CoP/Training Call:

Affordable Care Act: Opportunities to Reduce Medicare Disparities

Presenters:
Regina Davis Moss, PhD, MPH, MCHES
Associate Executive Director, Public Health Policy and Practice, American Public Health Association (APHA)

Rick Potter, CPA, MBA, CHCA
CEO, Health Services Advisory Group-California

Margie Banse
Health Information Supervisor, Healthcare Excel-Kentucky

December 10, 2013
2:00 PM Eastern Time
Housekeeping

Call Norms:

• All lines will be muted during the call.

• We will begin Q & A after the training portion of today’s call.

• Please submit questions via the WebEx chat box or press 14 and the monitor will call on you.

• We are recording this call, and will post slides, recording, and transcript on www.healthcarecommunities.org and www.cmspulse.org

• Evaluation: Please fill out our evaluation at the end of today’s call.
# Agenda

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<td>Regina Davis Moss, Ph.D., MPH, MCHES</td>
<td>Affordable Care Act -Overview</td>
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<td>Rick Potter, CPA, MBA, CHCA</td>
<td>Health Services Advisory Group of (CA)</td>
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<td>Margie Banse</td>
<td>Health Care Excel (KY)</td>
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Webinar Goals

- Provide an overview of the Affordable Care Act, providing examples of:
  - The major provisions that address health equity and health disparity.
  - Progress in terms of funding.
  - Opportunities for health equity

- Understand the impact of ACA at the state level from the perspective of two QIOs - the “on the ground story”
  - ACA Roll-out in California
  - ACA Roll-out in Kentucky
Affordable Care Act:
Progress Towards Advancing Health Equity

Regina Davis Moss, PhD, MPH, MCHES
Associate Executive Director, Public Health Policy and Practice

Disparities National Coordinating Committee
Community of Practice
December 10, 2013
Affordable Care Act (ACA)
ACA Provisions Specific to Race, Ethnicity and Language

**Improved Data Collection and Reporting by Race, Ethnicity and Language**

- Requires that population surveys collect and report data on race, ethnicity and primary language.
- Monitors health disparities trends in federally-funded programs.
- Collects/reports disparities data in Medicaid and CHIP.

**Workforce Diversity**

- Increase diversity among primary care providers, long-term care providers, dentists, mental health providers, and the nursing professions.
- Health professions training for diversity.
- Grants for Community Health Workers, providing culturally and linguistically appropriate services (CLAS).
- Community-based training for AHECs targeting underserved pops.
- Grants to train providers on pain care, including CLAS.
- Support for health professions/home care aid training for individuals from disadvantaged backgrounds.
- Investment in HBCUs and minority-serving institutions.

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
Specific Race, Ethnicity & Language Provisions

Cultural Competence Education and Organizational Support

- Develop, evaluate, and disseminate model cultural competence training and education curricula, via a web-based clearing house.
- Cultural competence training for primary care providers and home care aides.
- Curricula for cultural competence training in working with individuals with disabilities.
- Transfers Office of Minority Health to the Office of the Secretary of HHS.
- Establishes Offices of Minority Health divisions within key federal HHS agencies—CDC, AHRQ, FDA, CMS, HRSA, SAMHSA.

Health Disparity Research

- Elevates NCMHHD to Institute status.
- Increases funding to Centers for Excellence.
- Supports research in pain treatment/management, post-partum depression, and cultural competence.
- Creates Patient Centered Outcomes Research Institute (PCORI) to examine health disparities through Comparative Effectiveness Research (CER).

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
Specific Race, Ethnicity & Language Provisions

Health Disparities Initiatives Prevention

- Standardized drug labeling on risks & benefits.
- Culturally appropriate patient-decision aids and personal responsibility education.
- Establishes the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790) as law as well authorizes new programs within the Indian Health Services (HIS).

