





Population Health Issues & the Affordable Care Act

Nevada Population Health Conference
November 17, 2016



The Next Phase of the Affordable Care Act: High Deductible Plans

NEVADA POPULATION HEALTH CONFERENCE –
NOVEMBER 17, 2016



▶ “So you've got this crazy system where all of a sudden 25 million more people have health care and then the people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world.”

▶ Bill Clinton October 4, 2016

Quick Stats



- ▶ Twenty-four percent of employees enrolled in employer-sponsored high-deductible plans in 2015, up from 4 percent in 2006 (Source KFF)
- ▶ From 2011 to 2014, the number of consumer payments to healthcare providers increased 193 percent (Source InstaMed)
- ▶ The average annual out-of-pocket costs per patient rose almost 230 percent between 2006 and 2015 (Source KFF)
- ▶ Employee deductibles on average increased 67 percent from 2010 to 2015 (Source KFF)
- ▶ American's out-of-pocket medical expenses jumped 9 percent from 2014-2015 (Source KFF)

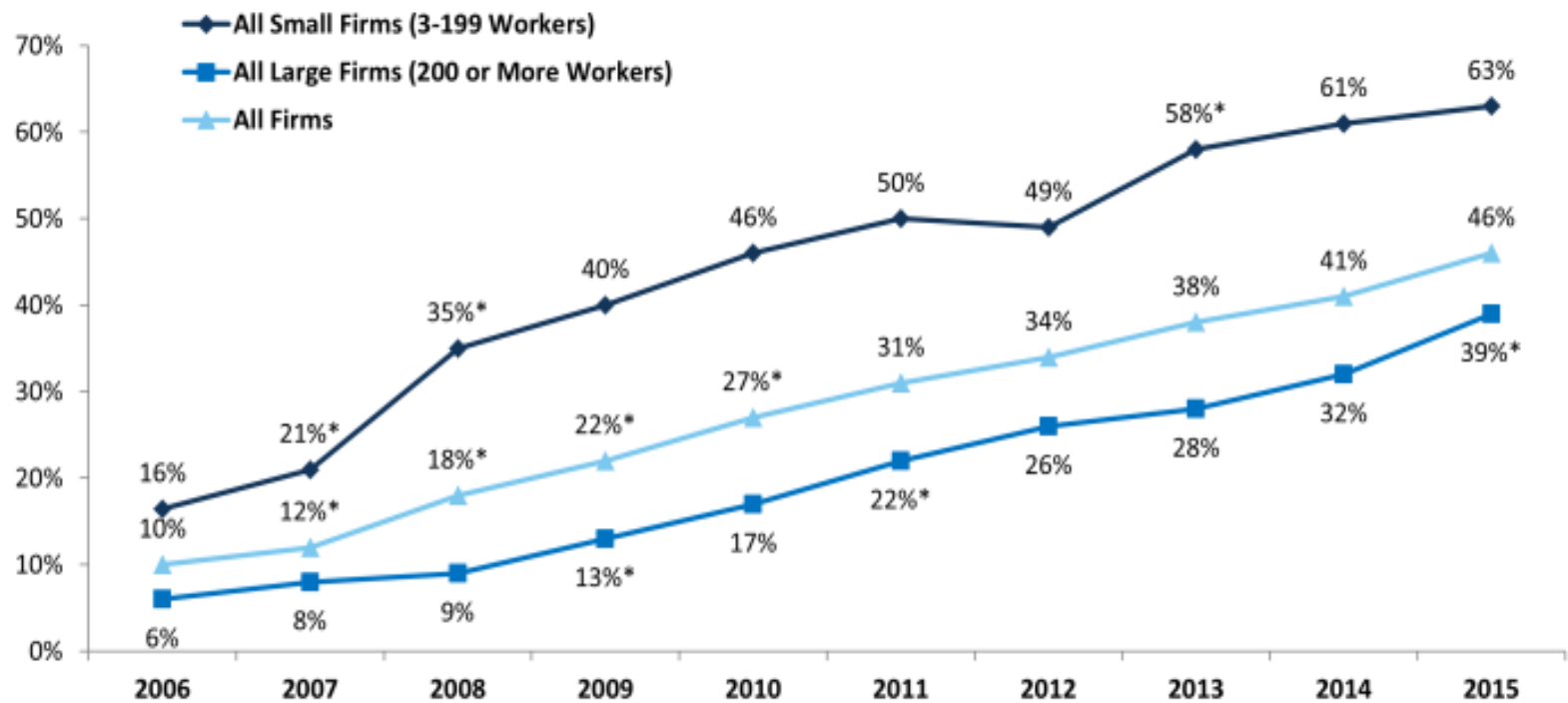
Quick Stats



- ▶ 43 percent of insured patients said they delayed or skipped physician-recommended tests or treatment because of high associated costs (Source KFF)
- ▶ In the individual market, almost 90 percent of enrollees in Affordable Care Act (ACA) Marketplaces are in a plan with a deductible above \$1,300 for an individual and \$2,600 for a family in 2015. (Source RWJF)

Exhibit G:

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, By Firm Size, 2006-2015



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

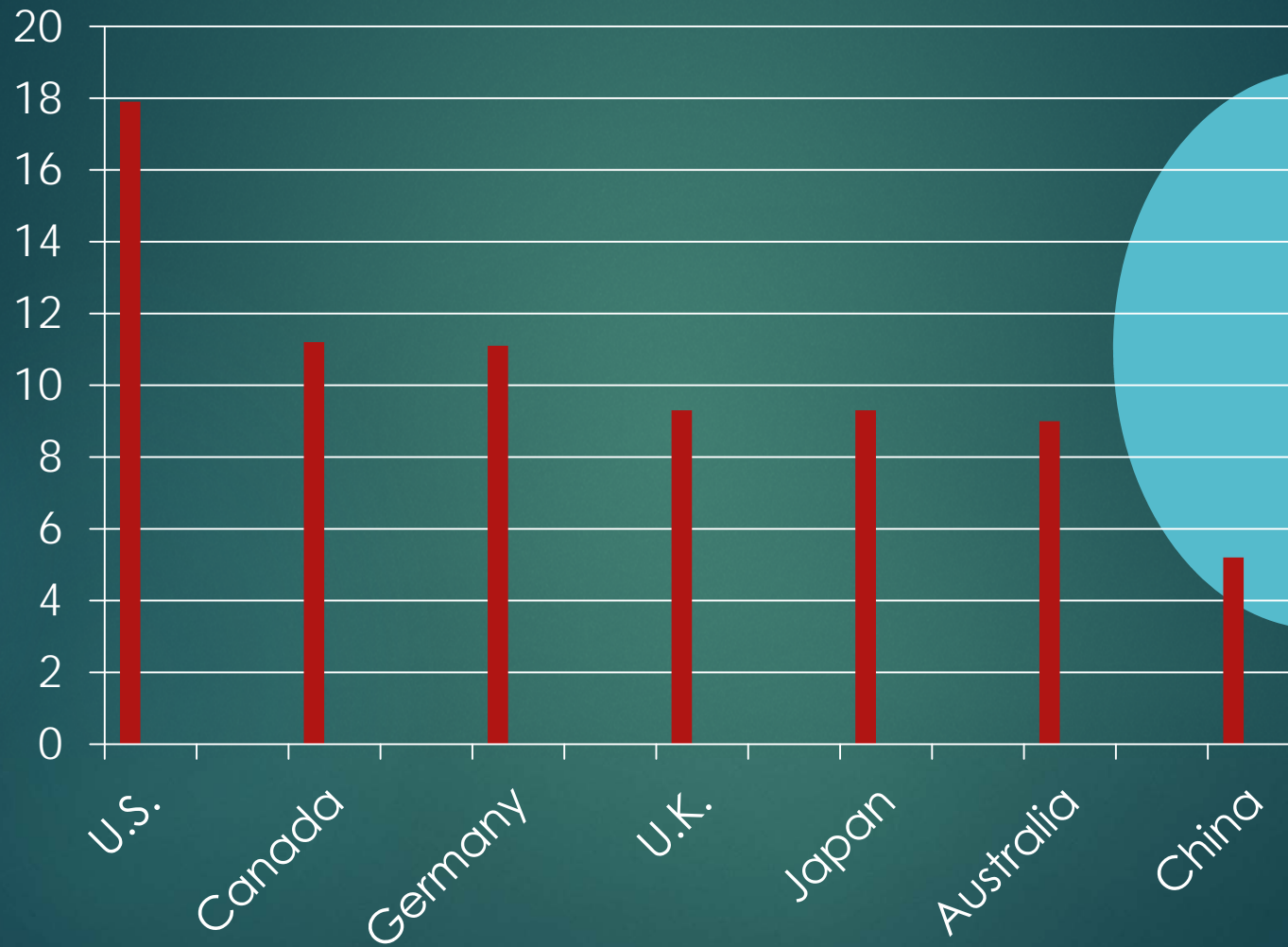
Compare to HSA participation

- ▶ From Employee Benefit Research Institute:
 - ▶ In 2014 about 54% of persons in high deductible plans also participated in a HSA
 - ▶ Around 8,000,000 adults were eligible to join a HSA but did not
 - ▶ Nearly one-third (30 percent) of the accounts in the did not have any employer or individual contributions in 2014. Overall, these accounts started 2014 with an average balance of \$1,054 and ended the year with an average balance of \$892.

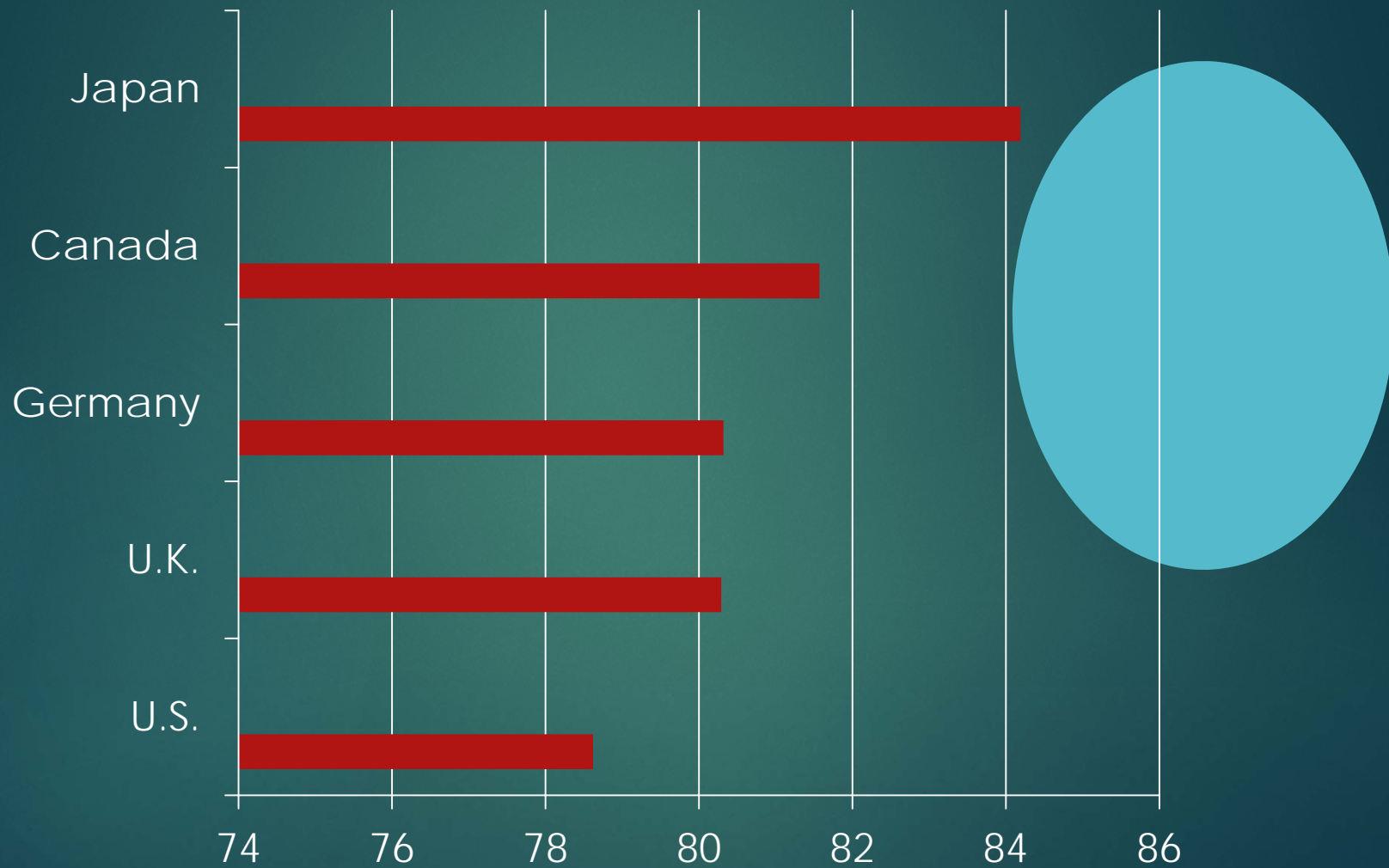
Back to the Beginning- Why the ACA? – The politics free version

