Silver Linings Playbook: The Affordable Care Act and Implications for Volunteers in Medicine Clinics

Presentation by Susan Dentzer
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This Presentation At A Glance

• Why ACA resembles Silver Linings Playbook

• Implementation successes to date

• Remaining challenges for the nation

• What it all means for VIM clinics: Some core questions
If you read the book or saw the movie...you know that Pat Solitano – former mental patient – wants to

- Be slim and muscular
- Be erudite
- See the Philadelphia Eagles win
- Get his ex-wife Nikki back
“This is what I learned at the hospital. You have to do everything you can, you have to work your hardest, and if you do, you have a shot at a silver lining.”
Parallels to ACA

- It isn’t delusional: We are seeing, and will see, many silver linings come out of ACA implementation.

- These include coverage expansion, healthier people, forced change on delivery system.

- But we shouldn’t delude ourselves that there is much more to be done.
Silver Lining #1: Coverage Expansion and Insurance Market Reforms
Coverage Expansion

- In first open enrollment period 2013-2014, more than 8 million selected a plan through the federally facilitated Marketplace (healthcare.gov)
- Surveys show about ½ formerly uninsured
- 3 million young adults stayed on parents’ coverage
- Estimated 7.2 million total have gained coverage through Medicaid and Children’s Health Insurance Program
- Enrollment in marketplaces continued beyond open enrollment period, with at least 1 million more people enrolling on exchanges

• Estimated 9.5 million fewer uninsured US adults after first open enrollment period under ACA

• Uninsured rate of adults ages 19 to 34 fell from 28 percent to 18 percent; 5.7 million fewer younger adults now uninsured

• 60 percent of people with newly acquired coverage visited a doctor, hospital or paid for a prescription

• 6 in 10 of those would not have been able to afford care prior to becoming uninsured

### Consumer Protections and Reforms in Individual Market

Many states have built on these Federal protections, making them a floor rather than a ceiling.

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Requires insurers to accept every individual who applies for coverage.(^a^)(^b^)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent coverage to age 26</td>
<td>Requires plans that already provide dependent coverage to make it available until a child turns 26.</td>
</tr>
<tr>
<td>Rescissions</td>
<td>Prohibits plans from retroactively cancelling coverage, except in the case of a subscriber’s fraud or intentional misrepresentation of material fact, and requires prior notice to the insured.</td>
</tr>
<tr>
<td>Affordability</td>
<td></td>
</tr>
<tr>
<td>Rating requirements</td>
<td>Prohibits health status and gender rating; allows rates to vary based solely on four factors: family composition, geographic area, age, and tobacco use.(^a^)(^b^)</td>
</tr>
<tr>
<td>Adequacy</td>
<td></td>
</tr>
<tr>
<td>Preexisting-condition exclusions</td>
<td>Prohibits insurers from imposing preexisting-condition exclusions with respect to coverage.(^a^)(^b^)</td>
</tr>
<tr>
<td>Essential health benefits</td>
<td>Requires coverage of 10 categories of essential benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.(^a^)(^b^)</td>
</tr>
<tr>
<td>Actuarial value</td>
<td>Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers—bronze (60%), silver (70%), gold (80%), or platinum (90%)—as a measure of the portion of costs covered by the plan, on average.(^a^)(^b^)</td>
</tr>
<tr>
<td>Annual cost-sharing limits</td>
<td>Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles.(^a^)(^b^)</td>
</tr>
<tr>
<td>Annual dollar limits</td>
<td>Prohibits annual limits on the dollar value of essential health benefits.(^a^)</td>
</tr>
<tr>
<td>Lifetime dollar limits</td>
<td>Prohibits lifetime limits on the dollar value of essential health benefits.</td>
</tr>
<tr>
<td>Preventive services without cost-sharing</td>
<td>Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.(^a^)</td>
</tr>
<tr>
<td>Transparency</td>
<td></td>
</tr>
<tr>
<td>Summary of benefits and coverage</td>
<td>Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing limitations, and exclusions of a plan; summaries must including specific coverage examples that illustrate how the plan covers common benefits scenarios.</td>
</tr>
</tbody>
</table>

\(^a^)\ Does not apply to grandfathered plans (those in existence before the Affordable Care Act that have not made significant changes since March 23, 2010).

