

ACP Comments on

Senate Finance Committee Description of Policy Options for Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

Part I: Insurance Market Reform

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| <p><u>Non-Group and Micro-Group Market Reform</u></p> <p>Federal Rating Rules. This proposed policy would impose federal rating, issue, and other rules for the non-group and micro-group (2-10 employees) market. Guaranteed issue and guaranteed renewal rules would be imposed (using the same rate adjustment factors used at issue) on all coverage offered in the non-group and micro-group market, and exclusion of coverage for pre-existing health conditions would be prohibited. Rates in this market would vary based only on the following characteristics: tobacco use, age, and family composition. More specifically, premiums could vary by a certain ratio for each characteristic, as follows:</p> <ul style="list-style-type: none"> • Tobacco use not to exceed 1.5:1 • Age not to exceed 5:1 • Family composition <ul style="list-style-type: none"> ○ single 1:1 ○ adult with child 1.8:1 ○ family 3:1 ○ two adults 2:1 <p>Premiums could also vary among rating areas to reflect geography. Taking all permissible factors together, premiums</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy.</p> <p>ACP recommends that as with FEHBP, premiums should not be risk-rated for pool enrollees, and participating plans should not decline coverage for subsidy recipients enrolling through the pool. The Secretary should develop, and pool operators should use, age-based and/or other specific risk adjustment mechanisms that, without affecting enrollee premium payments, effectively compensate plans for higher-cost enrollees.</p> |
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| <p>could not vary by more than a 7.5:1 ratio.</p> <p>The Secretary would be required to implement a system for risk adjustment comparable to that used for adjusting Medicare payments to private plans.</p> | |
| <p><u>Small Market Reforms</u></p> <p>Federal Rating Rules. The same federal rating rules that apply to the non-group and microgroup markets would also apply to the remainder of the small group market (as defined by the state).</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy.</p> <p>ACP recommends that small employers should have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees through a purchasing arrangement modeled on the Federal Employee Health Benefit Program.</p> |
| <p><u>Health Insurance Exchange</u></p> <p>Plan Participation. All state-licensed private insurers in the non-group and small group markets, and the public health insurance option if applicable, operating nationally, regionally, statewide, or locally would be required to participate in the Health Insurance Exchange. Private insurers would also be permitted to sell these policies directly to purchasers.</p> <p>Small Employer Participation in the Health Insurance Exchange. Micro-groups (2-10 employees) could purchase insurance through the Health Insurance Exchange immediately. The remainder of small employers can purchase through the Health Insurance Exchange once the federal rating rules are fully phased in by their state, but they would have to pick only one of the four benefit levels (lowest, low, medium or high) for their contribution level. The tax exclusion for employer-provided health insurance allowed under current law would continue to apply in a case where the small business opts to purchase through the Exchange. The</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent ACP policy.</p> <p>ACP recommends that tax credit recipients should have the options of buying coverage through state purchasing group arrangements modeled after the Federal Employees Health Benefits program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified non-group insurers. Plans that participate in the purchasing group would be required to agree to uniform new federal rules on risk-rating and renewability as a condition of participating in the program.</p> <p>ACP recommends that small employers should have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees.</p> |

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| small group health insurance policy would be deemed a “group health plan.” | |
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Part II: Making Coverage Affordable