Addressing Disparities in Health Insurance Reforms

- Enrollment outreach targeting low income populations.
- CLAS/information through health exchanges.
- Nondiscrimination in federal health programs and exchanges.
- Claims appeal process that is culturally/linguistically appropriate.
- Requires plans to provide information in “plain language.”
- Summary of coverage that is culturally/linguistically appropriate.
- Incentive payments for reducing health/healthcare disparities

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
General ACA Provisions with Implications for Racially and Ethnically Diverse Populations

**Health Insurance Reforms**

- Individual Requirement to have coverage.
- Expands Medicaid income eligibility.
- Employers with ≥50 employees required to offer coverage or pay penalty.
- Small Businesses (<25 employees) eligible for tax credit to purchase insurance (among workers in small firms, 57% Hispanics, 40% Black, 40% Native American, 36% Asian American are uninsured).
- American Health Benefit Exchanges.
- Multi-state option.
- Temporary High Risk Pools.
- Increases Federal Matching Rate for Medicaid.

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
Medicaid Eligibility by Race and Ethnicity

45% of Newly Eligible are Non-White

Percent of Population with Income below 138% FPL who will be eligible for Medicaid in 2014, by Race and Ethnicity

General Provisions with Racial & Ethnic Implications

**Improving Access Health Care**

- Expands Community Health Center (CHC) funding and operational capacity for medical, oral and behavioral health services.
- Increases funds for National Health Services Corps.
- Provides funding for School-based health centers, Nurse-managed health centers, Community Health teams, and creates a medical home option for Medicaid enrollees.
- Pilot project for emergency & trauma care.

**Quality Improvement**

- National Strategy for Quality Improvement.
- Quality improvement technical assistance.
- Develop, improve & evaluate quality measures.
- Link Medicare payments to quality outcomes.
- CMS office to improve care coordination for dual eligibles.

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
General Provisions with Racial & Ethnic Implications

Cost Containment

- Reduces Medicaid and Medicare DSH payments.
- Strengthens Medicaid drug rebate programs.
- Interoperable systems of enrollment.
- Demonstration projects for HIT.
- Enhancing public program fraud screening.

Public Health Initiatives

- Childhood obesity demonstration projects.
- Education campaign for breast cancer.
- National diabetes prevention program.
- Adolescent Personal Responsibility Education program (PREP)
- Prevention and Public Health Fund

Social Determinants of Health

- CPSTF reviews/recommends interventions that consider social, economic, and physical factors.
- Health Impact Assessments.
- Community Transformation Grants.

Source: Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity
### ACA Equity Progress

<table>
<thead>
<tr>
<th>Category</th>
<th>More Fully funded or Implemented</th>
<th>Partially Funded or Implemented</th>
<th>Not Funded or Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Marketplace</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Safety Net</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Workforce Diversity</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Data, Research, Quality</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Public Health &amp; Prevention</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27 (48%)</td>
<td>16 (29%)</td>
<td>13 (23%)</td>
</tr>
</tbody>
</table>

Source: Texas Health Institute, 2013
Challenges to Implementation

• Insurance Volatility

• Funding and Sustainability
  ➢ Shortfalls in appropriations
  ➢ State budget restrictions

• Lack of a stronger efficacy evidence base

• Opposition to federal marketplace and Medicaid expansion

• Undocumented immigrants left at margins

• Misinformation and confusion
Opportunities

• Equity is embedded in the law
• Enhanced emphasis on partnership development and community-based prevention
• Addressing Gaps in Access
• Increasing community-based initiatives
• Outreach and Education
Why We Must Continue to Advance Health Equity

• Over half of all babies currently born in the U.S. are non-white.

• 40% of youth under 17 are people of color.

• By 2042, 1 of every 2 people living in the U.S. will be a person of color.

• TX, CA, DC, NM, and HI have minority populations greater than 50%. By 2020, AZ, FL, GA, MD, MS, NV, NJ, and NY are projected to join the list.

• Continued disparities in access, quality and health will exact a human and economic toll on our nation.

Source: U.S. Census Bureau; Joint Center for Political and Economic Studies.
For Science, For Action, For Health!

