Reform Participation
  21216, 21217, 21223 & 21229
- Focus on Cardio-Vascular Disease
- Patient Empowerment
- Neighborhood Health Advocates
- PCHC serves on this Board & has a delivery site serving “the zone”
Innovative Approach to Expand Provider Capacity, Improve Clinical Outcomes & Address Social Determinants

- Integrated Care Model
  Behaviorist + Primary Care Provider = Care Team
- Clinical Pharmacy Services
  Pharmacist/physician practice agreements approved by CMS
Impact – Evidence Based Practice to improve clinical outcomes

Sanctity of the Session vs. Who’s in There Now?
Behaviorist Model – Evidence Based Response to Delivery Reform

- Pace of the Visit
  - Traditional Mental Health Visit
  - Fast-paced Primary Care Visit

- Behaviorist operates on a 15-minute, high impact “Stages of Change” model of motivational interviewing and cognitive behavioral approaches. Can be interrupted during a BHC session for an urgent patient hand-off.

- Expands provider capacity.
Figure 1: Comparison of CHS utilization with regional providers

- Primary Care Visits: 117%
- ER Visits: 32%
- Specialty Care: 58%
- Hospital Care: 63%
- Cost: 78%

Utilization level for other regional providers
PCHC – Care Management Impact

- An Emergency Room diversion project is within our grasp due to State’s implementation of Health Information Exchange.

- CRISP data informs our care management. PCHC was the first FQHC that joined CRISP. We receive real-time alerts within 15 minutes of one of our patients showing up at an Emergency Room or being admitted to a hospital. We can search by our patient’s name and date of birth to see any activity within a hospital, pharmacy, and other settings.

- This has helped inform our policies on management of “frequent fliers.” Now assessing if extended hours will have the needed impact (many patients go to the ER during normal business hours). Better refill monitoring possible to assure compliance with medication regimens.
Impact-Increased Community Based Enrollment Capacity

- Access to eligibility / enrollment
- We are in line to secure certification and training from the State for the newly hired Application Counselors, and PCHC’s current eligibility workers, case management staff and Medbank staff.
- Establish reporting mechanisms with the approved Navigator entity, so that enrollments are complete & PCHC’s federal funder receives timely reports.
Primary Care to Uninsured-Impact

- "High need" population- co-occurring, multiple morbidities, uninsured-underinsured with little/no resources to follow through on treatment options, which influences achievement of clinical outcomes. The State's Provider Evaluation Initiative will result in a high level of transparency about clinical outcomes with payers, funders, & prospective new clients with no consideration of case mix adjustments.

- Because there is no claims data on the uninsured in one central repository (except the FQHCs’ individual databases), there is no context of "Risk Adjusted Categories" established for these patients who have been invisible to the system. Medicaid has used the RAC system to establish premium levels for Medicaid since the 1115 Waiver was established in 1997. There is no trending or benchmarking possible to overlay patient complexity as a variable in the provider scoring process.
Impact - financial

- Medicaid expansion will mean better reimbursement rates for our PAC patients, who were –up to December, 2013 – paid at the regular Medicaid rate.

- PCHC has been listed on the CMS website as an “Essential Community Provider.” As such, a certain percent of the Qualified Health Plans’ contracts must be with ECPs. In certain communities, PCHC is the only ECP.
Impact-ECP Status & Contracting

- Insurer Relations - Transition
- Contract with Qualified Health Plans and possibly the State Co-op
- Contract with stand-alone QHP dental plans.
- Contract with State’s Reformed Mental Health/Substance Abuse Abuse Intermediary.
Primary Care for uninsured-funding

- By 2014, the uninsured will be comprised of what may be characterized as unsympathetic groups – those who choose not to buy insurance through the Exchange who pay a penalty tax; and the undocumented.

- PCHC will be challenged to raise funds to support care to these populations who will still not be able to afford out of pocket costs for diagnostics, care, treatment, medications, etc. since many funders believe that health care reform has resolved all issues of access and quality for which they formerly provided funding.
Questions?
Thank You!