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| <p><u>Benefit Options</u></p> <p>All health insurance plans in the non-group and small group market would be required, at a minimum, to provide a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services, which at least meet minimum standards set by federal and state laws. In addition, plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing (e.g., deductibles, copayments) for preventive care services. Another option would be to allow plans to charge nominal cost-sharing for prevention services.</p> <p>All insurers would be required to offer all four of the following benefit options:</p> <ul style="list-style-type: none"> • High option would have an actuarial value (defined as the percentage of health care expenses paid by the plan) of 93 percent; • Medium option would have an actuarial value of 87 percent; • Low option would have an actuarial value of 82 percent. • Lowest option would have an actuarial value of 76 percent. | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy but we recommend consideration of the following:</p> <p>ACP recommends that to participate in such a health insurance exchange pool, a health plan should be licensed in the applicable state (or be a FEHBP-participating national indemnity plan exempt from state regulation under FEHBP); should provide requested information, described below, to pool operators; and should offer coverage in one of the following three categories:</p> <p>1) Benchmark coverage. Such coverage should have benefits not less than, and out-of-pocket cost-sharing not greater than, one of the following:</p> <ul style="list-style-type: none"> a) The most highly subscribed FEHBP plan among federal employees during the prior year b) Nonwaivered Medicaid or SCHIP coverage in the state <i>or</i> c) The most highly subscribed plan in the state among either state employees or commercial, non-Medicaid HMO enrollees during the prior year. <p>2) Benchmark-equivalent coverage. To qualify as benchmark-equivalent, a plan should:</p> <ul style="list-style-type: none"> a) Have an aggregate actuarial value not less than a benchmark plan <i>and</i> b) Cover the most recent set of essential benefits recommended as recommended by an expert Commission and adopted by Congress. (Please see our comments below on the proposed expert commission). |
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| <p>Each plan design would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital, (2) outpatient hospital, (3) physician services, and (4) other items and services, including mental health services. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. Generally, Part D plans must offer two drugs in each class or category. The Secretary could allow some flexibility in plan design to encourage widely agreed upon cost and quality effective services but could discourage plan designs that could lead to adverse selection. Participating insurers in the Exchange would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased from the exchange, from a broker or directly from the insurance carrier).</p> | <p>3) Alternative coverage should offer benefits not less than, and out-of-pocket cost-sharing not greater than, an FEHBP fee-for-service or HMO plan that does not provide benchmark coverage.</p> <p>Additionally, an expert advisory commission should be created to recommend core set of benefits that participating health plans will be encouraged to offer. The commission should make periodic recommendations about benefits and cost-sharing to be included in health coverage for various groups, taking into account the special health care needs of children and of people with disabilities, differential ability to pay for services out of pocket among various populations, incentives for efficiency and cost-control, preventive care, disease management services, and other factors. We recommend such essential recommended benefits be approved by Congress on an up or down vote that limits amendments (base closing model).</p> |
| <p><u>Low-Income Tax Credits</u></p> <p>The proposal would provide a tax credit for low income taxpayers who purchase health insurance through the Exchange. The tax credit would be refundable and paid in advance. The tax credit would be in the form of a “premium subsidy” that would help offset the cost of purchasing health insurance. The tax credit would be available for individuals (single or joint filers) with modified adjusted gross income (“MAGI”) between 100 and 400 percent of the federal poverty level (FPL).</p> <p>The level of coverage subsidized would depend on the individual's MAGI. The individual would be required to pay a premium capped at a specified percentage of MAGI that increases as the individual's</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy.</p> <p>ACP recommends that states should have the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion to be paid for by a dollar-to-dollar increase in the federal matching program. States should also have the option to unify SCHIP and Medicaid coverage so that families are covered under a single program.</p> <p>Advance, refundable, and sliding scale tax credits should be made available to uninsured working Americans with incomes up to 200% of the federal poverty level. The tax credit should provide a premium subsidy equal to what the federal government now provides to its own employees. Although ACP policy</p> |

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| <p>MAGI increases. The tax credit is available to individuals between 100 and 400 percent of FPL. The subsidized coverage would be divided into three levels: high benefit option for individuals with MAGI between 100 and 200 percent of the FPL; medium benefit option for individuals with MAGI between 200 and 300 percent of the FPL, and low benefit option for individuals with MAGI between 300 and 400 percent of the FPL. The subsidized coverage would be tied to the premium for the second lowest cost option in the individual's area for the level of coverage subsidized. Individuals would be able to buy a higher level of coverage but they would pay the full difference in the premium. As an individual's MAGI increases, the tax credit phases out on a linear scale.</p> <p>Another option might be that the premium credit would be an amount calculated based on the enrollment-weighted average premium of the qualified low coverage option offered in the service area to be determined by the Secretary of Health and Human Services. In addition, there would be cost sharing assistance to limit the amount of cost-sharing an individual is required to pay up to the valuation of the high coverage option for those between 100 and 200 percent of FPL and the medium coverage policy for those between 200 and 300 percent of poverty.</p> <p>The tax credit would be effective for months of coverage beginning on or after January 1, 2013 (or sooner if possible).</p> | <p>recommends that an expert advisory commission be established to provide recommendations on expanding coverage to individuals with incomes above 200% FPL, we agree that individuals above 200% of the FPL will need assistance in ensuring access to affordable coverage. Accordingly, ACP is open to supporting advance, refundable, and sliding scale tax credits for individuals above 200% of the FPL but recommends that mechanisms be created to guard against “crowd out” of employer-based coverage.</p> |
| <p><u>Small Business Tax Credits</u></p> <p>The proposal would provide a tax credit to certain small employers for the purchase of employer provided health insurance. The credit would be provided for each full time employee covered and would be equal to 50 percent of the average total premium</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy.</p> <p>ACP proposes that small employers should have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees.</p> |