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Rick Potter, CPA, MBA, CHCA
Chief Executive Officer
Healthcare Services Advisory Group, California
Affordable Care Act (ACA) Rollout: Success in the Golden State

Rick Potter, CEO
Health Services Advisory Group of California, Inc. (HSAG of California)

December 10, 2013
ACA Enrollment at a Glance

79,981 enrolled.
#1 in the nation.
Enrollment By Age

18-34 yr. olds
6,924 enrolled
22.5% of enrollees
21% of population

35-64 yr. olds
22,129 enrolled
72% of enrollees
39% of population
Enrollment by Language

Mostly English speakers (85%)
Spanish speakers (3.2%)
Asian/Pacific Islander (3.9%)
Enrollment by Region

1. Los Angeles: 6,978 (22.6%)
2. San Diego: 2,891 (9.4%)
3. Inland Empire: 2,850 (9.2%)
4. Orange County: 2,379 (7.7%)
5. Sacramento Valley: 2,174 (7.1%)
Challenges and Impacts on Access
Challenges and Impacts on Access

1.1 Million Plans
Opportunities

Subsidy-eligible: 30% of applicants

Possibly eligible for Medi-Cal: 39% of applicants

<table>
<thead>
<tr>
<th>Eligibility for Subsidies</th>
<th>Individual Annual Income</th>
<th>Family of Four Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>$16k or less</td>
<td>$33k or less</td>
</tr>
<tr>
<td>Premium &amp; Cost-Sharing Subsidies</td>
<td>$29k or less</td>
<td>$59k or less</td>
</tr>
<tr>
<td>Premium Subsidies</td>
<td>$46k or less</td>
<td>$95k or less</td>
</tr>
</tbody>
</table>
Opportunities

Covered California invites your organization to be our partner in the Community Outreach Network.

The Community Outreach Network is comprised of a diverse group of community-based organizations that are partners with Covered California to raise public awareness about the new health insurance marketplace in California, established under the Patient Protection and Affordable Care Act of 2010.

The purpose of the Community Outreach Network is to increase awareness and understanding of health care coverage options, promote the value of purchasing health care coverage, change attitudes, motivate Californians to take the steps necessary to enroll and remove barriers to enrollment. To ensure the success of this network, we need the help of community leaders and stakeholders across the state.

Interested in participating in the Community Outreach Network?

Simply fill out the attached Community Outreach Network Interest Form and email it to Covered California at CommunityOutreachNetwork@covered.ca.gov. We'll contact you upon receiving the Interest Form.

For more information about Covered California, please visit our website at www.CoveredCA.com.

If you have questions, please submit your inquiry to CommunityOutreachNetwork@covered.ca.gov.

We look forward to working with you as a partner of the Community Outreach Network!
Expectations for Medi-Cal

20% ↑

1.4 million = newly eligible
More Opportunities

Out-of-pocket expenses

No lifetime limits on coverage
Impact on Quality of Care for Minorities
Consultation with California Tribes

Tribal Consultation -
Thursday, November 7, 2013
8:30 a.m. - 5:00 p.m.
Red Lion Inn, Sacramento

Agenda
Invitation Letter
Covered California’s Consultation Policy
PowerPoint Slides

Special Benefits for Eligible Members of Tribes
The Patient Protection and Affordable Care Act includes information specific to
American Indians and Alaska Natives. This page describes what American Indians and
Alaska Natives can expect when they consider buying a health insurance plan from
Covered California™.

Certain American Indians and Alaska Natives can buy a health insurance plan through
Covered California and receive some benefits, such as those described below.

American Indians and Alaska Natives are not required to purchase insurance, as most
other Americans are. There will be no penalty for American Indians or Alaska Natives
who do not have health insurance.