- ▶ In 2010 the United States was in the top three in the world in health care spending as a percentage of GDP
 - ▶ #2 according to Census Bureau
 - ▶ #3 according to World Bank
- ▶ Americans spent \$2.5 trillion on health care in 2009, accounting for 17.6% of the national economy
- ▶ Too many uninsured patients using emergency room as primary place to receive care – EMTALA-CARE

Health Care Spending as % of GDP - 2011



Life Expectancy By Country -2011



Back to the Beginning- Why the ACA? – The politics free version

1. Expand access
2. Assure broad participation to spread risk and costs
3. Contain runaway costs
4. Improve quality

Back to the Beginning- Why the ACA? – The politics free version

- ▶ ACA attempted to limit costs and spread risk by requiring everyone (or close to everyone) to pay into the system:
 - ▶ Individual mandate – requiring all individuals to have coverage or face a tax penalty
 - ▶ Employer mandate – requiring “large” employers to provide affordable coverage or face tax penalties
 - ▶ Medicaid expansion – expand Medicaid up to 133% of the Federal Poverty Level

The issues

- ▶ Will patients avoid care because of deductibles?
- ▶ Will insured patients be able pay their bills, in particular hospital bills, in high deductible plans?
 - ▶ If so, how will those costs be redistributed?
 - ▶ Isn't this one of the issues that ACA was trying to solve?
- ▶ What will be the economic impact on providers
 - ▶ Contracts with plans require them to accept the negotiated rate
 - ▶ The traditional bargain for this is that the provider traded a higher rate for a secure payer.
 - ▶ Now the provider gets the lower rate and may not be able to collect

Policy Considerations

- ▶ Should certain persons in high deductible plans be treated as uninsured for public policy purposes?
- ▶ How do we increase participation and contribution to HSAs?
 - ▶ Is it better to incentivize the employer or the employee?
- ▶ What protections do we give to medical providers?
- ▶ Will this all be solved by the courts?
 - ▶ Patient bankruptcies; provider bankruptcies; provider collection actions; organized provider action against the plans.
 - ▶ Can we prevent this from happening?

Is it sustainable?



Thank You!



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Brian Sandoval
Governor



Richard Whitley
Director

Department of Health and Human Services

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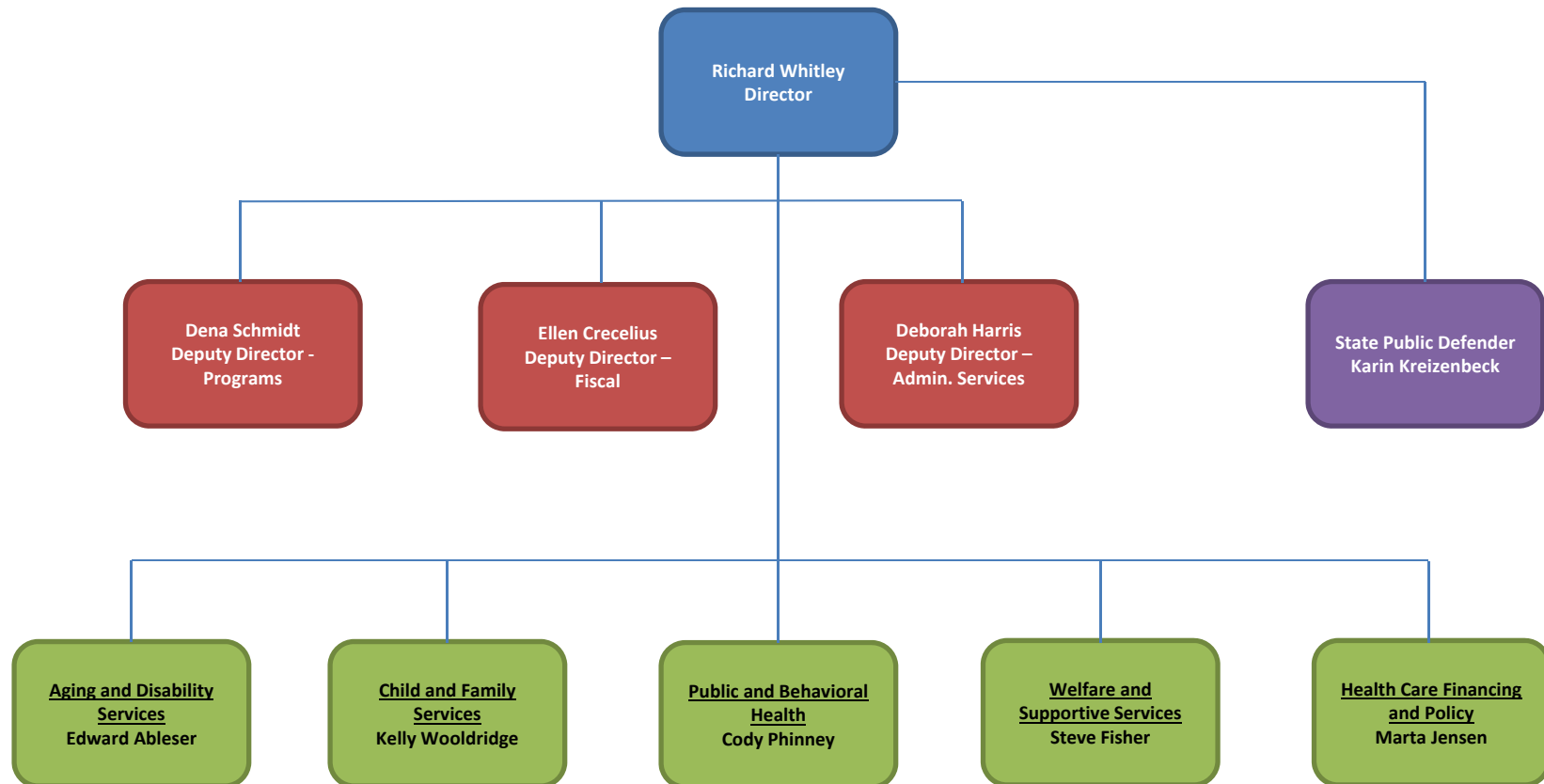
Mission

- The Department of Health and Human Services (DHHS) promotes the health and well-being of Nevadans through the delivery of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency.
- The department consists the following divisions: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy, Public and Behavioral Health, Welfare and Supportive Services, and the Public Defender's Office.
- Statutory Authority: NRS 232.290-465.

Helping People. It's who we are and what we do.



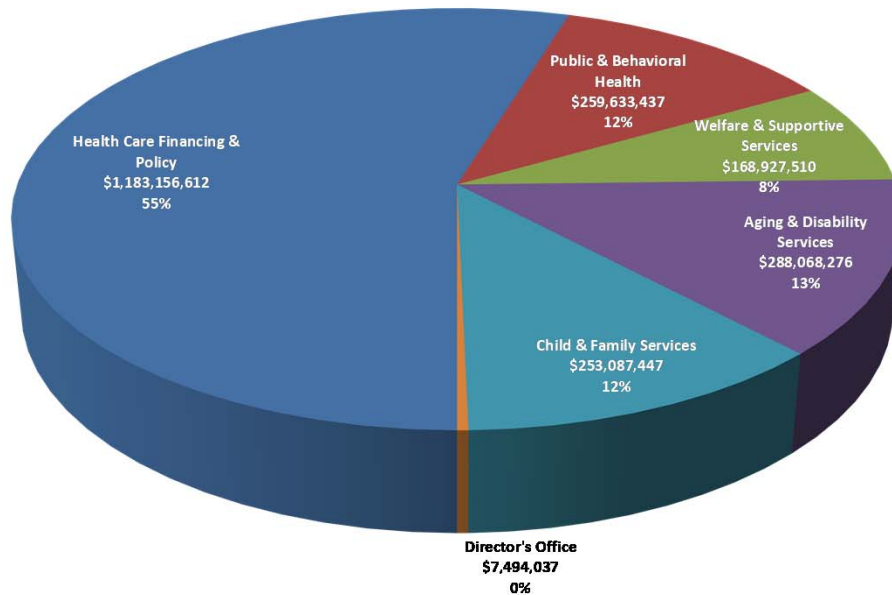
DHHS Organizational Chart





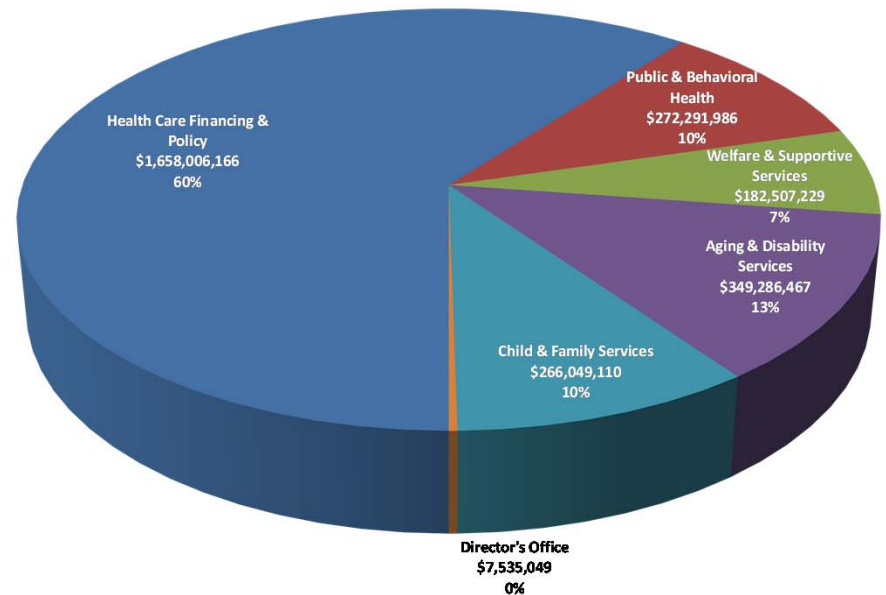
General Funds by Division, 2016-17 and 2018-19 Biennia

Legislative Approved General Funds 2016-17 Biennium



\$2,160,367,319

Agency Request General Funds 2018-19 Biennium

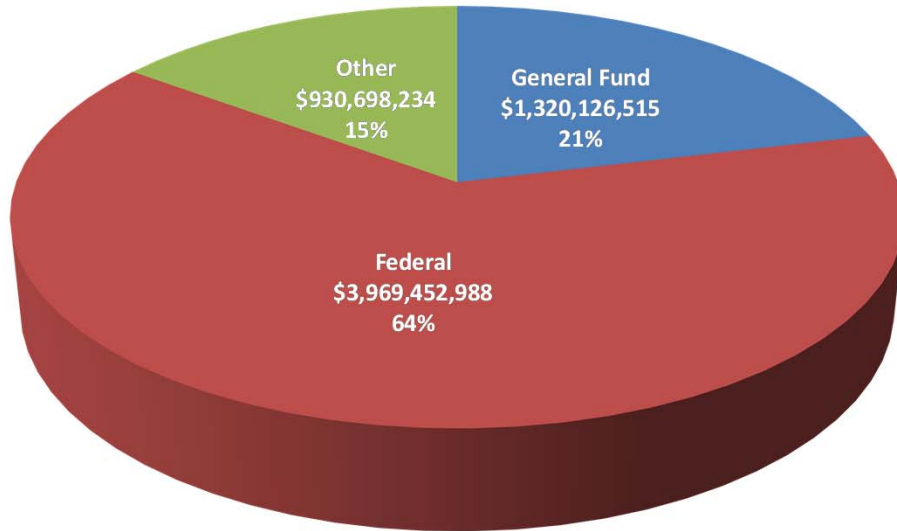


\$2,735,676,007



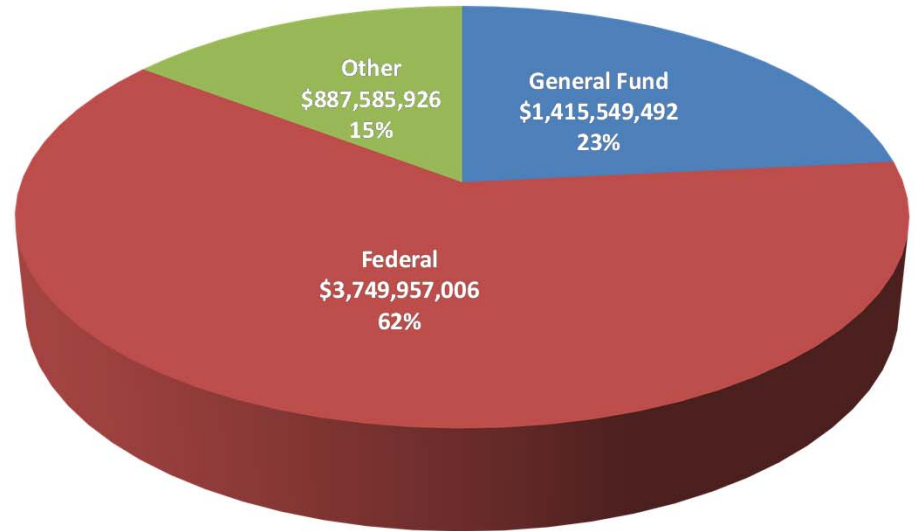
Budgeted Funding Sources, Fiscal Years 2018 and 2019

