IMPACT ARIZONA

HEALTHCARE REFORM HITS ARIZONA

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CONTENTS

Healthcare Reform Hits Arizona (Overview) 3

Selected Highlights and Timeline for Health Reform 8

Coverage and Regulation

Insurance Regulation and Health Insurance Exchanges 12

KidsCare and AHCCCS 22

The Healthcare System

Quality and Efficiency of Healthcare 30

The Safety Net 41

The Healthcare Workforce 47

Prevention 54

Special Populations and Issues

Reproductive and Early Childhood Health 63

Behavioral Health Services and Coverage 69

Long-Term Care Services and Coverage 75

Dual Eligible Beneficiaries 83

Indian Health 88

Appendix: Other Selected Resources on Healthcare Reform 95

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OVERVIEW

The *Patient Protection and Affordable Care Act*, along with the subsequent *Health Care and Education Reconciliation Act*, cuts a wide swath across the U.S. healthcare landscape.*

In addition to expanding coverage for millions of uninsured Americans, the Act focuses on efforts to improve the quality and delivery of care and to ensure an effective and well-trained workforce. Among other things, it addresses issues in primary care, long-term care, community health, behavioral health, early childhood and family support, chronic diseases, special populations, health disparities between populations, and prevention and wellness.

The Act is complex, ambitious and contentious. It faces significant legal, financial and administrative challenges in a volatile political and economic climate characterized by shrill polarization and social unrest. It remains to be seen how these forces will impact the Act in the years ahead, but it is safe to assume there will be changes, twists and turns in its provisions and implementation along the way.

Arizona Needs to be Engaged

Whatever the pros and cons of various aspects of the law, it seems only prudent for states to begin to prepare for its implementation to maximize the effective allocation of limited human and financial resources. Although Arizona is one of 22 states suing the federal government over the constitutionality of the Act and faces a dire budget picture over the near-term future, there are good reasons for state executive leadership and a representative body of system stakeholders to become actively engaged in selected aspects of the Act's implementation:

- The rhetoric of a federal takeover of health care notwithstanding, *the Act encourages local experimentation, involvement and control*. There will be numerous opportunities for localities and states to experiment with new ways of organizing, delivering and paying for care; defining and measuring quality of care; new approaches to workforce development and training; new ways of combating the burden of chronic diseases and health disparities; new efforts to lower costs through better care coordination of persons with multiple conditions and disabilities; opportunities to integrate behavioral and physical health care, and more. Arizona, which has always championed independence and innovation, can leverage federal support to experiment with new configurations and approaches for delivering high quality, cost-effective health care. The state can be a leader in exporting *ideas that work* to the rest of the nation.
- *The Act (along with the American Recovery and Reinvestment Act) provides resources for health system planning and infrastructure for such things as health information technology, community health centers and primary care.* Regardless of the fate of this Act or any subsequent piece of healthcare legislation, Arizona needs to invest in an ongoing, collaborative approach

* For the purposes of this report, the two pieces of legistation will be referred to collectively as healthcare reform or "the Act."

to health system planning (such as a comprehensive health workforce plan) and vigorously develop an integrated data and delivery infrastructure that promotes information exchange and transparency, quality of care, and primary and preventive care. The state is already leveraging federal and other resources for some of these purposes and should continue such efforts.

- *The Act provides opportunities for Arizona to improve its patchwork of state health and healthcare programs, the state data analytic infrastructure, and local-state/public-private partnerships.* An innovative state health exchange could help to streamline and integrate access to public and private health coverage programs. The state could enter into a partnership with Arizona businesses to promote workplace wellness. Public-private partnerships could be developed to address issues and conditions like diabetes and obesity, maternal and child health, and prevention and wellness generally. Data and learning networks comprised of state agencies, universities, providers and others could be developed to inform and disseminate best practices in care.

Little Action to Date

So far, Arizona has done little to take advantage of the many opportunities offered from healthcare reform.

Many health providers are moving ahead with reform, integrating systems and preparing for changing incentives to reorganize how they do business. State agencies have begun planning, and our state has already applied for and received some reform-related grants, such as grants for home visitation programs and insurance rate review.

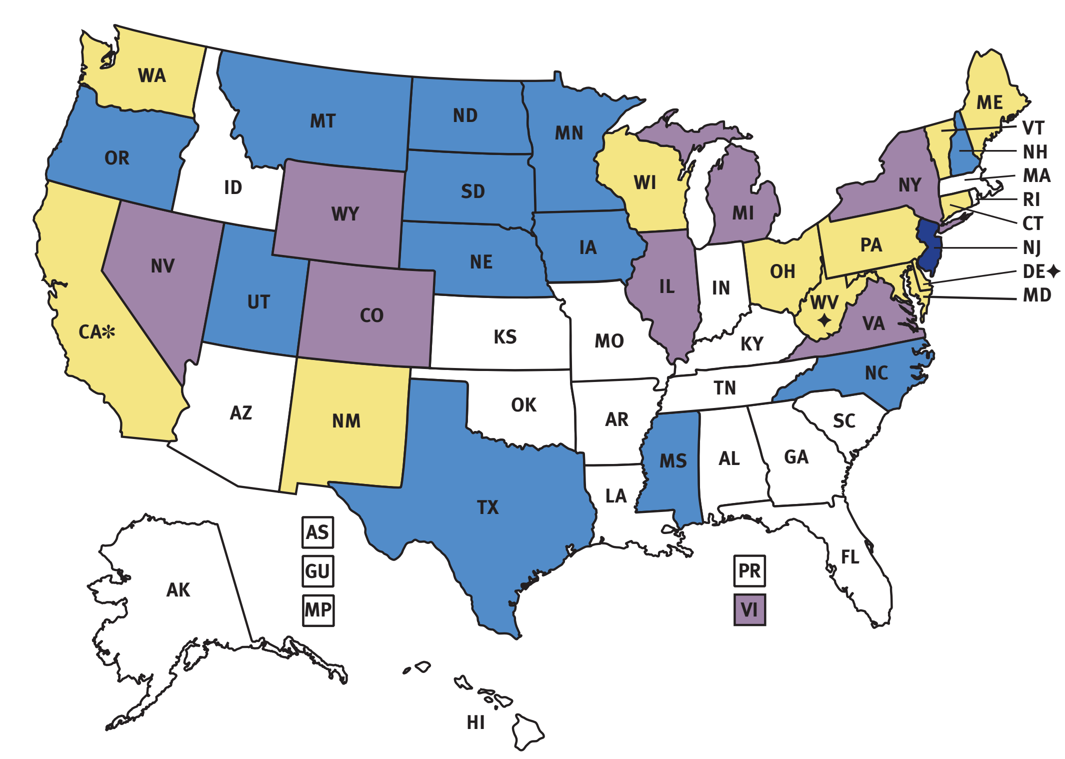
However, Arizona's efforts stand in stark contrast to the organized, collaborative efforts occurring in many other states. (See figure, below.) While political opposition to healthcare reform may explain part of the reluctance to take advantage of reform opportunities, it is important to note that other states such as Texas (whose political leaders publicly oppose healthcare reform) are moving forward with concerted efforts aimed at taking advantage of federal funding opportunities and reform implementation.

STATE ACTIONS IMPLEMENTING HEALTH REFORM

- Pending Bills
- Enacted Law, Adopted Resolution or Assigned to Existing Committee
- Executive Action
- Legistlative and Executive Action

✻ Introduced bills currently pending in the legislatures.

✦ Legislative action/enacted law requires executive action by the state agency or governor.



Source: NCSL, 2010.

Of course, in some instances, it may be in Arizona's best interest not to pursue federal funding opportunities. For example, the Arizona Department of Health Services wisely decided recently not to apply for a federal grant related to fingerprinting, noting that the limited duration for funding and the related implementation requirements would be close to impossible to achieve.

Nonetheless, it is difficult to understand how our state couldn't benefit from workforce planning grants or other opportunities to bring federal monies to the state to address long standing issues impacting the healthcare system (and the overall economy, in this instance).

There is some discussion that more organized, collaborative efforts may begin soon. However, our state will have a lot of catch-up to do. Arizona is already falling behind.

Will the Act Reduce Costs?

Not surprisingly, critics of the Act have raised concerns about its cost-containment measures and overall fiscal impact. While insuring upwards of an additional 32 million U.S. citizens is clearly going to increase public outlays, the Act's defenders project that total healthcare expenditures as a percent of gross domestic product (GDP) will be .5 percent lower in 2030 than they otherwise would have been. They project that the Act will reduce the federal deficit by $100 billion over the first decade and more than $1 trillion between 2020-2030 through such measures as reducing fraud and abuse, savings from administrative simplification, approving more generic biologic agents, eliminating subsidies to Medicare Advantage plans, reducing hospital readmissions, taxing "Cadillac" insurance plans, exploring new methods of payment and care coordination that incentivize quality over quantity of care, establishing a strong Independent Payment Advisory Board (IPAB), and more.[1] While some of these efforts appear promising, it is important to note that the history of cost containment in U.S. health care is not encouraging.

In the short term, states will continue to struggle to pay their share of the publicly funded Medicaid and CHIP health insurance programs. Even with significant new funding from the federal government, states such as Arizona will find it difficult to meet their obligations due to enrollment growth resulting (at least in part) from the economic downturn.

In the long term, there may be cost savings for the state. The Joint Legislative Budget Committee estimates that General Fund costs over the next 10 years (2011-2020) will be reduced by $2.3 billion under the 2010 baseline.[2] However, the budgetary impact of past expansions has varied wildly from predictions, so the ultimate effect is yet to be seen.

It is also unclear how state and federal revenues will continue to support programs such as Medicare, Medicaid and CHIP. Like many others, we foresee a future where resources for health care, education and other "public goods" will be severely constrained. We do not think Arizona or any other state is going to return to some halcyon past where unfettered economic growth and a sea of increasing revenues will "float everyone's boat." That is why we need to think of doing business differently and looking at innovative ways of paying for and delivering health care that actually results in broad access and increased quality at an affordable price.

The Act provides incentives and resources for Arizona and other states to begin to think differently about health care. Instead of staying on the sidelines and succumbing to a climate of negativism, we encourage state policy and healthcare leaders to pursue opportunities for experimentation, innovation and cross-sector partnerships.

We provide an overview of some of those opportunities here.

OUTLINE AND METHOD

In this *Arizona Health Futures* report, we lay out selected major changes contained in the 2010 health reform legislation, provide an overview of the potential impact of these changes on Arizona, and discuss various Arizona policy choices, opportunities and challenges. There are several important qualifications:

- *We don' t cover all the significant changes in the Act.* We are primarily interested in how Arizona may be impacted by various changes and focus our attention accordingly. For example, there are important changes in subsidies for small businesses to purchase health insurance, various changes in regulation and administrative simplification, taxes on certain types of health plans, etc., but these are national in their scope and impact, and have been well summarized by others. We don't discuss them here. (See Appendix, beginning on page 95, for additional sources of information.)
- *Conclusions are exploratory and provisional.* We suspect the Act will be modified in its content and implementation by economic, political and social forces in the years ahead, and what is the case today may not be the case tomorrow. That is one good reason for disseminating the report as an online publication that can be modified and updated as changes occur.
- *The report is a collection of condensed overviews* of different parts of the Act by individual authors, each with his or her analysis of selected provisions. We chose to provide a variety of perspectives on the Act rather than an SLHI-generated interpretation alone.

Three Interrelated Sections

This report is presented in three sections:

Coverage and Regulation

The Act requires nearly all U.S. citizens and legal residents to have qualifying health coverage. It significantly extends health insurance to some 32 million uninsured Americans through the expansion of public programs, employer-based insurance, and the individual insurance market. The Act provides for the creation of state-based health insurance exchanges and makes a number of important changes affecting the availability, regulation and oversight of both private and public health insurance programs and products in an effort to improve access to care.

We focus specifically on the expansion of the Arizona Health Care Cost Containment System (AHCCCS – the state's Medicaid program) and KidsCare (Arizona's CHIP program). We discuss the development of health insurance exchanges – and what form these might take in the state – and general insurance regulation and oversight as they impact Arizona.

The Healthcare System

Expanded coverage will have a profound effect on healthcare providers and the healthcare workforce. As more people are covered by health insurance, there will be increased demand for healthcare workers, and the role of healthcare providers – particularly those who traditionally care for the uninsured or underinsured – will shift.

However, expanded health coverage will not be the only factor affecting healthcare delivery and the healthcare infrastructure. While most of the initial attention on the health reform law has focused on expanding coverage, there are a number of important changes focused on cost containment and improving both the quality of medical care and overall health system performance.

As part of this section, we describe changes in reimbursement rates, new payment models, efforts to focus on quality of care and patient safety, and new models for organizing the delivery of care to foster greater system coordination and integration. We discuss greater emphasis on the central role of primary care in increasing quality and reducing costs. We provide an overview of changes designed to ensure a healthcare workforce that is prepared to respond to new demands for integrated, high quality care.

Efforts to move the health system's focus from an emphasis on acute care and chronic diseases to one on prevention and wellness will also be covered.

Special Populations and Issues

The Act contains numerous provisions aimed at improving health access and outcomes for citizens with unique, challenging or unmet health needs.

In this section, we provide an overview of opportunities related to reproductive and early childhood health, with a focus on new opportunities to prevent unwanted pregnancies and support pregnant women and families in the care and development of young children. We discuss changes in behavioral health services and coverage, including opportunities to better integrate and coordinate care with physical health through medical homes. We examine changes in long-term care services and coverage, and how they might play out in Arizona, and we discuss the special challenges facing dual eligible beneficiaries – people eligible for or enrolled in both Medicaid and Medicare – who tend to be among the poorest, sickest and mostly costly patients in the public system. We also provide an overview of changes in the Act that apply to Indian health and their implications for our state, tribes and American Indians.

References

1 Orszag, P., & Emanuel, E. (2010, August 12). Health care reform and cost control. *New England Journal of Medicine*, 363(7), 601-603.

2 Joint Legislative Budget Committee. (2010, March 30). Analysis of the cost of federal health care legislation. Phoenix, AZ: State of Arizona.

SELECTED HIGHLIGHTS AND TIMELINE FOR HEALTH REFORM

2010

- Creates a temporary national **high-risk pool** for individuals with pre-existing conditions.
- Provides **dependent coverage** for adult children up to age 26 for all individual and group policies.
- Prohibits plans from placing **lifetime limits** on the dollar value of coverage.
- Prohibits insurers from **rescinding coverage,** except in cases of fraud, and prohibits **pre-existing condition exclusions for children**.
- Provides **reinsurance** to employers (including states) that provide health benefits to early retirees.
- Mandates **coverage without cost sharing for preventive services** rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provides **tax credits to small employers** that provide health insurance for employees.
- Requires health plans to report proportion of premium dollars spent on clinical services, quality, and other costs, providing rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85 percent for plans in the large group market and 80 percent for plans in the individual and small group markets. (**Medical loss ratio** requirement effective plan year 2010; rebate requirement effective January 1, 2011.)
- Establishes **process for reviewing increases in health plan premiums** and requires plans to justify increases. Requires states to report on trends in premium increases and recommend whether certain plans should be excluded from the exchange based on unjustified premium increases.
- Creates a state option to provide **Medicaid coverage for family planning services** up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Creates a new option for states to provide **Children's Health Insurance Program (CHIP) coverage to children of state employees** eligible for health benefits if certain conditions are met.
- **Supports comparative effectiveness research** by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Reauthorizes and amends the **Indian Health Care Improvement Act**.
- Establishes the Workforce Advisory Committee to **develop a national workforce strategy**.
- Increases **workforce supply and supports training** of health professionals through **scholarships and loans**.

2011

- Establishes a **national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program)**.
- Eliminates **cost sharing for Medicare covered preventive services** that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening tests. Authorizes the Secretary **to modify or eliminate Medicare coverage of preventive services** based on recommendations of the U.S. Preventive Services Task Force.
- Provides Medicare beneficiaries **access to a comprehensive health risk assessment and creation of a personalized prevention plan** and provides **incentives** to Medicare and Medicaid beneficiaries to complete **behavior modification** programs.

- Provides a 10 percent **bonus payment** to primary care physicians, and to general surgeons practicing in **health professional shortage areas**.
- Provides **grants** for up to five years to **small employers** that establish **wellness programs**.
- Establishes the **National Prevention, Health Promotion and Public Health Council** to develop a national strategy to improve the nation's health.
- Creates an **Innovation Center within the Centers for Medicare and Medicaid Services**.
- **Prohibits federal payments to states for Medicaid services related to healthcare-acquired conditions**.
- **Creates a new Medicaid state plan option** to permit Medicaid enrollees with at least **two chronic conditions,** one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a **health home.** Provides states taking the option with 90 percent FMAP for two years for **health home-related** services including care management, care coordination and health promotion.
- Creates the State Balancing Incentive Program in Medicaid to provide **enhanced federal matching payments to increase non-institutionally based long-term care services**.
- Establishes the Community First Choice Option in Medicaid **to provide community-based attendant support services** to certain **people with disabilities**.
- Develops a **national quality improvement strategy** that includes priorities to improve the delivery of healthcare services, patient health outcomes, and population health.
- Improves access to care by increasing funding by **$11 billion for community health centers and by $1.5 billion for the National Health Service Corps** over five years; establishes new programs to support **school-based health centers and nurse-managed health clinics**.
- Establishes Teaching Health Centers **to provide payments for primary care residency programs** in community-based ambulatory patient care centers.
- Establishes a Graduate Medical Education (GME) policy allowing unused **training slots to be redistributed** for purposes of increasing primary care training at other sites.
- **Increases access to primary care by adjusting the Medicare GME program.** Expands primary care and nurse training programs to increase the size of the primary care and nursing workforce.

2012

- Allows providers organized as **Accountable Care Organizations (ACOs)** that voluntarily meet quality thresholds to **share in the cost savings they achieve** for the Medicare program.
- **Reduces Medicare payments** that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Creates the **Medicare Independence at Home demonstration program**.
- Establishes a **hospital value-based purchasing program in Medicare** and develops plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Creates new demonstration projects in Medicaid to pay **bundled payments** for episodes of care that include **hospitalizations** (effective January 1, 2012 through December 31, 2016), to make **global capitated payments to safety net hospital systems** (effective fiscal years 2010 through 2012), to allow **pediatric medical providers organized as accountable care organizations**

to share in cost-savings (effective January 1, 2012 through December 31, 2016), and to provide **Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of emergency conditions** (effective October 1, 2011 through December 31, 2015).

- Creates the **Consumer Operated and Oriented Plan (CO-OP)** program to foster the creation of **non-profit, member-run health insurance** companies in all 50 states and the District of Columbia to offer qualified health plans.
- Establishes a **national Medicare pilot** program to develop and evaluate paying a **bundled payment** for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.
- **Increases Medicaid payments for primary care** services provided by primary care doctors for 2013 and 2014 with **100 percent federal funding**.

2013

- Offers states that provide Medicaid coverage of **preventive services** recommended by the U.S. Preventive Services Task Force (rated A or B) without cost-sharing and with a **one percentage point increase in the Federal Medical Assistance Percentage** (FMAP) for these services.
- Directs HHS to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve inpatient care and achieve savings for the Medicare program through **bundled payment models** that span three days before and 30 days after a hospitalization.
- Requires **Medicaid payment rates to primary care physicians for primary care service delivery** be no less than 100 percent of Medicare payment rates for 2013 and 2014. Provides 100 percent federal funding for incremental costs to states to meet the requirement.

2014

- **Requires** U.S. citizens and legal residents to have **qualifying health coverage** (phase-in tax penalty for those without coverage).
- **Assesses employers** with 50 or more employees **that do not offer coverage** and have at least one full-time employee who receives a premium tax credit **a fee** of $2,000 **per full-time employee**, excluding the first 30 employees from the assessment. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.
- **Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges**, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- **Requires guaranteed issue and renewability** and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group markets and the exchanges.
- **Reduces the out-of-pocket limits** for those with incomes up to 400 percent of FPL.
- **Limits deductibles** for health plans **in the small group market** to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- **Limits** any **waiting periods** for coverage to 90 days.

- **Creates an essential health benefits package** that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual costsharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Requires the Office of Personnel Management to contract with insurers to offer **at least two multi-state plans in each exchange**. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- **Permits states the option to create a Basic Health Plan** for uninsured individuals with incomes between 133-200 percent FPL who would otherwise be eligible to receive premium subsidies in the exchange.
- Allows states the **option of merging the individual and small group markets**.
- Provides **refundable and advanceable premium credits and cost-sharing subsidies to** eligible individuals and families with incomes between 133-400 percent FPL to purchase insurance through the exchanges.
- **Establishes an Independent Payment Advisory Board** comprised of 15 members to submit legislative proposals containing recommendations **to reduce the per capita rate of growth in Medicare spending** if spending exceeds a target growth rate.
- **Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75 percent** and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided.
- **Expands Medicaid to all non-Medicare-eligible individuals under age 65** (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on Modified Adjusted Gross Income (MAGI) and provides enhanced federal matching for new eligibles.
- **Reduces states' Disproportionate Share Hospital (DSH) allotments for Medicaid.**
- **Permits employers to offer employees rewards** of up to 30 percent, increasing to 50 percent if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establishes 10 state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
- Allows **employers to adopt wellness programs linking premium discounts**, rebates, or rewards to enrollees meeting a health status standard if certain conditions are met.

2015 and Later

- Permits states to form **health care choice compacts** and allow insurers to sell policies in any state participating in the compact.
- Reduces Medicare payments to certain hospitals for **hospital-acquired conditions** by 1 percent.

Sources: The Kaiser Family Foundation and the Commonwealth Fund.

INSURANCE REGULATION AND INSURANCE EXCHANGES

Bradford Kirkman-Liff, DrPH

The Patient Protection and Affordable Care Act (Act) will affect the regulation of health insurance in Arizona. There will be new consumer protections and new oversight mechanisms. The Act in 2014 will create health insurance exchanges in which individuals and small employers will have choices among many different health plans and will receive subsidies to cover part of the cost of these plans. This section of the report describes the new consumer protections, the new oversight mechanisms and the new insurance exchanges.

KEY REFORM CHANGES

- **Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges through which individuals and small businesses can purchase qualified coverage beginning in 2014. States may form regional exchanges. Creates four benefit categories and a separate catastrophic plan.**
- **Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health plans in all states.**
- **Requires health plans to report the proportion of premium dollars spent on clinical and related costs (medical loss ratio) and provide rebates to consumers if they don't meet required standards. Establishes a process for reviewing and justifying increases in health plan premiums at the federal and state levels.**
- **Disallows plans to impose pre-existing condition exclusions for children under 19. Allows adult children up to age 26 to be covered under their parents' plan. Prohibits lifetime limits on dollar value of coverage.**
- **Develops a uniform insurance disclosure form to allow consumers to understand and compare policies. Establishes various consumer protection and review processes.**

WHAT ARE THE NEW CONSUMER PROTECTIONS?

After October 1, 2010, several new consumer protections go into effect:

- Health plans will cover essential preventive services without cost sharing. National panels of physicians will determine these essential preventive services. Currently, the only preventive services that Arizona law requires insurers to cover are immunizations and mammograms according to defined age guidelines.[1] There can be cost-sharing for these preventive services under current Arizona law. Under the reforms there will be greater financial access to preventive care, which in the long-run should reduce healthcare costs.
- Individual and group health insurers cannot impose pre-existing condition exclusions for children under 19. Arizona law does require immediate coverage for 31 days for newborn children, adopted children or children placed for adoption. It also requires continued coverage for a child with disabilities until it reaches the limiting age for dependent children. Arizona law currently does not prohibit pre-existing condition exclusions for children under 19, but health insurers may not impose a pre-existing condition waiting period of more than 12 months on any person in a group plan.[2] Reform will mean that children with pre-existing conditions will be covered from their first day of enrollment.
- Adult children up to age 26 can be covered under their parents' coverage. Arizona law currently does not regulate extension of dependent coverage. The reform should reduce the number of uninsured Arizona adults under the age of 26, which is estimated to be 280,000.[3]

- Insurers will be allowed to rescind coverage (cancel health insurance when claims from the covered patient are received) only in instances of fraud. Arizona law currently does not regulate rescission and other post-claim underwriting practices.