No health care expenses, depending on income
American Indians and Alaska Natives who earn less than about $96,000 for
a family of four will not have to pay certain out-of-pocket costs, such as
copays, if they buy their insurance through Covered California.
ACA and CA Medicare Beneficiaries

- Improved access to preventive services:
  - Mammograms
  - Prostate Exams

- Donut Hole Coverage
  - An average of $900.00 in savings for each Medicare beneficiary in California.
  - Lower premiums

Total Savings for CA
$725,920,751

Thank You!

www.hsag.com

This material was prepared by Health Services Advisory Group of California, Inc., the Medicare Quality Improvement Organization for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. CA-10SOW-9.0-120513-01
Margie Banse
Health Information Supervisor,
Health Care Excel
The Medicare Quality Improvement Organization for Kentucky
Kentucky’s Successful Rollout of kynect

Health Care Excel
Kentucky Medicare QIO
Approach and Method

- kynect made the conscious choice to stick to the basics. A simple interface.
- Hired 622 ‘knectors’
- Fully supported by Governor Steve Beshear - “My State Needs Obamacare. Now.”
- For more detail regarding the creation of kynect please view the article by Talking Points Memo, dated 10/28/2013 [www.huffingtonpost.com/2013/11/05/kentucky-obamacare-website_n_4214629.html](http://www.huffingtonpost.com/2013/11/05/kentucky-obamacare-website_n_4214629.html)
By the Numbers

As of 12/5/2013 approximately 100,000 Kentuckians have enrolled through kynect

- Prior to rollout approximately 625,000 Kentuckians were uninsured
- Launch was Oct. 1, 2013, and by Oct. 28, 2013 ...
  - 26,000 Kentuckians had enrolled
  - 50,000 Kentuckians had started applications
  - Site has had more than 300,000 unique visitors
Impact

- Statewide Workgroup
  - Sharing of Information, barriers and successes
  - Participants:
    - Health Care Excel (QIO)
    - Governor’s Office of Electronic Health Information
    - Cabinet for Health and Family Services
    - Kentucky Health Information Exchange (KHIE)
    - Both Regional Extension Centers
“Kimberly Cates has seen firsthand the consequences of not having coverage. For more than a decade, she has worked as a certified medical assistant in a family clinic in Paint Lick, KY., that treats the uninsured and indigent. The irony is lost on no one that the clinic cannot afford to offer Cates health care benefits.”

“I'm glad that I've done it and it's over with and I have it,” Cates says a few hours after signing up. “At the same time, it feels like, wow, $17 a month is nothing hardly. I've got insurance now.”

Her experience has also given her insight into what it really takes to enroll in health care -- not just to navigate a website, but to overcome fears and doubts and distrust.

Cates sent a text the following evening. “I applied to become a Kynector," she wrote.
ACA and KY Medicare Beneficiaries

- Donut Hole Coverage
  - An average of $928.00 in savings for Medicare beneficiaries in Kentucky.

- Total saving for KY: $180,902,076

Resources

Links for full articles used for this presentation


kynect Website  https://kyenroll.ky.gov/
Contact Information

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502.454.5112 ext. 2221
mbanse@kyqio.sdps.org
Useful Websites:

Department of Health and Human Services: http://www.hhs.gov/healthcare/rights/
AARP Health Care Law Navigation Tool: http://healthlawanswers.aarp.org/
To contact Medicare, call 1-800-MEDICARE, or visit: www.medicare.gov.
Enroll America: http://www.enrollamerica.org/
American Public Health Association: http://www.apha.org/advocacy/Health+Reform/ACAbasics/
Q&A

Please type your question into the chat box or press 14 on your telephone.
Four Affinity Groups will Launch in January, 2014

**Behavioral Health**

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**Community Engagement**

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**Data**

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Email: whitakers@dfmc.org
LEARN HOW TO SHARE YOUR SUCCESS ON THE CMS PULSE WEBSITE!

Contact Ava Richardson
Phone: 410-872-9682
Email: richardsonav@dfmc.org
DNCC VIRTUAL TRAININGS PAGE COMING SOON!

This new format will serve as a central repository for all virtual training presentations and materials

Sign up for the disparities listserv to stay current on all DNCC happenings!
Thank you for participating in today’s webinar.

At the close of the presentation, you will automatically be directed to an evaluation screen.