State Fiscal Year 2018



\$6,220,277,737

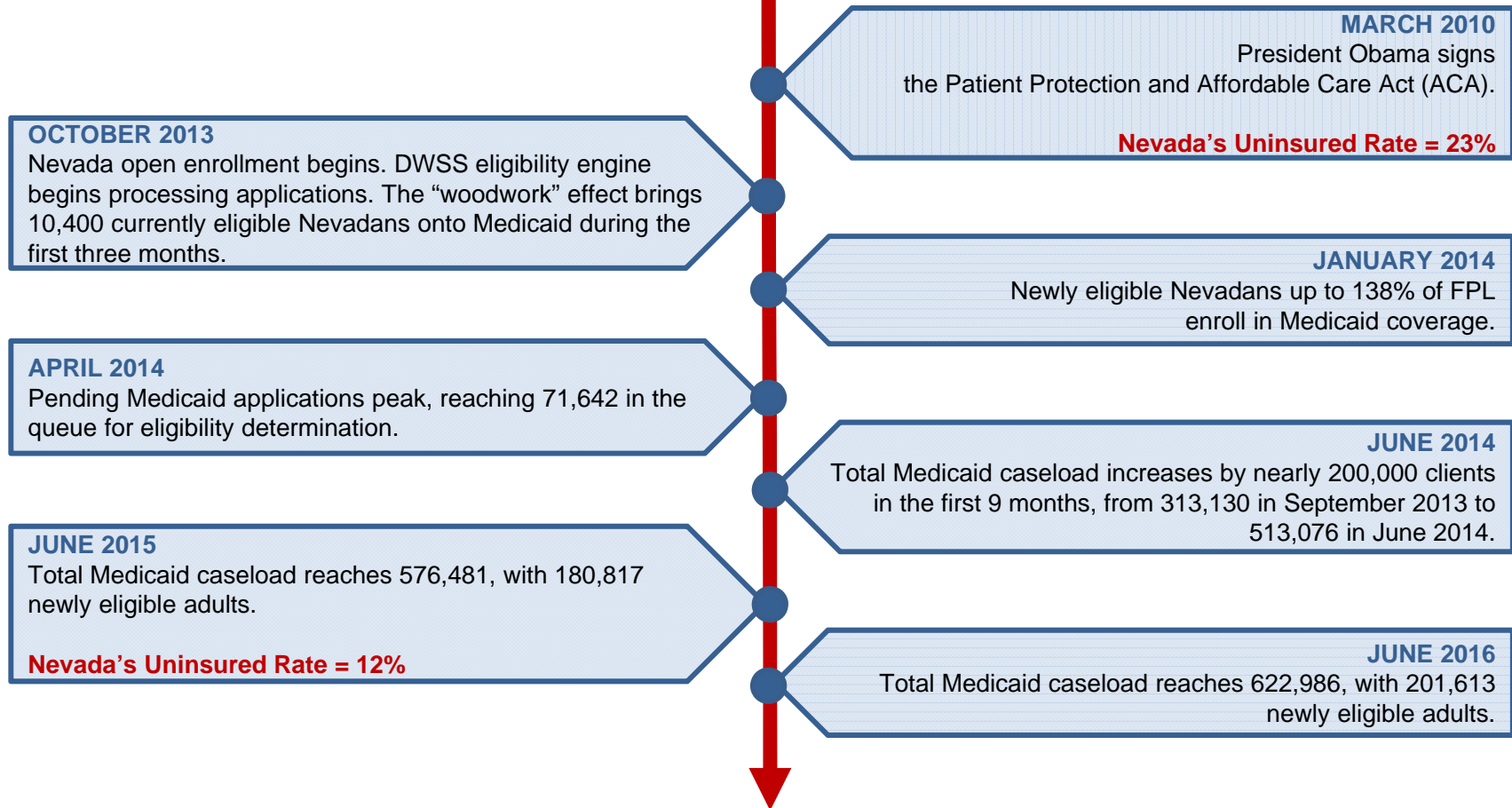
State Fiscal Year 2019



\$6,053,092,424

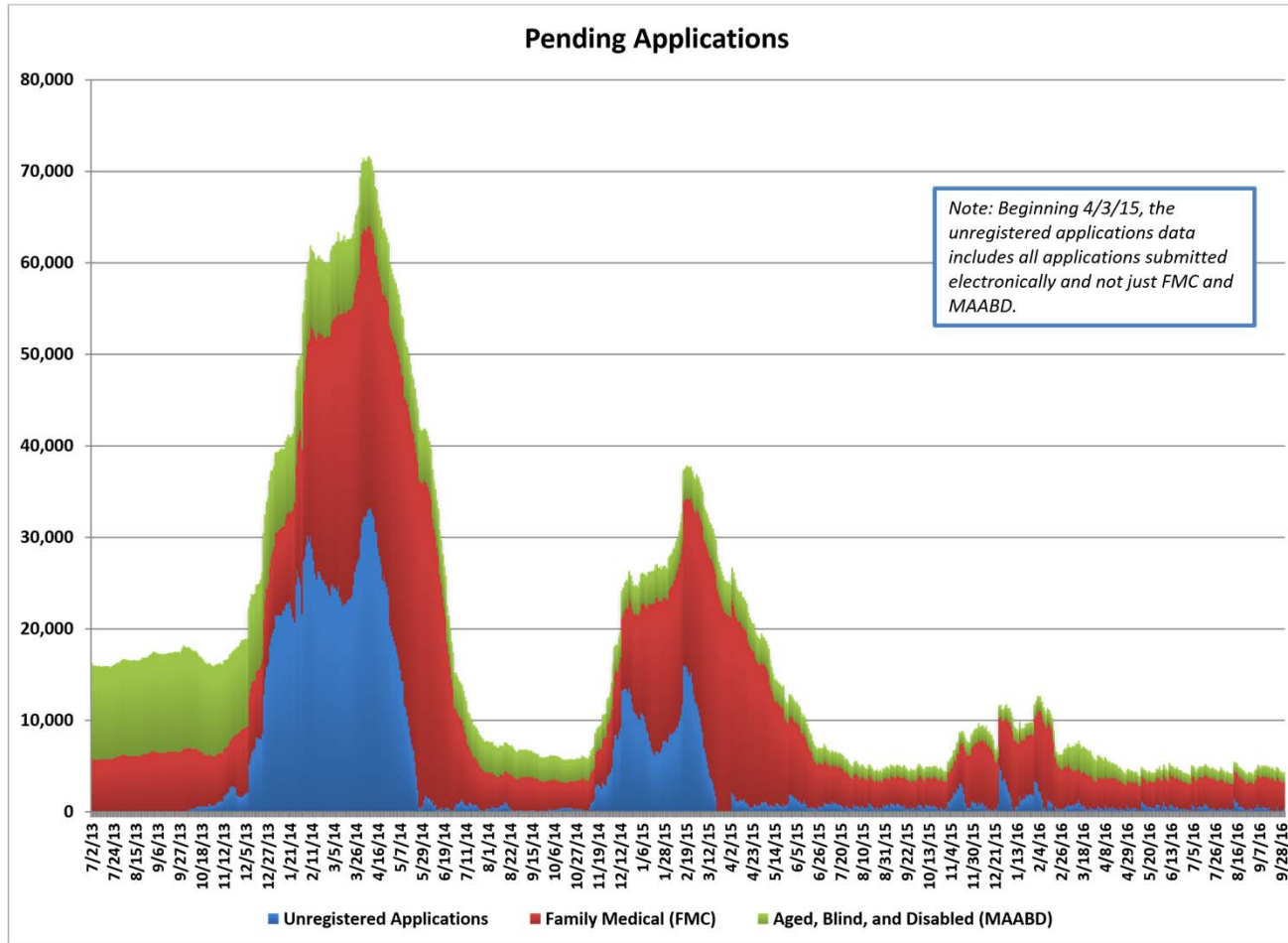


Affordable Care Act (ACA) Timeline



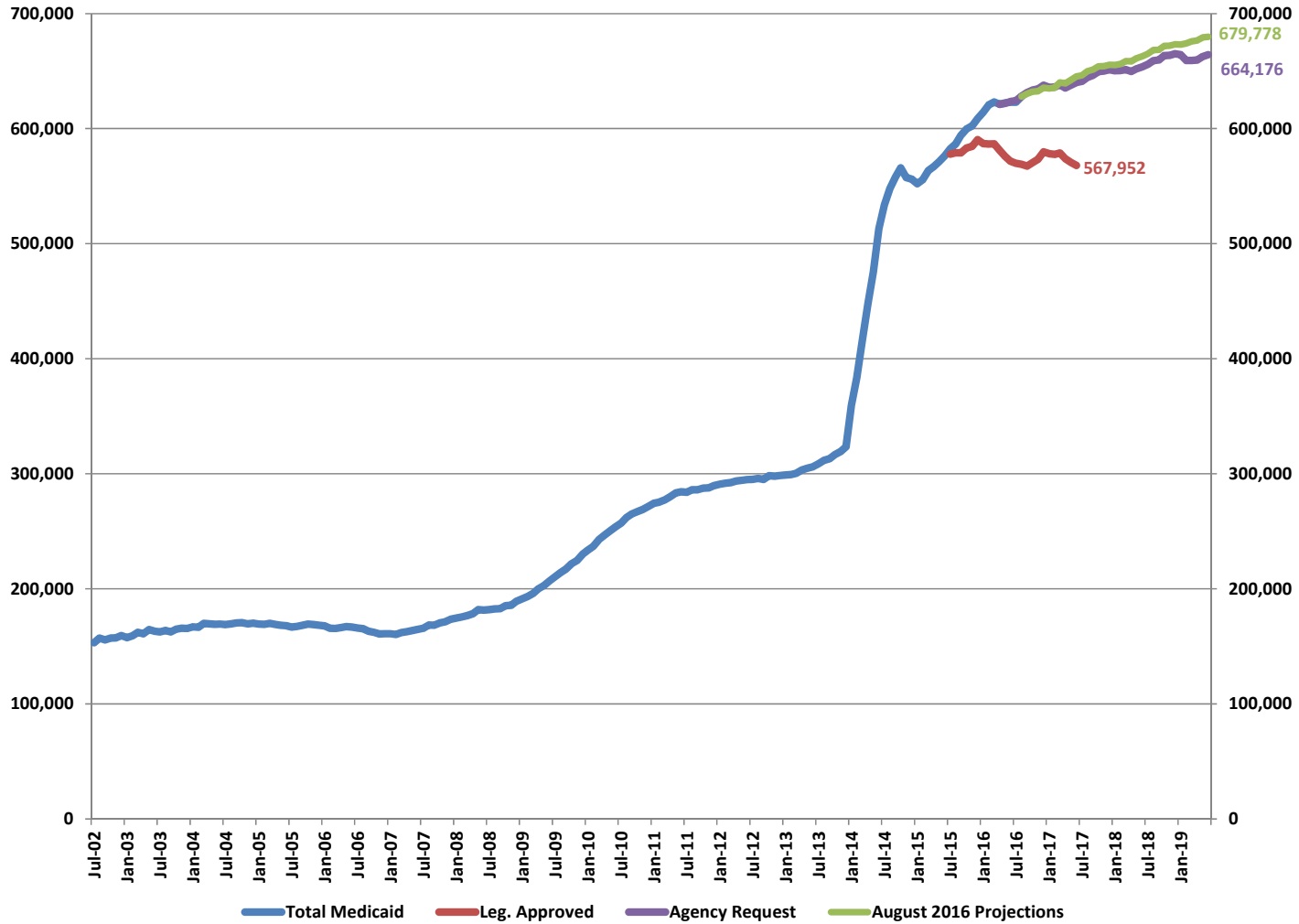


Pending Medicaid Applications



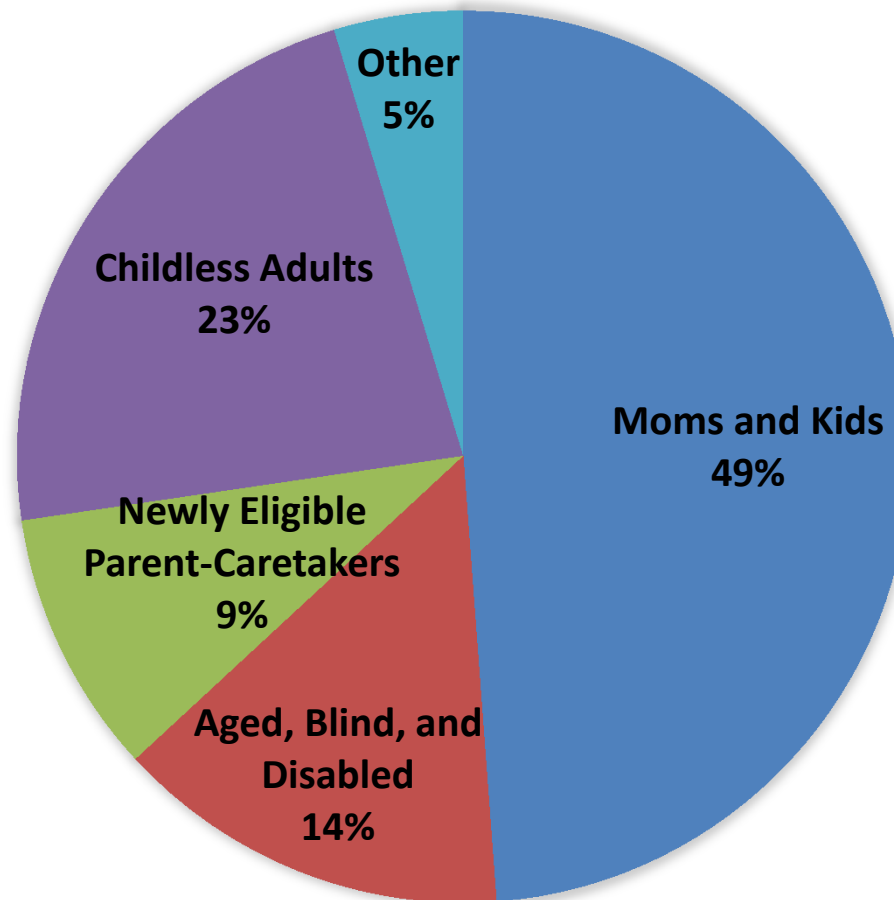


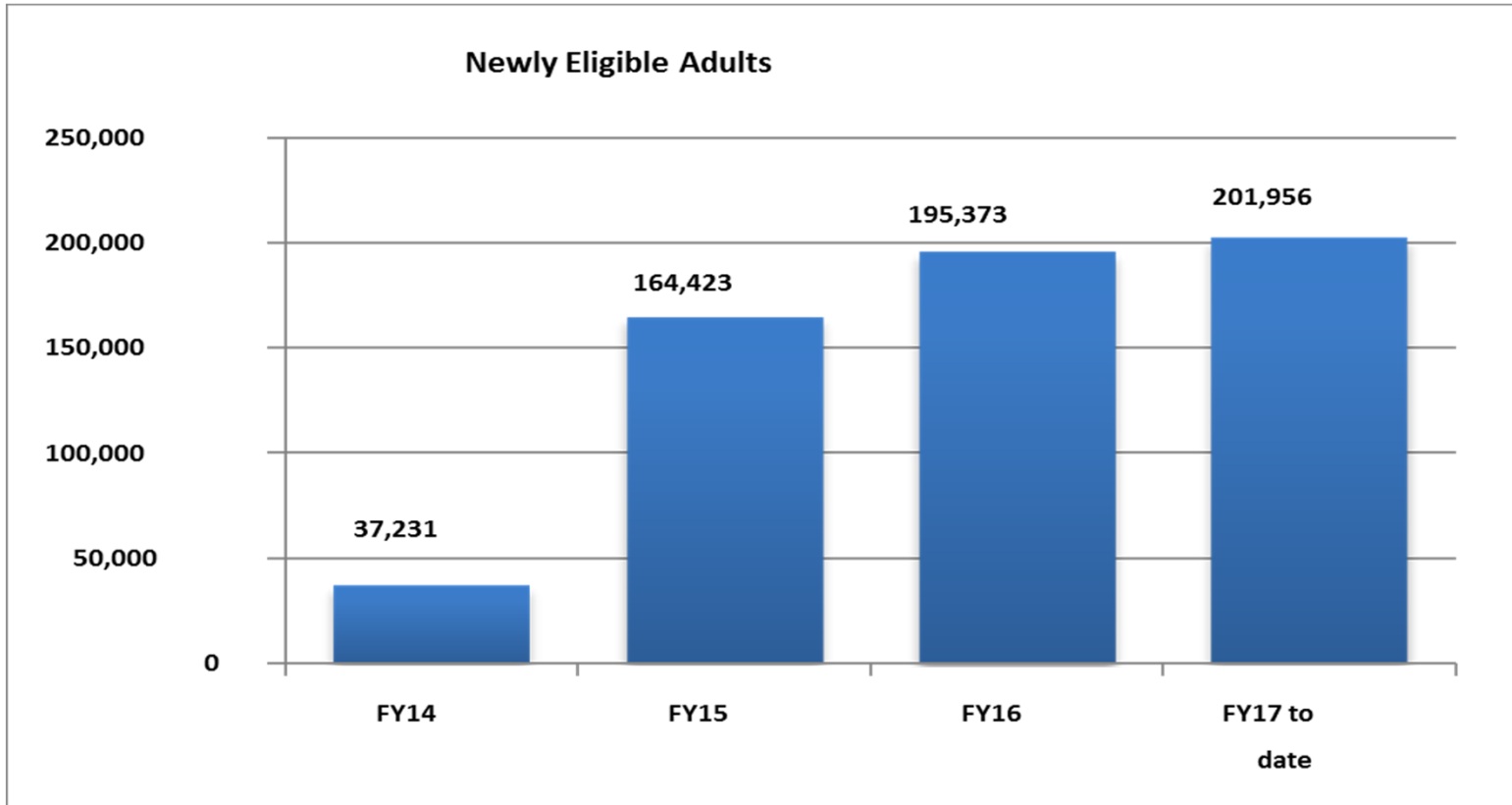
Medicaid Recipients





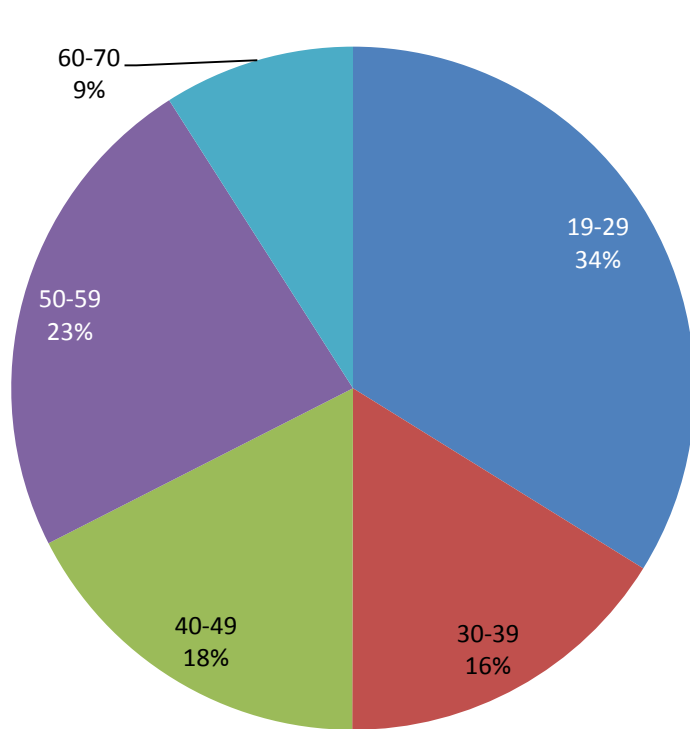
Medicaid Caseload



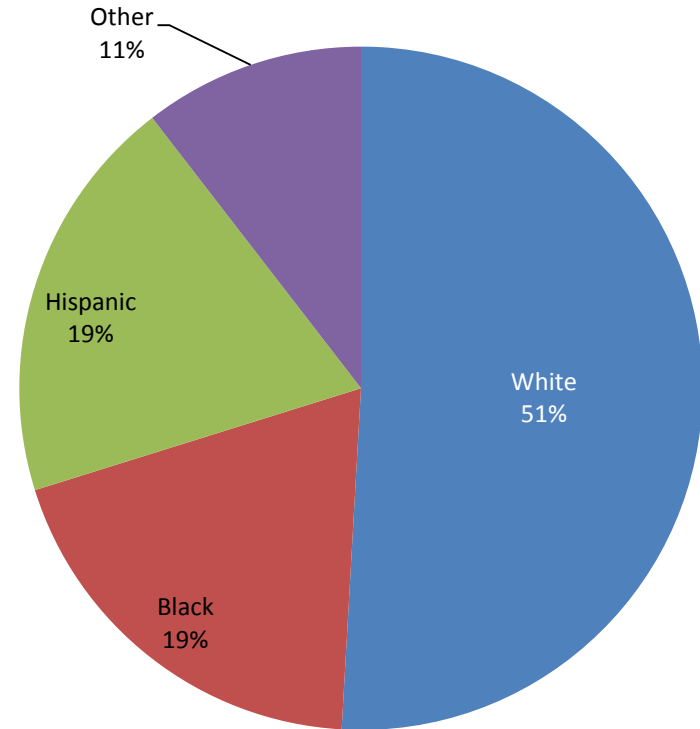


Demographics of Childless Adults in Medicaid

Percentage of Childless Adult Medicaid Clients by Age Group

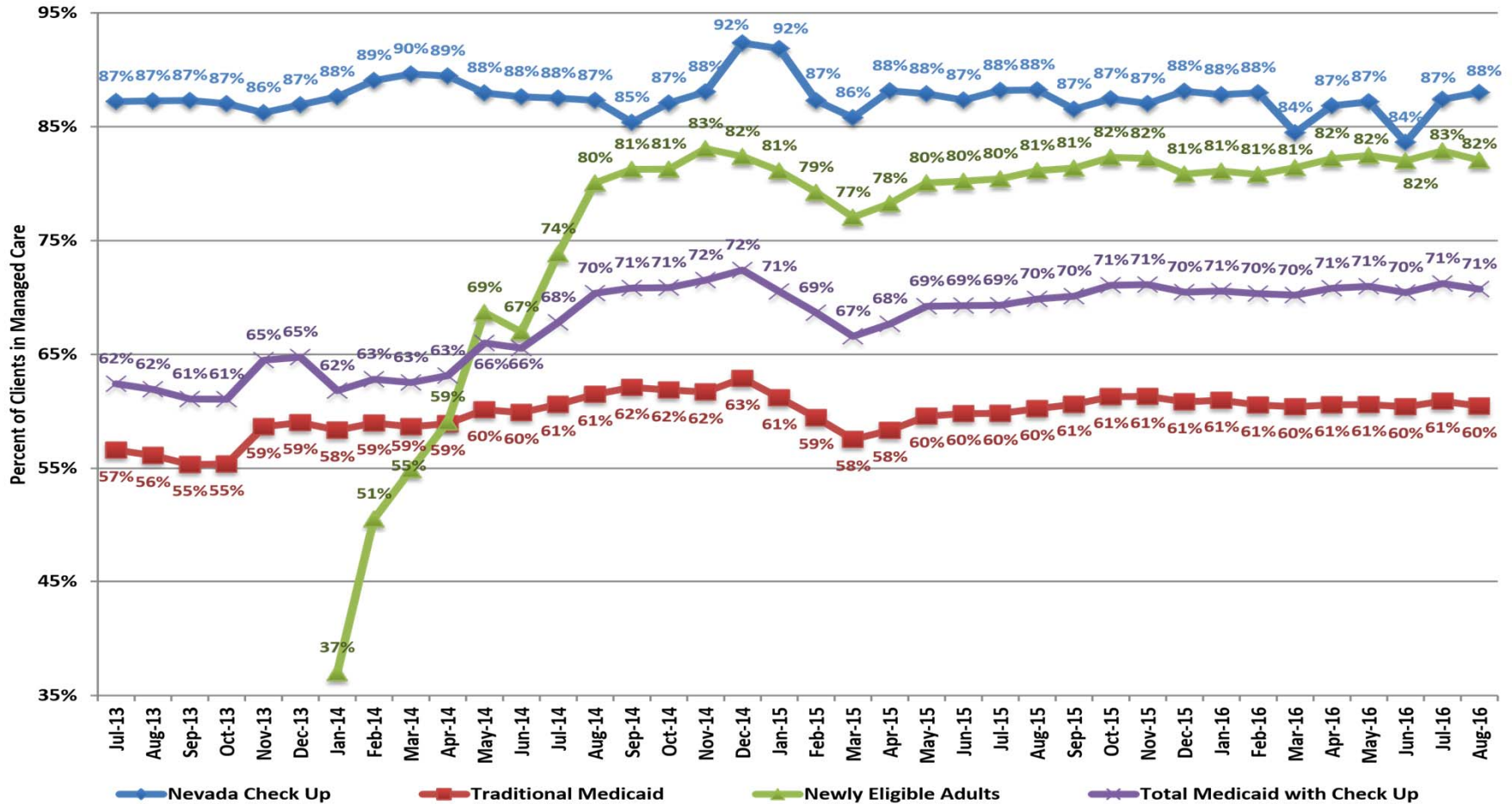