Employer-sponsored and individual health plans that had been in place prior to the enactment of health reform ("grandfathered") are exempt from several of the new consumer protections. However, if the plan significantly decreases the covered benefits or increases the deductibles and cost sharing by members, the plan has to comply with all of the new consumer protections. Estimates vary as to what percentage of plans are likely to lose their "grandfather" status over the next several years, ranging from 50 percent to 90 percent.[4,5]

Consumer Information and Assistance

The U.S. Department of Health and Human Services (HHS) is providing states grants to establish and operate independent offices of health insurance consumer assistance or health insurance ombudsman programs. The grants are aimed at helping states assist consumers with complaint filing and appeals. These grant monies will also help states collect and track consumer problems and inquiries, educate consumers on their rights and responsibilities and assist consumers with health coverage enrollment.

Unfortunately, Arizona is not pursuing such grant opportunities. The state recently chose not to submit a grant application that was due September 10th. It is unclear whether additional funding opportunities will occur. Such support could be useful, given recent state budget cuts. The Arizona Department of Insurance in 2009 eliminated 10 positions in the Consumer Affairs Division. Currently, it takes an average of five to six months for written complaints to be resolved.

As part of healthcare reform, HHS will also develop a uniform insurance disclosure form to help consumers understand and compare health insurance policies, including cost-sharing and covered benefits. In Arizona, statistics on enrollment, market share, complaints, enforcement actions and healthcare appeals are publicly available.[6] There is not, however, a uniform insurance disclosure form.

The Act also provides all health plan members nationally with standard protections to ask for a review of any unfavorable decision. Many Arizona residents already have this protection. According to state law, all fully-insured health plans are required to follow Arizona's uniform Health Care Appeals Process. In Arizona, insurers distinguish between "denied services" (care that the patient has not received) and "denied claims" (for care that the patient has received). To appeal either, the patient must start with an internal appeal.

Arizona's uniform Health Care Appeals Process is not currently available to residents with coverage through a Medicare HMO, Medicare supplement plan, long-term care coverage, multi-employer plans under ERISA, a federal employee plan, or any self-funded or self-insured plan. All of those plans are exempt from state legislation and can have their own appeals processes. Thus, health reform will create a uniform appeals process used by all plans with greater transparency.

KEY TAKEAWAYS:

- Arizona's residents covered by employer-sponsored health insurance will start to see stronger protections in fall 2010.
- The Arizona Department of Insurance will need to become extensively involved in consumer appeals, consumer assistance and consumer disclosure. This will require an infusion of resources into the Department of Insurance, which may (at least initially) be obtained through federal grants, if additional federal monies become available. However, it is unclear whether the state will pursue such funding.

WHAT ARE THE NEW OVERSIGHT MECHANISMS?

Under the Act, the U.S. Department of Health and Human Services, in conjunction with the states, will establish an annual premium review process. This will require health insurers to publicly disclose and justify their premium increases on their websites.

Currently, the state plays some role in overseeing insurance premium rate setting. Arizona law establishes a rating band for small group insurance and sets out factors that insurers can take into account within the band, including scope of coverage, family size or composition, geographic area or demographic characteristics. However, Arizona does not review rates for large indemnity groups or HMO groups or individual coverage, as Arizona law does not establish any rate-setting requirements nor require insurers to file such rates. The law does require insurers to submit annually an actuarial certification that their small group rates comply with the law. However, these certifications have limited value, as they do not have a common format, and there are varying interpretations about what constitutes compliance in each actuarial certification.

In the individual health insurance market, Arizona law currently requires insurers to file initial rates with every new policy form submitted for approval. The Arizona Department of Insurance relies on a checklist to determine whether the filing is complete and on an actuary's certification of compliance to determine whether the rates comply with the law. No initial filing has ever been disapproved. Arizona law also requires the insurers in the individual market to file each rate revision. The insurers submit information about the methods used to calculate the rate, including its "anticipated loss ratio" for the policy.

Health Reform Will Require Changes

Unlike some states, Arizona law currently does allow for some oversight of insurance companies and the rates they charge. However, health reform will require additional changes to Arizona laws, increasing the authority of the Arizona Department of Insurance. Rate review will become far more extensive. Federal law will require public comment and public hearings to be held, and formal hearings prior to enforcement actions will be a distinct possibility.

These changes will expand the Department of Insurance's workload. The Department of Insurance has received a $1,000,000 grant from the Department of Health and Human Services for health insurance premium review. Arizona will improve the filing review process by hiring an actuarial consultant to review 95 percent of submissions for compliance and make recommendations regarding whether filings are unjustified or excessive. Grant funds will be used to create a consumer-friendly website for publication of information for consumers on health insurance as well as easy-to-read information on filings and justifications by insurance companies for health insurance premiums increases. The state will also use the grant to improve efficiency and data-sharing in reviewing health insurance premiums.[7]

The Act also requires health insurers to show the percentage of premiums spent on clinical services and activities that improve healthcare quality. It also requires insurers to provide rebates to enrollees if this spending does not meet minimum standards. This percentage is known as the "Medical Loss Ratio" – 85 percent in the large group market and 80 percent in the small group/individual market. The National Association of Insurance Commissioners is involved in establishing uniform definitions of medical expenses and standardized methodologies for calculating measures of these activities. Arizona law currently does not regulate medical loss ratios and has no standards defining what costs are assigned to medical care and what costs are considered administrative. Predictably, health plans and regulators disagree about what "counts" as medical care.

KEY TAKEAWAYS:

- Unlike some states, Arizona does regulate the health insurance industry. However, statutory changes will likely be needed for it to conduct the expanded oversight required through healthcare reform.

- Arizona will need to expand the capacities of the Department of Insurance. Health reform will require it to conduct rigorous rate reviews and oversee whether insurers allocate adequate funds for clinical services and quality improvement activities. This will require an infusion of resources into the Department of Insurance, which should (at least initially) be obtainable through federal grants. However, the state may need to commit additional resources over the long term.

WHAT ARE THE NEW HEALTH INSURANCE EXCHANGES?

A health insurance exchange is an organized marketplace operated by a government agency or non-profit offering consumers information and a variety of health insurance purchase options.

All of the different insurance plans sold through the exchange have uniform consumer protections, and there is a standardization of deductibles and co-payments into tiers of plans that enable easy premium comparisons.

Under healthcare reform, each state will have an option to create two state-based exchanges: one for individuals ("American Health Benefit Exchanges") and one for small businesses ("Small Business Health Options Program," or SHOP Exchanges). A second option for a state is to establish a single exchange that serves both individuals and small businesses, allowing for some administrative efficiency to be realized.

Exchanges will open in 2014 and be administered by a governmental agency (either an existing agency or one newly created to administer the exchanges) or a non-profit organization. Between 2014 and 2016, states can limit the small business exchanges to firms with 50 or fewer employees. In 2017, states will have the option to open the exchanges to businesses with more than 100 employees. It is estimated that 746,000 Arizonans will obtain health insurance through the exchanges and receive various levels of subsidies to support their purchase of insurance.[8]

The exchanges will offer coverage from at least two federally-qualified multistate plans, a federally-supported non-profit "consumer operated and oriented plan" (CO-OP) as well as offerings from existing insurers in the state. There will be five standardized products in the market for each offered plan (Platinum, Gold, Silver, Bronze and Young Adult). These products will differ in their level of deductibles, co-payments, co-insurance, in-network and out-of-network coverage and prescription drug coverage.[9] The plans with the highest level of deductibles will meet the requirements for the plan to qualify as a High Deductible Health Plan. Individuals who select that type of plan will be eligible to open a Health Savings Account.[10]

INSURANCE EXCHANGE FEATURES

Benefits

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health benefits and substance use disorder services**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices**
- **Laboratory services**
- **Preventive and wellness services**
- **Chronic disease management**
- **Pediatric oral and vision care**

Levels of Coverage

- **BRONZE: The plan pays 60 percent of the full actuarial value of benefits; the individual is at risk for 40 percent of the costs.**
- **SILVER: The plan pays 70 percent of the full actuarial value of benefits; the individual is at risk for 30 percent of the costs.**
- **GOLD: The plan pays 80 percent of the full actuarial value of benefits; the individual is at risk for 20 percent of the costs.**
- **PLATINUM: The plan pays 90 percent of the full actuarial value of benefits; the individual is at risk for 10 percent of the costs.**
- **CATASTROPHIC COVERAGE: Coverage set at the level for Health Savings Account rules, except that prevention benefits and three primary care visits are covered. Only available for young adults.**

Individuals wanting coverage for themselves and family members or small employers wanting coverage for their employees will have to provide information to prove that all persons covered by the plans are U.S. citizens or legal alien residents.

Those purchasing coverage through the exchange will be able to receive premium subsidies based on their income. Cost-sharing subsidies will also be available (again based on income). Individuals and employers who want to purchase insurance outside of the exchange can do so, but they will not then receive the subsidies.

Federal grants have been made available to states to establish insurance exchanges starting in 2011. The Governor's Office recently applied for a grant, and received nearly $1 million for planning of the exchange beginning October 1, 2010.

Arizona Choices

Arizona has several choices regarding the administration of small business and individual insurance exchanges:

- Arizona could decide not to create health insurance exchanges. Individuals and small employers would then use the multi-state exchanges that the federal government will establish to provide access to coverage and the subsidies for individuals and employers in states without exchanges. This would probably result in that segment of Arizona's population being insured by multi-state for-profit health plans, regulated by federal agencies.
- Arizona could build on its experience with Health Care Group, which is a nascent health insurance exchange. Health Care Group, a division of the Arizona Health Care Cost Containment System (AHCCCS), has been in existence for more than 20 years and makes available to businesses with two to 50 employees two different health plans that operate in nine Arizona counties. Each health plan offers five different levels of front-end deductibles ranging from $500 to $3,000. The plans offered in Health Care Group use modified community rating, similar to what is proposed for the health insurance exchanges, rather than experience underwriting for each small group.

  Health Care Group has developed a website that provides information for employers on the different plans and options. The website allows employers and employees to make premium payments and to renew their coverage. Health Care Group also administers the Health Coverage Tax Credit Program (HCTC), which pays 80 percent of qualified health insurance premiums for trade-affected workers, retirees, and their families. Health Care Group is currently the only HCTC-qualified program for Arizona. Health Care Group has the electronic infrastructure and the organizational experience to be considered as the small group health insurance exchange. It has extensive experience with marketing health insurance to small employers. There would be no need to create a new organization and develop new software or websites. In fact, with minor modifications, the same site could serve as the individual insurance exchange.
- Another option would be for a different government program or agency to establish the health insurance exchanges. For example, the Arizona Department of Administration has managed a self-insured health coverage program for state employees for several years, known as Benefit Options. It has developed a website, enrollment procedures and monitoring mechanisms for the contracting health plans. The website provides extensive information on the different health plans and their provider networks. Such a site could serve especially well for the individual insurance exchange and, with modifications, could also serve for the small group exchange.
- Yet another option would be to have Health Care Group serve as the small group insurance exchange and the Department of Administration serve as the individual insurance exchange. Here, each agency focuses on those areas in which it has the greatest knowledge and expertise. The drawback is that this divides the exchanges between two government agencies, which may be less efficient than having one agency operate both exchanges.
- Arizona could contract with a quasi-governmental authority or a non-profit organization to obtain the federal grant funds to start up the Arizona Health Insurance Exchange. This non-profit organization would need to develop websites, purchase information technology for enrollment management, and develop the organizational capabilities to operate the exchanges

for both the individual and small group markets. The state could contribute some of its expertise from Health Care Group and the Department of Administration to this effort. By creating a quasi-governmental authority or a non-profit organization to obtain the federal grant funds to start up the exchange and to retain administrative fees from the operation of the exchange, the exchanges could have additional flexibility in contracting. They would also avoid the issue of yearly state budget deliberations, which could affect the stability of their operations. The exchange has to be a stable marketplace in which consumers and insurers can meet with transparent information on prices and benefits.

- Arizona could work with other states to develop a multi-state exchange. Developing a multi-state exchange would require deciding on a number of further questions: Which states should be involved in the multi-state exchange? Should the states contract with an existing government agency in one of the states to develop the exchange, or should they contract with a new non-profit organization that would create the multi-state exchange? How would the insurance plans sold through the multi-state exchange be regulated? How would the multi-state exchange be governed? A multi-state exchange would be a complex undertaking, but could provide greater financial stability and lower administrative costs.

Costs and Benefits

Each of these options has different costs and benefits. Upfront funding to establish an exchange in each state is part of the health reform legislation. Federal officials have expressed a preference that each state develop its own exchange or work with other states to develop a regional exchange, rather than have the federal government directly operate exchanges. If Arizona defaults to the federal government to operate an exchange, there will be no Arizona oversight of the plans offered in the exchange. Medical decision-making might end up being done by out-of-state medical directors working for multi-state plans, although, even with plans nominally based in Arizona, medical decision-making may be contracted to out-of-state physicians.

If Arizona were to create its own exchange, it could capitalize on the experience of Health Care Group and the self-insured Benefit Options program in developing the exchange. Although the exact level of federal funding for startup has not yet been defined, it appears that the intent is to provide sufficient federal up-front funding (such as it did when Massachusetts established its exchange) that the exchanges (through fees) would be self-sufficient (as required by the new law) by 2016. Whatever option is selected, it is important that the accumulated knowledge with operating different employee-choice programs should be used in designing these exchanges.

If Arizona were to work with other states to create a multi-state exchange, complex issues about governance, ownership and regulation of the health plans would have to be established. However, the lower cost of having several states to share the information technology infrastructure and the ability to negotiate lower contracts for insurance premiums could be worth the additional complications.

One important decision in the design of an Arizona exchange is to determine the rules that define which plans will be allowed to be offered to the individuals and small employers. One approach is to have a competitive process in which health insurers provide their rates for the five different levels of coverage, and those plans with the lowest cost and highest measures of access and quality are offered by the exchange. This is the method that has been used by Massachusetts. A second approach is to set a minimum standard for quality and access, and all insurers that meet those standards can offer their plans, regardless of their initial rates. The first approach would provide individuals and small employers with choices from five different health insurers for five different levels of coverage (for 25 insurance options), and the risk of not being selected would result in lower premiums than the second approach. The second approach would provide individuals and small employers with more choices, as there would not be any selection of insurers based on their premium price, but the lack of competition to have access to this market would result in higher premiums.

These are important decisions, and in several states the Governor has appointed a task force to review the issues and make a recommendation to the Governor and the Legislature. In some states, the Governor and Legislature have asked external consultants to provide recommendations. In other states decisions have already been made to move forward with creating state-level exchanges. At a minimum, policy leaders in Arizona have to make a decision as soon as possible about the process they will follow in deciding which option(s) to pursue.

The Importance of Linking the Exchange(s) and AHCCCS

Regardless of who operates the exchange, it is important that there be strong linkage between the exchange and AHCCCS. Part of the work of the individual insurance exchange will be the determination of the subsidy level, which is based upon income. The exchanges will be required to determine if an individual is eligible for coverage by AHCCCS, and if so, provide them with information on how to complete the AHCCCS enrollment process. It would be helpful if individuals who were found to be AHCCCS-eligible could be directly enrolled by the exchange, rather than having to re-apply at an AHCCCS eligibility office. By the same logic, AHCCCS eligibility workers who determine that an applicant is not eligible for enrollment due to their income should be able to do more than simply refer them to the insurance exchange with their income information that has already been examined. They should be able to determine their subsidy level and assist the applicant in choosing a health plan. In an ideal situation, every AHCCCS eligibility office or outreach worker would also be an officer or outreach worker for the insurance exchange, and every insurance exchange office would also be tied to AHCCCS eligibility. This is the model followed in Massachusetts, where the insurance exchange contracts with the organization that conducts Medicaid eligibility to also do subsidy determination for those who are not eligible for Medicaid and so are mandated to obtain coverage through the exchange.

Participation in the Health Insurance Exchange(s)

The most recent publicly available data on the fully insured health insurance market for Arizona (December 31, 2007) can be used to examine if a sufficient number of insurers would likely be able to participate in an exchange.

As seen in Table One, Blue Cross/Blue Shield of Arizona is the dominant plan in the fully insured individual health insurance market, with 71 percent of the market, followed by HealthNet at 12 percent and Aetna at 6 percent. Many of the for-profit health insurers have very small numbers of individual policyholders. These data indicate that there is a risk of a lack of competition in the individual health insurance market. It will be critical to determine if the individual mandate and subsidies attract at least one large multi-state firm to vigorously compete in Arizona within the exchange against the current market participants.

There are two alternatives to creating an Arizona individual health insurance exchange and hoping that strong competition will emerge. First, Arizona could choose not to establish an individual insurance exchange and wait for the federal government to create a multi-state exchange in which multiple insurers vigorously compete to serve clients. However, the federal government has indicated that it would prefer that states operate exchanges. The second alternative would be for Arizona to work with an adjoining state or multiple adjoining states (Utah, New Mexico, Nevada and Colorado) to have a multi-state exchange. This could be the easiest way to bring strong price competition to the Arizona market. A multi-state exchange could attract an insurer who has high market share in an adjoining state in the individual insurance market to enter Arizona through the multi-state exchange. Depending on the regulatory rules, an insurer who was not in the individual

Table One: Fully Insured Individual Health Insurance Market for Arizona from 12/31/07

INDIVIDUAL HEALTH ENROLLEES AS OF 12/31/07	ENROLLMENT	MARKET SHARE
Aetna[11]	12,644	6.3%
Blue Cross & Blue Shield of Arizona	142,097	71.0%
CIGNA[12]	8,269	4.1%
HealthNet[13]	24,133	12.1%
Humana[14]	4,866	2.4%
Assurant Health[15]	2,535	1.3%
Lifewise	4,435	2.2%
Other Insurers[16]	1,206	0.6%
Total Fully-Insured Enrollees	200,185	

insurance markets in any of these states might attempt a major expansion through a multi-state exchange.

Table Two shows that for the small group market there is no single dominant insurer as there is in the individual insurer market. The six different carriers that are part of UnitedHealthcare account for 41 percent of the market, followed by Blue Cross and Blue Shield of Arizona with 21 percent of the market. Aetna and Humana each have over 10 percent of the market. There appear to be sufficient firms competing in the small group health insurance market to promote vigorous price competition.

Table Two: Fully Insured Small Employer Group Health Insurance Market for Arizona from 12/31/07

SMALL EMPLOYER GROUP (2-50) ENROLLEES AS OF 12/31/07	ENROLLMENT	MARKET SHARE
Aetna[17]	49,801	12.6%
Blue Cross & Blue Shield of Arizona	83,162	21.0%
CIGNA[18]	11,264	2.8%
HealthNet[19]	29,798	7.5%
Humana[20]	39,529	10.0%
Lifewise	8,394	2.1%
UnitedHealthcare[21]	164,007	41.4%
Other Insurers[22]	10,614	2.7%
Total Fully-Insured Enrollees	396,569	

Lessons from Massachusetts

Lessons can be learned from the operation of the Massachusetts Connector, which operates the individual and small employer exchanges in that state under its innovative health reform program.[23] Massachusetts has had a mandatory individual purchase of health insurance since July 2007, and those three years of experience can be useful for Arizona.[24]

The Connector is a quasi-public authority, with 10 members appointed by the Governor and the Attorney-General. The Board of Directors of the Connector operates on a consensus basis. While unconventional in most organizations, this approach was adopted by the Chair and the Finance Secretary in order to keep all 10 members in agreement and ensure credibility for future decisions. As described in one report:

> *The practice of building consensus for earlier decisions built a culture both of compromise as well as an atmosphere of wanting the program to succeed. As the decisions became more difficult, this culture of consensus helped keep all the players in the room. No one wanted to be the first to vote "no." This gave advocates and progressives more say in the final decision than originally expected. In turn, it meant progressives had to compromise and accept ideas such as deductibles with which they were not comfortable.*[25]

The Connector itself is a small organization of 35 employees. Many of the operational functions have been contracted out to governmental agencies or private firms:

- State Medicaid employees do eligibility screening. Individuals who are interested in subsidized insurance and are of such low income that they qualify for Medicaid are referred to that program.
- The Connector uses a private vendor for customer service and health plan enrollment. This same vendor was already contracted by Massachusetts to provide these functions for Medicaid enrollees.
- In 2004, the Massachusetts Executive Office of Health and Human Services created the Virtual Gateway to provide the public, medical providers, community-based organizations and EOHHS staff with online access to health and human services. The Connector uses the Gateway to speed enrollment into the various health plans, and health providers can verify eligibility and enrollment through the same network.[26]
- Massachusetts has determined that controlling the cost of health insurance was more important that offering the widest possible range of choices to individuals. Individuals were offered five different levels of coverage by each of four insurers, for a total of 20 different health plan options. When other health insurers wanted to gain access to this population, the Connector required that there be a competitive bidding process, and took the four lowest bids. This restrained cost increases and kept insurance affordable.

This approach – having a limited number of employees for the exchange, building on existing Medicaid eligibility and enrollment systems, contracting to use Medicaid eligibility workers to do the assessment of income eligibility for insurance subsidies for the exchange and contracting with plans by competitive bidding to restrain cost increases – is an approach that Arizona should consider. These ideas can apply regardless of the agency or non-profit organization that operates the exchange and solicits the bids from different insurers to be offered to the population.

KEY TAKEAWAYS:

- Arizona will have to decide whether it wants to merge its individual and small group exchanges.
- Arizona will face interesting choices related to how Arizona's health exchange(s) will be operated:
  - Arizona could leave it to the federal government to create regional exchanges offering multi-state health plans.
  - Arizona could form a regional exchange with one or more states.
  - Arizona could build on the experience of the Health Care Group and the Department of Administration, managing and operating the exchange through one or more state agencies.
  - Arizona could have AHCCCS operate the exchange, allowing eligibility and subsidy determinations to be performed internally (as it currently performs for some programs such as KidsCare) or by contractors (DES or private contractors).
- Arizona will have to decide whether it wants to offer a wide array of health insurance choices through the exchange, or whether it wants a more centralized approach (emulating Massachusetts's experience) where health plans compete to be allowed to offer their product through the exchange, potentially driving down costs for consumers and improving quality.

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15 John Alden Life Insurance Co. or Time Insurance Company.

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AHCCCS AND KIDSCARE

Kim VanPelt, MPA

The Patient Protection and Affordable Care Act (Act) envisions a healthcare system where nearly everyone has health insurance. Insurance is available four ways – through an employer, a health insurance exchange, a private health insurer or through public (federal and state funded) health insurance, such as Medicaid (called AHCCCS in Arizona), CHIP (called KidsCare in our state) or Medicare.

To help realize this vision of near-universal coverage through one of four means, the Act greatly expands and strengthens the role that AHCCCS and KidsCare will play in providing coverage to Arizonans. The Act expands eligibility, incentivizes quality and encourages states to conduct outreach to enroll more eligible people in coverage. It also requires coordination with health insurance exchanges, making it easier for those people seeking coverage to identify affordable health coverage options and enroll in health coverage.

While the Act contains many features that will benefit Arizonans, healthcare reform poses numerous challenges. Expanded eligibility will conflict with Arizona policy makers' inclination to limit costs through constraints on enrollment. In addition, resources will be needed to alter and enhance eligibility systems. Finally, concerted efforts will be needed to plan and implement changes, coordinate systems, expand partnerships and leverage opportunities to improve quality and service delivery. Fortunately, the Act also commits significant new federal dollars to support these efforts in future years.

HEALTH COVERAGE GAINS, BUDGET IMPACT

Healthcare reform will dramatically expand the number of people receiving publicly financed health insurance in our state. It will raise eligibility levels for non-elderly adults (not including unqualified immigrants) to 133 percent of the Federal

KEY REFORM CHANGES

- **Expands Medicaid eligibility to 133 percent of poverty in 2014.**
- **Requires states to continue current eligibility and enrollment practices existing as of March 23, 2010. States reducing or limiting eligibility lose all federal dollars for Medicaid. Requirements for adults exist until 2014; for children, they extend through 2019.**
- **Increases the federal Medicaid match for those newly eligible. Also increases the federal match for non-pregnant childless adults enrolled in Medicaid over time.**
- **Shifts CHIP coverage for children ages 6-19 whose families earn between 100-133 percent of poverty to Medicaid in 2014.**
- **Increases in the federal CHIP match rate beginning in October 2015.**
- **Establishes new methodology for determining eligibility based on adjusted gross income (with some exceptions).**
- **Extends and increases federal funding for enrollment and renewal activities.**
- **Provides for a benefit package for newly eligible Medicaid enrollees equivalent to the exchange.**
- **Requires coordination with state exchanges, including a state-overseen website where people can apply for coverage.**
- **Augments provider oversight to protect against fraud.**
- **Allows for innovation opportunities to improve quality, reduce cost and improve care coordination.**

Poverty Level (about $29,000 a year for a family of four). Eligibility levels currently vary, although for most Arizona adults, eligibility is set at 100 percent of poverty. Nationally, half of those who are expected to gain coverage through healthcare reform will obtain coverage through Medicaid expansion.[1] In Arizona, an additional 76,400 adults and children will receive coverage through AHCCCS in 2014.[2] The federal government will pay most of the cost for those who are newly covered.

