Health Reform Version 2016: Trends and Issues

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What we will cover today

✓ Recent History of Health Care Reform

✓ Overview of Changes in Affordable Care Act (ACA)-and some related regulations

✓ Timeline of Major Changes

✓ Impact to Behavioral Health

✓ Resources
The Patient Protection and Affordable Care Act (PPACA) or “The ACA” Milestones

Almost five years ago (March 2010)...

U.S. Congress passed:

- Patient Protection and Affordable Care Act (HR 3590)
- Health Care and Education Reconciliation Act of 2010 (HR 4872)
March 2010

President Obama signed into law, creating:
- Patient Protection and Affordable Care Act (Public Law 111-148)
- Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)
- Together, commonly known as The Affordable Care Act (ACA) of 2010
Key Components of the ACA

The Affordable Care Act (ACA) of 2010:

- Impacts many areas of health care
- Result of many compromises
- Does not go into effect all at once
- Relies heavily on state/local implementation
Please Remember the ACA is:

Under Construction
So here’s where we landed...

Affordable Care Act makes major changes in 4 basic areas:

1. Insurance company accountability
2. Lowering costs and improving quality
3. Increasing access and choice
4. Patient rights and consumer protections—notice that HIPAA and Deficit Reduction Act was strengthened in this timeframe too
Process Implementation

1. Leave “good enough” alone
   - No drastic changes

2. Share the Responsibility
   - Everybody in the pool

3. Market-Based Solutions
   - Shift to competition for price and quality

4. Contain Costs
   - Focusing on the populations that have the highest health care costs

5. Innovate and Test
   - Half of ACA language focuses on pilot testing first to avoid implementation mistakes
Health Reform: What’s Ahead

How Timeline Works:
- Changes take effect over many years, through 2020
- Highlights of when major reforms go into effect will be covered
- Goal is to give more detailed information about changes coming soon and summarize changes down the road
What has Improved

Who:
0 People who can’t get insurance because of pre-existing medical conditions, including mental health conditions

Why:
0 Before ACA, people with pre-existing conditions often couldn’t get any insurance
What about PCIP’s

What:
- People who can’t get insurance because of pre-existing medical conditions can apply for a **Pre-Existing Condition Insurance Plan (PCIP)** *

- Law limits premiums to “standard rates” - the average amount private insurers in the state charge for premiums for similar coverage

- Limits out-of-pocket expenses
  - $5,950/year for individual (does not include premiums)

*PHP Mid-MI was the sole state administrator for the Michigan PCIP*
A few Last thoughts about PCIP’s

When:
- PCIPs were meant to be temporary:
  - End on January 1, 2014, when insurance companies won’t be allowed to deny people coverage because of pre-existing conditions
  - On January 1, 2014, the state-run health insurance Exchanges became operational.
ACA and Money Follows the Person

Who:
- People on Medicaid who need long-term care services

Why:
- In the past, Medicaid’s Money Follows the Person grants have provided flexible funding that lets a person who needs long-term care services get services that are most appropriate to what they need and want
- MFP funding gives flexibility to move from institutional to community-based services and keep funding
MFP (Continued)

What:
- ACA extends these grants and adds $2.25 billion in funding
- Broadens eligibility standards
- Helps states pay for the costs of moving someone from institution to home

When:
- MFP grants have been extended until September 2016

How:
- The program is continuing to operate as before
MFP Funds are Still in Force

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*2,200+ older and IDD individuals helped in Michigan due to this funding.
Recission is Prohibited

Who:
O Anyone who has insurance and might get sick

Why:
O Before ACA, when someone with insurance got sick with an expensive or chronic illness, insurance companies would often go back and search their application for mistakes, looking for reason to drop their coverage

O This is called **rescission**, and happened to thousands of Americans each year

**Webster:** “The unmaking of a contract or transaction.”
Recission (Continued)

What:
- Under ACA, insurance companies aren’t allowed to drop people’s coverage because they get sick

When:
- Rescission is now illegal

How:
- Department of Health and Human Services is responsible for regulation and enforcement details
Adults under 26 years of Age and the ACA

Who:
0 Children under 19 with pre-existing conditions

Why:
0 Before ACA, insurance companies could legally deny insurance to children because they had a pre-existing condition

What:
0 Under ACA, it is illegal for insurance companies to deny or restrict insurance to children because of pre-existing condition
Adults under the Age of 26

Who:
- Adult children up to age 26

Why:
- Before ACA, children were often dropped from parents’ insurance when they turned 18 or finished college. Many young people have difficulty finding jobs with employer-sponsored coverage and can’t afford to buy individual coverage, so they often would go without insurance.