Percentage of Childless Adult Medicaid Clients by Race





Percent in Managed Care by Client Type





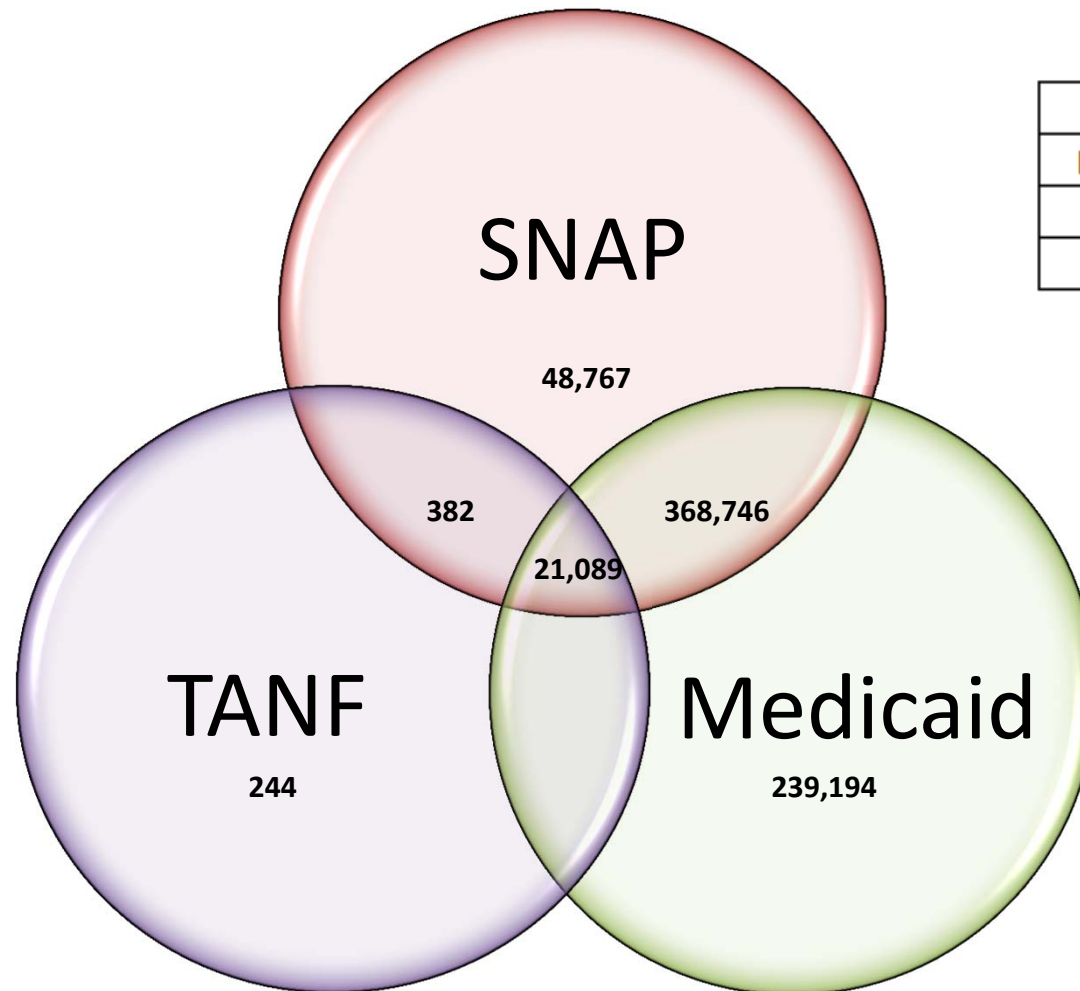
Blended Federal Medical Assistance Percentage (FMAP)

State Fiscal Year	FMAP	Enhanced (CHIP) FMAP	ACA Enhanced (CHIP) FMAP	New Eligibles FMAP
FY03	51.79%	66.25%		
	52.53%	66.77%		
FY04	54.30%	68.01%		
	55.34%	68.74%		
FY05	55.66%	68.96%		
FY06	55.05%	68.53%		
FY07	54.14%	67.90%		
FY08	52.96%	67.07%		
FY09	50.66%	65.46%		
	61.11%	72.78%		
FY10	50.12%	65.08%		
	63.93%	74.75%		
FY11	51.25%	65.87%		
	62.05%	70.44%		
FY12	55.05%	68.54%		
FY13	58.86%	71.20%		
FY14	62.26%	73.58%		100.00%
FY15	64.04%	74.83%		100.00%