\(^b^)\ Does not apply to policies renewed pursuant to the Obama Administration’s transitional policy for expiring coverage.

Affordability

- Individuals choosing silver plans tended to select the lowest or second-lowest cost plan (65 percent)

- Premium tax credits average $4,152

- Nearly 7 in 10 of individuals who selected a plan with tax credits through the federally facilitated Marketplace have coverage that costs $100 or less per month (after credits)

- Average premium = $69/month

## High Cost-Sharing for Consumers in Exchange Plans

- Exchange plans at lower tiers impose high cost-sharing on individuals before they reach their out-of-pocket maximums.

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
<th></th>
<th></th>
<th>Bronze</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lowest</td>
<td>Highest</td>
<td>Average</td>
<td>Lowest</td>
<td>Highest</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$1,500</td>
<td>$5,000</td>
<td>$2,550</td>
<td>$2,000</td>
<td>$6,350</td>
<td>$5,150</td>
</tr>
<tr>
<td><strong>Pharmacy Coinsurance for Tier 3 and 4</strong></td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
<td>20%</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Primary Care Visit</strong></td>
<td>$5</td>
<td>$50</td>
<td>$30</td>
<td>$15</td>
<td>$60</td>
<td>$39</td>
</tr>
</tbody>
</table>

More than double the average deductible in an employer-provided plan

Source: Avalere Health
More Affordability Challenges?

- Catastrophic plans also available for people under 30 and people with hardship exemptions.

- Premiums may be 20% lower, but deductibles = $6350 for individuals, $12,700 for family.

- Proposals for “copper” plans to be added to existing four metal tiers of actuarial value; would have even higher deductibles and cost sharing requirements than bronze plans (though subsidies available to those with lower incomes to offset these).
PREMIUM CHANGES FROM 2014

Ranges across all rating areas in 15 states

Maximum decrease $ Maximum increase

Lowest-price bronze plans
-40% +27%

Lowest-price silver plans
-44% +17%

2nd lowest-price silver plans
-46% +15%

IMPACT OF PREMIUM CHANGES

Percentage of subsidy-eligible population across 15 states**

63% Will see net premium increase in lowest-price silver plan

37% Will see net premium decrease in lowest-price silver plan

**Based on 175% FPL, 40 year-old non-smoker for all states except D.C., based on 215% FPL, 40 year-old non-smoker in D.C. due to Medicaid eligibility standards.

SOURCE: Public individual market exchange filings released as of July 3, 2014 for CO, CT, DC, IN, ME, MD, MI, NV, NY, OR, RI, TN, VT, VA, WA. Rates are preliminary and have not gone through the rating process. Last updated July 5, 2014.
# Medicaid Cost-Sharing

## Updated Medicaid Cost Sharing Rules

<table>
<thead>
<tr>
<th>Service</th>
<th>Individuals with Family Income ≤100% FPL</th>
<th>Individuals with Family Income 101-150% FPL</th>
<th>Individuals with Family Income &gt;150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services (physician visit, physical therapy, etc.)</td>
<td>$4</td>
<td>10% of cost the agency pays</td>
<td>20% of cost the agency pays</td>
</tr>
<tr>
<td>Inpatient Stay</td>
<td>$75</td>
<td>10% of total cost the agency pays for the entire stay</td>
<td>20% of total cost the agency pays for the entire stay</td>
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<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
<td>$4</td>
<td>$4</td>
</tr>
<tr>
<td>Non-Preferred Drugs</td>
<td>$8</td>
<td>$8</td>
<td>20% of cost the agency pays</td>
</tr>
<tr>
<td>Non-emergency Use of the Emergency Department</td>
<td>$8</td>
<td>$8</td>
<td>Cannot Equal or Exceed the Amount the Agency Pays for the Service</td>
</tr>
</tbody>
</table>
Who Signed Up?