What:
- Children can stay on (or be added to) their parents’ insurance until they turn 26

When:
- Started on September 23, 2010 and is required by law to continue for at least 30 days, with annual open enrollment periods.
Who:
0 Anyone who has insurance or will ever use insurance

Why:
0 In the past, insurance companies have used lifetime coverage limits to limit amount of money they will pay out for a customer’s health care needs

0 If someone got sick and reached their lifetime coverage limit during treatment, the insurance company could just stop paying for treatment

What:
0 Insurance companies not allowed to put caps on amount they will spend (in full force January 2015) on lifetime coverage costs for essential benefits

0 Essential benefits include things like hospital stays, doctor visits, and prescription drugs
Preventative Services and Commercial Insurance

Who:
- Anyone who has private insurance

Why:
- Before ACA, many health plans charged for preventive services, so people often chose to skip them
- Preventive services can help avoid many costly health problems down the road
Commercial Insurance and ACA

What:

- Private insurance plans have to cover certain recommended preventive services, like cancer screenings

- Insurance companies are required to offer these services free to patient - without deductible, coinsurance, or copayment charges

- Law ensures many free preventive health services for children, including many vaccines

How:

- Coverage for these services is offered through existing private insurance plans
Medicaid and Chronic/Long Term Care

Who:
- People who use Medicaid’s Home and Community-Based Services (HCBS)

Why:
- In 2005, 1915(i) was added to Social Security Act
- Gave state Medicaid programs option to provide HCBS to people with disabilities before they need institutional care
- Many states did not choose to provide these services
  - Of note, Michigan is one of the bigger HCBS States
HCBS (continued)

What:
- ACA changes and adds to Section 1915(i)
  - Removes many barriers to states to offering these services
  - Allows states to amend their plans instead of having to apply for waiver
  - Improves quality of services and access to HCBS for people with disabilities

  - Expands services that state can offer as part of HCBS
  - Allows states to extend full Medicaid benefits to people using HCBS
HCBS (continued)

When:
- Changes went into effect on October 1, 2010

How:
- As long as people meet a state’s eligibility requirements, HCBS have to be offered to every eligible person in the state
- States can now provide services to people with incomes up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate ($2,022 per month in 2011)
(Old) Medicare’s Drug “Black Hole”

Why:
- Under Medicare Part D, when person’s prescription drug costs reach a certain amount ($2,840 in 2011):
  - Medicare stops paying for any prescription drug costs
  - They have to pay for 100% of their drugs out-of-pocket, until they reach the maximum out-of-pocket amount
- Once they reach this maximum ($4,550.00), they are out of the donut hole - Catastrophic Coverage begins, and Medicare starts to help cover the costs again
The “Rx” for Medicare Part D

What:
- People in donut hole get up to 50% discount on brand name drugs, 7% discount on generics for 2011, 14% for 2012, 21% in 2013, etc.
- People who qualify for Extra Help, and join a Medicare drug plan, will have no coverage gap.

When:
- Discount started January 1, 2011
  - Will grow until 2020, when donut hole is closed completely

How:
- Full cost of drugs (rather than discounted amount) still counts towards person’s out-of-pocket maximum
Prevention and Medicare

Who:
- Anyone on Medicare

Why:
- Preventive services can help avoid many costly health problems down the road

What:
- People on Medicare can get a free wellness visit and personalized prevention plan each year
- Must have had Part B for longer than 12 months
- No copayment, deductible, or coinsurance charges for recommended preventive services

How:
- Coverage for these services are offered through existing Medicare plans
ACA and persons with disabilities

Who:
- People with disabilities who are on Medicaid with income less than or equal to 150% of Federal Poverty Level, or if greater, meet an institutional level of care

Why:
- People with disabilities have the right to choose to live in and receive services in their homes and communities whenever possible
ACA and Alternatives for Institutional Care

What:
- Provides HCBS such as attendant services and supports to increase a person’s ability to live in the community
- Allows Medicaid plans to choose HCBS as a rule, rather than the exception

When:
- CFC (Community First Choice) Option was effective October 1, 2011

How:
- ACA provides a 6 percentage point increase in federal Medicaid match for states that choose the CFC Option
Key for Those of us in Behavioral Health