FY16	64.79%	75.35%	92.60%	100.00%
FY17	64.74%	75.32%	98.32%	97.50%
FY18	64.78%	75.35%	98.35%	94.50%
FY19	64.05%	74.83%	97.83%	93.50%
FY20	62.75%	73.92%	79.67%	91.50%

Note: The green cells reflect a 2.95% increase for the period April 2003 through June 2004. The blue cells reflect the ARRA stimulus adjusted FMAP for October 2008 through December 2010. The FMAP values for FY18 through FY20 are projections.



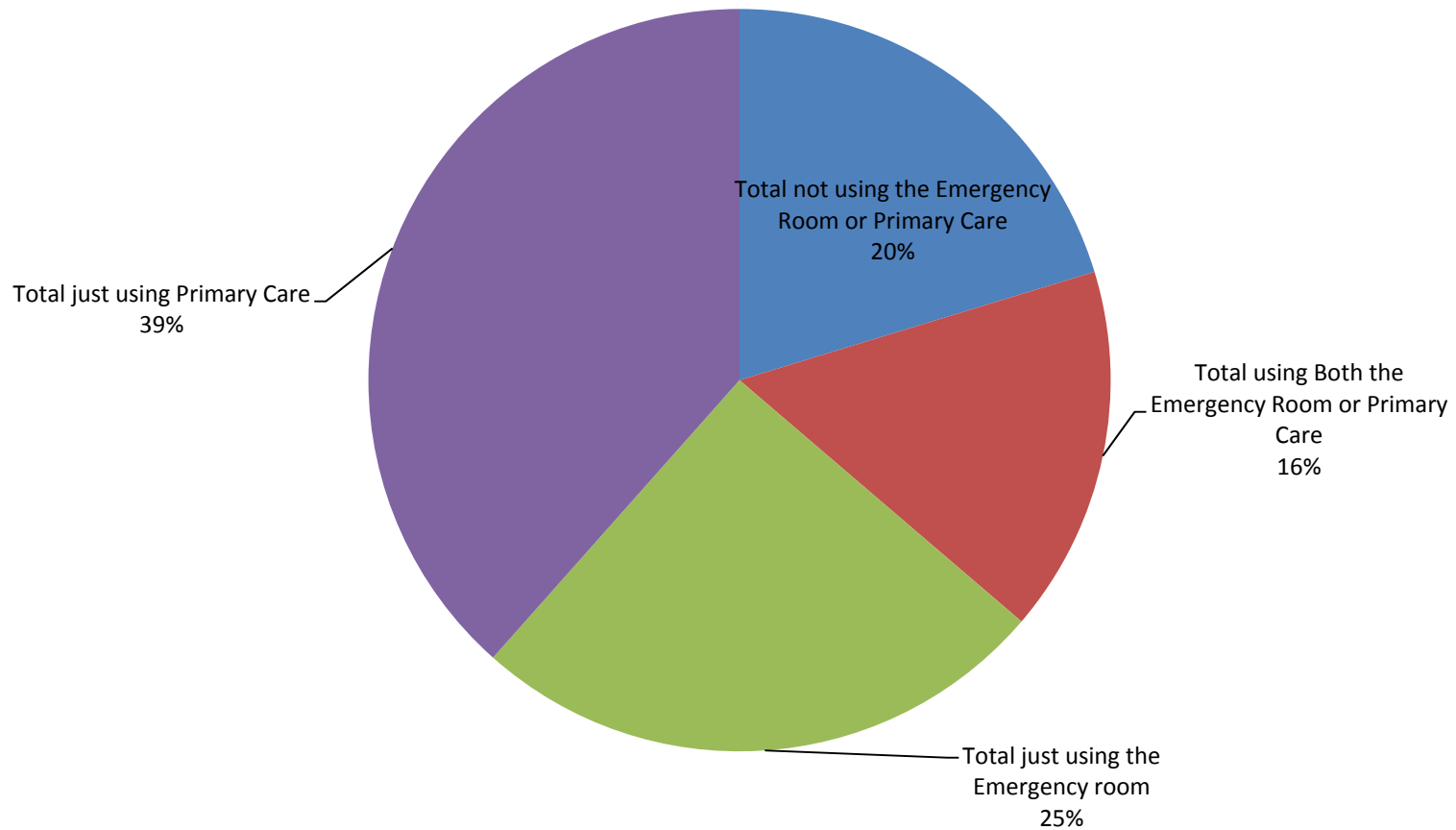
Recipients by Program



Program	Recipients
Medicaid	631,564
TANF	24,250
SNAP	438,984



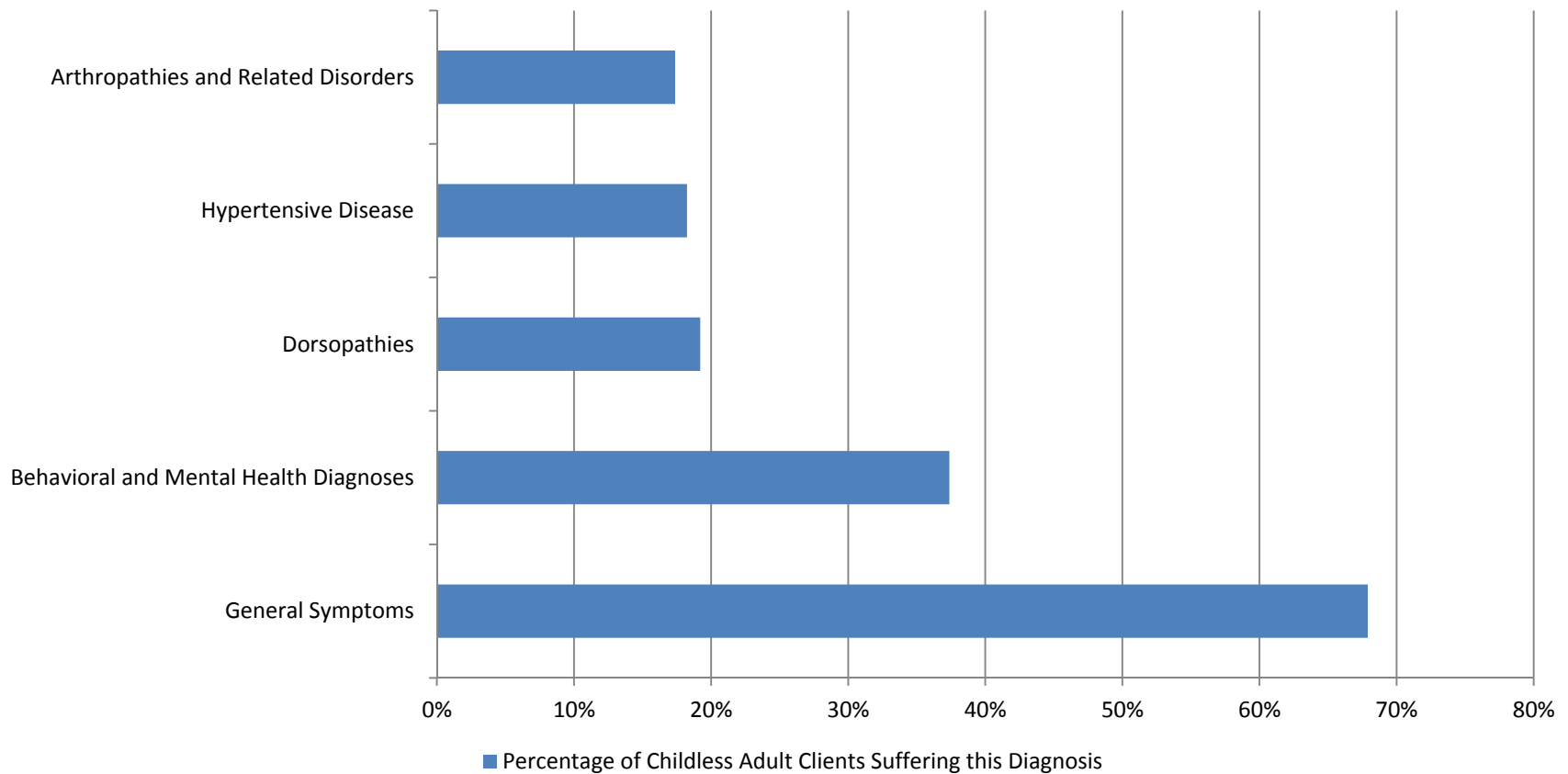
Newly Eligible Use of Primary Care and Emergency Room