Healthcare reform will also dramatically expand the number of enrollees who are already eligible for coverage yet not currently enrolled. (This will likely occur as public awareness increases as a result of the Medicaid expansion.) AHCCCS estimates that 123,000 non-elderly adults and children would gain coverage by 2014, representing half of those who would be eligible but uninsured.[3]

The Act also increases the amount the federal government will pay for coverage for many individuals currently enrolled in AHCCCS in future years. Those billions of additional federal dollars will add Arizona jobs, strengthening the economy.[4] However, in the short run, reform does nothing to address Arizona's economic woes.

Over the long term, healthcare reform may reduce state costs. Because the federal match for many of those currently eligible will increase, Arizona's total obligation for Medicaid and CHIP may actually decrease over the next 10 years. The Joint Legislative Budget Committee estimates that General Fund costs over the next 10 years (2011-2020) will be reduced by $2.3 billion under the 2010 baseline.[5] However, the budgetary impact of past expansions has varied wildly from predictions, so the ultimate effect is yet to be seen.

State Response to Budget Deficit

Arizona, like many other states, was struggling with how to pay for Medicaid and CHIP before healthcare reform was enacted. Enrollment in the program has increased rapidly in recent years, responding to growth in unemployment and the economic downturn. Arizona's Medicaid program has had the largest enrollment growth rate in the country in recent years.[6]

In an effort to control the state's rising tab for Medicaid and address the state's budget deficit, the Arizona Legislature eliminated KidsCare and coverage for nearly one quarter of the AHCCCS population (310,500 people) during the past legislative session. However, before the session ended, the Legislature reinstated KidsCare (keeping an existing enrollment cap in place) and maintained existing AHCCCS eligibility levels through the end of the state's fiscal year contingent upon the receipt of additional federal stimulus dollars.

The Legislature's change of heart – resulting in continued coverage for hundreds of thousands of Arizonans – was a practical decision. When healthcare reform became law last March, states were required to maintain existing eligibility levels. States reducing eligibility levels existing at the time the healthcare reform law was signed jeopardized losing all federal support for their Medicaid programs. In Arizona, that amounted to a potential loss of over $7 billion annually – a whopping amount that is nearly the size of the state's entire general fund.

As noted above, the Legislature's "quick fix" to maintain eligibility and meet new federal maintenance of effort requirements was contingent upon the federal government continuing the flow of enhanced federal stimulus funding for Medicaid past December 2010. Recently, the federal government did indeed extend the enhanced federal funding for Medicaid for six months, but not at the level policy makers assumed when they passed the FY 2011 budget. As a result, Arizona must still reconcile a $150 million budget gap in AHCCCS funding for FY 2011.

KEY TAKEAWAYS:

- Healthcare reform will result in hundreds of thousands of Arizonans maintaining or gaining coverage through AHCCCS.
- Arizona may need to identify additional revenue for it to continue current AHCCCS eligibility levels until 2014 to meet new federal maintenance of effort requirements.
- New revenue or additional budget cuts will have to be identified to address a $150 million shortfall for FY 2011 due to enhanced federal funding for Medicaid not meeting state budget assumptions.
- Because the federal government will pick up a bigger share of the costs for covering some existing populations receiving Medicaid, state costs for AHCCCS may decrease over the next 10 years.
- Healthcare reform will eventually bring billions of additional federal dollars to the state, strengthening the economy and creating more jobs.

PUTTING OUT THE WELCOME MAT: OUTREACH AND STREAMLINED ENROLLMENT

The Act contains provisions designed to encourage states to implement outreach and streamlined application and enrollment strategies. As noted above, the expanded role of Medicaid in achieving near-universal coverage is integral to reform. Thus, efforts to support and expand outreach and streamline eligibility and enrollment practices are important to successful implementation.

The Act includes an extension and an additional $40 million in CHIP Reauthorization (CHIPRA) outreach grants to support the enrollment of children, as well as a new program to create "navigators" to assist with public education and enrollment more generally starting in 2014. It also creates an option for hospitals and other providers to play a role in enrollment.

Historically, Arizona's outreach efforts have been limited. For example, while the state provided some (mostly media-related) outreach efforts when KidsCare was first created in 1998, the state soon devoted little to no resources to outreach.[7] Many other states have had more robust and sustained commitments to outreach, paying for activities including media, community-based or school-based application assistance or toll-free hotlines.[8] Such outreach efforts may be more needed today than ever, with many people losing their jobs – and their health insurance – for the first time.

Several recent outreach and enrollment assistance efforts could be expanded as part of healthcare reform implementation. The federal government awarded a two-year grant in 2009 as part of CHIP reauthorization to a coalition led by the Pima Community Access Program coalition for outreach and enrollment assistance.[9] In recent months, First Things First (the state's early childhood health and education agency) also awarded grants to community-based organizations to conduct outreach and enrollment/renewal assistance for families with young children eligible for Medicaid and CHIP. Such efforts could potentially be built upon in the future, and the state could submit for federal matching dollars to expand state-funded efforts even further. In addition, the state may be able to loosen current restrictions placed on contracted health plans in marketing their products, allowing them to play a greater role in encouraging enrollment.

Arizona Online Application Is a Plus

The Act also contains new requirements aimed at streamlining enrollment in Medicaid and CHIP. In some instances, Arizona is ahead of other states in meeting these requirements. For example, Arizona has implemented an online, joint application for Medicaid and CHIP. The new law requires such an online application. In other instances, the state will have to implement changes outlined in the new law, such as creating an electronic match with Treasury to facilitate enrollment in Medicaid, CHIP and the exchange.

To further meet the intended outcome of streamlining enrollment in Medicaid and CHIP, the state could implement additional practices already adopted by other states aimed at diminishing enrollment and renewal barriers and increasing administrative efficiencies. Numerous states have implemented such changes in recent years.[10] Nine states were awarded bonuses by the federal government last December for implementing certain policies known to increase enrollment and retention and achieving specific enrollment targets.[11]

Of course, both outreach and streamlined enrollment and renewal practices will result in more people enrolled in Medicaid and CHIP. Once again, this is where the "culture of coverage" envisioned through healthcare reform collides with our state's current political culture of cost containment. Rather than expanding coverage, our state is currently reducing it. Indeed, the current cap on KidsCare has resulted in over 17,000 fewer children enrolled in KidsCare since January.[12]

KEY TAKEAWAYS:

- Successful implementation of healthcare reform requires a "culture of coverage" that conflicts with Arizona's current political priority of cost containment.
- There are a number of resources and opportunities that exist to promote coverage for those who are eligible but not yet covered.

ELIGIBILITY SYSTEM CHANGES AND INTEGRATION AMONG SYSTEMS

The Act also creates new methodology that states must use to determine income eligibility for Medicaid, CHIP and subsidized coverage available through the exchange. The new standards will create some efficiencies by requiring the state to use existing tax income data as part of eligibility processes. However, these changes will also require substantial alterations of existing information systems.

Arizona's current information systems for Medicaid and CHIP are quite old. For example, the eligibility system administered by the Arizona Department of Economic Security (DES) and used for Medicaid and other public benefits dates back to 1986. AHCCCS staff interviewed expressed skepticism that the current systems could be easily (or cost-effectively) modified. However, they did note that the state's web-based application system for Medicaid, CHIP and other public benefits (Health E-Application) might be modified to meet the new requirements.

Altering these eligibility systems will take years and require a commitment of additional (currently unquantified) state dollars. (The federal government will pay part – but not all – of the expense for these required modifications.) Specifications for the new systems still need to be determined as details of required eligibility changes are fleshed out by the federal government. The requirements will ultimately depend on how the new or modified systems are integrated with other information systems, including the health insurance exchange.

The Act explicitly requires individuals seeking coverage through an exchange, Medicaid or CHIP to be able to apply through any program, screened for eligibility through all programs and referred for enrollment in the program for which they are eligible. The law also provides that the exchange may be able to screen for Medicaid eligibility and that any determinations of Medicaid eligibility made by the exchange can prevail for state agencies. States are required to oversee a single website where consumers can go to find information on health insurance options and enrollment. Massachusetts has developed such a site (a web portal) called the Health Connector. Undoubtedly, these requirements will necessitate coordination between exchange planning and changes to state eligibility systems.

Close linkage between public health coverage and private, subsidized insurance offered through the exchange would benefit consumers and reflect the reality that some families may end up receiving coverage from a variety of sources. It may also provide flexibility in preparing for potential future coverage shifts.

Changes in Enrollment and Public Education

As Arizona plans for eligibility changes and coordination among coverage programs, it may want to re-examine how it conducts its current eligibility and enrollment processes for public health insurance programs. Arizona generally administers eligibility for its KidsCare and AHCCCS programs separately. AHCCCS processes applications for KidsCare using one eligibility system. The Arizona Department of Economic Security (DES) processes applications for Medicaid using another eligibility system. Evidence suggests that aligning or combining eligibility, enrollment and renewal for the two programs reduces the amount of fragmentation, resulting in fewer children unnecessarily losing health coverage as family income changes and their income eligibility changes.[13] Closer alignment between the two programs may ultimately require not only changes to information systems, but also changes to rules and state law.[14]

Arizona may also want to reconsider how it informs the public about its health coverage programs. When KidsCare began in 1998, it was given a different name to appeal to families with higher incomes than those typically served by AHCCCS. The separate naming reflected a national trend to decouple publicly financed health coverage from welfare to avoid some of its stigma. With the advent of healthcare reform, Arizona may wish to look at the branding of its public health coverage programs again as eligibility for adults expands and children (ages 6-19 whose families earn between 100-133 percent of the Federal Poverty Level) are shifted from CHIP to Medicaid in 2014. The state could brand all coverage for children the same regardless of whether it is received through Medicaid or CHIP (similar to states such as Vermont). Or it could rebrand all coverage for children and adults with the same name, again making Medicaid coverage more appealing to working families.

Recent DES and KidsCare office closures attributed to state budget cuts may also provide impetus for additional system redesign. While an increasing number of Medicaid and CHIP applicants apply online, there will likely continue to be a need for offices where people can submit documentation or applications. Community partners could play a greater role in this area in the future, making it easier for working families to receive application assistance and relieving overburdened state welfare offices.[15] Of course, if such partners are given authority to deem people eligible, AHCCCS will have to monitor eligibility determinations to ensure program integrity.

While the deadline for implementing changes to eligibility systems is not until 2014, states have begun moving forward with implementation, noting that the 2014 deadline is not that far away. For example, Wisconsin recently released a request for proposals calling on bidders to provide “maintenance, operation, modification and enhancement” services to its eligibility system and an automated system that would support the creation of an exchange for that state.[16]

KEY TAKEAWAYS:

- Arizona needs to begin planning for changes to eligibility systems immediately. As part of that effort, Arizona should look for opportunities to better coordinate existing coverage programs and partner with the community. It should also begin to identify new sources of revenue for such enhancements.
- Changes to eligibility systems and potential system redesign should occur in conjunction with planning for healthcare exchanges. Eligibility and enrollment for publicly funded insurance and insurance offered through the exchange will need to be coordinated. An integrated web portal should be created.

BENEFITS

As part of healthcare reform, states will have to define the array of services available to those newly eligible. The state could make coverage for newly eligible adults narrower than the standard comprehensive Medicaid package. The new law minimally calls for "benchmark" or equivalent coverage based on private health insurance plans in each state, or federally approved coverage. The state could choose not to include some services available currently to those who receive services under Medicaid or CHIP, such as some services needed by persons with serious mental illnesses.[17] (See the Behavioral Health Services and Coverage section of this document, beginning on page 69.)

KEY TAKEAWAY:

- The state will need to determine the benefit package for those newly eligible for Medicaid. This will be a critical (and likely contentious) task that will have profound access and cost implications.

PROVIDERS

As more people are enrolled in Medicaid and CHIP, the number of contracted providers needed to provide health services will increase. The Act includes provisions that address and incentivize provider expansion, including a modest two-year increase in Medicaid provider rates for primary care. However, the effect of these provisions may be thwarted by recent and potential future rate cuts. While there has been no reduction yet in the overall number of providers, it is unclear whether prolonged cuts – or additional cuts resulting from further budget reductions – might affect service provision to an expanded Medicaid population.

The Act will also result in AHCCCS having to negotiate new contracts and new capitation rates with its contracted health plans. Determining these new rates may be challenging, given the uncertainty of how many additional people might be enrolled, their health status, and their health care utilization. While it is possible that this risk might affect the number of health plans participating, this uncertainty may be ameliorated by AHCCCS limiting health plans' risk exposure (as it has done in the past with expansion populations). It is also possible that there may be greater health plan participation due to the potential increase in Medicaid enrollees.

Enhanced provider oversight may also affect the number of providers. Healthcare reform includes new efforts and requirements aimed at protecting against fraud. These include expansion of provider audits and mandated provider compliance programs. The new requirements also include screening processes, with accompanying fees, for providers and suppliers to complete when enrolling or getting revalidated for Medicaid participation. While such efforts may reduce fraud or the risk of fraud, they may also reduce the number of participating providers and increase the amount of time it takes for providers to be included as part of a health plan's network.[18] These new (and other recent) requirements will also result in new demands on AHCCCS to monitor providers, potentially requiring additional state dollars.[19]

KEY TAKEAWAY:

- Enrollment may drive increased need for healthcare providers. However, budget cuts, risk, and regulatory requirements may stymie efforts to expand the number of providers.

ADDITIONAL OPPORTUNITIES TO INNOVATE, IMPROVE QUALITY

As noted in another section of this report, healthcare reform provides opportunities and incentives to innovate, improve quality and reduce costs. (See the Quality and Efficiency of Healthcare section of this document, beginning on page 30.) The state also has flexibility under its 1115 waiver[20] (which it must periodically renew and which the federal government must approve) to introduce new innovations and reforms (with certain limitations). At the time this was written, AHCCCS was drafting its new waiver, adding proposed language that would allow the state to adopt new payment methods that incentivize quality.

Other provisions contained in the Act also provide the state with the opportunity to innovate. Section 1332 of the Act allows states to create and administer what could be considered an additional public coverage option. States may elect to provide health coverage through managed care plans, rather than through the exchange, for adults between 133 percent and 200 percent of poverty. Coverage must meet certain cost-sharing standards. Funding for the program would equal 95 percent of what would have been spent on the exchange for the population. Depending on the benefit design, this option might be particularly attractive to adults with health problems if the benefit package is made more generous than that offered through an exchange. It might also allow people who churn on and off of Medicaid due to fluctuations in income to maintain their coverage, or allow families whose children are enrolled in KidsCare to all be on the same health insurance plan, resulting in administrative efficiencies and more consistent care for consumers.

KEY TAKEAWAY:

- Healthcare reform will provide opportunities for our state to further innovate and improve the quality of care delivered through AHCCCS.
- New public health coverage options provide opportunities for our state to reduce the amount of "churning," allow more families to share the same insurance plan, or provide greater access to care for people with special health needs.

AHCCCS INFRASTRUCTURE

Implementation of healthcare reform will add to AHCCCS' responsibilities, present new implementation challenges and provide new opportunities for what AHCCCS does so well – innovate. Efforts will be needed to plan for and implement required programmatic changes, manage enrollment growth and leverage opportunities.

AHCCCS has long enjoyed a national reputation for innovation and effective and efficient management of our state's Medicaid program.[21] However, budget cuts have reduced AHCCCS' staff by 30 percent in recent years. In lieu of increased staffing, public and private sector support and partnerships (including support from foundations and businesses) may be needed to ensure that needed expertise is garnered and system capacity is strengthened.

The state may also wish to explore partnerships with the private sector (including health plans and insurers) to augment the state's administrative capability. However, the state should approach delegation of required tasks with caution and plan for appropriate oversight of contractors. States have experienced wide ranging experiences with contractors in administering various functions of Medicaid and CHIP programs, including some well-publicized disasters.[22]

KEY TAKEAWAY:

- Staffing cuts may weaken AHCCCS' ability to implement reform changes. Public and private support and partnerships may be needed to bolster chances for success.

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QUALITY AND EFFICIENCY OF HEALTH CARE

Roger A. Hughes, PhD

While most of the initial attention on the Patient Protection and Affordable Care Act (Act) has focused on expanding coverage, the legislation contains a number of provisions directed at improving the quality of medical care and overall health system performance. These include changes in how Medicare and Medicaid are administered and reimbursed, pilots allowing experimentation on new methods of healthcare delivery and payment, efforts to reduce fraud and simplify administration, comparative effectiveness research, and increased emphasis on primary care and greater system integration.

Taken together, these changes seek to advance the larger agenda of promoting *value-based health care*: achieving the highest possible quality at an affordable price.

Many of these issues have been discussed in past *Arizona Health Futures* reports.[1] Here, selected aspects of the Act are presented, and opportunities and challenges for Arizona are considered. The impact of the Act and earlier legislation on state health information efforts either under way or planned is also discussed, given the increasing importance of health information technology (HIT) and health information exchange (HIE) to improving quality and system performance.

KEY REFORM CHANGES

- **Provides grants and incentives for the development of new methods of team-based care delivery and alternative payment models for medical services.**
- **Promotes the development of value-based health care through incentives for value-based purchasing and reporting on quality metrics.**
- **Promotes the role of primary care through incentive payments, higher payments for primary care physicians and patient-centered medical homes.**
- **Takes steps to reduce preventable hospital readmissions and hospital-acquired conditions.**
- **Creates an Innovation Center, Payment Advisory Board and Patient-Centered Outcomes Research Institute to investigate and expand more effective and efficient methods of service delivery, payment and clinical care.**

VALUE-BASED PAYMENT AND QUALITY REPORTING

Efforts to improve the quality and efficiency of health care are of one piece: it is impossible to talk about different approaches to paying for medical care without also talking about changes to how care is organized, and vice versa. In the context of this integration, the law provides new opportunities to change how health care is paid for, potentially impacting the cost and quality of health care in Arizona in the near future.

Alternative Payment Models

The intent of the new federal law is to steer a course away from the potential excesses of straight fee-for-service by focusing on payment models that reward *quality* of service, rather than just *quantity*.

Some of the alternative payment models currently being investigated include:[2]

- **Bundled acute case rates** – a warranty for a given procedure, such as hip replacement surgery or heart bypass surgery.
- **Global fees** – each provider organization receives a fixed, per-person payment based on the patient's health condition or a risk-adjusted capitation rate.
- **Primary care medical home fees** – the medical home receives either a fee for all primary care or a blended payment comprising both fee-for-service and monthly medical home fees.
- **Gainsharing** – shared savings available to physician group practices and other accountable health systems that improve quality and reduce costs.

The *bundled payment model* is a case in point. Here, providers receive a single fee for an entire episode of care, rather than for specific procedures, and they then determine the optimal allocation of medical resources to deliver high quality care. In effect, all of the services associated with a patient's acute or chronic medical condition are "bundled" together and paid in a lump sum.

THE NATIONAL HEALTH CARE QUALITY STRATEGY

As a result of the health reform law, the Secretary of the U.S. Department of Health and Human Services is required to develop a strategic plan (January 2011) that will:

1. **Improve health outcomes, efficiency and patient-centeredness of health care for all populations**
2. **Identify areas that have the potential for rapid improvement in the quality and efficiency of patient care**
3. **Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques**
4. **Improve federal payment policy**
5. **Enhance the use of healthcare data**
6. **Address the health care provided to patients with high-cost chronic disease**
7. **Improve research and dissemination of strategies and best practices**
8. **Reduce health disparities**

Bundled payments strike a middle ground between fee-for-service and capitated payment systems. Under fee-for-service systems, medical professionals are paid for every service delivered, potentially leading to unnecessary healthcare utilization and added costs. Under capitation, an entity is paid a single rate to care (usually prospectively) for an individual regardless of their health status. Critics of capitated systems note that they may result in underutilization of needed health care, or potentially expose providers to unnecessary risk.[3]

Bundled payment projects are not new. Studies conducted on Medicare bundled payments for Coronary Artery Bypass Graft (CABG) surgery in the 1990s estimated that they reduced spending for such procedures by as much as 15.5 percent.[4] Bundled payment encourages two behaviors that fee-for-service payment discourages: collaboration of physicians, hospitals and other providers involved in a patient's care; and efforts to reduce avoidable complications of care and their related costs. The bundled payment case rate reimbursement model accommodates benchmarked performance incentives by integrating evidence-informed clinical science with aligned incentives that address the current, siloed fee-for-service model.

The Act accelerates experimentation with bundled payments specifically and with alternate payment models generally. The Act:

- Establishes a demonstration project in up to eight states to evaluate integrated care around a hospitalization by studying the use of bundled payments for hospital and physician services under Medicaid (2012-2016). (Sec. 2704).
- Develops a national voluntary pilot program to encourage hospitals, physicians and post-acute care providers to improve patient care and achieve savings in Medicare through bundled payment models (2013-2018). (Sec. 3023)

- Establishes a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) to research, develop, test and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care in both public programs (2011). (Sec. 3021)
- Establishes a Medicaid demonstration program in up to five states to study changing the payment structure in safety net hospitals from fee-for-service to a global capitated payment structure (2010-2012). (Sec. 2705)

Both opportunities and challenges exist for implementing bundled payments in Arizona. On the opportunity side, the impetus is building among both providers and employers to pay for value rather than volume. The pressure to stem the rising tide of medical costs is intense, and there is a growing awareness among providers that the straight fee-for-service model is most likely at its apex and cannot be expected to continue upward without significant economic and political backlash. Conversations with Arizona hospitals and physicians indicate an interest in exploring innovative payment models like bundling, gainsharing, medical home fees and some aspects of capitation as alternatives.

On the challenge side, it is easier to implement models like bundled payments in systems where provider groups are tightly aligned and integrated. On a comparative basis, Arizona has fewer large integrated health systems than other parts of the country. Physicians in this state tend to practice in smaller groups, with few-multi specialty practices. Although there are signs that this is beginning to change, we are starting at the back of the pack.

CENTER FOR MEDICARE AND MEDICAID INNOVATION

Effective January 1, 2011, the Act establishes a new Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models and rapidly deploy the best of them to reduce healthcare costs and enhance quality of care. Several things are notable about the CMI:

- The CMI would run pilot programs rather than demonstration projects. The Secretary of HHS could expand the pilots if they did in fact lower costs and improve quality. This is a departure from the past, when the need for congressional approval either delayed or derailed past initiatives.
- The CMI would have broad authority to consider a multitude of payment and delivery models for testing.
- The CMI would not have to require projects to be "budget-neutral" during their initial testing period. This will encourage potential applicants whose innovations may require initial upfront investment that increase costs in the short term but hold the promise of significantly reducing them long term.
- The CMI has a $10 billion appropriation through 2019. This will give it flexibility to pay for services not covered by traditional Medicare and support activities such as electronic data sharing and quality improvement.

Source: Mechanic, R., & Altman, S. (2010, March 3). Medicare's opportunity to encourage innovation in health care delivery. *New England Journal of Medicine*. Retrieved September 17, 2010 from http://healthcarereform.nejm.org/?p=3108

MEDICAID

The Arizona Health Care Cost Containment System (AHCCCS) – Arizona's Medicaid program – is well positioned to take advantage of alternative models like bundled payments:

- AHCCCS is a mandatory managed care program for the vast majority of Medicaid patients. It has contractual relationships with managed care organizations (MCOs) that can serve as the underlying structure for experiments with service arrays that drive quality over quantity.
- AHCCCS is more integrated with a cross section of Arizona's healthcare providers than other states that rely on a designated "safety net" system. This may lead to more opportunities for experimentation around episodes of care in diverse settings.
- AHCCCS has a history of innovation in cost control and quality improvement. It has a reputation as one of the best run Medicaid programs in the country.

Because AHCCCS is further along than many other states when it comes to plan-provider integration through MCOs, there may be fewer opportunities to take advantage of pilot and demonstration programs around bundled payments, which target the transition from more traditional fee-for-service models.