People eligible for this Medicaid category cannot be:

- Age 65 or older
- Pregnant
- Entitled to or enrolled in benefits under Medicare Part A
- Enrolled under Medicare Part B, or:

- Part of any of the other “mandatory” groups described in the Medicaid law
  - Such as certain parents, children, or people who are eligible because they get Supplemental Security Income (SSI) benefits
ACA and Alternatives (Continued)

- Most people get benchmark (or benchmark-equivalent) benefits

- All rules that apply under the Medicaid program in general apply to this new eligibility group:
  - Including rules related to cost sharing, retroactive coverage, and immigration status

- This expansion also gets rid of the asset test for:
  - New eligibility group
  - People eligible through Medicare or other programs
  - People with disabilities
The “CLASS” Act

What:
- The Community Living Assistance Services and Support Act (CLASS Act) would have provided for voluntary, self-funded, long-term care insurance through the workplace.
- Insurance will help pay for long-term care costs for people with disabilities and elderly people.
- People could use cash benefit to pay for their choice of variety of long-term care services, including home health care workers, assistive technology, adult day care, transportation, or assisted living.

When:
- Suspended (for now) due to fiscal issues.
ACA and “the Marketplace”

Who:
- Everyone in the private insurance market

Why:
- In the past, it has been complicated for people to compare private insurance plans
- People buying individual plans have not been able to negotiate for better prices, the way people buying group coverage can
Health Information Exchanges

What:

- States created exchanges, a marketplace where people can comparison shop for standardized health packages

- Exchanges provide a way for individuals and small businesses to buy more affordable coverage

- People will also be able to join together in groups to negotiate more affordable group insurance

- Provides subsidies for low-income people on a sliding scale
Health Exchanges (Continued)

What:
- The exchanges inspect policies to make sure they meet standards
- They can ask insurance carriers to justify their rates

When:
- Started January 1, 2014
Health exchanges: Summary of Benefits

How:
- Exchange packages include essential health benefits:
  - Outpatient care
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services
  - Prescription drugs
  - Rehabilitative services and devices
  - Laboratory services
  - Preventive services and chronic disease management
  - Pediatric services
How You Can Get Involved

- The ACA includes many new regulations
- Each new regulation goes through a period known as NPRM: Notice of Proposed Rule Making
- During this period the public can comment, giving input and expertise about the proposed regulation before the final version of the regulation is written
- HealthCare.Gov has a section where you can find more information on regulations, including those with “NPRM” periods that are open for comment: www.healthcare.gov/center/regulations/index.html
Conclusion: Health Reform is Working

- 16.5 million Americans enrolled in the Marketplace or have stayed on their parents private health plan.
- Medicare’s solvency is increased and over 11 million have enrolled in Medicaid or CHIP since October 2013. In-part due to Medicaid expansion.
- No more pre-existing conditions, no more lifetime limits, better access to wellness and prevention.
- Despite a massive, but lower $1.206 Trillion net price-tag, In 2014 health care spending grew at the slowest rate on record (since 1960).
Health Reform Impact (cont.)

- Health care price inflation is at its lowest rate in 50 years.
- Unpaid medical bills are even down by about 20%.
- Unprecedented focus on efficiency, accountability, and impact of health care services are also in place/being developed. E.g. ACOs, PCMHs, AHCs (this is a new one...), etc.
Summary of Reform: Fraud and Abuse

- HIPAA/HITECH Changes
- Deficit Reduction Act
- False Claims Act/FERA (Federal Enforcement Recovery Act)
- Anti-Kickback Statute

Role of the State and Federal Regulatory bodies: Trends in fines and penalties

They are hitting it “outta the ballpark folks...”
Increased Enforcement

- **Changes to the Public Disclosure Bar:** FCA cases cannot be barred if based on a public disclosure of information arising from certain proceedings, such as civil, criminal or administrative hearings, or news media reports. ACA amended the language of the FCA to allow the federal government to have the final word on whether a court may dismiss a case based on a public disclosure. See 31 U.S.C. 3730(e)(4)(A).