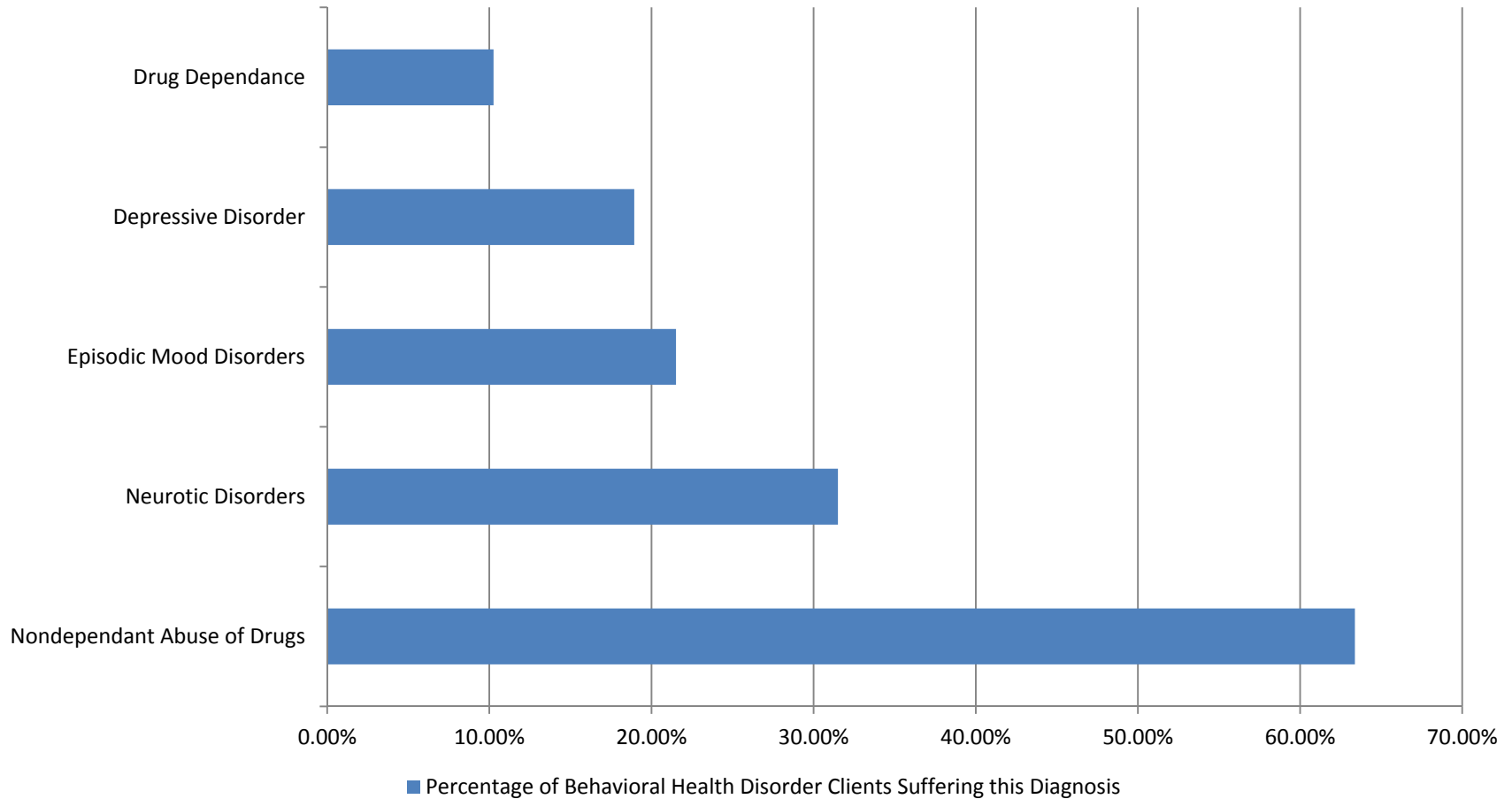
5 Most Common Diagnoses among Childless Adult Medicaid Recipients

5 Most Common Diagnoses Among Childless Adult Medicaid Clients





5 Most Common Mental or Behavior Health Diagnoses





Department of Health and Human Services Website dhhs.nv.gov

- *Quick Links*
 - DHHS Quick Facts
- *About Us*
 - Budget Information
- *Reports and Publications*
 - Reports
 - Welfare Fact Book,
 - Medicaid Fact Book and Executive Summary,
 - Medicaid State Plan
 - Public Assistance Caseload
 - Medicaid Chart Pack
 - Behavioral Health Chart Pack

Population Health

Holly Lyman , MPH, Director Community Health



Dignity Health[™]
St. Rose Dominican

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious. Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

That's the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease. Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The care team involves physicians, nurse practitioners,

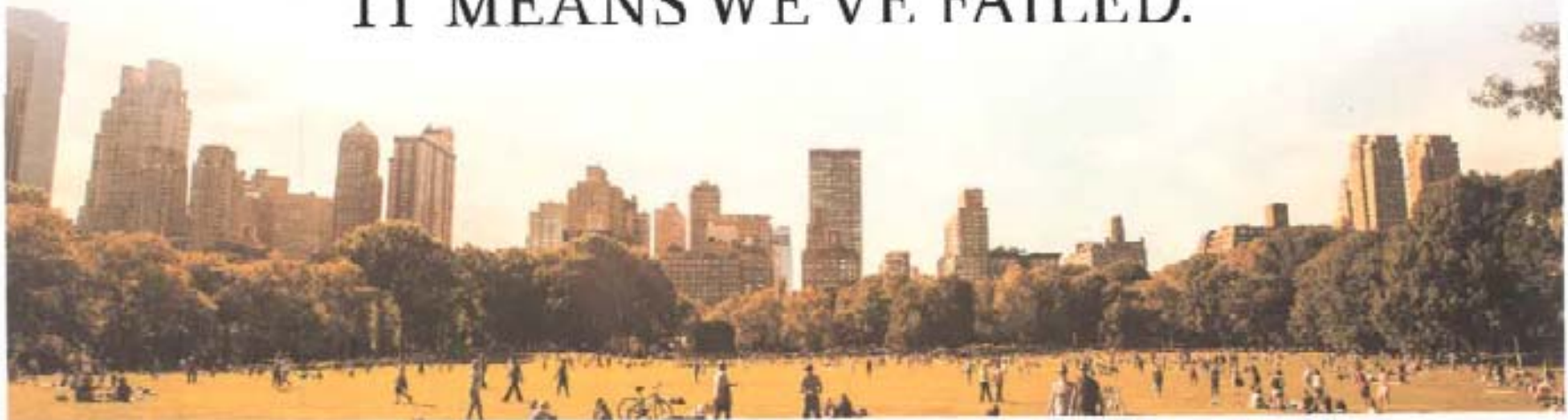
registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides. Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify issues such as

problems with medication management and provide continuing support after discharge. It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds

1-800-MOUNT SINAI
mountsinaihealth.org



IF OUR BEDS ARE FILLED, IT MEANS WE'VE FAILED.



What **Makes** Us Healthy



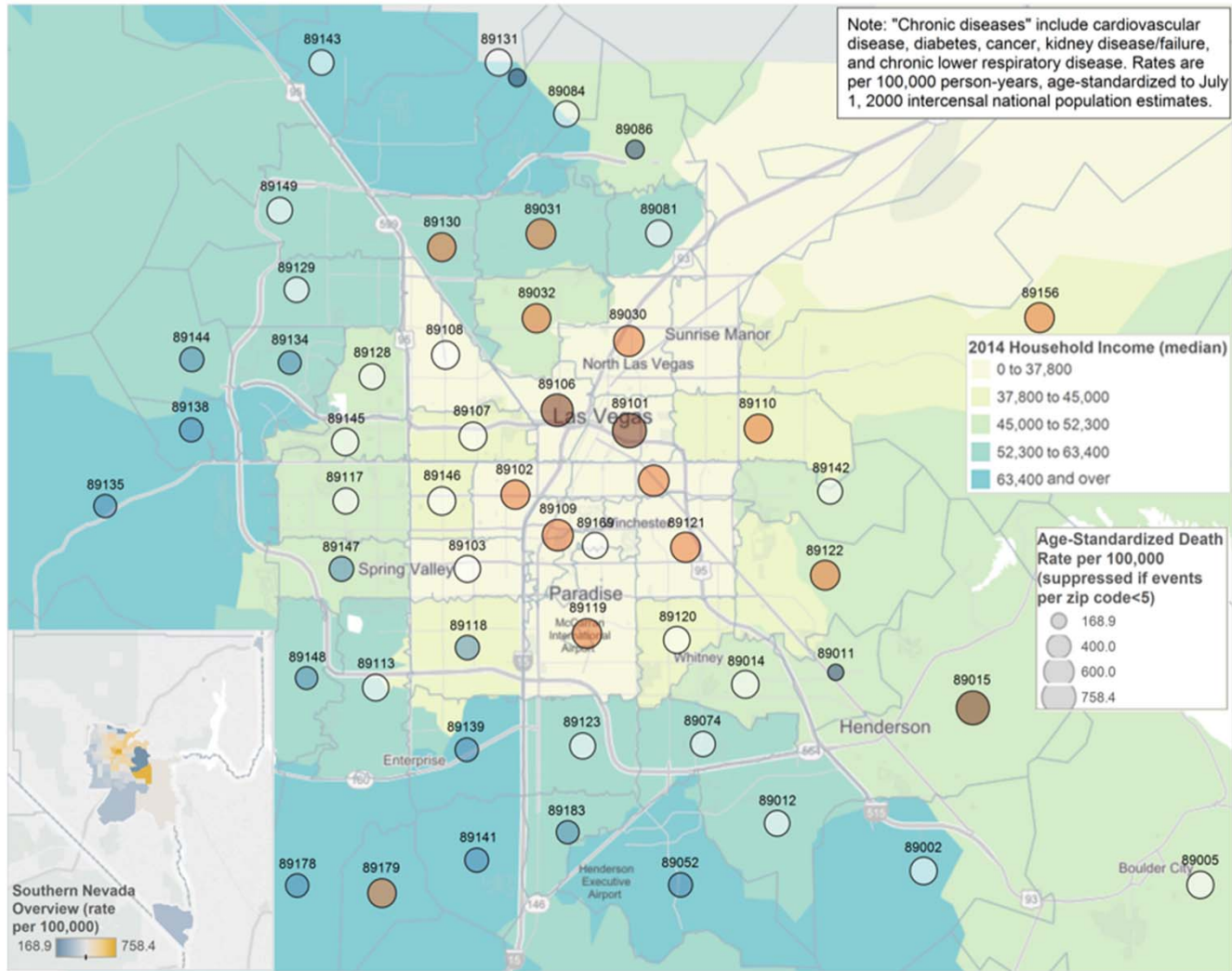
What We **Spend** On Being Healthy



Source: Bipartisan Policy Center, "F" as in Fat: How Obesity Threatens America's Future (TFAH/RWJF, Aug. 2013)

ZIP CODE MORE IMPORTANT THAN GENETIC CODE

Age-Adjusted Chronic Disease Mortality, SNHD CHA 2016



Source: Southern Nevada Health District

Dignity Health Population Health Management Strategy

*Through an integrated Population Health Management Strategy, Dignity Health will provide health care that improves the well-being and quality of life for the individuals and **communities we serve**.*

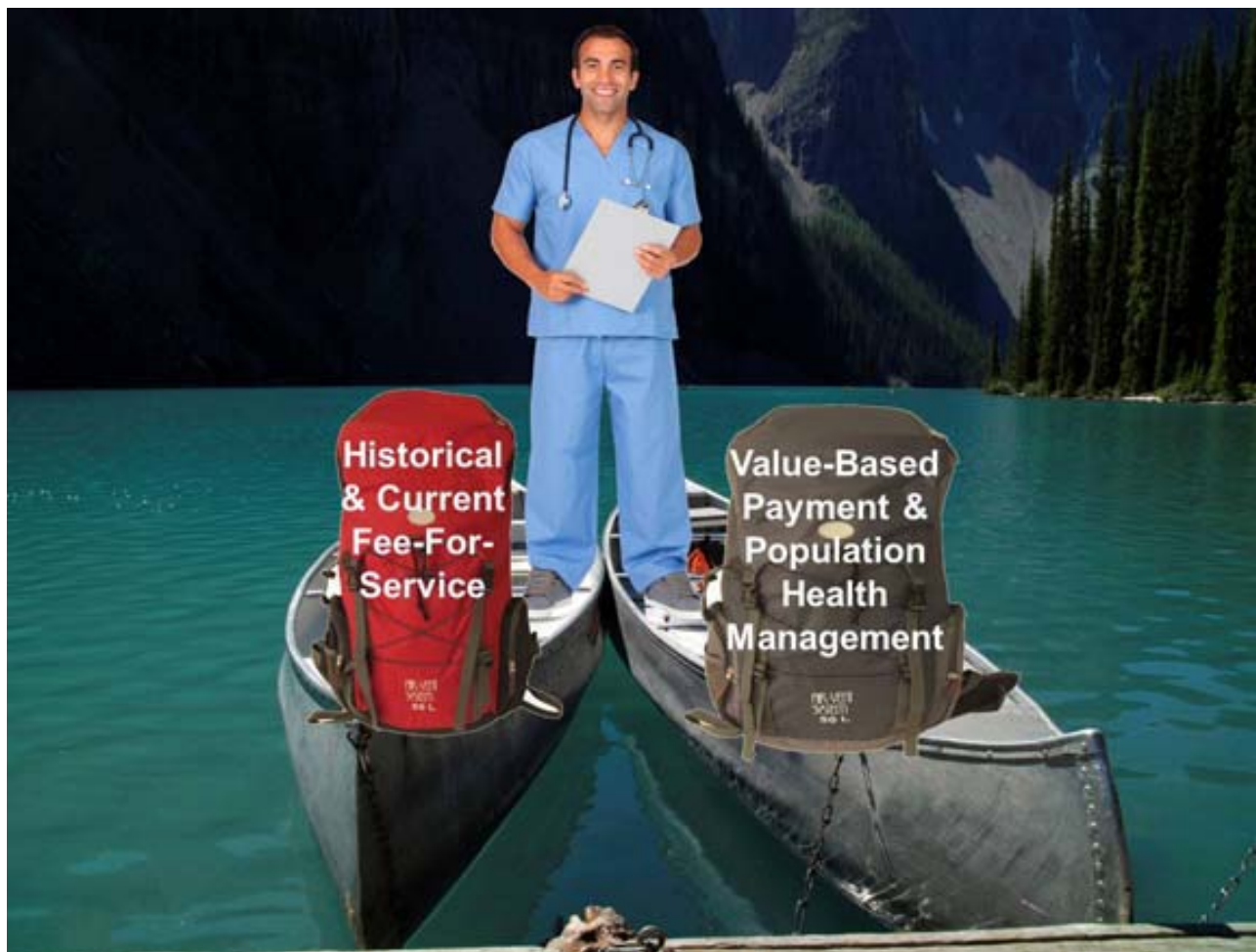
Mission: To transform patient behavior and health outcomes through the implementation of innovative Population Health Management strategies.