• Many younger adults: Exchange enrollment in a number of states was in younger demographic (18-34 years) – e.g., Washington

• Some sick: Kaiser Family Foundation Survey shows that, among those who signed up for exchange coverage, 1 in 5 rate their health as fair or poor

• “Sick Drawn to New Coverage in Health-Law Plans” - Wall Street Journal, June 20 2014

• Enrollees ‘showing higher rates of serious health conditions than other insurance customers, according to an early analysis of medical claims [from Inovalon]...

• ‘Among those health-law marketplace enrollees who have seen a doctor or other health-care provider in the first quarter of this year, around 27% have significant health issues such as diabetes, psychiatric conditions, asthma, heart problems...’
What Happened To Those Who Became Covered?

- More adults reported having a personal doctor.
- They had fewer difficulties paying for medical care.
Many confused about health insurance

Kentucky experience: ‘I didn’t pay my premium last month because I didn’t use my coverage’
Problematic sign-ups?

- 89% of inconsistencies (Social Security numbers, e.g.) between data submitted by applicants and that in Federal Data Hub unresolved

- Some internal controls, such as verifying legal presence in US, didn’t meet requirements (and some number may have enrolled illegally)
Coverage Expansion: The Remaining Cloud for the Nation...And A Responsibility for VIM Clinics

- In states that had expanded Medicaid by June 2014, Medicaid and CHIP enrollment rose by more than 18.5 percent compared to July-September 2013 baseline period.
- In states that did not expand Medicaid, Medicaid and CHIP enrollment rose by 4 percent.
- Many low-income adults in particular remain uninsured, including in states that expanded Medicaid.

STATES REFUSING TO EXPAND MEDICAID WILL LEAVE 5.7 MILLION AMERICANS UNINSURED

4.3 MILLION RESIDENTS IN STATES EXPANDING MEDICAID COVERAGE WILL GAIN ACCESS TO AFFORDABLE HEALTH INSURANCE

Medicaid Non-Expansion

- 24 states have so far declined to expand in any way
- Will have passed up $88 billion in federal funding in 2014-2016
- About 2/3 of uninsured rural residents live in states that have not expanded Medicaid
- Rural individuals more likely to fall into “coverage gap” (below 100% FPL)
- Alabama, Mississippi, Maine, South Dakota in particular

Source: Kaiser Commission on Medicaid and Uninsured May 2014 Issue Brief, “The Affordable Care Act and Insurance Coverage in Rural Areas,” by Vann R. Newkirk II and Anthony Damico
Figure 2: Projected Increase in Utilization of Preventive Care if States Expand Medicaid, by Current Expansion Status

Increase in annual number of individuals receiving specified type of care

- States Expanding Medicaid
- States Not Yet Expanding Medicaid

Sources: Urban Institute; Baicker et al. (2013); CEA calculations.
Note: Estimates reflect effects when expanded coverage is fully in effect. See text for methodological details. Increases in receipt of mammograms reflect only women 50 and older.
Figure 3. Projected Annual Number of Additional Cholesterol-Level Screenings if Each State Decides to Expand Medicaid

Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details.
A Silver Lining: Delivery System Reform Incentive Payment (DSRIP) Waivers

- Medicaid funding tied to payment and delivery system reforms, including system redesign, infrastructure development, population health, and quality care improvements

- To date, six states—California, Texas, New Jersey, Kansas, New York, and Massachusetts—have received approval as part of 1115 waivers; several other considering

- Texas’s waiver (Transformation and Quality Improvement Program) has potential to increase state revenues to $30 billion over 2011-2016

- In some states, only public hospitals are eligible entities, while in others “safety net providers” (including nonpublic hospitals and other categories of providers) are eligible through a collaborative provider network or through affiliation with an anchor public hospital.
The Remaining Clouds/Concerns