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| <p>cost paid by the employer for employer sponsored coverage in the employer's State. For this purpose, full time employee means an employee who generally works 30 hours a week. The credit would vary based on the type of coverage (i.e., single, adult with child, family or two adults) provided to the employee. The full amount of the credit would be available to an employer with 10 or fewer full time employees, and whose employees have average annual wages from the employer of less than \$20,000. The credit would phase out for employers with more than 10 employees but not more than 25 full time employees. Simultaneously, the credit would phase out for an employer for whom the average annual wages per employee is between \$20,000 and \$40,000.</p> <p>The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable.</p> | <p>Additionally, ACP policy would permit small businesses to purchase coverage through the exchange, and enrollees premiums would be the same as those receiving tax credits.</p> |
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Role of Public Options

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| <p>SECTION III: Public Health Insurance Option</p> <p><i>Proposed Option A</i></p> <p>There are several major issues that must be resolved in detailing a public health insurance option. The first issue is how providers will be reimbursed for services they provide to enrollees of the public option. The second is whether or not the public option will be required to establish provider networks or can it compel providers to participate. The third is whether the public option will be required to have reserve funds to cover their incurred but not reported claims. The</p> | <p><u>ACP Policy</u></p> <p>ACP's proposal to provide all Americans with access to affordable health insurance coverage calls for qualified persons to have access to coverage offered through a purchasing pool or health exchange modeled on the FEHB, with the same types and variety of health plans offered to federal employees and subsidized through advance, refundable, and sliding scale tax credits, as discussed above. Federal employees do not currently have access to public health insurance options, such as enrollment in Medicare, other than the qualified private insurance plans offered</p> |
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| <p>fourth is whether or not the premiums collected by the public option will be required to cover costs or can shortfalls will be subsidized by the federal treasury. Finally, there is the issue of administration of the public option and whether it will be done by a federal agency or by a third party.</p> <p>Three separate options for a public health insurance plan are described below.</p> <p>Approach 1: Medicare-Like Plan</p> <p>This proposal would establish a “Medicare-like” public health insurance option to be offered through the Exchange. The public option would be administered by a new agency within the Department of Health and Human Services (HHS). Eligibility rules, markets, and income related tax credits for the public option would mirror those for all other plans offered through the Exchange. Medicare providers would be required to participate in the public option, and would be paid Medicare rates plus 0-10%. Rating rules would apply to the public option in the same way that they apply to plans offered through the Exchange in the non-group and small group markets. (Rating rules restrict the variation in price of insurance policies according to the risk of the person or group seeking coverage and are explained in the section on non-group market rating rules and risk adjustment.)</p> <p>Risk adjustment would apply to the public option in the same way that it applies to plans offered through the Exchange in the non-group and small group markets. (Risk adjustment is an adjustment in the payment for an insurance policy which reflects the expected variation in expenditures of sicker or healthier individuals. See the section on non-group</p> | <p>through the FEHBP. ACP currently is analyzing the concept, feasibility, and desirability of also providing a public plan option in addition to qualified plans offered through the FEHBP and will have more specific recommendations to offer at a later time. Accordingly, ACP is unable to provide specific comments relating to options A and B. Among the issues we expect to address in our analysis of qualified insurance options, private or public, that might be offered by an health insurance exchange are the following questions:</p> <p>What will the physician payment structure be for plans offered through a health exchange, including the degree by which the payment structure supports or undermines patient-centered primary care?</p> <p>Will payments be sufficient to ensure adequate participation by physician specialty and locale and competitive with other plans in the geographic market and will there be safeguards to ensure such?</p> <p>Will the benefits required of participating plans include coverage of preventive and care coordination services and the Patient Centered Medical Home (PCMH)?</p> <p>How will such plans be administered to ensure a level playing field and to reduce conflicts of interest?</p> <p>Will physicians and patients alike have the choice of deciding, on a plan-by-plan basis, if they wish to participate in a qualified plan?</p> <p>ACP notes, for example, that basing payments to physicians under qualified plans on the existing Medicare rates would result in across-the-board payment cuts to physicians under the Sustainable Growth Rate; the continued undervaluation of primary care services; and continued incentives for volume-based care instead of value-based payments, unless Congress were to mandate major reforms in Medicare payment policies, including repeal of the SGR, as ACP has recommended in its</p> |