Vision: To empower consumers through new Population Health Management care models consistent with our healing ministry

Shared Values & Beliefs

- Provide **whole-person, patient-centered care** to patients and their families
- Build compassionate **clinically-integrated care management** teams to improve access and quality of care and excellence in patient experience
- **Offer technology and resources** to ensure information access, effective communication and coordination of care
- **Develop innovative solutions to engage and empower patients** to manage their health wherever they are along the continuum
- **Provide high-quality, evidence-based health care** to improve overall health of the communities we serve

2 Canoes



David Nash, MD, MBA, Dean
Jefferson College of Population Health

Value Based Agreements

- Dignity Health is committed to transitioning from the traditional fee for service environment to fee for value.



Population Health Continuum - Tomorrow

Hospitals/Physicians

External Partners

Community Health



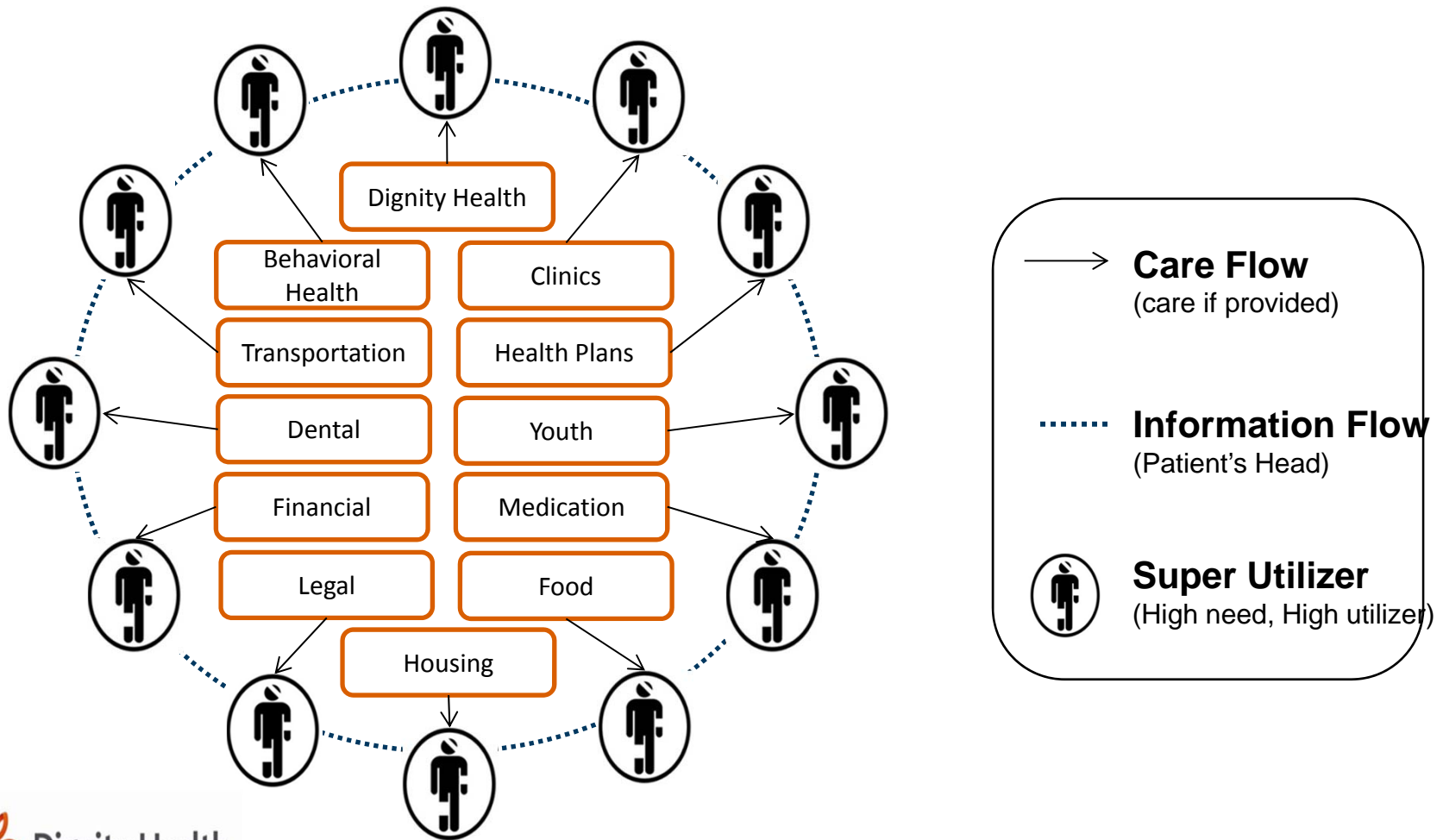
Unified Data Repository and Technology
Integrated or Coordinated Workflows

Benefits

- Enhance Engagement
- Defined Accountability
- Increase Collaboration
- Improve Communication
- Empowered Consumers
- Accurate Outcomes Data
- Better Alignment
- Meaningful Partnerships
- Scalable Solutions
- Effective Programs

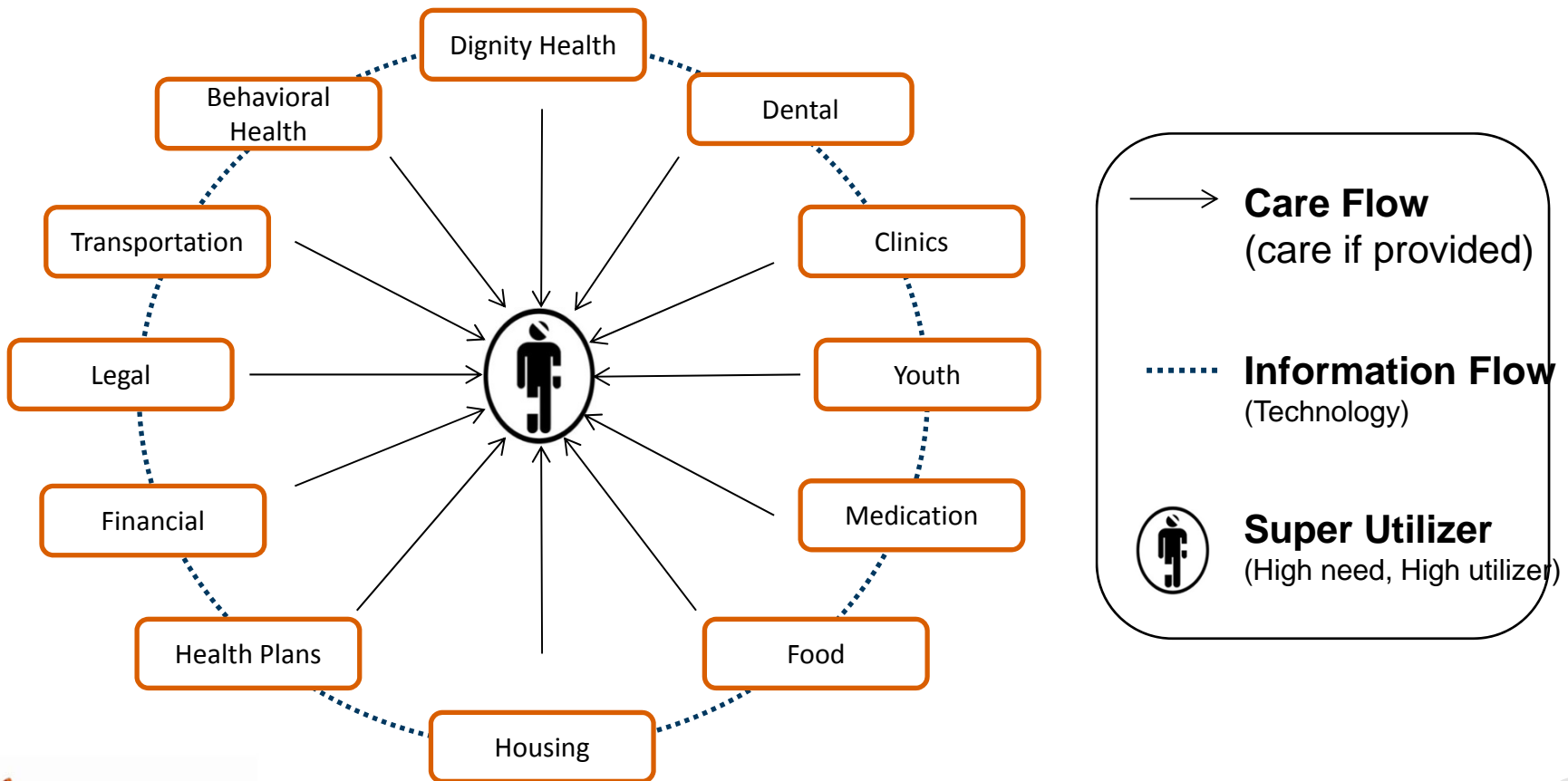
Current State of Care

In the current state of care, information flow is in silo hindering optimal care flow. Super utilizers may tap into multiple community providers but no method to manage care.



Inverting the State of Community Care

The **inverted state of care** pushes the Network of Community Providers out and places the patient in the center. Information flow resides with providers allowing for improved management of the fragile population.



Our Care Navigation tools facilitate collaboration between Community Health teams and community service providers



Phase 1
St. Rose Pilot

Population Health Curaspan – Launched Feb 24

- Electronic Referral System
 - Inpatient care coordination teams to refer for Evidenced Based Programs
- Trained all Social Workers, Care Coordinators and Nurse Managers
- PHASE II - Add Key Community Partners
 - Volunteers in Medicine (medical home)
 - Catholic Charities (homeless services)
 - Three Square (food)
 - Westcare (mental health)
 - Lutheran Social Services/Clark County Social Services

Dignity St. Rose Community Service Programs

- 23 Community Service Programs participating in phase 1 of Dignity Nevada pilot
 - 13 Intake users
- 3 Dignity Health hospitals participating in phase 1 of Dignity Nevada pilot
 - 12 social workers and 10-12 Care Coordinator Assistants (CCAs)

Community Service Programs

Dignity St. Rose - ADA 12-hr Class for Newly Diagnosed
Dignity St. Rose - Cardiac Nutrition
Dignity St. Rose - CDC Diabetes Prevention Program
Dignity St. Rose - Congestive Heart Management Prgm.
Dignity St. Rose - Dash Diet nutrition plan
Dignity St. Rose - Enhance Fitness group exercise program
Dignity St. Rose - Freedom From Smoking
Dignity St. Rose - Kidney Smart management
Dignity St. Rose - Powerful Tools for Caregivers
Dignity St. Rose - Stanford Cancer Thriving and Surviving
Dignity St. Rose - Stanford Chronic Disease Self-Mgmt.
Dignity St. Rose - Stanford Positive Self-Mgmt. for HIV
Dignity St. Rose - Stepping On: Fall Prevention Program
Dignity St. Rose - Tai Chi
Dignity St. Rose - Better Breathers Club
Dignity St. Rose - Medical Nutrition Consultations
Dignity St. Rose - Stanford Diabetes Self-Mgmt. Program
Dignity St. Rose - Nevada Tobacco Quitline
Dignity St. Rose - WIC (Women Infant Children Nutrition program)
Dignity St. Rose - SNAP (supplemental nutrition program)
Dignity St. Rose - Nevada Health Link/Medicaid Enrollment
Dignity St. Rose - Breast Cancer Navigator
Dignity St. Rose - Helping Hands Transport for Seniors

Curaspan Referrals since Feb 2016

Referrals	
WIC / SNAP	59
NDPP	31
CDSMP	26
DSMP	45
DASH Diet Nutrition	6
Tai Chi	1
Freedom from Smoking	13
Champ	34
Better Breathers	29
Cancer Thriving & Surviving	10
NV Health Link	25
Cardiac Nutrition	12
Kidney Smart	10
Powerful Tools for Caregivers	22
Helping Hands	15
Stepping On	7
ADA - 12 hour	21
SNAP	11
NV Tobacco Quit Line	8
Enhance Fitness	2
PSMP	2
Medical Nutrition Consults	21
Total	410

Siena	139
DeLima	87
San Martin	184

Program Completes	
WIC	19
CDSMP	4
Helping Hands	3
DSMP	10
Freedom From Smoking	2
CHAMP	9
Better Breathers	7
Cardiac Nutrition	1
CDC NDPP	1
SNAP	2
NV Health Link	12
Powerful Tools For Caregivers	1
PSMP	1
ADA	1
Kidney Smart	2
	75

Chronic Disease Management

Chronic Disease Management Evidence-based Programs

- Diabetes Management
 - ADA, AADE, Stanford, CDC DPP
 - Kidney Smart
- Congestive Heart Active Management (CHAMP)
- Stanford Chronic Disease Self-Management Programs
 - English & Spanish
 - Positive Self Management for HIV, Cancer Thriving & Surviving
- Stepping On: Fall Prevention
- Better Breathers COPD
- Powerful Tools for Caregivers
- Enhance Fitness

Social Services

- Helping Hands of Henderson
 - Provided 7,512 round trip rides for 412 homebound seniors in Henderson
- Nevada Health Link Enrollment Facilitators
 - Enrolled 353 uninsured in a health plan
- Nutrition/Food
 - 3700 WIC Clients, 300 SNAP enrollments
 - 63 Cancer patients received \$92,087 in financial assistance (Rent, utilities, food, transportation)
- Housing
 - Corporation for Supportive Housing Project

Corporation for Supportive Housing

Dignity Health funded CSH with a 2-year innovation grant for \$125,000 to develop 50 new homeless supportive housing units in Southern Nevada. Over 65 organizations attended to collaborate on creating supportive housing in Southern Nevada.