- How many will remain uninsured? Probably at least 20 million, including:
  - Those who are exempted from mandate on unaffordability or other grounds
  - The undocumented

- How much care will those with high deductibles and copays be able to afford? Will they need to seek inexpensive or free sources of care?
The Remaining Clouds/Concerns

- How much access do the newly insured have – particularly to primary care providers?
  - CMS conducting new national survey of adult Medicaid beneficiaries’ access beginning in fall 2014
  - HHS has recently announced $400 million in new funding for community health centers and health clinics
Silver Lining #2: With Better Access to Care and Shift to Population Health Focus, People May Be Healthier
Chronic Illness and its Costs

• Chronic diseases (diabetes, cardiovascular, some cancers, etc.) account for 84% of U.S. health care spending

• Chronic illnesses of those under age 65 = 67% of health care spending

• If trauma is added (assault, attempted suicide, motor vehicle accidents), about 80% of total spending is for people under age 65

Aging Baby Boomers Are in Bad Shape – Let Alone Their Kids

- In 2008, 41 percent of those born between 1946 and 1964 had three or more chronic conditions

- 51 percent had one or two chronic conditions

- Only 8 percent had no chronic conditions

- 72% of men and 67% of women were overweight or obese

Rising Mortality, Declining Life Expectancy For Many


- Female mortality rates increased in 42.8 percent of counties, while male mortality rates increased in only 3.4 percent.

- Factors associated with areas that had lower mortality: higher education levels; low smoking rates

Source: DA Kindig, ER Cheng, “Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006.” Health Affairs, March 2013

Cloudy Picture:
Prevention and Public Health Fund

- Originally authorized in ACA at $18.75 billion for FY 2010-2022
- In 2012, Congress passed and the president signed legislation that cut Fund by $6.25 billion to offset a scheduled cut to Medicare physician payments.
- Sequestration cut $51 million from the intended FY 2013 funding level of $1 billion
- HHS diverted $453.8 million to Health Insurance Exchange (Marketplace) implementation activities.

<table>
<thead>
<tr>
<th>The Prevention and Public Health Fund in FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount originally authorized by the ACA in 2010</td>
</tr>
<tr>
<td>Amount authorized after February 2012 cut</td>
</tr>
<tr>
<td>Sequester cut to the fund, March 2013</td>
</tr>
<tr>
<td>Amount diverted to insurance enrollment activities, April 2013*</td>
</tr>
<tr>
<td>Other HHS funds to supplement Prevention Fund activities, April 2013*</td>
</tr>
<tr>
<td>Amount remaining for Prevention Fund public health activities in FY 2013</td>
</tr>
</tbody>
</table>

*The net diversion of resources is $332.5 M ($453.8 M out, $121.3 M back in.)

- Good news: in FY 2014 $1 billion actually Appropriated for prevention and public health!

Source: American Public Health Association
### Prevention and Public Health Fund (PPHF)