Nevertheless, AHCCCS intends to maximize funding opportunities under the Act. Currently, AHCCCS is attempting to modify the federal waiver under which it operates to experiment with methods of improving quality using alternative payment methods. If it receives federal approval for these waiver changes, AHCCCS will use federal matching dollars to cover expenses and share cost savings with providers, plans, the state and federal government when they are achieved through bundled payments and other innovations in payment reform and new service delivery configurations.

The key is program flexibility. For AHCCCS to continue to explore new models of organization, integration and payment, CMS must provide some measure of programmatic leeway for experimentation. An overly prescriptive approach to defining and implementing bundled payments, accountable care organizations (ACOs) and other organizational configurations will serve neither the states nor the federal government well.

MEDICARE

On the Medicare side, much of the emphasis on episode-of-care bundled payment is a continuation and refinement of CMS's Acute Care Episode (ACE) demonstration project that began in May 2009. Acute care episodes – e.g., gall bladder surgery, a hip replacement – may have only one hospital and doctor group participating, limited medical codes, and clearly delineated and controlled conditions of care. The Medicare voluntary pilot program on payment bundling for acute episodes of care, set to start in 2013, allows providers to share in any savings, subject to quality performance. It provides a means for providers to experiment with bundling services on the acute side before moving into the more complex arena of chronic diseases and coordination of care across acute, ambulatory and home settings.

These changes will impact Arizona in a number of ways:

- **Integration.** Physicians and hospitals that are integrated through formal practice arrangements will be in a better position to participate in bundled payment pilot programs than those that are not. There is a clear trend in Arizona and elsewhere toward system integration and consolidation (hospitals employing more physicians, for example). Integration of primary care with behavioral health should be a clear focus. The state has some good candidates for pilot demonstration sites.
- **Infrastructure.** Bundling requires a robust, transparent exchange of clinical data. Electronic medical records (EMRs) and health information exchanges (HIEs) are beginning to populate Arizona, but progress is sporadic and unevenly distributed. It makes little sense to automate and digitize the exchange of clinical information if the processes on which that information is based – e.g., relationships between providers, coordination and documentation of care – are not well established in the first place.
- **Alignment of Purpose and Value.** Bundling, pay-for-performance, gainsharing and other approaches to payment reform require a shared commitment to practicing evidenced-based medicine, measuring processes and outcomes, reporting out, and being assessed and paid based on value. Hospitals and physician groups that choose to reorganize their practices and payment systems based on value must carefully select partners who share that commitment. This isn't a financial arrangement alone.
- **Accountability of Care.** Bundling payments for medical codes such as diabetes and pneumonia is more difficult than for straightforward surgical procedures; managing a chronic disease through the continuum of the doctor's office, hospital, home and other settings is more complex than in the acute setting alone. Not only is it challenging to determine who is responsible for what, but it is hard to prospectively plan for all of the complications that could arise, the prevalence of outliers in the patient mix that skew performance on quality metrics, and patient noncompliance. Providers rightly resist being held accountable for – and measured by – outcomes beyond their control.

PAYMENT AND QUALITY REPORTING

The Act extends efforts that have been under way for some time toward developing and reporting on quality metrics, and paying for value – effectiveness and efficiency of outcomes – rather than straight fee-for-service payment alone that incentivizes volume of services over value.

The Act:

- Prohibits Medicaid payment for services related to a healthcare-acquired condition. (Sec. 2701)
- Establishes a Medicare hospital value-based purchasing program (2013). A percentage of hospital payments will be tied to hospital performance on quality measures related to common and high-cost conditions such as cardiac, surgical and pneumonia care. (Sec. 3001)
- Extends the Physician Quality Reporting Initiative (PQRI) through 2014, which provides incentives to physicians who report quality data to Medicare. Reduces payment to physicians who do not submit measures to PQRI (2014). (Sec. 3002)
- Develops a value-based payment modifier under the physician fee schedule in Medicare. A budget-neutral payment system will adjust payments based on the quality and cost of care (2015). (Sec. 3007)
- Creates Medicare payment penalties for conditions acquired in hospitals (2015). (Sec. 3008)

Over the next three years all acute care prospective payment system hospitals in Arizona with sufficient volume will participate in the Medicare value-based purchasing initiative. How 'value' will be defined and rewarded will not be determined until the regulations are written, but the overall direction is clear. Financed by DRG payment withholdings, bonuses will be based on how hospitals meet established process measures for heart attack/failure, pneumonia and surgical care; clinical outcome measures such as hospital-acquired infections; patient perceptions; and efficiency measures such as Medicare spending per beneficiary.[5]

Beginning in 2012, hospitals will also face penalties for high readmission rates for heart attack, heart failure and pneumonia. Other diseases and procedures may be added in the future for all patients with the target conditions, not just those covered by Medicare, when determining rates.

Other sections of the law establish a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, hospice, skilled nursing facilities and home health agencies.

Physicians face the same "carrot and stick" approach. The PQRI, which provides incentives to physicians who report quality data to Medicare, is extended through 2014. Beginning in the same year, physicians who do not submit quality data will have their Medicare payments reduced.

Conversations with Arizona stakeholders reveal the following opportunities and challenges:

- Without exception, Arizona healthcare leaders interviewed regarded prospective changes in payment, value-based purchasing (VBP) and pay for performance as inevitable. There is a shared sentiment that the current system is unsustainable, and that something has to be done to improve quality, increase efficiency and control costs. More people are willing to get on board with quality metrics and VBP as a result.
- Some Arizona hospitals and physician groups are already ahead of the payment and quality curve. At these organizations, there is a shared commitment to reporting on, and being assessed by, quality metrics and to practice evidence-based medicine. The most important factor in changing organizational culture to foster this shift is key physician and executive leadership at the outset. Lessons learned at these leading organizations can be applied elsewhere. There is a wholesale change in physician culture taking place, with major implications for training programs.

- Being committed to pursuing value and coming to a consensus on what and how to measure value are two different issues. With changes being proposed in the value-based purchasing measures at a rapid clip, hospitals are challenged to keep up. They are well advised to keep focused on the Hospital Compare measures. "Because VBP is a zero-sum game, hospitals will have to compete to maintain full payment."[6]

- VBP for both hospitals and physicians requires access to clinical and claims information when it occurs, not months after the fact. Providers can't very well manage patients if they don't know where they've been, who they have seen, and what was done in a timely and accurate fashion. This requires not only interoperable ways to populate health records electronically, but also agreements to exchange data between the appropriate participants. Arizona is beginning to build this infrastructure, but progress is spotty, and there is a long way to go.

- Setting readmission expectations is difficult. An Arizona hospital with a higher than average readmission rate may be in a catchment area comprised of a large number of elderly Medicare patients with multiple chronic diseases. That may not be taken into account in applying penalties. Current measures also don't take into account whether readmissions are planned. These challenges will need to be addressed.

KEY TAKEAWAYS:

- The value-based healthcare train promoted in various sections of the Act has already left the station. Arizona providers, payers and other stakeholders in the healthcare system know they have to get on board or be left behind. The status quo is unsustainable.

- It is a mistake to think Arizona can't leverage resources provided through the Act to realize greater practice integration, coordination of care and better patient outcomes at an affordable price. Arizona providers are hooking up in new configurations at a rapid pace to do just that. This will only accelerate in the future.

- AHCCCS is a national leader in state Medicaid innovation. It is in a strong position to leverage bundled payments, ACOs and other innovations in healthcare payment and delivery.

CHANGES IN THE DELIVERY OF CARE

The Act continues and expands efforts to provide more coordinated and cost effective care to all Americans, and especially to the growing number of persons with chronic diseases. In order to maximize the ability of providers to respond to new payment incentives, the law encourages the development of such care delivery approaches as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs).

ACO Definition

"ACOs are defined as groups of providers that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services."[7]

PCMH Definition

A PCMH is a clinical setting centered around an integrated team of primary care providers that provides first contact and continuous care, coordination of care, comprehensiveness of care (referring out to specialists as needed) and a focus on the whole person, wellness and prevention.[8]

The ACO is the broader concept, and may include a constellation of PCMHs centered around a hospital, for example. In one sense, PCMHs are the building blocks for the ACO "house."

Highlights on ACOs and PCMHs include:

- **Sec. 2703.** Provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home comprised of a team of health professionals that would provide a comprehensive set of medical services, including care coordination.
- **Sec. 2706.** Establishes a demonstration project that allows pediatric providers to be recognized and share in cost savings as ACOs under Medicaid (2012).
- **Sec. 3022.** Allows voluntary ACOs that meet quality-of-care targets and reduce the costs of care relative to benchmarks to share in the Medicare cost savings they achieve (2012). Provides flexibility to implement innovative payment models currently used in the private sector. ACOs must have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.
- **Sec. 3502.** Establishes and funds community health teams to support the development of medical homes by increasing access to comprehensive, community-based coordinated care. Sec. 10321 clarifies that NPs, PAs and other primary care providers can participate in community care teams.

PATIENT EDUCATION AND INCENTIVES

There is a huge amount of patient education that needs to occur before American health care can make a successful transition to value-based care. If American consumers find their choices of providers limited to defined ACOs and PCMHs, or otherwise perceive little value in choosing to sign up with a particular plan and/or group, then it won't be value-based health care.

Currently most Americans don't make their own healthcare purchasing decisions, and they certainly don't have access to comparative and reliable information on services and outcomes. Many are spoiled by on demand, fee-for-service procedures that cost them little. That has to change. New configurations will have to both educate patients on the benefits of joining these new networks and provide incentives for ongoing, preventive care, medication and disease management, and wellness programs. What is a hospital-centric system today could well evolve into a patient-centric system tomorrow, with home-monitoring and a suite of outpatient services defining the core.

Whatever the evolution of the model, patient behavior has to change with it.

Opportunities and challenges for Arizona with regard to evolving delivery-of-care models mirror those in the payment arena:

- **Diversity of Structure.** There are multiple models of ACOs: integrated delivery systems, multi-specialty group practices, physician-hospital organizations, independent practice associations and "virtual" physician organizations. There is no "one best way" approach. It would be a mistake to assume that Arizona can't experiment with ACOs because of the preponderance of small, independent practices and the relative lack of large, integrated systems. There are some interesting models being pursued right now, and more are planned for the immediate future. An innovative ACO project being undertaken by the Tucson Medical Center and its affiliated physician groups is one of three sites selected for a national pilot project undertaken by the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. Others are under way. There is no reason, for example, why a payer like AHCCCS couldn't link independent primary care PCMHs in rural Arizona in a virtual ACO, borrowing from models developed in North Carolina[9] and elsewhere.
- **Eligibility.** The federal policy challenge is developing eligibility criteria for ACOs that strike a balance between being so restrictive that they discourage healthcare organizations from applying, and making criteria challenging enough to ensure a return on the investment. There will probably be several levels of eligibility criteria, which would allow both smaller configurations (one hospital, several PCMHs, a specialist referral panel, 15,000+ patients, basic lab and medication data, etc.) to larger configurations with a full portfolio of chronic care model processes, formal quality improvement programs and fully functional EMRs. The central idea is to have enough flexibility in terms of qualifying as a PCMH or ACO that practices can "get in," participate in higher levels of payment as more criteria are met, and access technical assistance and support.
- **Clinical Infrastructure.** Groups experimenting with PCMHs in Arizona – such as UnitedHealthcare and federally qualified health centers – know that providing technical assistance and support to practices is critical. This includes EMR systems (patient registries, health record "banks," etc.) to gather and exchange clinical and claims data in a timely, efficient and

transparent manner as well as practice redesign to facilitate continuity and integration of care. One common approach is to contract with outside vendors of EMR and medical practice support. Another model that Arizona might follow is to establish clinical guidelines and a practice collaborative, similar in structure to something like the Colorado Clinical Guidelines Collaborative.[10] Arizona is developing HIT/HIE collaborative capacity, but what is required as well is a broader collaborative of organizations focused on clinical guidelines, practice redesign, PCMHs and ACOs, and other innovations.

- **Established Ground Rules.** Trust between the stakeholders in Accountable Care Organizations and Patient-Centered Medical Home projects rests on agreement on, and a firm commitment to, principles and ground rules. For example, some PCMH projects might adopt joint principles developed by the Patient-Centered Primary Care Collaborative,[11] a common three-tier payment model (fee-for-service, care coordination per member per month, and a pay-for-performance component), and the PPC-PCMH three-level recognition program.[12] Reaching agreement on a common framework for conducting business and assessing progress – all of it in an open, transparent manner – is critical for success. This is something that an Arizona clinical guidelines and practice collaborative could help to provide.

KEY TAKEAWAYS:

- Value-based health care is as much about developing a culture of team-based, evidence-based care as it is about rearranging financial incentives. Build shared values first. Nurture trust and leadership. Practice will follow.
- There is no "one right way" to achieve greater quality and efficiency in health care. Arizona should encourage a diversity of practice arrangements and innovations in care.
- Arizona may want to develop an Arizona Clinical Guidelines Collaborative similar to what was done in Colorado. It could become a true learning, dissemination and technical assistance community of practice.
- There is a huge need to involve and educate consumers in the value-based healthcare movement. If targeted outcomes aren't valued – and sought – by consumers, it's not value-based care.

PRIMARY CARE

The Act seeks to reestablish primary care as the foundation of U.S. healthcare delivery to help improve health outcomes and begin to bend the cost curve. The Act authorizes funding to stabilize and expand the primary care workforce, increases primary care provider rates, provides for adjustments in the resource-based relative value scale that potentially favors specialist over generalist services, and encourages innovations in primary care practice, such as the PCMH discussed above. (Also see The Healthcare Workforce section of this document, beginning on page 47, for more discussion on primary care.)

The Act also includes numerous provisions aimed at strengthening primary care by altering how primary care providers are paid and practice:

- **Sec. 3024.** Creates the Independence at Home demonstration project to provide high-need Medicare patients with primary care services in their homes and allow teams of health professionals to share in any savings if they reduce preventable hospitalizations and readmissions, improve health outcomes and efficiency of care, reduce the cost of health services and achieve patient satisfaction (2012).
- **Sec. 1202.** Increases Medicaid payments for primary care services provided by primary care doctors (family medicine, general internal medicine, pediatric medicine) to 100 percent of Medicare payment rates for 2013-2014. States will receive 100 percent federal financing for the increased payment rates (2013, 2014).
- **Sec. 5501.** Provides a 10 percent Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas from 2011-2015.

- **Sec. 3134.** Stipulates that the Secretary of the Department of Health and Human Services has the flexibility to identify and adjust potentially misvalued Medicare service codes (which may discriminate against primary care services).

It is unclear whether these provisions will make an appreciable dent in reconstituting primary care as the center of U.S. health care, and in Arizona specifically.

- **Paying Primary Care Physicians More.** While it is easy to argue that primary care physicians (family physicians, general internists and pediatricians, geriatricians, etc.) ought to be paid more, an increase of 10 percent (in health professional shortage areas) is probably insufficient to make much of a dent in enticing more people into the field. What is required is a long-term, significant correction, not a five-year modest "fix." With regard to bringing Medicaid primary care provider rates up to 100 percent of Medicare rates, AHCCCS traditionally reimburses primary care physicians at 95 percent of Medicare rates. (Without doubt, these rates are less today, given no automatic medical inflation adjustments to rates over the past several years because of state budget cuts.) The impact here is likely minimal, especially in light of potential cuts to Medicare rates themselves.
- **Adjusting the Resource-Based Relative Value Scale (RBRVS).** The RBRVS, launched in 1992, has become the accepted method for determining physician payment for most practice settings. Unfortunately, CMS "has not maintained the accuracy and relative valuation of the evaluation and management service codes to reflect the expanded content of modern generalist care."[13] Because primary care physicians spend much of their time providing cognitive services (coordinating care, counseling, acquiring and managing information, etc.) relative to performing medical procedures, their compensation has declined to levels that are 30 percent to 60 percent lower than specialists. It is one thing to say that the Secretary has the flexibility to make "adjustments" in these "skewed" codes, and quite another to think that specialists who profit from the status quo will go along with it, especially if the increases in primary care payment come out of their rates.
- **Innovations in Practice.** There is significant potential in engineering practices around ACOs and PCMHs, and using new methods of payment such as bundled payments and forms of capitation coupled with fee-for-service and pay-for-performance. But will patients willingly join medical homes if they perceive it as limiting their choice of providers? Will specialists who believe they can effectively organize and provide the care of patients with chronic diseases like diabetes and arthritis be willing to "cede" coordination and managing functions to primary care providers in these new organizational arrangements?
- **Increased Local Interest.** Interviews confirm a great deal of interest in, and activity around, innovations in primary care-based practice and payment. The coordination of and management of chronic diseases is a growth industry, especially with an aging population. More hospitals are entering into relationships with primary care providers to provide community-based services; health plans are demonstrating early success in improving patient outcomes and reducing unnecessary and expensive care (ED visits, hospital readmissions, etc.) through the use of primary care PCMHs; community health centers continue to innovate with strong primary care services for vulnerable populations; AHCCCS is investigating bundled payments as one way of integrating the coordination and management of care by primary care clinicians into the entire continuum of care to achieve better health outcomes at a more affordable cost.

KEY TAKEAWAY:

- The incentives provided by the Act to establish the "primacy" of primary care in the U.S. system are insufficient, by themselves, to move the needle. A much larger, longer-term commitment is needed.

HEALTH INFORMATION TECHNOLOGY (HIT)

The Act generally emphasizes the continued development and deployment of HIT on issues such as care coordination, quality reporting, health disparities, population-based medicine and research, among other areas. It also focuses on standards for financial and administrative transactions in the electronic realm, such as standardized provider enrollment processes in health plans.

Of more immediate interest in Arizona is the implementation of the Health Information Technology (HITECH) Act as part of the 2009 American Recovery and Reinvestment Act. This legislation provided significant financial support to encourage the adoption and use of HIT in the form of certified electronic health records (EHRs) and electronic health information exchange (HIE). The idea, similar to sections of the Act summarized above, is to provide a series of "carrots and sticks" to bring healthcare providers to standards of "meaningful use" – applying HIT to improve the quality and delivery of care.

Arizona Health-e-Connection, a broad membership-based organization established in 2007 as the result of a state planning effort, received a $10.8 million award in 2010 to develop the Arizona Regional Extension Center (REC), which is charged with assisting primary care providers in adopting EHRs and meeting meaningful use requirements. Further, the Governor's Office of Economic Recovery received a $9.3 million award to establish a statewide health information exchange. Projects already under way to create HIEs – the Arizona Medical Information Exchange (AMIE) and the Southern Arizona Information Exchange (SAHIE) – have combined their efforts to form a new statewide exchange. Stakeholders involved in all of these efforts will closely coordinate their efforts and collaborate in the critical years ahead.

HIT AND ARIZONA PHYSICIANS

Recent research on the use of EMRs and Arizona physician attitudes toward HIE found, among other things, that:

- **Almost 20 percent of Arizona physicians have neither internet nor email access at their practice setting.**
- **Paper remains the prevalent storage medium for medical records – only 28 percent of Arizona physicians have eliminated use of paper records.**
- **Cost is the most frequently cited reason for lack of EMRs, followed by time/training.**
- **More than 45 percent of physicians practicing in Arizona use some form of EMRs.**
- **Over half (54 percent) of EMR users transmit medical data electronically to other parts of the system, such as labs or pharmacies.**
- **The most trusted organization by physicians to manage an HIE is a hospital system, followed by a regional health information organization (RHIO).**

Source: Johnson, W., et al. (2010). The use of electronic medical records and physicians' attitudes toward a health information exchange. Center for Health Information and Research, Arizona State University.

Arizona will face a number of opportunities and challenges in implementing HIT as they relate to innovations in practice and payment promoted in the Act to move toward a value-based healthcare system. One sees the same issues come up over and over again:

- **Governance.** Sharing health information electronically between various parts of the healthcare system in a transparent manner with full patient privacy and confidentiality protection requires a robust, representative governance structure. SLHI recently commissioned an Arizona HIE Governance and Collaborative Capacity Assessment[14] that found a broad measure of trust and collaboration among Arizona HIE stakeholders, but with limited functional capacity – the operational resources necessary to implement HIEs. The opportunity is a willingness to collaborate and form HIE governance structures. The challenge is to find the resources to implement the actual exchange of information.
- **Expectations and Timelines.** There is a potential mismatch between the expectations and timelines of HIT implementation of EHRs and HIEs outlined in federal programs and conditions of readiness on the ground, especially in states like Arizona that have been decimated by budget deficits. For example, bringing over 2,000 Arizona primary care physicians up to standards of meaningful use in less than a two-year period through the REC may be unrealistic. Recent CMS rules lighten meaningful use requirements and increase the odds of qualifying for incentive payments, but the timeline is still tight. Other states are in a similar position. There is a need for federal officials to provide additional flexibility in execution and timelines.
- **Technical Assistance.** Implementing HIT, like implementing ACOs and other changes in payment and care delivery organization, requires significant resources in the form of education and technical assistance for system design, product selection and installation, and ongoing support. This is a central function of Arizona Health-e-Connection, the state REC, but it requires more resources than the REC currently can provide on the front end. Public-private partnerships are one viable solution, but these, too, require financial resources – a challenge in the current economic climate.

- **Getting Clinical Processes Right.** There's a well-known "cart before the horse" problem with HIT: hospitals, physicians and other providers may install and implement EHRs before they have thoroughly thought through and designed optimal clinical and practice management systems. The problem is that providers are "under the gun" to get up and running with EHRs, and some may not be ready in terms of clinical practices and relationships (not to mention a lack of capital). "Too much, too soon" can be as problematic as "too little, too late" in HIT.

KEY TAKEAWAYS:

- Federal HIT expectations and timelines are out of whack with conditions on the ground in Arizona and most other states. The feds need to provide more flexibility – and time.
- Despite the challenges, half of Arizona physicians appear to be moving forward with health information technology.

ABOUT THE AUTHOR

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THE SAFETY NET

Kim VanPelt, MPA

Safety net systems, providers and clinicians – including public and private hospitals serving the indigent, community health centers and school-based clinics – will be greatly affected by healthcare reform.

Even though the number of uninsured will decrease, there will still be strong demand for safety-net services. Financial constraints, changed incentives and new payment models will result in providers collaborating to compete. New funding will also be available for community health center and school-based health clinic expansion. The state may want to play a role in monitoring the impact of reform on the safety net and fostering systems development to improve access to care.

KEY REFORM CHANGES

- **Decreases uncompensated care through the expansion of Medicaid and subsidized coverage through the exchange.**
- **Reduces Medicare payment rates.**
- **Reduces Disproportionate Share Funding for safety-net hospitals.**
- **Penalizes hospitals for preventable readmissions.**
- **Provides new funding for the expansion of community health centers and their workforce.**
- **Establishes new grant programs for community-based teaching programs and a new program for the development of primary care residency trainings programs.**

NEED FOR SAFETY-NET SERVICES WILL CONTINUE

Healthcare reform will expand the number of people with health insurance dramatically. However, some will remain uncovered. These include low-income people exempt from insurance mandates; unqualified legal immigrants and undocumented immigrants; those eligible for Medicaid who are unable to overcome enrollment barriers; and those who refuse or are unable to meet the new mandate.

A recent analysis of the uninsured in Massachusetts, where health insurance reform measures enacted in 2006 have left only 4.1 percent of the state's population without coverage, found that those who continue to be uninsured were more likely to be:

- Male, young and single
- Racial/ethnic minorities and non-citizens
- Unable to speak English well or very well
- Living in a household in which there was no adult able to speak English well or very well[1]

Given the demographics of Arizona's population, a sizable number of uninsured Arizonans will likely remain even after mandates for coverage are imposed. Arizona's population is far younger than the national median. A high percentage of our population is also made up of ethnic minorities or non-citizens. (Recent reports of many leaving the state because of SB 1070 may alter this somewhat – but the precise impact of that change is yet to be determined.)

Enrollment barriers to public health coverage will also likely have an impact on the number of people insured. Historically, state policy makers have imposed numerous barriers, making it challenging for people to enroll in or renew their public (AHCCCS, KidsCare) health coverage, such as onerous renewal and cost-sharing requirements. These barriers, if continued, will likely keep many Arizonans uninsured and dependent on the safety net for care.

Many of those who are newly insured as a result of reform will continue to receive care where they did in the past. Indeed, when Massachusetts implemented healthcare reform, many of those newly insured continued to receive services at community health centers and safety-net hospitals.