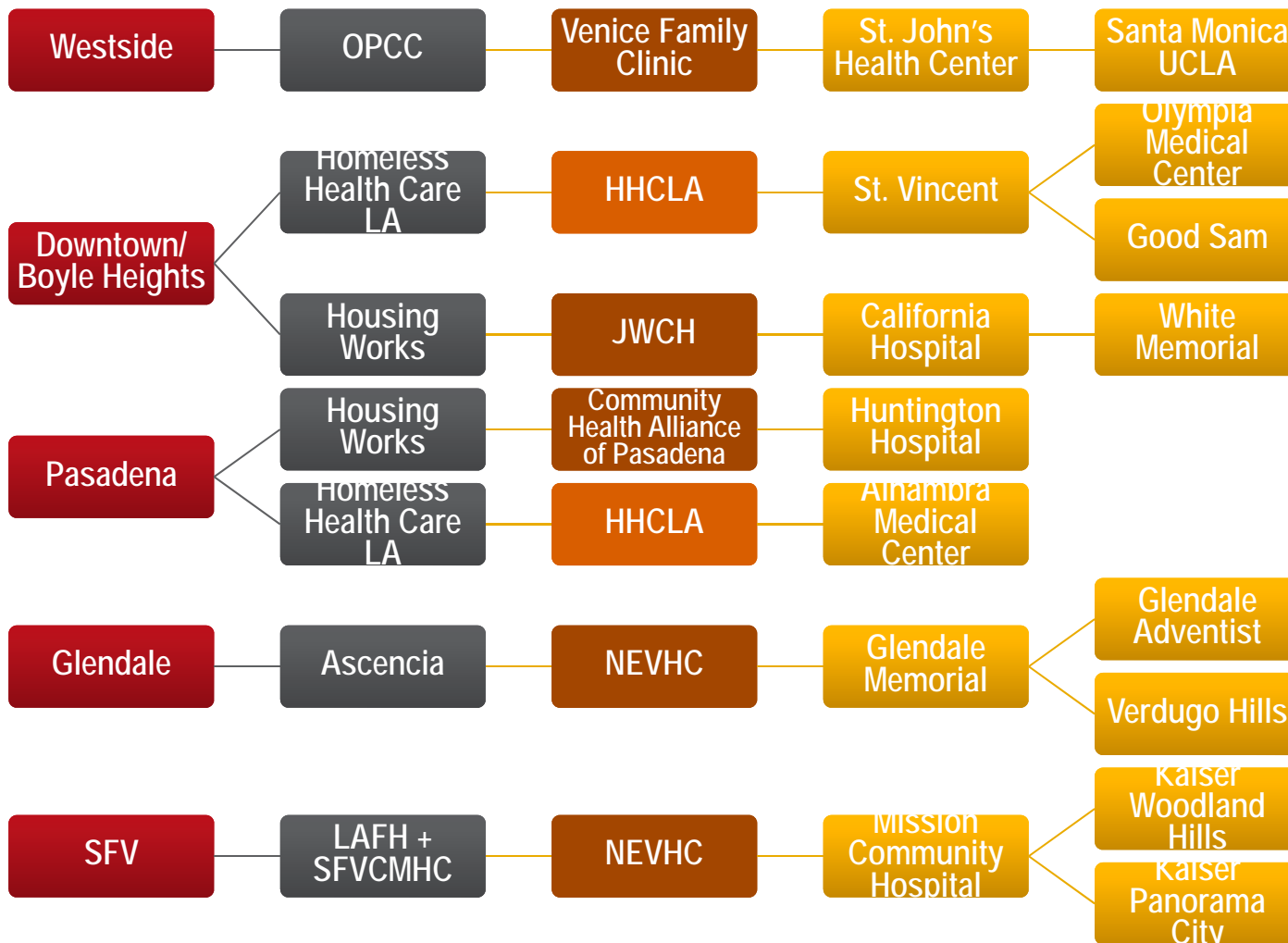


10th Decile Project Collaboratives L.A. County

162 housed to date



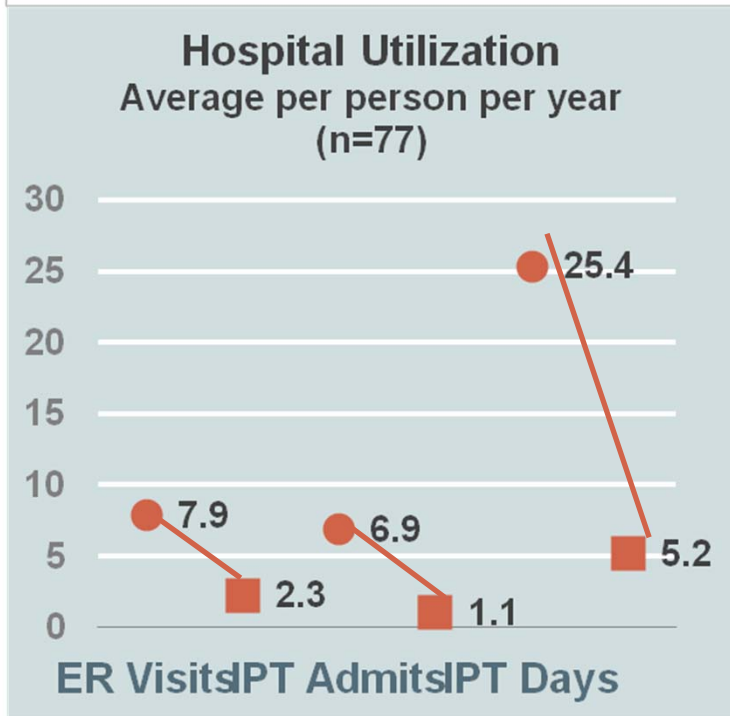
6 COMMUNITIES + 8 HOMELESS SERVICES/BH PROVIDERS + 5 FQHCs + 15 HOSPITALS



Hospital Utilization and Cost Avoidance

➤ 79% Decrease In Actual Hospital Costs Per Client Per Year
(Updated Oct 2014)

10th Decile Project (163 housed to date)



- 12 mos. prior (baseline)
- 12 mos. in 10th Decile Project

ER utilization down 71%
Hosp. readmissions down 84%
Inpatient days down 80%

10th Decile Project Hospital Savings



- 12 mos. prior (baseline)
- 12 mos. in 10th Decile Project

Total costs down 79%

Average cost avoidance per person per year: \$54,106
Est. total 10th Decile Project cost avoidance to date: \$9 M

Case Study – Patient Jeffrey Banks

(name and story used with patient's permission)

Pt ID	Patient Name	Pt Age	Date of Birth	MR#	Pt Type	ED Cases	Cases	Admit Date	Discharge Date	Charges
24477291	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	7/5/2012	7/5/2012	\$481
24488660	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	7/7/2012	7/7/2012	\$1,546
24597908	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	7/30/2012	7/30/2012	\$1,546
24632580	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	8/4/2012	8/4/2012	\$1,546
24826380	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	9/11/2012	9/11/2012	\$1,546
24879934	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	9/20/2012	9/20/2012	\$1,550
24888885	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	9/23/2012	9/23/2012	\$767
25034992	BANKS, JEFFREY D	49	3/23/1963	632875	OUT	1	1	10/22/2012	10/22/2012	\$771
26319616	BANKS, JEFFREY D	50	3/23/1963	632875	OUT	1	1	6/19/2013	6/19/2013	\$1,530
26332478	BANKS, JEFFREY D	50	3/23/1963	632875	OUT	1	1	6/22/2013	6/22/2013	\$2,180
26371062	BANKS, JEFFREY D	50	3/23/1963	632875	OUT	1	1	6/30/2013	6/30/2013	\$1,522

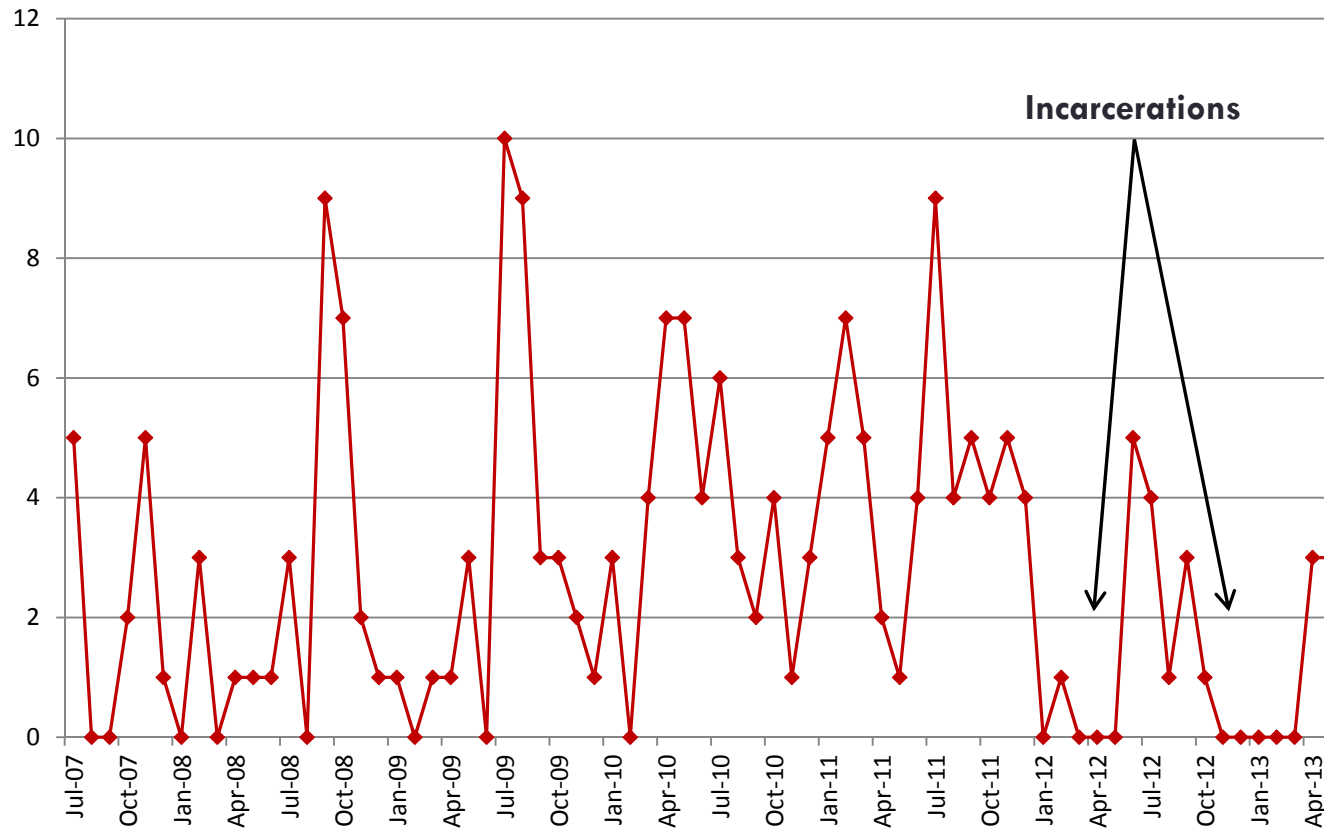
Totals...

- 192 Visits to the ED since July 2007 – no IP admits
- Total account charges of \$358,417

Case Study – Patient Jeffrey Banks

(name and story used with patient's permission)

Jeffrey Banks - ED Visits 2007-2013




Case Study – Patient Jeffrey Banks

(name and story used with patient's permission)

Since FUSE engagement (6/30/13)

- Zero ED visits or hospital admits
- Stably housed at AHI 209 W. Jackson
- Receiving care by Dr. Cardenas at Barrow TBI Clinic
- Employed at local restaurant - obtained food handler's card





Unleash the
healing power
of Humanity