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| <p>market rating rules and risk adjustment.) The public option would incorporate any medical delivery system reforms adopted from the overall reform effort. The public option would not have solvency requirements. The public option would start and accept enrollees on the same date that the Exchange begins.</p> <p>Approach 2: Third Party Administrator Proposal 2 would be similar to Proposal 1 with the following differences. First, instead of being operated by HHS, the public option would be administered through multiple regional third-party administrators (TPAs) who would be required to report to the Secretary. This governance structure will be separate from the agency overseeing competition among other private plan options. Second, the TPAs would be required to establish networks of participating medical providers. Payments for participating providers would be negotiated by the TPAs. Lastly, the public health insurance option would be required to have reserve funds.</p> <p>Approach 3: State-Run Public Option Proposal 3 envisions a State-run public option. This option could either be mandatory or optional for States but the details of its administration will be left to the States. One possible option for the States might be to allow individuals to purchase coverage through the State employee plans.</p> <p><i>Proposed Option B</i></p> <p>Option B does not include a public health insurance option and instead relies on private options in a reformed and well regulated private market</p> | <p>comments on delivery system reform. ACP looks forward to learning more about how the SFC’s options would address these and other questions and will share our additional thoughts on a public plan option at a later date.</p> <p>ACP policy supports a Medicare buy-in program for individuals from ages 55 to 65.</p> |
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| <p><u>Medicaid Coverage</u></p> <p>Effective soon after enactment, all state Medicaid programs would be required to raise income eligibility for pregnant women, children, and parents. For example, make parents, pregnant women, and all children eligible up to 150 percent FPL. In addition, states would be required to maintain income eligibility for all previously eligible populations upon enactment, and this maintenance of effort would expire when the Secretary of HHS determines that the Exchange is fully operational. The Secretary would be directed to identify obsolete eligibility categories in light of these eligibility expansions.</p> <p>No income disregards would be permitted for any Medicaid eligible population. Income would be measured based on modified adjusted gross income (MAGI), the same definition used by the Exchange to determine eligibility for the tax credit. This would ensure alignment between eligibility for Medicaid and eligibility for credits to purchase coverage through the Exchange.</p> | <p><u>ACP Policy</u></p> <p><u>This proposal is generally consistent with ACP policy.</u></p> <p>ACP proposes that States should have the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion to be paid for by a dollar-to-dollar increase in the federal matching program. States should also have the option to unify SCHIP and Medicaid coverage so that families are covered under a single program. The ACP is open to extending Medicaid eligibility to more than 100% of the FPL but safeguards would need to be in place to reduce crowd-out of private insurance. ACP also supports simplifying enrollment in the Medicaid and SCHIP programs.</p> |
| <p><u>Medicaid Program Payments</u></p> <p>Through 2015, the federal government would fully finance all expenditures for benefits provided to individuals newly eligible for Medicaid as a result of increases in income eligibility. The state share of these costs would be phased in over the next five-year period. Thus, in each year of this period, states would become responsible for an additional 20 percent of the otherwise applicable state share of benefit costs. After this phase-in period, the state share of these</p> | <p><u>ACP Policy</u></p> <p><u>This proposal is generally consistent with ACP policy.</u></p> <p>ACP supports a dollar-for-dollar increase in federal reimbursement to states that expand their Medicaid programs to cover all individuals with incomes up to 100% FPL.</p> |