Care delivery patterns will also likely stay somewhat static – at least in the short run – due to challenges people may face in accessing other types of providers. For example, Massachusetts found that people continued to visit emergency rooms in that state after healthcare reform, likely due to challenges accessing services in the community.[2] A long-existing federal law requires hospitals to screen ER patients, and if the patient needs urgent or emergency care, provide that care or transfer the patient to a facility than can provide it – regardless of the ability to pay.

KEY TAKEAWAYS:

- Healthcare reform will decrease the amount of uncompensated care.
- There will continue to be high demand for services delivered by safety-net providers.

FINANCIAL FUTURE IS UNCLEAR

Under healthcare reform, local safety net providers will gain and lose revenue, making the net result difficult to predict.

The Act expands eligibility for AHCCCS, resulting in providers (hospitals, community health centers, school-based health centers) being able to recoup dollars that have long been uncompensated.

Hospitals, for example, are expected to earn approximately $40 billion more in new revenues nationally, due to eligibility expansion, by 2019.[3] Similarly, Massachusetts officials interviewed noted that community health centers saw increases in clients – and revenues – post reform.

The Act also contains significant new monies for community health center operations and graduate medical education. Such money comes on the heels of recent stimulus money awarded for both Disproportionate Share Hospital funding (DSH) and community health center operations.[4] To ensure that the Federally Qualified Community Health Centers are adequately reimbursed for providing a full range of services, Medicare will begin paying health centers, prospectively beginning October 2014.

However, the financial impact of reform is not completely rosy for safety-net providers. For example, coverage expansions included in healthcare reform were paid for, in part, by hospitals being willing to accept lower Medicare payment rates and forgo other revenues.

The Act will reduce the amount of federal funding (called "Disproportionate Share Hospital" funding or DSH) provided to states for hospitals currently delivering a high percentage of their services to Medicaid recipients and the uninsured. Medicare Disproportionate Share payments will be reduced by 75 percent beginning in 2014, and gradual subsequent adjustments will be based on the remaining number of uninsured. Medicaid Disproportionate Share Hospital funding will also begin reducing gradually beginning in 2014. By 2020, national Medicaid Disproportionate Share funding will be reduced by $20 billion annually.[5]

The theory behind these reductions is that the decrease in the uninsured and increases in Medicaid eligibility will balance each other out.[6] However, the exact methods for determining the reductions are yet to be determined. What we do know is that the new

method is supposed to take into account the percentage of the state's population that is uninsured, current levels of DSH spending and the use of DSH funding in Medicaid waiver programs. Given these factors, Arizona's DSH reduction may not be too dramatic if the state continues to have a large number of uninsured.

Other factors are more likely to financially strain safety-net providers.

- State funding cuts will continue to take their toll. The state recently reduced Medicaid provider rates, and additional rate reductions are possible. State funding (including federal match) for DSH was also reduced by nearly $40 million over the past two years. Primary care dollars (which provided basic health services, prenatal care and dental checkups to low-income residents at community health centers serving 51,000 people in 2008 at a cost of $14.5 million) has been sliced in recent budgets and is unfunded for fiscal 2011.[7]

  Staff interviewed at the Arizona Department of Health Services (responsible for overseeing the primary care program) noted that recent budget cuts and the end of federal stimulus dollars are already weighing on community health centers. Some have noted that they are having challenges making payroll.

- Providers will also be impacted by a changing client mix. As safety-net providers' patients become increasingly comprised of Medicaid (versus private insurance) clients, providers will be less likely to shift healthcare costs onto private payers. Such a shift now occurs due to Medicaid's lower reimbursement for health services. Increasingly, providers will have to shift service delivery and reduce their costs and adjust to lower Medicaid reimbursement.

KEY TAKEAWAYS:

- Safety-net providers will see both financial gains and losses as a result of healthcare reform.
- State cuts to DSH may add to financial strains – and potentially affect the viability of some providers.

Collaborate to Compete

Under health reform, squeezed budgets and lower reimbursement will not be the only factors driving cost-containment and service delivery changes.

The Act creates new penalties for excess preventable hospital readmissions. Hospitals wanting to prevent such readmissions will be incentivized to form partnerships with care providers and organizations that support patients' recovery and overall health in less expensive, community or home-based settings. A hospital executive interviewed noted that even though hospitals cannot control whether people follow up on a doctor's instructions after they leave the hospital, hospitals may ultimately be held responsible for ensuring that appropriate care was delivered. Thus, they need to have those partnerships in place to protect their bottom line.

New models of care delivery will also be incentivized under reform, rewarding providers who improve the quality and cost-effectiveness of care delivered. (See the Quality and Efficiency of Healthcare section of this document, beginning on page 30.)

Increasingly, safety-net providers will have to "collaborate to compete." To survive under health reform, safety-net providers and clinicians will have to focus on cost-containment, care coordination and delivering care in the most appropriate, cost-effective setting possible.

New collaborations, joint ventures, mergers and acquisitions are likely both horizontally as well as vertically. Hospitals will increasingly link themselves with community health centers, school-based health clinics, primary care practices, outpatient (including retail and urgent care) clinics and allied-health professionals.

A new requirement in the reform law also requires that insurance plans operating under health insurance exchanges contract with essential community providers, including community health centers, again driving collaboration.

Community health centers, which will likely see increased demand for their services, will also be incentivized to form new relationships. Community health centers often report challenges accessing specialty services for their uninsured or publicly insured patients. Thus, they too will be interested in forming new relationships.[9]

KEY TAKEAWAYS:

- New incentives, payment models and financial pressures will force safety-net providers to collaborate to compete.
- New collaborations, mergers and acquisitions among safety-net providers will result.
- Hospitals will partner with community health centers, school-based health centers and others to help ensure that care is delivered in the right place, at the right time.

New Monies for Expansion

The Act recognizes the important role that community health centers and school-based health centers will play in a reformed healthcare system, and provides vital resources for their support and expansion.

Federally funded community health centers are located in or serve high-need communities designated as being underserved areas or populations. They provide comprehensive primary healthcare services as well as supportive services (education, translation, transportation, etc.) that promote access to health care. These organizations are governed by a community board composed of a majority (51 percent or more) of health center patients who represent the population served.

The Act allocates $12.5 billion for the expansion of community health centers and placement of healthcare professionals in underserved areas beginning in 2011. It also establishes new grant programs for community-based teaching programs and a new program for the development of primary care residency training programs. This money is coming on the heels of other new monies for community health center expansion that were also awarded as part of the Recovery Act (ARRA). These included $3.9 million for three new Federally Qualified Health Centers located in Phoenix and Flagstaff.[10]

The Act's new grant opportunities are already beginning to become available. $250 million in grants for existing community health centers was announced in mid-August.[11]

The Act also provides new funding for school-based health centers. Such funding includes $200 million over four years for construction and equipment, and authorization (but no current appropriation) for school-based health center operations (such as salaries for medical professionals).[12]

Grant applications were recently announced for $50 million in funding for equipment, only to be canceled due to concerns related to limited application development time and concerns related to the application criteria and caps for multi-state school-based health centers. [13] Nonetheless, grants are expected to be released again sometime during the federal fiscal year 2011. If similar to the previous grant opportunity, school-based health centers, hospitals and community health centers are among those that could apply.

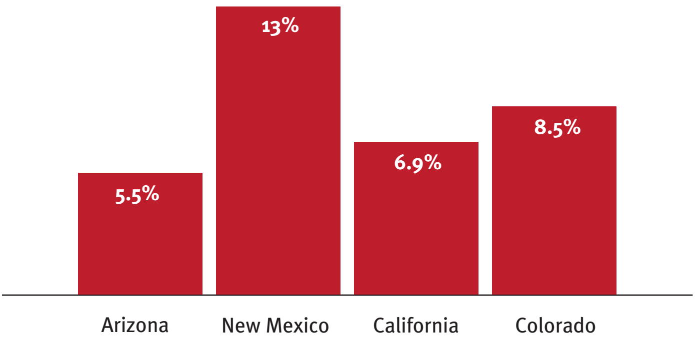
KEY TAKEAWAY:

- New federal monies may allow Arizona to greatly expand capacity at existing community health centers and school-based health clinics. It can also allow Arizona to increase the number of community health centers and (potentially) school-based health clinics.

Planning and Monitoring Needed

As noted above, healthcare reform provides new funding to expand and create new community health centers. Some of these monies may be used to help federal health center "look-alikes"[14] gain Federal Qualified Health Center (FQHC) status, allowing the centers to garner increased federal funding.

Percent of People Served by a Community Health Center[15]



Changing guidelines on how medically underserved and health professional shortage areas are designated also may result in new opportunities to place community health centers and National Health Service Corps workers in new geographic areas, resulting in greater access to care. In 2008, fewer Arizonans received services at a community health center than neighboring states. (See chart, above.)

The state may want to help play a role in facilitating creation of these new facilities, ensuring that they are located in areas with the highest healthcare needs. In 2006, the U.S. General Accounting Office (GAO) reported that 39 percent of medically underserved areas in Arizona lacked a community health center.[16] Such efforts could be guided by some form of state needs assessment. The effort could be overseen by the Arizona Department of Health Services or a neutral community partner.

The state may also want to facilitate partnerships among community members planning new health centers and others. Partnerships could be made with foundations or other entities to build organizational capacity, such as has been done recently with St. Luke's Health Initiatives, the Office of Health Systems Development and some nascent community health centers. The state could also facilitate partnerships with other community healthcare providers, such as hospitals, encouraging care coordination and support.

Monitoring may also be needed to gauge the financial health of safety-net providers. As previously noted, the financial impact of health reform on safety-net providers is unclear. Where people will ultimately receive services is also uncertain.

Arizona (and other states) will have an interest in monitoring the financial health and viability of its providers. While consolidation and integration among providers (both horizontally and vertically) may lead to better cost containment, incentivize creation of accountable care organizations or other such models, and benefit consumers, it is important to ensure that market share does not become too concentrated, potentially driving up costs for consumers.[17] It is also important to ensure that Arizonans living in rural areas have adequate access to healthcare services.

Arizona may want to consider collecting additional hospital and provider data to more closely monitor their financial health. The Massachusetts Division of Health Care Finance and Policy began collecting and analyzing data on hospital margins quarterly after reform was implemented in that state, informing many state policy decisions. State law currently requires hospital and other providers to submit annual financial statements to the Arizona Department of Health Services (ADHS). However, ADHS performs no analysis of such data. (AHCCCS does use such data currently to help determine provider payments, and such data is also available to the public.)

KEY TAKEAWAYS:

- Arizona may want to help identify areas where the state might most benefit from community health center expansion, and facilitate or support creation of centers in those areas.
- The state, foundations, and others may want to provide support or resources for community boards to build organizational capacity and solicit federal funding for community health center creation or expansion.
- The state may want to play an expanded role in monitoring the viability of safety-net providers as reform is implemented.

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FQHC Look-Alikes receive many of the same benefits as FQHCs, including: enhanced Medicare and Medicaid reimbursement; eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program; and automatic designation as a Health Professional Shortage Area (HPSA). The HPSA designation provides eligibility to apply to receive National Health Service Corps (NHSC) personnel and eligibility to be a site where a J-1 visa physician can serve.

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THE HEALTHCARE WORKFORCE

Carol Ann Lockhart, PhD

The Patient Protection and Affordable Care Act (Act) supports greater investments in prevention, primary care, the coordination and integration of care delivery and a prepared workforce.

Nearly all aspects of the new reform law affect the healthcare workforce in one way or another. The most obvious change will be the increased demand for services as more people become insured. The uninsured use between 50-60 percent of the care used by insured individuals, suggesting that a 40-50 percent increase in demand for care may occur as a result of coverage expansion.[1]

Increased access to coverage and health services begins in 2010 but will not be fully implemented until 2014. Between now and then, patients and providers will begin experiencing an increased – and changing – demand for healthcare, requiring changes in how care providers are trained, how they practice, and where services are delivered. While these changes will affect a broad swath of the healthcare workforce, their impact will be most profoundly felt in the area of primary care.

KEY REFORM CHANGES

- **Expands assessment, planning and coordination for the healthcare workforce at the federal and state level.**
- **Offers state healthcare workforce planning and implementation grants.**
- **Expands workforce recruitment, education/training/residency and retention programs for primary care, public health, pediatrics, geriatrics and behavioral health.**
- **Offers grants to schools and individuals to increase the number of physicians/ osteopaths, advanced nurse practitioners, physician assistants, nurses, dentists and allied health professionals.**
- **Offers demonstration projects, diversity education and support to Area Health Education Centers.**
- **Expands funding for primary care and prevention services at community health centers, nurse-managed health clinics and school-based clinics.**

WORKFORCE PLANNING

To support the expected demand for healthcare practitioners, the Act provides funding to plan and implement strategies aimed at increasing primary care positions in the states by 10-25 percent over 10 years (2010-2020). The law:

- Provides states with grants for comprehensive workforce development planning ($150,000 for one year)
- Makes available implementation grants ($1.5 million/year for two years with a possible third year) leading to primary care workforce expansion
- Contains new requirements for states to provide information to a National Healthcare Workforce Commission under these reforms

The new law requires states' Workforce Development Boards to act as the planning bodies for any grants submitted. As of the writing of this report, it appears that neither the Arizona Workforce Development Board nor the Governor's Council on Workforce Policy is applying for one of the state grants. (Such grants were recently announced. Applications were due July 19, 2010, giving states little time to apply.)

Past Arizona workforce planning efforts have largely been carried out in a fragmented manner by a variety of health-related agencies, organizations, associations, colleges, universities or regional bodies with support from local hospitals, foundations and businesses. Those efforts have resulted in some successes, but little has been done on a statewide basis in spite of significant and frequent requests to do so.

However, between 2001 and 2010, the state demonstrated its ability to plan for workforce shortages at a statewide level. To address nursing shortages and meet the demands of an aging population with multiple conditions, the Governor's Council on Workforce formed a task force on nursing shortage (2001-2006). In 2005, with broad support, Senate Bill 1517 appropriated $20 million over five years to expand community college and state-funded university nursing faculty. In 2009, a State Board of Nursing Analysis found that RN enrollment had grown 134 percent, increasing from 2,664 in 2001 to 6,246 in 2009.[2] Unfortunately, student capacity is now declining in public (e.g., state university) RN programs due to limited admissions or closing programs as a result of budget reductions. Nonetheless, private RN program capacity (e.g., Grand Canyon University) remains stable.

Arizona Needs Statewide Health Workforce Planning

Some states such as Pennsylvania have been planning for workforce expansion under healthcare reform even before the bills became law, noting that when states such as Massachusetts implemented significant coverage expansions, access to care was strained and emergency room use grew.[3] States such as Colorado, Ohio, California, Illinois, Nebraska, New York, Iowa, Maryland, and Wisconsin have formed regional collaboratives that bring together government agencies, foundations, and other philanthropic organizations to target financial resources and strategic thinking on creating jobs and careers related to the healthcare workforce.[4]

Arizona has a number of groups able and willing to engage in and help fund a workforce planning process. Unfortunately, without a statewide initiative similar to the former Governor's Council on Workforce Policy for nursing, efforts seem unlikely to reach the level of visibility and consequence necessary to result in significant, coordinated change.

KEY TAKEAWAYS:

- Coverage expansion and other elements of healthcare reform will increase the need for healthcare (especially primary care) providers.
- If primary care and other providers cannot keep pace with demand, patients will go where they can most readily find care – hospital emergency departments.
- Unless there are organized planning efforts among multiple stakeholders, Arizona's efforts to address the state's workforce needs will continue to be fragmented, underfunded and – more than likely – inadequate.
- Arizona should encourage the Health Resources Services Administration (the federal agency charged with releasing workforce planning grants) to allow a second round of applications from states.
- If Arizona does not participate in the federal planning and implementation grants, the Governor's Council on Workforce should develop a task force and charge it with strategic planning related to primary care and prevention, just as it did to address the nursing shortage. The effort should include an assessment of workforce needs, identified strategies and policy changes to address shortages, funding (ideally from public and private sources), and measurable targets against which progress can be measured.

CHANGING CARE DELIVERY

Healthcare delivery is morphing to meet increasing demands for coordination, cost containment and quality. In response, the workforce charged with delivering care is shifting. Healthcare reform is accelerating many of these changes through strategies aimed at addressing quality and through initiatives that address healthcare workforce composition, scope of practice and training. (See the Quality and Efficiency of Healthcare section of this document, beginning on page 30.)

Focus on Primary Care

As a result of healthcare reform and other forces changing the way care is practiced, health care will increasingly be delivered in primary care settings. Accordingly, many of the Act's provisions are aimed at increasing the number of primary care providers.

Healthcare reform addresses these changing workforce needs through new health career education loans, scholarships, grants and revised repayment requirements aimed at attracting new entrants to the healthcare workforce. The new law also offers existing workers the opportunity to pursue advanced degrees and supports the development of faculty needed to prepare the healthcare workforce. Funding targets those interested and willing to work in the areas of:

- Primary Care
- Public Health
- Pediatrics
- Geriatrics
- Behavioral Health

Potential recipients include current and future physicians (medical doctors and doctors of osteopathy), advanced nurse practitioners, physician assistants, nurses, dentists and select allied health workers.

Funding allocations are fairly specific over the next few years, becoming less defined over the latter part of the decade. (Such monies – whether allocated or not – ultimately have to be appropriated from year to year, the likelihood of which may change as political winds shift over time.) Current funding allocations expand or include new funding for:

- Use of unused training slots for physician graduate medical education (GME) residents for:
  - Primary care training at non-hospital sites
  - Primary care and general surgery residencies
  - Training in outpatient settings
  - Expansion of residency programs in rural and underserved areas
- Primary care nurse practitioner training programs and demonstrations
- Funding to Area Health Education Centers (AHECs) for recruitment/retention and education (particularly in rural areas)
- Funding for the National Health Service Corps
- Low-interest student loans and scholarships with improved loan repayment requirements
- Support for multiple nursing programs, including funding for:
  - Nurse faculty loans
  - Nurse practitioner fellowships and traineeships in geriatric and elderly care
  - Workforce diversity grants

- Family Nurse Practitioners to work in nurse-managed clinics/community health centers
- Scholarships for mid-career training for public health and allied health professionals

Funding has already started to flow to state universities and the Arizona Board of Regents for health profession education with the award of $2.3 million for nursing education. The grants provide funding in advanced education, practice, quality, retention, workforce diversity and geriatric education.

Shift in Training and Incentives

Health reform funding supports a shift in focus for physician GME residency training from hospital to non-hospital training sites and community health centers in an effort to better prepare physicians and others for delivering primary care in the community. Such change may not occur easily. A medical school physician/dean interviewed stated:

> *"Changes to residency programs (moving to more community-based programs) will mean an active fight from hospital-based programs and require active involvement in the development of the rules and regulations [from primary care programs]."*

The Act also includes other provisions incentivizing the number of primary care professionals. It increases reimbursement to primary care physicians, nurse practitioners and clinical nurse specialists for Medicare-covered services. Further, it provides very modest payment increases for Medicaid primary care physicians for 2013 and 2014 at no extra cost to the state.

While these new opportunities and incentives are perceived by many as needed, it is unclear how effective they may be in helping Arizona meet increased workforce demands. Whether students and health professionals interested in seeking these education and training opportunities receive their training here (where they are more likely to practice) or go out of state will very much depend on the capacity of various educational programs to meet the increased demand. In turn, the capacity of various institutions (including whether they have an adequate number of faculty) will depend on their ability to leverage national as well as state dollars.

State support for the healthcare workforce has diminished during the past few years in this tough budget climate. The state recently cut Graduate Medical Education ($15 million) for residency programs – and there is no indication when funding may return, given Arizona budget difficulties.[5] (In 2009, 41 states provided full funding for GME.)[6] In response, some hospitals have cut their residency programs. Other hospital/university-based programs are "holding on" in the hope that health reform will allow them to receive funding, according to one professional interviewed in charge of such programs. If academic programs cannot find funding to support their residencies, Arizona will most likely see a decline in the number of slots for GME residents, including primary care.

It is also unclear whether educational opportunities and small increases in pay will be enough to attract aspiring healthcare professionals to primary care. Primary care physicians are generally viewed as being unhappy with their lot. Their many challenges include:

- Lower income than other physicians
- Stress from seeing large numbers of patients, often with multiple health problems in brief visits
- Demands for 24/7 care delivery
- Challenges finding places to practice and live in underserved areas where they can make a life for themselves and their families, including work for a spouse, good schools for their children and social and cultural amenities

Roles of Other Providers, Foreign Medical Graduates

In addition, uncertainty about how Medicare fees for doctors will change in future years may offset any new incentives aimed at attracting primary care practitioners. A planned 21 percent decrease in Medicare payments for evaluation and management services, a major portion of the services offered by primary care practitioners, is set to occur in November 2010. Such reductions have usually been cancelled, but the issue that remains is the lack of consistent and improving incentives to provide primary care.

Nurse practitioners and physician assistants are expected to play a greater role in primary care given the increased demand for care and the anticipated shortage of primary care physicians. Foreign medical graduates may also help fill Arizona's primary care gap.

U.S. primary care residencies often go unfilled, leaving openings for foreign graduates to enter the country to complete their training. Many stay on, setting up practice and becoming citizens. According to a Massachusetts policy expert interviewed, 25-40 percent of the primary care physicians in that state are foreign graduates at any given time. Foreign medical graduates currently represent 30.5 percent of the primary care physicians practicing in Arizona.[7] However, it is unclear whether international attention on Arizona's new immigration law might affect our state's draw of foreign professionals.

The state and various educational institutions already administer an array of programs (grants, stipends, loan forgiveness, university and college funding and practice opportunities) aimed at attracting health profession students. Under health reform, funding for these programs will expand significantly. To maximize their effectiveness, the state must define more clearly what students they want to prepare to respond to statewide defined needs, not single institution needs. State monies for students and programs should go to support policy that enhances the health of Arizona's citizens and meets defined outcomes.

KEY TAKEAWAYS:

- Some physician GME residency training will shift from hospitals to non-hospital training sites (such as community health centers) to better prepare physicians and others for delivering community-based primary care. Clinical and public health settings of all types should begin to explore how they might support that shift and cooperate in designing practice experiences for physicians, nurse practitioners, physician assistants and other students.
- Arizona's healthcare training and education providers and programs should apply for federal workforce funding as soon as possible rather than waiting, since politics or priorities may shift, affecting funding availability.
- Arizona's schools and universities need the capacity to respond to expanded demand for educational programs, or students (and faculty) will seek opportunities out of state. Such capacity depends – at least in part – on stable state funding.
- To effectively meet the state's workforce needs, Arizona should tie public funding for workforce related programs to policies that produce and attract health professionals who will offer the types of services needed by our state's population in the locations where there is a defined shortage or gap in available resources.

INTEGRATED CARE DELIVERY

The increased emphasis on primary care and prevention in the reformed health system comes along with new expectations for coordinated care delivery through "medical/health homes," expanded use of electronic medical records, changes in payment approaches and new accountability for care quality and outcomes, all of which will demand new skills and attention.[8] These and other changes in technology and healthcare delivery will demand workforce education/re-education for all in the field.

Group Health Cooperative of Seattle, a provider that has conducted a medical home pilot project since 2006, found they needed more resources, enhanced staffing ratios and a different mix of staff to deliver care based on the new model. They found that "physicians and care teams require reasonable–size practice populations to allow physicians to know their patients better, comprehensively address their needs, and avoid burnout."[9]

Learning new skills and changing practice patterns will likely result in new stresses and strains for health professionals. In particular, some physicians may not be happy with new requirements and demands on visible accountability. Said one nurse practitioner educator interviewed, “Nurses think rules and follow rules. Physicians don’t follow rules. They make the rules.”

Primary care providers in small practices will be required to offer broader services that are well planned and coordinated with other providers and services. If they cannot or will not provide these services themselves, they may join organizations that already have such capabilities, possibly breaking existing alliances and forming new ones.

Some physicians practicing solo or in small groups, older physicians and other practitioners may simply decide not to accept the required changes and retire or pursue other work – depleting the primary care workforce even further. Larger systems of care, which already provide some coordinated and integrated care, will have to respond to new demands and have the requisite systems in place to do so. However, incorporating physicians who decide to join or contract with them may engender stress and disruption for all those involved.

KEY TAKEAWAYS:

- Healthcare reform will alter how health care is practiced. Existing staff may need to be retrained and the organization and composition of staff may need to be altered to respond to changing practice patterns.
- Practitioners will be increasingly pressured to form alliances and meet accountability requirements, resulting in the exit of some providers who are unhappy with the new demands.