- **Original Source Requirement.** A plaintiff may overcome the public disclosure bar if they qualify as an “original source,” the definition of which has also been revised by ACA. Previously, an original source must have had “direct and independent knowledge of the information on which the allegations are based.” An original source is now someone who has “knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions.” See 31 U.S.C. 3730(e)(4)(B).
Fraud and Abuse Changes

- Increased sentencing guidelines for fraud offenses by 20-50% for crimes at more than $1,000,000 in losses.
- Obstructing a fraud investigation is now a crime; easier for the government to recapture funds acquired through fraudulent practices. Easier for DOJ to investigate potential fraud or wrongdoing at facilities like nursing homes.
- Stepped-up oversight of Medicare, Medicaid, and CHIP, e.g. mandatory licensure checks. Providers can be fingerprinted, site audited, and have criminal background checks before billing for any services.
And there’s more…

- Additional $350 million/ ten years to fight fraud through Health Care Fraud and Abuse Control Account (HCFAC) from FY 2011 through 2020.
- Expand CMS’ integrated data repository to include info from Medicaid, VA, DOD, SSDI, and Indian Health Service; enhances agreements with Federal agencies to share data, identify criminals and prevent fraud. The DOJ and Office of the Inspector General (OIG) received clearer rights to access CMS claims and payment databases. DHHS has authority to require States to report additional Medicaid data for program integrity, oversight and administration.
And More…

- DHHS can prohibit new providers to prevent or combat fraud, waste or abuse. Allows Fed to withhold payment to Medicare/Medicaid providers if a credible allegation or investigation is pending.
- Requires providers to detail how they will follow the rules. Other provisions focus on high fraud-risk providers and suppliers, e.g. Durable Medical Equipment, home health, and CMHCs.
- Requires providers to detail how they will follow the rules. Other provisions focus on high fraud-risk providers and suppliers. For example, CMHCs will now be required to serve at least 40 percent non-Medicare beneficiaries to crack down on centers that only bill Medicare and are not legitimate CMHCs.
What has Changed with Sanctions?

- Sanctions include:
  - denial of payment for the service,
  - civil monetary penalties of triple the value of each erroneous/fraudulent claim, and
  - exclusion from the Medicare and/or Medicaid programs (forever).
  - OIG and Dept of Justice are trending at least double the cost of each claim violation regardless of whether it is an “error.” Triple the claim cost if determined to be fraud.
Trends in HIPAA and HITECH

- HIPAA governs handling and disclosure of “Protected Health Information” (PHI)
- **HITECH** (Health Information Technology for Economic and Clinical Health) Act Changes—2009: Increases breach notification requirements. HIPAA now also includes Business Associates (45 CFR Parts 160 and 164).
  - Office for Civil Rights (OCR) requires health care providers and HIPAA covered entities to notify affected individuals of a breach within 3 days, and DHHS, and the media where breach affects more than 500 individuals. **
  - Breaches affecting fewer than 500 individuals will be reported to DHHS annually.
  - Business associates of covered entities are required to notify the covered entity of breaches at or by the business associate.
HIPAA: Notice of Consumer Rights

- Access, Inspect and Obtain a copy of their medical records
- Request an Amendment of their medical records
- Request Privacy Protections on how entity will use and disclose PHI about them for the purposes of treatment, payment or health care operations
- Request to receive confidential communications
- Request restrictions on confidential communications
- Request a Tracking Record of when a facility discloses a patient’s PHI
So Everybody has...

- Developed/distributed compliance p/p, including a Code of Conduct.
- Designated a CCO and compliance committee.
- Developed appropriate education and training.
- Developed protocols for raising compliance issues and seeking guidance. (e.g. Whistleblower Act)
- Enforcement capacity of disciplinary standards.
- Implemented effective auditing and monitoring mechanisms.
- Developed effective responses to potential problems

Increased Enforcement (cont.)

- **Overpayments.** FERA redefined “obligation” under the FCA to include “retention of any overpayments.” However, FERA / ACA clarified over-payments under Medicare/Medicaid must be reported and returned within 60 days of discovery. Failure to report and return an overpayment exposes a provider to liability under the FCA.

- **Statutory Anti-Kickback Liability:** 42 U.S.C. 1320a-7b(b) Criminal statute which makes it improper for anyone to solicit, receive, offer or pay remuneration in exchange for referring patients to receive certain services that are paid for by the government. ACA changed the language “claims submitted in violation of the AKS automatically constitute false claims under FCA. Further “a person need not have actual knowledge ... or specific intent to commit a violation” of the AKS. Providers will not be able to argue that they did not know they were violating the FCA because they were not aware the AKS existed.
Questions??

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References


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