**Detailed Activities by Agency**

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2011 Final Allocation</th>
<th>FY 2012 Final Allocation</th>
<th>FY 2013 Final Allocation</th>
<th>FY 2014 Omnibus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Prevention</td>
<td>50.000</td>
<td>83.000</td>
<td>60.302</td>
<td>105.000</td>
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<tr>
<td>Viral Hepatitis Surveillance/Screening</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td>Workplace Wellness</td>
<td>10.000</td>
<td>10.000</td>
<td>0.000</td>
<td>10.000</td>
</tr>
<tr>
<td>CDC Subtotal</td>
<td>610.900</td>
<td>809.000</td>
<td>462.916</td>
<td>831.300</td>
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<tr>
<td>CMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health Insurance Enrollment Support</td>
<td>0.000</td>
<td>0.000</td>
<td>453.803</td>
<td>0.000</td>
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<td>CMS Subtotal</td>
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<td>453.803</td>
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<td>HRSA</td>
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<tr>
<td>Alzheimer's Disease Prevention Education and Outreach</td>
<td>0.000</td>
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<td>1.847</td>
<td>0.000</td>
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<tr>
<td>Mental and Behavioral Health - health professions</td>
<td>0.000</td>
<td>10.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td>Public Health Traineeships</td>
<td>0.000</td>
<td>1.136</td>
<td>0.000</td>
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<td>Public Health Workforce Development</td>
<td>20.000</td>
<td>23.864</td>
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<td>HRSA Subtotal</td>
<td>20.000</td>
<td>23.864</td>
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<tr>
<td>SAMHSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Recovery</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>50.000</td>
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<tr>
<td>Prescription Drug Monitoring Program</td>
<td>0.000</td>
<td>4.000</td>
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<tr>
<td>Primary &amp; Behavioral Health Integration</td>
<td>35.000</td>
<td>35.000</td>
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<td>SAMHSA Healthcare Surveillance</td>
<td>18.000</td>
<td>18.000</td>
<td>14.733</td>
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<td>Screening, Brief Intervention and Referral to Treatment</td>
<td>25.000</td>
<td>25.000</td>
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<tr>
<td>Suicide Prevention - Garrett Lee Smith</td>
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<td>10.000</td>
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<td>SAMHSA Subtotal</td>
<td>88.000</td>
<td>92.000</td>
<td>14.733</td>
<td>62.000</td>
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<td>ACL</td>
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<td>Chronic Disease Self-Management</td>
<td>0.000</td>
<td>10.000</td>
<td>7.086</td>
<td>8.000</td>
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<td>Alzheimer's Disease Prevention Education and Outreach</td>
<td>0.000</td>
<td>4.000</td>
<td>0.150</td>
<td>14.700</td>
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<td>Elderly Falls Prevention</td>
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<td>0.000</td>
<td>5.000</td>
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<td>Elder Justice Research</td>
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<td>6.000</td>
<td>2.000</td>
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<tr>
<td>ACL Subtotal</td>
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<td>20.000</td>
<td>9.236</td>
<td>27.700</td>
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<td>SUBTOTAL, All GDM</td>
<td>19.100</td>
<td>30.000</td>
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<td>0.000</td>
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<tr>
<td>Sequestered Funds</td>
<td>51.000</td>
<td>72.000</td>
<td></td>
<td></td>
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<tr>
<td><strong>Total, All Activities</strong></td>
<td>750.000</td>
<td>1,000.000</td>
<td>1,000.000</td>
<td>1,000.000</td>
</tr>
</tbody>
</table>

*Funds previously allocated through the PPHF, now through discretionary*
Silver Lining: Growing focus on “population health”

• An approach that treats the entire population – not just of the patients in the hospital, but of the community -- as the “patient.”

• The application of strategies, interventions and policies that address a community’s, region’s or nation’s most pressing health concerns.

• A call for unifying our extremely well funded health care system with our woefully underfunded public health system to address these needs.

• Source: “Population Health Implications of the Affordable Care Act: Workshop Summary,” Institute of Medicine, 2013
Hospitals’ New Roles in Population Health

- New requirements under ACA on tax-exempt hospitals and health systems
- To retain 501(c)(3) [tax exempt] status, organization must conduct a “community health needs assessment” at least every three years
- Must adopt implementation strategy to meet the community health needs identified through the assessment
- Penalty: $50,000 excise tax for each year that a tax-exempt hospital subject to these provisions fails to satisfy requirement
Focus on the “Upstream” Determinants of Health

**Social Milieu**
- Economic stability
- Clean air, soil, and water
- Peace, mutual respect, and equity
- Appreciation of cultural arts
- Ease of travel and communications

**Community**
- Adequate levels of economic and social development
- Access to quality schools
- Access to quality health care
- Safe, walkable neighborhoods
- Accessible, affordable, nutritious foods
- Safe, affordable transportation options

**Family**
- Healthy, supportive relationships
- Smoke-free living environment
- Safe and secure shelter
- Access to nutritious foods
- Child, elder, and disabled care assistance