SCOPE OF PRACTICE

The scope of care provided by licensed primary care practitioners is not discussed in the Act. However, growing emphasis on cost control and workforce shortages – which are magnified through many of the Act’s provisions – will necessitate changes in who delivers healthcare services.

Decisions related to scope of practice (who can practice what healthcare services) rest with states. Teasing out which practitioner can provide what services (and at what price) is important to address if Arizona hopes to meet increased and changing workforce needs resulting from healthcare reform.

Physicians, nurse practitioners, physician assistants, dentists and others offer some level of primary care within the scope of their state authorized license, but the “scope” of that care is often in contention. Physicians control the definition of “medical practice” and other providers must seek to “carve out” pieces of that care and have it included in their scope of practice, which still does not prevent physicians from providing the same types of care. Said one physician/dean interviewed, “Physicians need to allow a non-physician team model to predominate and leave physicians to focus on what they do best.”

The 2010 report, *Who Will Provide Primary Care and How Will They Be Trained?* states:

> *“Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes.”* [10]

A recommendation noted in a previous SLHI policy primer on regulating the health workforce noted:

> *"Blurred and conflicting boundaries between scopes of practice do not facilitate care for the public. Arizona should review its licensure and scope of practice acts to ensure that they are flexible enough to allow health professionals to practice to the fullest extent of their technical training and ability. Narrow definitions of practice will make shortages worse with technical rules and limits on practice. A proliferation of different and narrowly defined levels of skills will leave everyone trying to protect their turf and few paying attention to society's needs."*[11]

KEY TAKEAWAY:

- Increased emphasis on primary care, medical/health homes and coordinating teams suggest that using personnel in the most appropriate and expansive roles possible may be a good – and possibly necessary – idea if we are to meet patient demands for care.

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PREVENTION

Kim VanPelt, MPA

Healthcare reform brings significant new investments to primary prevention efforts. It will also provide increased access to secondary preventive health services such as screenings, provide opportunities to expand disease management programs and foster workplace wellness efforts. New opportunities will also exist to change how publicly funded health insurance encourages people to be healthy. Together, these investments and opportunities could begin to shift a healthcare system that – for too long – has focused more on fighting illness and disease than encouraging health and wellness.

Evidence-based prevention efforts offer the promise of not only improving population health, but also possibly bending the cost curve. Today, three-quarters of healthcare expenditures are linked to chronic conditions. Data from the World Health Organization suggests that 80 percent of new cases of stroke, coronary disease and other chronic conditions are potentially preventable. Obesity has doubled since the 1980s, and research suggests that obesity accounts for 15-25 percent of the growth in healthcare spending.[1]

KEY REFORM CHANGES

- **Prohibits insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost sharing for preventive services.**
- **Provides grants for small and mid-sized employers to implement wellness programs.**
- **Encourages employers to create wellness programs by increasing from 20 to 30 percent the allowable premium discount for employees who participate.**
- **Creates a Prevention and Wellness Trust Fund to provide $34 billion in mandatory funding over the next 10 years for community-based prevention programs, a child obesity program, and related programs.**
- **Awards competitive grants to state and local governments and community-based organizations to implement and evaluate proven community preventive health activities to reduce chronic disease rates.**
- **Provides Medicare beneficiaries access to an annual wellness visit, including a comprehensive health risk assessment and creation of a personalized prevention plan, with no co-payment or deductible.**
- **Provides states with an enhanced federal match for expanding preventive services under Medicaid.**
- **Offers grant opportunities for Medicaid programs (or its partners) to implement chronic disease prevention.**

Insurance Coverage for Preventive Services

Under healthcare reform, people with private health plans and Medicare will have the full cost of a range of preventive services and immunizations covered, so people can stay healthy without worrying about the expensive co-payments or deductibles that now often keep them from getting the care they need.

Beginning in 2010, all new group health plans will be required to offer preventive services without cost sharing. In 2014, all new health plans in the individual and small group markets and all qualified health plans in exchanges will be required to cover "preventive and wellness services and chronic disease management."[2] These include services for various population groups such as:

Children

- Oral fluoride supplementation to preschool children older than six months whose primary water source is deficient in fluoride
- Vision screening for children under five
- Evidence-informed preventive care and screening for infants, children and adolescents
- Additional children's preventive care and screenings

Women

- Bone mass measurement for women beginning at age 65 (or 60 for those at risk)
- Mammograms for women age 40 and older
- Additional women's preventive care and screenings

At-Risk Populations

- HIV screening for adults with increased risk for infection
- Diabetes screening for people with high blood pressure
- Colorectal screening for adults aged 50-75
- Diet or behavioral counseling in primary care to promote healthy eating for at-risk populations

All Populations

- Smoking cessation counseling
- Immunizations[3]

These requirements are not applicable to existing or "grandfathered" plans. However, it is unclear what will ultimately constitute grandfathered plans,[4] although interim rules suggest that fewer than half of existing health plans might achieve grandfathered status.[5] Also, the federal government will need to further clarify in some instances what constitutes preventive services. For example, it is unclear whether birth control is considered preventive care for women at this time.[6]

Most reforms go into effect in 2014, but some are effective earlier (such as requiring that all new plans after September 23, 2010 provide "Bright Futures" preventive care with no cost sharing). Arizona may want to consider strong monitoring and oversight to ensure that the reforms work as intended.[7] There may also be a role for organizations to play in encouraging consumers to avail themselves of the new covered services when appropriate.

While these new provisions will provide greater access to care for consumers, they may also have important consequences for many healthcare providers. It appears that the federal legislation did not specify who would bear the cost of lost revenues from co-pays and other cost sharing. Physicians and other health providers interviewed are reporting that they will feel the brunt of this lost revenue – potentially putting a serious dent in their bottom lines.

KEY TAKEAWAYS:

- Healthcare reform will expand coverage of preventive services. There may be a role for state agencies, universities, foundations, consumer groups or health-related organizations to play in educating consumers and monitoring whether consumers receive newly covered services.
- It is unclear who will ultimately pay the price for eliminating cost sharing for preventive services. Will it be providers, consumers or health insurers?

Medicaid and Medicare Coverage

In the new healthcare reform law, cost sharing for evidence-based preventive services under Medicare will be eliminated, mirroring requirements of new private plans. Increased access to preventive services should result.

For Medicaid (AHCCCS) recipients, the changes related to prevention will mostly depend on state action. If Arizona were to expand covered services to include those recommended by a federal task force (including services such as those listed above), Arizona would receive an enhanced payment from the federal government (one percentage point in the FMAP for these services) to apply to the cost. AHCCCS members could gain access to important preventive services such as smoking cessation counseling.

The irony is that while these opportunities will now be available as early as federal fiscal year 2013, Arizona recently has been moving in the opposite direction in providing preventive services. Arizona recently eliminated adult well visits in addition to other optional covered services.[8] Thus, it appears that the prospect of expanding preventive services in light of Arizona's budget crisis appear slim.

Healthcare reform will also provide grant opportunities related to prevention for AHCCCS. Under a provision called "Incentives for Prevention of Chronic Diseases in Medicaid," states can apply for $100 million in grants to develop interventions that target tobacco, weight loss, cholesterol, blood pressure and diabetes. Grants (which must be at least three years in duration) will be awarded no later than January 1, 2011. The state is allowed to enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out the program.[9]

While tight budgets and recent staff reductions to AHCCCS may make it challenging to implement such opportunities, coverage expansion occurring in 2014 will significantly add to the number of people on AHCCCS. Moreover, the addition of people with higher incomes will likely mean that more people will remain on AHCCCS for longer periods of time – further driving the long-term need to address prevention.

AHCCCS may want to consider partnering with the Arizona Department of Health Services (ADHS) to take advantage of some of these opportunities. ADHS has considerable experience implementing successful prevention efforts. It also has relationships with community-based efforts occurring across the state.

KEY TAKEAWAYS:

- Healthcare reform presents new opportunities – and new demands – for AHCCCS to expand preventive services and disease management.

Workplace Wellness

Well-designed, evidence-based workplace wellness efforts can lead to long-term health and productivity improvements.[10] In a recent meta-analysis of the literature on costs and savings associated with workplace disease prevention and wellness programs, researchers found that medical costs fall by about $3.27 for every dollar spent on wellness programs and that absenteeism costs fall by about $2.73 for every dollar spent.[11]

Beginning 2014, businesses may allow premium reductions of up to 30 percent for employee participation in wellness programs. Such rewards are currently limited to 20 percent.[12] Nationally, businesses such as Safeway have reported significant savings in their healthcare costs by implementing such measures. Their efforts include a reduction in annual premiums for employees who pass or make significant progress in addressing their tobacco usage, healthy weight, blood pressure or cholesterol levels.[13]

ELEMENTS OF SUCCESSFUL WELLNESS PROGRAMS

To be successful, programs must be:

- **Comprehensive**
- **Tailored to the population**
- **Marketed creatively**
- **Embraced by top management**
- **Protective of employee privacy**
- **Able to collect data from third parties to inform decisions and interventions based on de-identified, aggregated data**

Beginning in 2011, small employers may be eligible to receive federal grants to provide employees with access to comprehensive workplace wellness programs. Funding would be available to employers with fewer than 100 employees who did not provide a workplace wellness program as of March 23, 2010. The government has appropriated $200 million for this temporary program for fiscal years 2011 through 2015.[14]

These new federal grants could incentivize many small businesses to offer employee wellness programs. One-third of Arizona salary and wage employment is connected to a small business. Approximately 92,000 small businesses have fewer than 100 employees.[15] While no data exists estimating how many small businesses in Arizona offer employee wellness programs, one national study suggests that fewer than one quarter of businesses with under 1,000 employees offer wellness or employee assistance programs.[16]

Efforts appear to be under way to encourage and assist employers to take advantage of these new opportunities. Under the new law, the Centers for Disease Control and Prevention is charged with providing technical assistance to businesses interested in implementing workplace wellness initiatives. The Arizona Department of Health Services plans to play a role in encouraging and supporting some large employers to offer employee wellness programs. The Arizona Chapter of the American Heart Association and the YMCA of Southern Arizona are among those who already work with businesses to implement workplace wellness efforts.

Nonetheless, more could be done to expand these efforts. The Governor's Office, the Department of Health Services or health foundations could play a role in identifying and mapping existing, organized efforts to expand workplace wellness programs throughout the state, identifying gaps that might exist statewide. Once gaps are identified, efforts could be organized at a local level (spearheaded by county health departments, community-based organizations, health foundations or others) to implement workplace wellness programs in local communities and expand existing workplace wellness efforts occurring elsewhere whenever possible.

Small business associations, public health agencies, health foundations, or the Governor's Office (which has organized coalitions in the past related to prevention and physical activity) could also play a critical role in providing information and supporting small businesses in designing or implementing wellness programs and applying for such grants.

The likely success of encouraging businesses to participate in wellness initiatives is unknown. Employer benefits experts noted that many mid-size businesses (over 50 employees) are anxious about how healthcare reform might affect health insurance premiums and costs of administering benefits. They cited reluctance among many employers to implement new programs until the true impact of reform on their businesses is better understood.

Some businesses or organizations may also be reluctant to implement or encourage financial incentives for healthy behaviors for other reasons. During the healthcare reform debate the topic was contentious, with many national experts noting that "rewards" for healthy behavior may essentially become a punishment (in terms of higher costs) for people with compromised health status.[17]

Still, employee benefit experts interviewed suggest that these incentives and grants may be one of the best ways for employers to ensure that their employees take advantage of the expanded array of preventive health services and screenings offered under reform. They note that insurance companies may not have a financial incentive to encourage screenings and prevention since employees often switch jobs long before the financial rewards of prevention can be realized by an insurer.

KEY TAKEAWAY:

- Organized efforts aimed at encouraging businesses to take advantage of new workplace wellness grants and incentives might go a long way toward improving health among Arizonans.

Community-Based Prevention

Healthcare reform includes significant new funding for community-based prevention efforts. These investments could help promote healthy behaviors and bend the cost curve. The Trust for America's Health estimates that small investments in proven community-based programs to increase physical activity, improve nutrition and prevent smoking and tobacco use could save the country more than $16 billion annually within five years.[18]

The new health reform law funds community-based prevention efforts at an unprecedented level. It creates a $16 billion fund to support expanded and sustained investment in prevention, public health and wellness activities, including prevention research and health screenings and initiatives. Beginning in 2015, $2 billion annually will be available.

The details of these monies to be awarded to states on a year-to-year basis have not yet been determined. The first release of $500 million from the fund appears to devote monies meant for prevention to workforce development and capacity building for the public health infrastructure. Nonetheless, over $126 million in grants was announced for fiscal year 2010 for federal, state and community prevention initiatives; the integration of primary care services into publicly-funded community-based behavioral health settings; obesity prevention and fitness; and tobacco cessation.[19] Insights into how funds might be allocated in the future can be gleaned from the wide array of grant programs (funded or not funded) included in the federal reform legislation. (See chart on following page for examples.)

Examples of Grants Available for States and Communities

GRANT NAME/ FOCUS	WHO CAN APPLY
Community Transformation Grants – Funds programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness, or other activities consistent with the goal of promoting healthy communities. Can be used for activities including (but not limited to) creating healthier school environments; creating infrastructure to support active living and access to healthy food; workplace wellness programs; addressing the social, economic and geographic determinants of health; addressing special population needs. (Sec. 4201)	State and local government agencies (including tribes); community-based organizations (non-profit and national networks of community-based organizations). 20 percent of the grants will be awarded to rural and frontier areas.
Healthy Aging, Living Well – Funding to conduct five-year pilot programs providing public health community interventions, screening, and clinical referrals for individuals who are between 55-64 years old. (Sec. 4202)	State or large local health departments or Indian tribes
Oral Health Demonstration Grants – Available for prevention activities such as school-based dental sealants and community water fluoridation. (Sec. 4102)	A wide array of community-based providers of dental services, including (but not limited to) federally qualified health centers; state or local health departments; tribal dental programs; health system providers; and medical dental, public health, nursing, and nutrition educational institutions.
Community-Based Diabetes Prevention – Funds can be used for community-based prevention activities, training, outreach, and evaluation.(Sec. 10501)	State, local and tribal health departments and non-profit entities.
Individualized Wellness Plans for At-Risk Individuals – Pilot programs will be established to test the impact of providing at-risk populations who use community health centers with individualized wellness plans designed to reduce risk factors for preventable conditions identified by comprehensive risk assessment. (Sec. 4206)	Up to 10 community health centers nationally.
Childhood Obesity Demonstration Project – Provides funding for grants to develop a comprehensive and systematic model for reducing childhood obesity. Grantees shall develop a curriculum, form partnerships, and carry out community-based activities to reduce childhood obesity. (Sec. 4306; CHIPRA Sec. 401)	Cities, counties or Indian tribes; local or tribal educational agencies; an accredited university, college or community college; federally qualified health centers; local health department; healthcare providers; and community-based organizations. Priorities are based on a number of enumerated factors.

What is known at this point is that there is a wide array of current state, county and community-driven efforts occurring in Arizona related to prevention and disease management that could be brought to scale or expanded with the help of these grant or pilot program opportunities. A few examples include:

- The Arizona Department of Health Services is currently partnering with the Greater Valley Area Health Education Center and others to implement the evidence-based Chronic Disease Self Management Program (CDSMP) throughout Arizona. CDSMP is an evidence-based, best-practice program that has demonstrated positive impact on health status, health behaviors and healthcare utilization.
- Maricopa County, the American Heart Association and other community partners have established a coalition working to address childhood obesity. Strategies include establishing school-based health councils and expanding access to safe, attractive and accessible places for physical activity. This same coalition was an applicant recently for a federal stimulus grant (Communities Putting Prevention to Work). While their grant application was not funded, they may be well-positioned to receive new funding as it is available.
- Efforts are under way in local communities and statewide to address childhood obesity. These include Maryvale on the Move (a collaboration among St. Luke's Health Initiatives, Golden Gate Community Center, Rehoboth Community Development Center, Wesley Community Health Center and others) and a collaboration among Save the Children, Children's Action Alliance and other organizations.
- First Things First is implementing early childhood nutrition efforts in several of its regional council areas, including implementing elements of the evidence-based Nutrition and Physical Activity Self Assessment for Child Care program focusing on nutritious eating in early childhood settings.

KEY PARTNERS: PIMA COUNTY COMMUNITIES PUTTING PREVENTION TO WORK

- **K-12 Schools**
- **University of Arizona**
- **Carondolet Foundation**
- **Neighborhood-Based Organizations**
- **YMCA and their Workplace Wellness Partners**
- **Community Food Bank**

Arizona can look in its own backyard to identify criteria that will likely be used to award many of the prevention grants to states. Last March, Pima County Health Department and a coalition called Activate Tucson received a three-year, $16 million economic stimulus grant from the Centers for Disease Control and Prevention. It was the largest per capita grant awarded among the 44 communities nationally that received funding.[20]

According to one coalition member, the request for proposals emphasized building upon the success of existing coalitions in changing policy, systems and environmental change. Activate Tucson was able to fulfill those criteria easily. The coalition of over 200 members has existed since 2004 and has a proven track record in achieving results.[21]

Public health leaders interviewed noted a number of strategies that might help Arizona position itself to both receive and successfully implement prevention efforts in our state. Suggestions generally fall into four major categories. They include:

1. Local Approach

- Ensure that prevention efforts have a local focus. Whether grants are awarded at a state or community level, there should be a strong emphasis on how to engage and involve local community organizations already working to implement local prevention strategies. A focus on local efforts may also better position the state for grant opportunities. Several people noted that the Centers for Disease Control and Prevention appear to be making a shift towards focusing on locally-driven collaborations. Focusing on the local may also make prevention efforts more effective.
- Inventory and map existing prevention efforts occurring in communities. Identify evidence-based, replicable prevention efforts (such as the YMCA's Activate America program – the model for Activate Tucson) occurring in the state that could be

replicated in other communities. Such an inventory could be performed by the Governor's Office, the Arizona Department of Health Services, a university or a health foundation. Efforts by the Arizona Department of Education to summarize and assess gaps in school district wellness assessments (currently submitted by each school district) would also be useful to help assess what is currently occurring in schools throughout Arizona.

2. Coordination and Collaboration

- Move beyond siloed approaches to prevention. Some experts noted that it was critical that prevention efforts not focus on one disease or one cause (such as tobacco or nutrition) alone.
- Improve coordination and collaboration. Provide support (in-kind or financial) for coalitions to integrate and coordinate various prevention strategies in their local communities.
- Encourage and strengthen partnerships and involvement of higher education in local prevention efforts. Pima County representatives noted that their partnership with the University of Arizona was a critical factor in their success in securing the federal Communities Putting Prevention to Work grant.
- Garner commitment from the Arizona Department of Education (or specific school districts) to partner in prevention efforts, making it easier for coalitions to achieve partnerships with local schools. Representatives from the Maricopa County coalition pointed out how difficult it was to secure the commitment and support of individual schools (given the large number of school districts in the county) in recent federal grant application efforts. The Arizona Department of Health Services has made recent progress in partnering with schools that could be built upon.
- Create partnerships and involvement with organizations or groups that impact the built environment (e.g., city planning, transportation, housing) at both a state and local level to focus on how policy or environment might be altered to promote healthy eating, active living and connected communities.

3. Policy and Advocacy

- Make sure policy and environmental change are part of the focus of state and local prevention efforts. Recent grants (federal as well as large national foundation grants) increasingly focus on policy change and changes to the built environment (such as creating safe, walkable communities) in their funding criteria.
- Strengthen the ability of local coalitions to inform and recommend policy change at a state level based on lessons learned from implementing local prevention efforts. Creation of an advisory committee to the governor or legislature on prevention might be helpful in identifying and leveraging needed statewide policy change.

4. Leadership and Innovation

- Demonstrate leadership. The state of Washington, for example, appears to be positioning itself for prevention grants by publicly committing to integrating prevention/wellness strategies into all of its planned reform efforts.
- Don't conduct business as usual. Many people noted that if Arizona receives funding at the state level, it was critical to give local areas flexibility in implementing prevention efforts. Merely providing pass-through money to implement services limits the ability of local areas to leverage existing community assets and innovate in comprehensive program design and execution.
- Seek additional private support for prevention efforts. Such support from businesses and foundations will strengthen state, regional and local grant proposals by demonstrating that they are effectively leveraging other community resources.

KEY TAKEAWAY:

- To increase Arizona's chances of attracting federal grants and effectively implementing prevention efforts, state leadership and innovation and local collaboration are needed.

ABOUT THE AUTHOR

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REPRODUCTIVE AND EARLY CHILDHOOD HEALTH

Kim VanPelt, MPA

Healthcare reform provides new opportunities to prevent unwanted pregnancies and support pregnant women and families in the care and development of their young children. These changes may affect a wide swath of Arizonans, including teenagers, women of childbearing age and their partners and at-risk families.

KEY REFORM CHANGES

- **Increases access to family planning through Medicaid expansion in 2014.**
- **Makes it easier for Arizona to obtain federal approval to expand AHCCCS planning services to women and men earning up to 150 percent of the federal poverty level.**
- **Provides new monies for comprehensive sex education programs and abstinence education programs.**
- **Requires insurers to cover maternity and childbirth services.**
- **Provides new monies to expand evidence-based home visitation programs.**
- **Requires businesses with 50 or more employees to provide break time (and space) for nursing mothers.**

FAMILY PLANNING

Family planning services are a critical element of basic health care and allow women and men to thoughtfully plan the size and spacing of their families. Unfortunately, many Arizona women lack access to family planning services. In 2006, 53 percent of fertile non-Native American, low-income women (144,000 women ages 15 - 44) were unable to access family planning options, up from 51 percent in 2004.[1]

Healthcare reform *may* require family planning services to be available free of charge by many health insurers beginning September 23rd, 2010, allowing greater access to such services. While final regulations have not been determined by the federal Health Resources and Services Administration, family planning services may be included in the list of preventive services that must be offered without a co-pay or out-of-pocket costs.

While changes to insurance coverage for family planning are still uncertain, healthcare reform *will* change the availability of family planning for low-income Arizonans. Beginning in 2014, eligibility for AHCCCS (Arizona's Medicaid program) will increase to 133 percent of the Federal Poverty Level, allowing family planning (a covered service) to be available to many more low-income men and women in our state.

The new healthcare reform law also provides an *additional* state option to expand the availability of publicly funded family planning services even further. Currently, Medicaid-paid family planning is available to those earning at or below 100 percent of the Federal Poverty Level. In addition, women earning up to 150 percent of the Federal Poverty Level can obtain family planning services through Medicaid – *if* they have had a pregnancy paid for by AHCCCS previously and they don't have any private health insurance currently.[2] These family planning services are limited in duration. Women can only receive AHCCCS-covered family planning services for a two-year period.

Under healthcare reform, states can further expand Medicaid coverage for family planning services *immediately* through a simple state Medicaid plan amendment, bypassing the previous, cumbersome state waiver process. Under the state plan amendment process, states can expand the availability of family planning to *all* Medicaid eligible women *and men* whose incomes are at or below the income level set for pregnant women receiving Medicaid in a state.[3] (In Arizona, pregnant women whose household incomes are up to 150 percent of the Federal Poverty Level qualify.)

Expansion of family planning may be cost-beneficial for the state. The federal government pays 90 cents of every dollar spent by state Medicaid programs on family planning. The cost savings achieved by preventing a pregnancy and birth by a woman may be considerable. Over half of the births in Arizona are currently paid for by AHCCCS, at a cost of approximately $6,629 for each covered birth. Conversely, the cost of paying for family planning services for a Medicaid recipient is approximately $17 annually.[4]

Cost Savings and Better Outcomes

States with more expansive family planning coverage have demonstrated cost savings. One recent study concluded that states save $4.02 for every dollar they spend on family planning waivers.[5] The Centers for Medicare and Medicaid Services (CMS) have also found evidence that family planning services avert births resulting in state savings. The table below highlights CMS's 2003 study findings:

STATE	YEAR	BIRTHS AVERTED	NET SAVINGS ($ IN THOUSANDS)	TOTAL BIRTHS	BIRTHS AVERTED AS % OF TOTAL BIRTHS
Alabama	2000-2001	3,612	$19,029	61,877	5.84%
Arkansas	1997-1998	2,748	15,524	36,672	7.49%
	1998-1999	4,486	29,748	36,797	12.19%
California	1999-2000	21,335	76,183	525,234	4.06%
New Mexico	1998-1999	507	1,334	27,255	1.86%
	1999-2000	1,358	5,009	27,207	4.99%
	2000-2001	1,528	6,511	27,176	5.62%
Oregon	2000	5,414	19,756	45,804	11.82%
South Carolina	1994-1995	2,228	13,364	51,485	4.33%
	1995-1996	3,151	19,616	51,022	6.18%
	1996-1997	3,769	23,067	51,666	7.29%
Average		4,558	$20,831	85,654	5.32%

Source: Edwards, J., Bronstein, J., & Adams, K. (2003, November). Evaluation of Medicaid family planning demonstrations. The CNA Corporation, CMS Contract No. 752-2-415921.