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| <p>costs would be equal to the applicable proportion established under the FMAP formula. Alternatively, the federal government could pay an increased share for benefits provided to all populations for a certain duration.</p> <p>For services provided to existing eligibility groups, and under existing waivers authorized in section 1115 of the Social Security Act, both the federal and state governments would share in the costs, as established under the FMAP formula. For administrative services, the current law rules for determining the federal and state share of costs would apply.</p> <p>Finally, this option could require that payments to all providers not fall below a given percent (<i>e.g.</i>, 80) of Medicare reimbursement rates for the same or similar services.</p> | |
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Section V: Shared Responsibility

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| <p><u>Personal Responsibility Coverage Requirement</u></p> <p>Open Enrollment Periods in the New Market. All individuals would have a personal responsibility requirement to obtain health insurance coverage. The initial open enrollment period for eligible individuals in the non-group market would last approximately three months. Special enrollment periods would be allowed for</p> | <p><u>ACP Policy</u></p> <p>This proposal is generally consistent with ACP policy.</p> <p>ACP proposes that once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the coverage plan, by applying individual mandates, employer mandates,</p> |
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| <p>qualifying events.</p> <p>There would also be an annual open enrollment period when individuals could change plans. If an individual takes no action, they will maintain coverage in their current plan. Another possible option is that during an initial 45-day open enrollment period, all coverage would be guaranteed issue, with no limits on pre-existing conditions. For those who did not enroll during their initial enrollment opportunity, carriers could exclude pre-existing conditions for up to 9 months and charge higher premiums.</p> <p>Coverage and Enforcement. All individuals would be required to purchase coverage through (1) the individual market, meeting requirements of at least a lowest cost option, (2) any grandfathered plan, or (3) in the group market, a plan that has an actuarial value equal to the lowest coverage option, with no annual or lifetime limits allowed. Exemptions from the coverage requirement would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens.</p> <p>Consequences of Non-Coverage. In order to ensure compliance, taxpayers would be required to report the months for which they have the required minimum coverage for themselves and family members on their federal income tax returns. In addition, the insurer would be required to report months of qualified health coverage to the individual covered and to the Internal Revenue Service. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the</p> | <p>automatic enrollment in publicly funded plans, or some combination of these approaches.</p> <p>ACP's believes that without mandates (such as those requiring employers to provide coverage and individuals to acquire coverage) "achieving universal coverage nationally or in a state is unlikely."</p> |
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| <p>case of self-insured plans). The consequence for not being insured would be an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange for the area where the individual resides. The excise tax would be phased-in and would equal 25 percent of the premium for the first year that the requirement is in effect; 50 percent of the premium for the second year; and 75 percent of the premium for the third year and subsequent years. The penalty would apply for any period for which the individual is not covered by a health insurance plan with the minimum required benefit but would be prorated for partial years of noncompliance.</p> <p>Individuals could apply for an exemption from the penalty in three circumstances: (1) where the lowest cost option available to an individual exceeds 10 percent of income; (2) where an individual is below 100 percent of poverty; and (3) hardship.</p> <p>Effective Date. The individual requirement would be effective beginning January 1, 2013 (or sooner if possible).</p> | |
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SECTION VI: Options to Improve Access to Preventive Services and Encourage Health Lifestyles

