



Week of January 2, 2012

Health Care Policy Weekly Update

The 2012 Health Care Reform Implementation – What to Expect? Major components of the health care law could easily remain standing even if the U.S. Supreme Court rules later this year that the individual mandate is unconstitutional. (The Court is hearing the health care coverage mandate constitutionality case this March.) Still, regardless, many of the health care reform provisions that could survive still have to be implemented. So, 2012 looks like it could be a busy year for health care law implementation, including the ongoing monumental task of creating state-based health insurance exchanges.

The following are implementation components to watch in 2012:

- States have the heaviest lifting to do this year. Each must do enough continue to lay the groundwork to create insurance exchanges to have a functioning new marketplace for insurance plans by 2014, when the overhaul ([PL 111-148](#), [PL 111-152](#)) requires every American to have health insurance. Even if the Supreme Court nullifies the mandate requirement, the law's provisions requiring exchanges and the availability of subsidies to some Americans to buy coverage could survive. To prepare for the exchanges, state legislatures must pass laws to create the new marketplaces and specify how they will operate.

States also must prepare information systems to handle plan selection, payment and enrollment, among other functions. And, they will have to design exchanges in a way that permits efficient enrollment in the Medicaid program if that's the coverage for which an applicant qualifies. Further, each state also will need to begin making decisions on what they will determine as the "essential benefits" that insurers must provide if they are selling coverage in the exchange.

Many states have left most of the work until this year. In many cases, they haven't passed the needed supporting legislation. Only nine states have passed laws creating exchanges since the passage of the health care law, according to the National Conference of State Legislatures - [NCSL database](#) - <http://www.ncsl.org/?TabId=22123>

If CMS does not certify by January 1, 2013, that a state's exchange will be ready for business by Jan. 1, 2014, the federal government will run the exchange for that state. CMS officials have taken some of the load off states' shoulders by saying they will help with certain exchange-related functions while letting the state run its own exchange. And the agency will give states that eventually want to open their own exchange the right to do so even if the federal government has to fully operate the marketplaces for a while.

- The federal government also has work to do. CMS has proposed hundreds of pages of rules governing the creation of exchanges, but the agency has yet to issue the final regulations.
- The final regulation for ACOs is in place. CMS is expected to begin accepting and reviewing applications for prospective ACOs in the coming weeks, and to begin signing contracts with them later this year.

- CMS also has taken steps to launch a “Value-Based Purchasing” program designed to improve the quality and efficiency of care. The health care law requires payments to hospitals starting October 2012 to be lower or higher based on how well they perform on certain measures of quality. But the program in some respects has been initially scaled back since some of the individual measures were delayed because they were not made publicly available on Hospital Compare for a full year prior to implementation as required by the health care law. Hospital Compare is the CMS website that rates hospitals on their quality. So, for example, payments won’t be lowered by October 1, 2012 for poor performance on several measures of hospital-acquired infections. In addition, CMS won’t implement on October 1st a provision varying payment based on how efficiently a facility treats Medicare beneficiaries. The law also directs the agency to develop other value-based purchasing programs this year for skilled nursing facilities, home health agencies and ambulatory surgical centers.
- This year also marks the start of a schedule of lower payments to Medicare Advantage plans that phase in through 2017. But in 2012, Medicare Advantage plans, the private, managed care plans in Medicare, also can get paid more if they perform well based on a system of quality rankings.
- Consumer protections won’t dramatically be expanded in 2012 compared with the coverage requirement issued in 2010 for young adults up to age 26 or the major Medicaid expansion that starts in 2014 covering individuals with incomes up to 133 percent of the federal poverty level.
- Medicare patients will get a little more help this year with their prescription drug costs. The program launched in 2011 requiring 50 percent discounts on brand-name drugs for patients in the “doughnut hole” continues in 2012. This year the federal government picks up a higher share of generic drug costs for seniors in the doughnut hole. In 2011, Medicare drug coverage plans picked up 7 percent of the cost of generic drugs in the doughnut hole; in 2012, they will cover 14 percent of those costs, rising to 75 percent of generic drug costs in the doughnut hole in 2020.
- This year, CMS is starting an “Independence at Home” pilot program in which teams of doctors and nurses can sign up to treat frail patients in the patients’ homes, sharing in savings from keeping them out of hospitals and nursing homes.
- CMS also is required to start testing new forms of payment in Medicaid, such as “bundled payments for episodes of care.” The term refers to providing a single payment for a variety of services delivered to treat a particular medical condition, rather than paying separately for each service that is provided. The aim is to encourage more efficient treatment.
- Finally, the health care law this year will require doctors and hospitals to report more data on race, ethnicity, sex, primary language and disability status as a way to lessen racial and other disparities in treatment. (Source: CQ HealthBeat, January 3, 2012)

New Program Enlists Medical Professionals to Change Health Systems: The Center for Medicare and Medicaid Innovation announced Tuesday that officials will pay 73 doctors, health care executives, academics and other health care professionals \$20,000 each this year to spend up to 10 hours per week trying to change health systems in ways that the center’s leaders believe will improve care.

The Innovation Center’s advisers network is a new program that is funded by the 2010 health care law. The 73 individuals announced Tuesday are funded through an initial round of grants. In its first year, the Innovation Advisors Program is expected to pay up to 200 professionals to participate in the program.

Another round of applications will be accepted in the spring, with more advisers to be chosen by June. The 73 advisers in the initial announcement were selected out of 920 applicants and came from large and small hospitals and other health care centers from 27 states and the District of Columbia. Anyone

who applied for the first round does not have to reapply because their applications will automatically be considered for the second set of grants.

The new fellows will spend much of the first six months of the program in seminars. The rest of the time is supposed to be spent testing new ways of delivering care in their institutions or implementing changes that they proposed as part of their applications. The group will meet regularly to discuss trends, successes and challenges.

Applicants had to be associated with a public health or health care facility, institution or department. The candidates came from a range of professions, including physicians, nurses, allied health professionals, instructors, and health care executives. More information about the Innovation Advisors Program, including a fact sheet and list of participants and their home organization, can be found at:

<http://innovations.cms.gov/initiatives/innovation-advisors/index.html>

(Source: CQ HealthBeat, January 3, 2012)