**Individual**
- Active living
- Nutritious diet
- Resilient
- Perceives self-worth
- Practices prevention; avoids harm

Source: Office of Health Equity, California Department of Public Health, 2013
Silver Lining #3: Law is Forcing Health System Change – And Possibly Moderating Cost Growth and Improving Sustainability of System
The First-Ever National Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care

2. Strengthen person and family engagement as partners in their care

3. Promote effective communication and coordination of care

4. Promote effective prevention and treatment of chronic disease

5. Work with communities to promote healthy living

6. Make care affordable
Goals of Payment and Delivery System Innovation
Improving value and affordability

Old Model

- Reward unit cost
- Inadequate focus on care efficiency and patient centeredness
- Payment for unproven services; limited alignment with quality

New Model

- Reward health outcomes and population health
- Lower cost while improving patient experience
- Improve quality, safety, and evidence
Example: Medicare ACOs

Estimated 5.5 million Medicare beneficiaries now have care coordinated by 343 Medicare Shared Savings Plan and 32 Pioneer ACOs.
ACO’s in Medicaid

- Underway or about to launch in Alabama, Colorado, Maine, Massachusetts, Minnesota, Oregon, Texas, Utah, and Vermont

- Formation of integrated or collaborative networks
Opportunities and challenges of a lifelong health system

- Goal of system to optimize health outcomes and lower costs over much longer time horizons

- Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time

- Health trajectories modifiable and compounded over time

- Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368,17:1569-1571
Selected Other Innovations

- CMS’ “Strong Start Initiative”
- Testing ways to reduce early elective deliveries with no medical indication across all payers
- Test and evaluate three models of enhanced prenatal care for reducing preterm births, decreasing cost of medical care during pregnancy, delivery and over the first year of life among Medicaid and CHIP enrollees
- 27 grants for up to $41 million awarded in 2013 for testing enhanced prenatal care through group or centering visits, at birth centers, and at maternity care homes
State Innovation Models under Center for Medicare and Medicaid Innovation

State Innovation Models Initiative: General Information

The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP).

The Participating States

- **Arkansas**: majority of population in patient-centered medical homes
- **Minnesota**: majority of population in ACO’s, including long-term services and supports
- **Oregon**: “Coordinated Care Organizations”
- **Round Two Awards Coming Soon**

Examples:

Source: Centers for Medicare & Medicaid Services
Impact on Cost?

• Coverage broadened, but not as much as it could be given Medicaid non-expansion

• Plan premiums affordable, although they will rise in 2014 and deductibles for many are high and possibly unaffordable

• Access issues remain, particularly in less populated areas of country

• Delivery system transforming, but slowly

• Serious health challenges remain for much of US population; population health approaches beginning to address
What Does All of This Mean For You?

• To extent more people are becoming uninsured, your patient volume is declining and will continue to decline.

• To extent 20 million-plus remain uninsured, your volume won’t disappear - although where depends heavily on state action.

• To extent many people with insurance will still face very high deductibles and co-pays, they will be as good as uninsured for much of their care.

• Issue for you: Since you don’t treat patients with insurance, what will you do for them?
What Does All This Mean For You?

• As new delivery systems emerge, what opportunities exist for you to partner with other community providers to address care and coverage gaps?

• Are you at the table in SIM grant discussions, for example?

• What are potential barriers – e.g., meeting HIPAA and meaningful use requirements – to playing a greater role in community coordination of care?

• To the extent that the attention of health care delivery system shifts more to the upstream determinants of health, what opportunities exist for you to partner with other stakeholders in the community to address these issues?
To go back to the book and movie...

There are clouds and silver linings...
...And there is you!

“We’re still here. We’re not going anywhere.”

—Nancy Franks, former volunteer president, Volunteers in Medicine Clinic, Chattanooga, TN

Source: Chattanooga Times Free Press, 4/6/14
GO EAGLES!!!
Questions or Comments?

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