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| <p><u>Promotion of Prevention and Wellness in Medicare</u></p> <p>This option would authorize a personalized prevention plan for all enrolled beneficiaries once every five years unless deemed inappropriate. Beneficiaries would first receive a comprehensive health risk assessment including at least a complete medical and family history, age-, gender, and risk appropriate measurements</p> | <p><u>ACP Policy</u></p> <p>ACP policy supports preventive health care including periodic health exams as appropriate and believes that all plans should cover evidence-based preventive services without deductibles or co-insurance, including evidence-based benefits recommended by the U.S Preventive Services Task Force. The payments to physicians for providing such services need</p> |
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| <p>(including height, weight, body mass index, and blood pressure if not already part of the patient’s record). The assessment would also identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health professional as determined by the Secretary. The Secretary would design the assessment, in consultation with relevant groups and entities, as well as set standards for the electronic tools that could be used to deliver the assessment. No co-payment or deductible would apply.</p> <p>Within six months of completing the comprehensive health risk assessment (HRA), the option would authorize Medicare payment for a visit to a qualified health professional to create a personalized prevention plan. The plan would include the following elements: review and update medical and family history; measure the patient’s blood pressure, body mass index and any other measurements identified above not included the HRA; provide a schedule and referral for recommended, appropriate, covered preventive services and immunizations; provide a strategy to address identified conditions and risk factors; identify all medications currently prescribed and all providers regularly involved in the patient’s care; and offer health advice and referral to Medicare-covered health education and preventive counseling or referral to community based interventions to address modifiable risk factors such as weight, physical activity, smoking, and nutrition. Optional elements, if appropriate, include referrals for diagnostic testing, or referrals to review treatment options for beneficiaries with chronic conditions; end of life care</p> | <p>to be sufficient to cover the substantial physician work and practice expenses associated with this benefit including increased payment to the primary care physicians who would be the source of such prevention services for most enrollees. Legislation will also need to ensure a sufficient supply of primary care physicians to provide these and other benefits. In addition, ACP recommends coverage of comprehensive geriatric assessments for elderly patients and care coordination payments to physicians for such assessments. ACP also recommends that the Patient-Centered Medical Home, which is designed to provide comprehensive and longitudinal care including preventive services, should be made a permanent part of the Medicare benefit structure and also made available to SCHIP, Medicaid and enrollees in other qualified health plans, as discussed in ACP’s recommendations on delivery system reform.</p> |
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| <p>planning, and administration of appropriate Medicare covered immunizations and screening tests. No co-payment or deductible applies.</p> | |
| <p><u>Options to Prevent Chronic Disease and Encourage Healthy Lifestyles</u></p> <p>Prevention and Wellness Innovation Grants</p> <p>This option would establish a competitive grant program to promote health and human services program integration, improve care coordination and access to preventive services and treatments, and better integrate the delivery of health care services to improve health and wellness outcomes. The option identifies three approaches states may choose to implement while allowing flexibility to encourage innovation. Additionally, the option would require the Department of Health and Human Services (HHS) to review and make improvements in the administration of its low income programs.</p> <p>Promotion of Team-Based Care. States would submit an application to the Secretary to create locally integrated delivery systems including establishing multidisciplinary care teams. Multidisciplinary community health teams would be required to provide: 1) comprehensive care management and patient and family support in conjunction with primary care providers; 2) care coordination and health promotion activities including access to the range of services needed to maintain and improve health, such as behavioral services and nutritional counseling; and coordination with local public health offices; 3) social and economic support to facilitate patient and family assistance with social support</p> | <p><u>ACP Policy</u></p> <p>ACP supports research on alternative methods of health care delivery.</p> <p>ACP believes that the federal government should provide dedicated funding to states that have requested federal support for their efforts to redesign their health care delivery programs to achieve measurable expansions of health insurance coverage, and to redesign health care financing and delivery systems to emphasize prevention, care coordination, quality, and the use of health information technology through the PCMH..</p> <p>ACP supports creation of transformation grants to states to implement PCMHs for SCHIP, Medicaid and other payers, with a preference for all-payer PCMH programs. We believe that the PCMH is best suited to provide the multi-disciplinary care that is described in this proposal.</p> |

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| <p>services and referral to and coordination with community based programs; and 4) comprehensive transitional care from inpatient to institutional care settings or care provided in community-settings as well as assuring appropriate follow up.</p> <p>Providing Individualized Plans. This option would allow states to implement service integration and delivery reform activities, including developing an individualized plan for health and human service needs of low-income beneficiaries.</p> <p>Other Innovative Approaches. States would be allowed to submit a proposal that meets the goals and objectives of this grant. These proposals must include an evaluation component that assesses the impact of the proposed innovation on the health status of participating individuals. Upon completion of the grants, the Department of Health and Human Services (HHS) would conduct a study of best practices to improve wellness outcomes for low-income families. Following the study, HHS would issue best practices for states on how to establish a well integrated model of care for health maintenance, reducing chronic disease, promoting patient care, and facilitating coordination between health and human service systems. Within two years after HHS issues recommended best practices, states would be required to submit a plan to better integrate services for low-income families, including a description of what programs already provide for individualized plans, and ways to facilitate integration of health and human services.</p> | <p>ACP policy is generally consistent with this proposal.</p> <p>ACP supports creation of federal waiver authority and dedicated funding to support the efforts by states to develop their own innovative coverage and delivery system reforms, including the PCMH, as an alternative to such reforms offered on a federal level, with safeguards to ensure that eligibility and coverage under such state program would be at least equal to that under a federal program.</p> |
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