Note: Births averted as a % of total births calculated based on Census data for the research year.

There are additional benefits to expanding family planning services and preventing unwanted pregnancies. Births that are spaced by three to five years are more likely to result in healthy babies. By averting unintended pregnancies, children born by mothers with AHCCCS coverage may have better health outcomes. One study suggests that unintended pregnancies result in a 30 percent greater likelihood that an infant's health will be compromised.[6]

If Arizona does expand family planning services through Medicaid, money currently devoted to family planning may be "freed up" for other purposes benefiting maternal and child health. Each year, Arizona receives over $7 million from the federal government as part of Title V, or the Maternal Child Health Block Grant. Approximately 12 percent of these monies are devoted to family planning.[7] If family planning were to be expanded under AHCCCS, some or all of these federal dollars could potentially be devoted to other maternal or child health needs such as Children's Rehabilitative Services.

KEY TAKEAWAY:

- Healthcare reform makes family planning more affordable and accessible for low-income women and men. Arizona can take steps now to expand the number of people receiving such services even further, saving the state money in the long run.

SEX EDUCATION

Arizona has one of the highest teen birth rates in the country.[8] In addition, the prevalence of some sexually transmitted diseases among teenagers has been increasing in recent years. For example, during 2003-2008, the rate of chlamydia increased 45 percent among 10-19 year olds.[9]

Healthcare reform may provide new opportunities for our state to curb these trends through the expansion of sex education. Beginning in FY 2010, the state of Arizona can apply for and receive approximately $1.2 million per year for five years for evidence-based, comprehensive teen pregnancy prevention. Such monies are likely to be awarded to community organizations or schools through an RFP process. If the state does not apply or use its allotment of dollars, community organizations may apply.

The Arizona Department of Health Services will also likely receive about $1.1 million for abstinence education. However, to be eligible for such money, Arizona must put up a match of $4 for every $3 that the federal government provides. To meet this match, the state could require abstinence providers to make available in-kind matching dollars. Such an in-kind match could further leverage the use of Lottery dollars for pregnancy prevention efforts. (Statute restricts the use of these dollars for pregnancy prevention.)

The new law will also provide up to $10 million in grants to entities to implement innovative youth pregnancy prevention strategies to target services to high-risk, vulnerable and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, teenagers and youth residing in areas with high birth rates.

Challenges to Address

While new funding presents fresh opportunities, several challenges and obstacles may need to be addressed for Arizona to most effectively use new federal dollars.

First, more data may be needed. Little is known about the myriad of existing sex education efforts occurring in schools. Unlike 40 other states, Arizona does not require the schools to provide sex education or information on sexually transmitted infection prevention.[10] Instead, each school district decides whether sex education is provided or not and what such programs look like. Accordingly, little information is currently collected by the Arizona Department of Health Services or the Arizona Department of Education on the status of current sex education efforts in school districts. Lack of information may make it challenging for community-based organizations to target efforts aimed at attracting federal funds.

Coordination across programs and funding streams may also be an issue. Both public and private organizations may seek to implement programs in various geographic areas, creating the potential for duplication and inefficiency in program delivery. To address this challenge, the Governor's Office, the Department of Health Services or an organization such as the Arizona Public Health Association could convene organizations engaged in sex education efforts (e.g., schools, abstinence providers, Planned Parenthood and other comprehensive sex education providers) to share information and coordinate efforts. Similar coalitions have existed in the past.

Finally, statutory barriers may also prevent effective implementation. A recently passed law requires parents to give permission for their children to attend sex education classes (opt-in versus opt-out), making it challenging to administer sex education in the schools.[11]

KEY TAKEAWAY:

- Healthcare reform brings new opportunities for Arizona to implement evidence-based, comprehensive teen pregnancy prevention programs in addition to abstinence education, potentially allowing the state to effectively ameliorate high teen pregnancy rates and reduce the prevalence of sexually transmitted diseases.

MATERNITY BENEFITS

Beginning in 2014, many health plans will be required to cover maternity and childbirth services as part of the benefit package. Insurers won't be allowed to charge higher rates to women who are pregnant or refuse to cover them or their childbirth costs.

These new requirements may make maternity and childbirth services vastly more accessible and affordable for women – particularly those who have health insurance through the individual or small group health insurance markets. Federal law currently requires employers with 15 or more employees to provide coverage for maternity care if they also cover other temporary disabilities.[12] However, Arizona is one of 32 states that currently does not have a law that extends the requirement to offer or cover maternity benefits to small group and/or individual policies.[13]

KEY TAKEAWAY:

- Healthcare reform may make maternity benefits more readily available to women who have private coverage purchased through the individual or small group markets.

EARLY CHILDHOOD AND FAMILY SUPPORT

Healthcare reform provides new opportunities for states to strengthen early childhood home visiting programs. Early childhood home visiting programs provide voluntary, in-home services to families with children beginning prenatally up to kindergarten entry age. Trained home visitors – nurses, social workers, early childhood education specialists or other trained para-professionals – meet with families in their homes to help advise them on their children's health and development and build skills to help their children grow and thrive. Research studies have found that quality, evidence-based home visitation services produce positive measurable outcomes for children and families that are real and lasting: better health, greater school readiness, academic achievement, parental involvement, economic self-sufficiency, reduced child maltreatment and injuries and less juvenile delinquency.[14]

Over the next five years, $1.5 billion in grants will be provided to states and tribes to expand home visiting programs. Recently, the Arizona Department of Health Services (ADHS) applied for and received $1.7 million for Arizona. ADHS is now working with other agencies including First Things First and the Arizona Department of Economic Security to develop Arizona's plan for how those monies will be spent in our state, including choosing the evidence-based model(s) that will be implemented.

As a condition of receiving these new monies, the state is required to supplement and not supplant resources currently directed to home visiting in the state. While these maintenance of effort requirements still need to be clarified by the federal government, it is important to note that Arizona may *potentially* jeopardize its ability to receive these grant monies if further reductions are made to state-funded home visitation programs, such as those currently funded through First Things First or the Arizona Department of Economic Security. (In recent years, home visitation programs such as Healthy Families have been cut dramatically.)

Arizona is Well-Positioned

Arizona is well-positioned to administer these new grant monies. First Things First and the Arizona Department of Economic Security currently fund a number of home visitation programs (e.g., Healthy Families, Nurse Family Partnership, Parents as Teachers) that meet the evidence-based standards contained in the new healthcare reform law. Arizona has already started the groundwork for implementation, due to creation of an interagency, public/private taskforce comprised of members that include representatives from the Arizona Department of Health Services, the Department of Economic Security, First Things First and community providers. This group began assessing the need for (and gaps in) home visitation in our state well before the new law was signed.

As a result of the new infusion of money for home visitation, the state may be able to "free up" lottery dollars currently committed to non-evidence-based programs (such as the Health Start program), allowing those dollars to be used for other maternal and child health purposes. Those monies could also be used to fill in "system gaps" that are identified through the statewide needs assessment of home visitation that is being performed as a requirement of healthcare reform, or to further expand evidence-based home visitation programs. Such changes may depend on final guidance from the federal government on maintenance of effort requirements and would require changes in state law.

Finally, the new law requires employers with 50 or more employees to provide break time for nursing mothers to express milk in a private space other than a bathroom. The Arizona Department of Health Services developed and implemented a similar policy some years ago among its employees. The policy could be used as a model for implementation among employers.

KEY TAKEAWAY:

- Arizona is well-positioned to receive new federal moneies to expand evidence-based home visitation programs. However, their availability may be tied to a continued commitment by state agencies to maintain current funding levels for home visitation programs. Such funding may be in jeopardy due to potential budget cuts and a 2010 ballot measure (which could eliminate First Things First).

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BEHAVIORAL HEALTH SERVICES AND COVERAGE

Linda Huff Redman, PhD

One group of Americans that stands to benefit from the New Patient Protection and Affordable Care Act (Act) are those individuals who have behavioral health disorders (i.e., mental health and/or substance abuse disorders). It is estimated that 26.2 percent of adults in America suffer from a mental disorder in a given year, with about six percent suffering from a serious mental illness, and that one in five children aged 0 to 18 years have a diagnosable mental disorder.[1] A recent health survey conducted in Arizona found that in comparison to national prevalence rates for adults, Arizona had a higher rate of bi-polar or manic depressive disorder and a much higher rate of anxiety disorder.[2]

KEY REFORM CHANGES

- **Enhances coverage of behavioral health (mental health and substance abuse) services by including them as part of the basic benefit plan for Medicaid and individual and small group markets.**
- **Requires application of mental health parity and mandated Medicaid coverage of certain drugs important for people with behavioral health disorders.**
- **Implements multi-faceted strategies to address capacity issues and gaps in behavioral health workforce.**
- **Includes behavioral health as a component of initiatives promoting medical homes and integrated and coordinated care delivery.**
- **Provides funding for Medicaid emergency psychiatric demonstration projects and research and services related to treatment of depression.**

Even with this high prevalence of behavioral health disorders, the ability to access behavioral health services in Arizona has been mixed. Over the past decade, Arizona has continued to work on improving its public behavioral health system, which is funded primarily through Medicaid/Children's Health Insurance Program (CHIP) monies. This public system of care offers a comprehensive behavioral health benefit package to Medicaid/CHIP eligible individuals.[3] However, access to behavioral health services in Arizona continues to be very limited for those individuals who either have no insurance or have individual or small group private insurance. Such insurance often does not include behavioral health coverage.

With the recent downturn in the economy, access to behavioral health services in Arizona has become even more of a problem. Factors contributing to this include: more restrictive eligibility and coverage for certain individuals in the public behavioral health program, an overall increase in the percentage of uninsured in the state, and an unstable behavioral health provider network that is struggling to maintain program operations in the face of recent reductions in provider fee schedules and overall reduction in program funds.

As the Act is implemented over the next four years, behavioral health services will become more financially accessible for Arizonans with behavioral health disorders. In addition to benefiting from the general insurance and Medicaid/CHIP healthcare reform provisions (such as establishment of high-risk pools, Medicaid coverage expansion, and elimination of preexisting condition requirements), the new law includes a number of provisions which specifically address the needs of and provision of care to individuals with behavioral health disorders. These include adding behavioral health as a basic benefit for Medicaid and individual and small group insurance markets, application of mental health parity requirements, and development of medical homes for those with behavioral health disorders.

These provisions, along with other behavioral health provisions (such as demonstration programs), are specifically aimed at improving coverage and access to prevention, treatment and recovery services for individuals with behavioral health disorders. The law affords Arizona the opportunity to further develop and enhance both its behavioral health provider network (such as through workforce development initiatives and the establishment of centers for excellence in treatment of depression) and the manner in which services are provided to individuals (e.g., medical homes, co-location of providers). Two of the central challenges for Arizona will be to make sure that 1) the behavioral health network will be able to adequately address the needs of Arizonans by 2014 when public and private coverage is expanded, and 2) the consumer population understands how to access these services.

EXPANDING COVERAGE OF BEHAVIORAL HEALTH SERVICES

The Act clearly acknowledges that behavioral health services are an integral component of the healthcare service packages to be offered under the new healthcare reform system. Although the coverage expansion provisions will not begin until 2014, these provisions ensure coverage of behavioral services by:

- Requiring the inclusion of behavioral health services in the essential benefit package to be offered by qualified health plans, including plans in the health insurance exchange and those in the individual and small group markets outside the exchange (with the exception of grandfathered individual and employer-sponsored plans).[4] The scope of this essential benefit package must be similar to that provided under a typical employee plan. Additionally, the mental health parity requirements as set forth in the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 are applied to the qualified health plans. This means that behavioral health benefits must be provided in the same way as all other covered medical and surgical benefits.
- Requiring the inclusion of behavioral health services in Medicaid benchmark benefit packages that are provided to the new Medicaid expansion group of parents and childless adults with incomes below 133 percent of the Federal Poverty Level (FPL). This expanded coverage will be especially beneficial to adults with serious mental illness. Frequently, this group has difficulty obtaining Supplemental Security Income benefits that would qualify them for Medicaid. Additionally, the Act requires certain Medicaid plans (i.e., benchmark plans) that were designed to mimic private insurance and have fewer benefits than traditional Medicaid to comply with the requirements of mental health parity law.
- Requiring Medicaid to cover smoking cessation agents, barbiturates and benzodiazepines, all of which are drugs that are frequently used by individuals with behavioral health disorders.

Benefits and Services in Arizona

The impact of these new coverage requirements on Arizona will vary. For example, under its current Medicaid/CHIP program (AHCCCS), Arizona already covers smoking cessation agents, barbiturates and benzodiazepines. On the other hand, Arizona's individual or small group insurance market is currently not required to offer behavioral health services as a covered benefit. The recent application of the mental health parity requirements in January 2010 only applies to employers that have more than 50 employees. Furthermore, while AHCCCS offers a comprehensive array of behavioral health services to eligible Medicaid and CHIP enrollees, Medicaid eligibility for parents and childless adults is limited to those with incomes below 100 percent of FPL as opposed to 133 percent of FPL under healthcare reform Medicaid expansion.

With these new coverage expansions, Arizona will need to determine the scope of behavioral health services that will be covered under the Medicaid basic benefit package offered to childless adults and parents; provide outreach and education for Arizonans with behavioral health disorders about the availability of these new public and private benefits; and enhance its current behavioral health provider network so that it is able to meet the increased demand for behavioral health services.

KEY TAKEAWAYS:

- Arizona will need to determine the scope of behavioral health services offered under the Medicaid benefit package for the expanded coverage group and decide whether the services available will be the same as those that are currently provided to Medicaid eligibles.
- Arizona should work in partnership with consumer advocacy organizations to develop a statewide plan for outreach and education for individuals with behavioral health disorders about all the healthcare reform provisions that may benefit them. This should include the coverage expansions as well as more recent changes such as establishment of a high risk pool, insurance coverage for young adults and elimination of preexisting condition restrictions.
- Arizona needs to work in partnership with behavioral health providers and health plans to assess the adequacy of the current provider network and subsequently develop and implement strategies to rectify any identified gaps in the provider network in order to meet the increased demand for behavioral health services with the implementation of the expanded coverage in 2014.

DEVELOPING A QUALITY BEHAVIORAL HEALTHCARE WORKFORCE

In order to improve access to and the delivery of high-quality healthcare services to all Americans, a major component of the Act is increasing the supply of qualified healthcare professionals/workers and enhancing healthcare workforce education and training. This is being accomplished through a variety of broad-based strategies: the availability to states of planning and implementation workforce development grants, establishment of a federal National Health Care Workforce Commission to evaluate and make recommendations to Congress and the Administration on development of a healthcare workforce, and establishment of the Center for Health Care Workforce to analyze healthcare workforce-related issues and evaluate workforce-related programs.

The Act's healthcare workforce provisions specifically target behavioral health professionals (psychologists, substance abuse prevention and treatment providers, social workers, etc.), direct care workers (psychiatric aides, health aides, etc.) and para-professional child and adolescent mental health workers. The Act also identifies behavioral healthcare workforce capacity at all levels as one of the high-priority workforce development areas and allows behavioral health providers (such as community mental health centers) to serve in the capacity of a teaching health center or training provider.

In addition to the broader-based workforce development strategies, the Act includes a limited number of provisions that focus more specifically on improving the healthcare workforce in relation to treating individuals with behavioral health disorders. Beginning in 2010 this includes:

- A new five-year pediatric specialty loan repayment program that includes child and adolescent mental and behavioral health care as one of the subspecialty focus areas. Each selected qualified health professional must agree to provide care in an area with a shortage of the specified pediatric subspecialty.
- Grants to higher education institutions to support the recruitment and training of students and make available clinical experience in the field of social work and psychology. The grants can also be used to establish or expand internship programs or pay behavioral health services for pre-service or in-service training of paraprofessional child and adolescent mental health workers. Funding for this program has been authorized through 2013.
- A new United States Public Health Services Track that grants advanced degrees in specific fields. The law specifically states that not less than 100 behavioral and mental health professional students must graduate annually. The Track will be located across the United States at accredited health professions education training programs at academic health centers that are selected by the Secretary of the U.S. Department of Health and Human Services (HHS).

Recent Progress, New Opportunities

A shortage of qualified behavioral health workers has been an ongoing issue in Arizona. Over the last 10 years, the Arizona Department of Health Services' Division of Behavioral Health Services – in partnership with behavioral health providers, advocacy groups and higher education institutions – has worked on expanding the behavioral health workforce, especially in the area of community-based services (peer support specialists, support and rehabilitation providers, case managers, child psychologists and mental health specialists).[5] These efforts have also focused on enhancing the quality and expertise of the workforce through the provision of focused training programs on topics such as recovery, provision of support and rehabilitation services and the role of family and child teams.

Recent state budget cuts and subsequent provider staff reductions have undermined some of this progress. Nonetheless, Arizona may be able to continue to move forward through healthcare reform. The state, in partnership with providers and educational institutions, may be able to take advantage of some of these healthcare workforce development initiatives under the Act to further enhance the behavioral health workforce. This will be particularly critical as the state prepares for the coverage expansion in 2014.

- Arizona should explore the feasibility of applying for any relevant workforce development grants.
- Arizona should actively educate individuals about available educational and training opportunities such as the pediatric specialty loan repayment program or the US. Public Health Services Track.

BEHAVIORAL HEALTH AS A COMPONENT IN MEDICAL HOMES

Person-centered medical homes are collaborative care models that offer the opportunity to improve coordination and integration of behavioral health and primary care systems. Highly functioning and responsive medical homes can enhance efficiency and quality while improving access to needed health care and support services, including appropriate referral and linkage with specialty services such as community behavioral health care.

As a result of federal legislation in 2006, the Centers for Medicare and Medicaid Services (CMS) is in the process of implementing a Medicare medical home demonstration program. In the Act, provisions were included to support and further expand the development of the medical home model as a component of the service delivery system afforded to individuals through both the private and public health insurance market.

A key component of this effort is the availability, beginning 2011, of a new Medicaid state plan option for the provision of medical homes for Medicaid enrollees with chronic conditions including mental health disorders. States must use medical homes that meet certain defined standards, consult with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) about addressing behavioral health issues, monitor and report on performance and outcomes, and develop and implement a proposal for using health information technology in provision of medical home services. To further incentivize states to select this option, HHS will award planning grants to states for the purposes of developing a Medicaid state plan amendment and will provide a 90 percent federal match for the first two years the Medicaid state plan amendment is in effect.

In addition to promoting the use of medical homes for Medicaid individuals with behavioral health disorders, the healthcare reform law also supports and promotes the community behavioral health provider's role in establishing medical homes that promote coordination of care for individuals with serious behavioral health disorders. Under the Act, HHS is required to establish:

- A program to support person-centered medical homes (either through contracts or grants) through the establishment of community-based interdisciplinary teams that would include behavioral health providers along with other healthcare professionals. A state or state-designated entity or Indian tribe or tribal organization would be eligible to receive a grant or contract under this provision.

- Beginning in 2010, a demonstration project in which the Center for Mental Health Services under SAMHSA will provide funding to qualified community mental health programs for provision of on-site primary care services to adults with mental illness who have co-occurring primary care conditions and chronic diseases, making medically necessary referrals to specialty care professionals, development of necessary information technology and facility modifications.

Medical Homes in Arizona

As in many states, the establishment of highly functioning medical homes in Arizona is still in its infancy. As part of the most recent AHCCCS health plan bid in 2008, AHCCCS initiated a process to develop, implement and expand the medical home concept. The current AHCCCS health plan contract[6] requires AHCCCS health plans that provide services to children with special healthcare needs to have a method for identifying providers who are willing to provide medical home services as defined by the American Academy of Pediatrics. Last year, UnitedHealthcare announced a three-year, person-centered medical home initiative in Arizona that will involve 17,000 patients, including individuals enrolled in their Medicaid health plan. Additionally, the state, along with the AHCCCS health plans/healthcare providers and/or Regional Behavioral Health Authorities (RBHAs)/behavioral health providers, has been exploring the feasibility of establishing programs in which medical and behavioral health services are co-located.

The Act's provisions, especially the medical home Medicaid State Plan option and planning grant, provide the State with the opportunity to receive financial support as they move forward in trying to further develop the medical home model in Arizona and develop effective strategies for the integration and coordination of care for individuals with complex medical and behavioral health needs. While there is support for the development of medical homes in Arizona, some health providers have noted the challenge of paying for high-functioning medical homes in the current environment in which provider rates continue to be cut.

KEY TAKEAWAYS:

- AHCCCS should explore the feasibility of submitting a state Medicaid Plan for the medical home option along with submitting a medical home planning grant.
- AHCCCS and the Arizona Department of Health Services should work together along with community providers and health plans/RBHAs to explore the feasibility of submitting a grant for either of the demonstration programs described above.

OTHER POTENTIAL BEHAVIORAL HEALTH FUNDING OPPORTUNITIES

The Act supports and provides funding to HHS for initiatives targeted at addressing two specific areas related to delivery of behavioral health services. Beginning in 2011, these include:

- A three-year Medicaid emergency psychiatric demonstration project in which up to eight state Medicaid programs would be able to reimburse non-governmental freestanding psychiatric hospitals for emergency psychiatric treatment provided to eligible Medicaid recipients between 21 and 65 years of age. Currently, these hospitals are required to provide services under EMTALA, but are not able to receive Medicaid payments for services provided to Medicaid eligible adults between 21 and 65 years of age due to the Medicaid coverage preclusion for Institutions for Mental Disease (IMDs).
- Establishment of national centers of excellence for depression. Five-year grants will be competitively awarded to institutions of higher education or public/private nonprofit research institutions for the establishment of between 20 to 30 centers for excellence for treating depression. Activities carried out by these centers would include development and dissemination of evidence-based interventions, training and technical assistance to mental health professionals, public outreach and education, collaboration with other centers to improve treatment standards, clinical guidelines, diagnostic protocols and care coordination practices and translational research.

While the first demonstration project affords the opportunity of obtaining additional federal dollars for a service currently not being covered under Medicaid, additional cost-benefit analysis needs to be conducted prior to deciding if this is a demonstration that Arizona should pursue. At one time Arizona had a waiver from the federal government to pay for IMD services, but that waiver

was rescinded several years ago. Arizona's philosophy is to keep individuals in the community, avoiding unnecessary psychiatric care and supporting crisis intervention through the use of community-based alternatives such as mobile crisis teams, urgent care centers and rapid response teams. Arizona may be better served by continuing to develop these systems of care as opposed to pursuing this demonstration.

The 2008 Arizona Health Survey found that 8.4 percent of adults have been told that they have clinical depression.[7] Depression is also frequently found with individuals who suffer from other chronic conditions such as diabetes or chronic heart failure. While Arizona does not currently have any nationally recognized center for depression, Arizona does have a center for excellence in postpartum depression. The establishment of a center for excellence for depression in Arizona would serve to complement this already established center for excellence in postpartum depression and would also provide a vehicle for further enhancing the behavioral health network in the state.

KEY TAKEAWAYS:

- AHCCCS, in partnership with the Arizona Department of Health Services and the provider community, should evaluate and look at the cost-benefit of submitting an application for the emergency psychiatric demonstration program.
- The state should encourage and work with the universities and/or other nonprofit research institutions to establish a center for excellence for depression in Arizona through the submittal of the grant application to HHS.

ABOUT THE AUTHOR

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3 In May AHCCCS reported at the Arizona Behavioral Health Planning Council that of the total number of AHCCCS enrollees (1,259,000), 175,000 were behavioral health recipients resulting in a 9.3 percent penetration rate.

4 A "qualified health plan" (QHP) will be a health plan that is certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package.

5 To ensure the availability of certain providers in specific areas of the state, the ADHS Bureau of Health Systems Development has established a loan repayment program and stipend program as incentives for child psychologists and mental health specialists, speech/language pathologists and occupational and physical therapists who will address the needs of children age birth to five. The program is part of the First Things First Early Childhood Therapists Incentives Program. http://www.azdhs.gov/hsd/ftf_therapist_incentive.htm

6 The medical home concept is not addressed in the AHCCCS contracts for the other Medicaid programs - ALTCS, ADHS - Children Rehabilitative Services or ADHS-DBHS.

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LONG-TERM CARE SERVICES AND COVERAGE

Linda Huff Redman, PhD

Across the nation, systems of care are struggling to improve healthcare quality, including long-term care services delivered to aging and disabled populations. Arizona, as a Sun Belt state, has an even greater challenge in meeting the needs of these populations due to its high and growing number of aging residents.[1]

The Patient Protection and Affordable Care Act (Act) focuses considerable attention on long-term care. In addition to improving general healthcare delivery and access to behavioral health services, the Act contains a broad array of provisions specifically focusing on long-term care. These provisions are tackled from a variety of perspectives: the delivery system, providers and consumers.

From the service delivery side, the Act supports the development of more effective systems of care, champions home and community-based services (HCBS), improves nursing home transparency and prevents the depletion of resources needed to pay for long-term care. Provisions related to long-term care providers include the development of a qualified and adequate direct care workforce and efforts to improve nursing home quality and compliance. While the consumer stands to benefit from the majority of the long-term care provisions, the Act also includes specific abuse protections for this population. It also provides consumers with the tools necessary to navigate the system and resolve issues through the provision of funding for resource centers, a long-term care ombudsman and a nursing home comparison website.

KEY REFORM CHANGES

- **Establishes federal voluntary long-term care insurance program – Community Living Assistance Services and Supports (CLASS).**
- **Promotes increased access to Medicaid home and community-based long-term care services.**
- **Includes development of a long-term care workforce as part of expansive new healthcare workforce initiatives.**
- **Enacts extensive nursing home reform measures aimed at consumers, quality improvement, and reporting.**
- **Supports consumer education programs like the Aging and Disability Resource Centers and Long Term Care Ombudsman.**

Because of Arizona's early investments in home and community-based services, our state will not benefit as much from some of the long-term care provisions as states who are still struggling with management of high numbers of people in costly institutions. Nonetheless, the Act contains opportunities for Arizona to support and expand programs already in place. More importantly, Arizona residents stand to gain from many of the other long-term care provisions such as availability of private long-term care insurance; nursing home transparency and improvement; and program enhancements related to consumer outreach, support and protection.

NATIONAL VOLUNTARY LONG-TERM CARE INSURANCE PROGRAM

While the number of Arizonans needing long-term care services will continue to grow, the ability of individuals to pay for the high cost of long-term care services is a challenge. Nursing home costs are averaging more than $75,000 a year and home care services about $20 per hour.[2] Since Medicare offers only limited long-term care services (90 days in a nursing facility and limited home health coverage), many individuals will need to rely on their own resources or family members for any needed long-term care services.

For some, Medicaid serves as their long-term care safety net. But access to long-term care services under Medicaid often requires individuals to deplete most of their assets to qualify for services. Efforts have been made to encourage individuals to purchase long-term care insurance (such as the long-term care partnership program).[3] However, it is estimated that only about 10 percent of all older adults have long-term care policies, with cost of these policies continuing to be a key barrier, along with consumers being denied coverage due to their health risk.[4]

CLASS

The Act establishes the Community Living Assistance Services and Supports Program (CLASS), a federally-administered voluntary insurance program for long-term care services and supports. The goal of this long-term care insurance program is to provide individuals with functional limitations a financing alternative for long-term care services and supports. This additional support is intended to help these individuals continue to live in the community, defray the cost of institutional care and avoid the need to become impoverished in order to access these services through Medicaid. The program is not designed to replace the need for basic health insurance or potentially the care that is provided by family, friends and neighbors.

The U.S. Department of Health and Human Services (HHS) will administer the CLASS program, which will include the following key elements:

- Adults who work for a participating employer will be automatically enrolled, unless they choose to opt out. The self-employed and employers who do not offer the class program can enroll through a separate enrollment process.
- Individual adult workers will be able to participate in the program with no medical underwriting and no lifetime or aggregate benefit limits.
- The program is required to be fully self-sustaining through the premiums payment made by the enrolled individuals. These payments may be made through automatic payroll deductions.
- The program will be consumer-directed. A cash benefit is paid to eligible enrollees who have a disability expected to last at least 90 days, meet the function/cognitive eligibility criteria and have paid premiums for five years.
- The benefit will be at least an average of $50 a day and will vary depending on the functional limitation of the individual.
- For those individuals who are eligible for both CLASS and Medicaid, a portion of the CLASS benefits will be used to offset the costs to Medicaid. For example, a Medicaid enrollee residing in HCBS will be able to retain 50 percent of their CLASS cash payment with the remainder going to the state to offset the individual's Medicaid costs.
- The program will become effective January 2011, with the first payouts to individuals to begin in 2017.

At this time, it is hard to know the impact CLASS will have on Arizona. Much will depend on the number of eligible adult workers enrolling in the program and the effectiveness of the cash payments in preventing or deferring the depletion of their resources, thus decreasing their need for Medicaid. It is also possible that if CLASS recipients are eventually enrolled in AHCCCS (Arizona's Medicaid program), AHCCCS will benefit financially by receiving a share of the cash payment made by the CLASS program.

Regardless of the overall impact, there are a number of CLASS-related activities that will require involvement by state agencies or local community organizations.[5] These include:

- Conducting an outreach and education campaign to encourage participation in the CLASS program or promoting purchase of long-term care insurance.
- Having Arizona's federally-designated Protection and Advocacy System – Arizona Center for Disability Law – enter into an agreement with HHS no later than January 1, 2012 to provide advocacy services (such as information on accessing the appeals process, assistance with annual recertification and notification and assistance in obtaining services) to CLASS eligibles.

- Identifying public or private entities that will enter into an agreement with HHS to provide advice and counseling to eligible CLASS beneficiaries on access and coordination of long-term services, eligibility for other benefits and services, service and support plan development and assistance with decision making. Likely entities to take on this responsibility may be Arizona's Aging and Disability Resource Centers (such as the Maricopa County Area Agency on Aging) and/or other community organizations such as Arizona Bridge for Independent Living or New Horizon Independent Living Center.
- Collaborating with HHS to establish the Eligibility Assessment System, which will provide eligibility assessments of active CLASS enrollees who apply for benefits. This may entail amending the current agreement the state has with HHS for making medical disability determinations for Supplemental Security Income and Social Security Disability Insurance programs.[6]
- Assessing within two years of enactment of CLASS (2013) whether there is an adequate supply of entities within the state to serve as fiscal agents to provide employment-related benefits for personal care attendant workers who provide personal care services to CLASS enrollees, and designating or creating fiscal agents so that there will be an adequate supply of personal care attendant workers when the payouts being in 2017.
- Revising AHCCCS policies and systems to be able to facilitate the interface between the AHCCCS program and the CLASS program for those individuals who are beneficiaries of both programs. This may entail the need to work with HHS and the Treasury Department to establish links between AHCCCS and the CLASS enrollment and payments systems in order to enable the identification of joint beneficiaries and the transfer of funds between the agencies.

KEY TAKEAWAYS:

- Despite being a federal program, Arizona will have a number of tasks it will be required to complete to implement the CLASS program.
- A key to the program's success will be the development and implementation of an outreach and education campaign to encourage participation in the CLASS program. Arizona should partner with community organizations to educate and encourage working adults and their employers' participation in the program.

EXPANDED HOME- AND COMMUNITY-BASED SERVICES UNDER MEDICAID

Historically, the acknowledged bias in Medicaid has been the provision of institutional care for persons with long-term care needs over the much preferred and less costly alternative of HCBS. Despite the regulatory barriers, there has been a concerted effort by states over the past decade to make HCBS accessible through the limited HCBS program options available under Medicaid (e.g., HCBS waivers, special demonstration projects). However, progress in shifting to a community-based service delivery system has been slow. To further encourage states to change their delivery models, the Act includes provisions making it easier for states to offer HCBS under Medicaid as well as providing certain financial incentives to do so. These include:

- Availability of a new Medicaid state plan option (Community First Choice Option) beginning October 1, 2011 to provide consumer-controlled attendant services and supports to Medicaid eligible individuals who are at risk of institutionalization. Under this option, states are allowed to pay for items such as one month's rent, utility deposits and household furnishings in order to facilitate the member's transition into the community. Finally, states that select this option can receive an increase of six percentage points in federal financial participation for services provided through this option.
- Changes to the HCBS Medicaid state plan option (1915(i)) that was enacted as part of the Deficit Reduction Act of 2005 (DRA) to provide HCBS to Medicaid eligible persons who have lower levels of need without the budget neutrality requirements associated with HCBS waivers. These changes (effective immediately) remove a number of the barriers (such as service and eligibility limitations) that have discouraged states from participating in this Medicaid state plan option.

- A five-year extension (from 2011 to 2016) of the Money Follows the Person demonstration program that was authorized by the DRA. Thirty-one states have been awarded grants to transition an estimated 37,000 Medicaid eligible nursing facilities residents to community-based settings.
- A temporary five-year mandate beginning in 2014 that states include spousal impoverishment protection for persons whose spouses qualify for Medicaid HCBS services. Previously, this had been at the option of the individual states.
- Establishment of the State Balancing Incentive Payments Program, in which states that are spending less than 50 percent of their long-term care service dollars on HCBS can receive an enhanced federal reimbursement for all HCBS provided under their Medicaid program for a four-year period beginning October 1, 2011. The state must use the additional Medicaid funding for new and expanded services and make certain structural changes to their long-term care programs (e.g., single entry point, conflict-free case management, standardized assessment tool).

While these provisions have the potential to change the nature of the service delivery system for individuals needing long-term care services across the nation, they offer a more limited set of opportunities for Arizona. Through its Medicaid 1115 demonstration project waiver,[7] Arizona has over the past two decades developed a Medicaid long-term care service delivery system (ALTCS) that is committed to supporting members in the community and as such includes a strong comprehensive HCBS component. Currently, under ALTCS:

- Over 70 percent of the ALTCS members who are elderly or physically disabled and over 95 percent of the ALTCS members with developmental disabilities have their long-term care needs met in a non-institutional setting such as their own home, a family home, or an assisted living facility.
- More than 50 percent of Arizona's total Medicaid long-term care expenditures are directed toward HCBS.
- AHCCCS already applies and uses spousal protection provisions for persons who receive HCBS services when making an ALTCS determination.

Of all the options offered under the Act, the one that holds the most promise for Arizona is the Community First Choice Option. Attendant care is already a key service provided under Arizona's ALTCS program. If the Centers for Medicare and Medicaid Services (CMS) would allow Arizona to adopt this option through a Medicaid state plan amendment, Arizona would be able to receive an enhanced federal match rate for the provision of these services. The state could also receive reimbursement for the provision of transition services if CMS ultimately does not approve Arizona's current request for coverage of these services.

In addition to the Community First Choice Option, Arizona may also want to see if there is any way to take advantage of the enhanced federal reimbursement under the State Balancing Incentive Program, even though Arizona appears to be spending more than 50 percent of its long-term care dollars on HCBS.

KEY TAKEAWAY:

- Although the impact and benefit of these provisions are limited for Arizona due to its well-developed community-based long-term care system, Arizona should explore adopting the Community First Choice Option for attendant care services along with any other strategies to benefit from the enhanced federal financial match that are afforded to other states through the State Balancing Incentive Payments Program.

BUILDING A QUALITY LONG-TERM CARE WORKFORCE

In addition to enhancing the nation's long-term care delivery system through the promotion of HCBS and private long-term care services, the Act also addresses the need for developing a sufficient and high-performing long-term care workforce. The Act specifically focuses on the recruitment, training and ongoing education of a long-term care workforce as a component of their overall healthcare workforce development initiatives. This includes:

- Grants for higher education institutions to provide assistance for direct care workers employed in long-term care settings to participate in educational training programs.
- Grants for long-term care facilities and community-based long-term care entities to provide training and technical assistance regarding management practices that will promote retention of direct care workers.
- Demonstration projects for states to develop core training competencies and certification programs that are aimed at recruiting low-income individuals to qualify as personal or home care aides. The training standards developed under these grants are to be utilized as the gold standard. The Health Resources and Services Administration (HRSA) has already posted the application for these grants, which was due on July 19, 2010 and will be awarded to six states. It is unknown whether any entity in Arizona applied.
- Grants to community colleges or community-based training programs to provide infrastructure support for the development, evaluation and demonstration of a competency-based uniform curriculum to train qualified nursing assistants and home health aides at alternative sites or through telehealth methodologies. HRSA has posted the application for these grants which were due on July 22, 2010 and will be awarded to 10 entities.
- Grants to geriatric education centers to use short-term intensive courses to train healthcare professionals in geriatrics and to provide annual free training to family caregivers and direct care providers. This money is also to be used to provide geriatric incentive awards to individuals (advanced nurse, clinical social worker, pharmacist or psychologist) to pursue a doctorate or other advanced degree in geriatrics or related fields. It appears that both ASU and the Arizona Board of Regents received grants ($148,000 and $385,000, respectively) as a result of the new geriatric education center grants.

Despite the current reprieve with the tight Arizona job market, a shortage of a direct care workforce continues to loom as an area of concern for Arizona.[9] HRSA ranks Arizona 19th in terms of number of health aides and 46th in terms of nursing aides, orderlies and attendants.[10] The Arizona Department of Economic Security reports the projected 10-year job growth rate in Arizona for home health aides at 69 percent (48 percent nationally) and for personal and home care aides at 48 percent (40 percent nationally), and for nursing aides, orderlies attendants at 50 percent (24.9 percent nationally).[11] As an outgrowth of Arizona's Interagency Council on Long-Term Care, Arizona established the Direct Care Workforce Committee (a public-private partnership) to specifically promote and facilitate direct care workforce initiatives that include recruitment and retention, training and raising the qualifications of direct care professionals in Arizona.[12] Achievements to date include but are not limited to:

- Development of standardized competency for direct care workers (personal/attendant care and homemakers)
- Guidelines for training and testing of direct care workers including a model curriculum
- Professional development workshops and training workshops on the new model curriculum

AHCCCS has further worked to enhance the direct care workforce by expanding the qualifications of who can provide direct care (allowing spouses to be paid caregivers under an attendant care service option) and increasing the hourly pay for certain direct care staff (attendant care). While the grant opportunities may provide Arizona with additional resources to enhance its current training programs and recruitment and retention efforts, the state has already achieved or is in the process of addressing many of the goals set forth in the demonstration programs.

KEY TAKEAWAYS:

- Although many of the grant application deadlines have closed for this year, Arizona, through its Direct Care Workforce initiative, should continue to review additional funding opportunities that would further support and enhance its current workforce efforts.
- Arizona should monitor activities and outcomes from the grants to identify any best practices, especially as they relate to development of model curriculum and competencies.

NURSING HOME REFORM

The Act contains a wide range of provisions that address the delivery of nursing facility services, many of which target nursing home transparency and improvement issues. Some of the major changes address:

- Improving the transparency of information available to consumers by expanding the type of information a nursing facility must disclose, making improvements to the nursing home compare website, and revising the Medicare cost reports to identify direct care worker wage and benefit expenditures.
- Enhancing nursing facility compliance with federal rules by improving the types of notification and transfer processes for facility closures, establishing a new pilot program to monitor large interstate facilities with quality of care issues, and establishing a National Training Institute for federal and state surveyors.
- Improving quality of care provided to residents by requiring dementia and abuse prevention training for nurse aides; requiring nursing facilities to establish an internal ethics and compliance program to prevent and detect violations and promote quality of care; funding two demonstration programs to develop best practices for changing facilities' cultures and for using technology to improve resident care; and implementation by CMS of a quality assurance and performance improvement program for nursing facilities.
- Increasing responsiveness to residents' concerns by establishing a new state complaint resolution process along with a standardized complaint form; and providing grants to state survey agencies to develop complaint investigation systems as well as other grants to improve the capacity of the state long-term care ombudsman programs.

In 2007, Arizona was reported to have one of the lowest percentages of individuals in nursing homes (1.5 per 100 age 65 years or older were nursing facility residents). At that time there were 137 nursing facilities with approximately 16,200 nursing facility beds and a resident population in which Medicaid was the primary payer for 61 percent of the residents and Medicare for 13 percent of the residents.[13] Based on the current CMS five-star quality rating program ("Nursing Home Compare"), AARP reported that one-third of Arizona's nursing homes rated above average in health inspections. Arizona, like other states across the nation, has established nursing home quality initiatives that include the nursing home compare website, consumer information materials and a partnership with Arizona's quality improvement organization to provide assistance to nursing homes to improve their performance. Additionally, the Arizona Department of Economic Security (DES) long-term care ombudsman program assists consumers in accessing nursing homes and resolving complaints.

For Arizona, the new nursing home reform provisions have the potential to improve quality of care provided by nursing homes in Arizona as well as to improve the transparency of information made available to Arizona consumers. At the same time, there is a fear among nursing homes providers that the overall impact will be an increase in the administrative burden concurrent with a reduction in the rates paid for the needed care.

KEY TAKEAWAYS:

- As the state licensing agency for nursing facilities, the Arizona Department of Health Services will need to work in partnership with Arizona nursing facilities, associations and CMS to implement the changes in nursing home requirements and survey inspections. The state may want to consider applying for grants designed to support state survey agencies in developing complaint investigation systems or workforce development. (See the Behavioral Health Services and Coverage section of this document, beginning on page 69.)
- Consumer advocacy groups such as the DES long-term care ombudsman office and the Area Agencies for Aging will need to develop outreach strategies for educating consumers about key nursing home reforms (complaint resolution process, reporting requirements) that impact their consumers.

CONSUMER EDUCATION

Throughout the Act, there is a focus on meeting consumers' needs and supporting efforts and initiatives to educate and assist the consumer in navigating the long-term care system. In particular, this support is reflected in the enhancing of funding for two consumer-based programs.

- For the next five years, $10 million in annual funding is made available to support and expand the state's aging and disability resource centers. The role of these centers is to streamline access to long-term care services and support for consumers as well as to support state efforts to develop one-stop shopping. DES, through the Division of Aging, has received federal funding for developing the state's Aging and Disability Resource Centers (referred to as AZLinks). In addition to establishing local public-private partnerships in seven counties of the state, AZLinks has developed a reference manual on long-term care topics and regional supplements on local agency-specific information, a website to provide information and links, and a screening tool and common intake form for those seeking services. CMS and the Administration on Aging have announced the availability of grant monies for Aging and Disability Resource Centers, with a grant deadline of July 30, 2010.
- Beginning in 2011, grants to improve the capability of the state's long-term care ombudsman program in resolving complaints and enable them to conduct pilot programs will be available. Additionally, HHS is charged with and funded to establish ombudsman training programs. The DES Office of Long Term Care Ombudsman has the primary responsibility for identifying, investigating and resolving complaints made by or on behalf of residents of long-term care facilities and to assist, advocate and intervene on behalf of the resident. The Office, which coordinates these services through the local Area Agency on Aging, would be eligible to apply for one of these grants.

KEY TAKEAWAY:

- The state should explore the different funding opportunities made available to support the role of the Aging and Disability Resource Centers and the Office of Long Term Care Ombudsman program in working with consumers.

ABOUT THE AUTHOR

Linda Huff Redman, PhD is an independent healthcare consultant with 14 years of experience advising organizations that serve low income populations on a broad range of healthcare related issues. Her expertise includes Medicaid program and provider organization restructuring, redesign of programs serving special need populations, federal fund maximization, managed care Medicaid RFP submittals, performance reviews, and federal waiver and strategic plan development. Previously, Dr. Redman spent eight years with Arizona's Medicaid agency (AHCCCS) as the Deputy Director.

References

1 By the year 2020, it is predicted that over 26 percent of Arizonans will be over age 60, up from about 17 percent in 2000. Office of the Governor. (2005, August). Aging 2020 – Arizona's plan for an aging population. Phoenix, AZ: State of Arizona. Retrieved July 30, 2010 from http://azgovernor.gov/aging/Documents/Aging2020Report.pdf. Moreover it is expected that Arizona's 85+ population will more than double from 2007 to 2030 – an age group that is most likely to need long-term care services. See AARP. (2009, December). Long-term care in Arizona. Washington, DC: AARP Research Center. Retrieved July 30, 2010 from http://assets.aarp.org/rgcenter/health/state_ltcb_09_az.pdf

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3 The long-term care partnership program is a public-private partnership between the states and private insurance companies that is designed to encourage the purchase of private long-term care insurance, especially among moderate income individuals, reducing future reliance on Medicaid as the funding source for long-term care. Under this program a state Medicaid program will not count some or all of the resources of an individual when determining eligibility if the individual has purchased a long term care insurance policy that meets the partnership requirements. The individual will first rely on benefits from private insurance.

4 Tumlinson, A., & Aguiar, C. (2009, June). Closing the long-term care funding gap: The challenge of private long-term care insurance. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. Retrieved July 30, 2010 from http://www.kff.org/insurance/upload/Closing-the-Long-Term-Care-Funding-Gap-The-Challenge-of-Private-Long-Term-Care-Insurance-Report.pdf

5 Justice, D. (2010, April). Long term services and supports and chronic care coordination: Policy advances enacted by the Patient Protection and Affordable Care Act. Denver, CO: National Academy for State Health Policy. Retrieved July 30, 2010 from http://www.chhs.ca.gov/Documents/NASHP%20Long%20Term%20Care%20Analysis%20of%20Health%20Care%20Reform.pdf

6 Currently, the Disability Determination Service Administration within the Department of Economic Security is responsible for making medical disability determinations.

7 Under §1115 of the Social Security Act, the Secretary of Health and Human Services can allow states to "experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid statute." The statute authorizes the Secretary to waive compliance with any state Medicaid plan requirements to develop plans that suit states' healthcare needs and goals. Since Arizona began providing Medicaid on October 1, 1982, AHCCCS has been exempt from specific provisions of the Social Security Act, pursuant to a 1115 Research and Demonstration Waiver.

8 University of Arizona's Geriatric Education Center is one of a national network of 45 such federally funded centers.

9 One of the goals in Arizona's Aging 2020 Plan for an Aging Population was to strengthen Arizona's economy by capitalizing on an integrated and well-trained, paraprofessional and professional workforce. Arizona Office of the Governor. (2005, August) Aging 2010: Arizona's plan for and aging population. Phoenix, AZ: State of Arizona. Retrieved July 30, 2010 from http://azgovernor.gov/aging/Documents/Aging2020Report.pdf

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IMPACT ARIZONA

DUAL ELIGIBLE BENEFICIARIES

Linda Huff Redman, PhD

Dual eligibles are individuals eligible for or enrolled in the federal Medicare program as well as the state Medicaid program (called either the AHCCCS or ALTCS programs in Arizona). The dual eligible population is typically comprised of elderly and/or disabled individuals. They tend to be among the poorest, sickest and most costly beneficiaries in these two programs.[1] Dual eligible individuals account for 16 percent of all Medicare beneficiaries but 25 percent of Medicare expenditures. They account for 18 percent of all Medicaid beneficiaries but 46 percent of all Medicaid expenditures.[2] Unfortunately, the current dual system of care for this vulnerable population frequently results in poorly coordinated care for those with complex medical conditions, consumer confusion in navigating these systems of care and provider cost shifting between the programs.

KEY REFORM CHANGES

- **Promotes integration of care delivery to dual eligible beneficiaries by:**
  - **Requiring federal government to take steps to improve coordination between Medicare and Medicaid.**
  - **Authorizing five-year state demonstration projects related to provision of care to dual eligible beneficiaries.**
- **Extends authorization of Medicare Special Needs Plans; requiring these plans to be NCQA-approved.**
- **Eliminates cost sharing for Part D drugs for at-risk dual eligible beneficiaries who are receiving Medicaid home and community-based services.**

The Patient Protection and Affordable Care Act (Act) lends support to ongoing efforts to improve healthcare policy relative to the dual eligible population. In particular, the Act includes a number of provisions that are directed at studying, planning and developing recommendations for more substantive national program changes in the future. Only a limited number of the Act's provisions directly impact how care is to be delivered to dual eligible individuals. These include the opportunity for individual state Medicaid programs to implement special Medicaid waiver demonstration programs[3] directed at caring for dual eligibles, the extension of Medicare Special Needs Plans (SNPs) until 2014 and the elimination of cost sharing for Medicare Part D drugs.

In Arizona, the dual eligible population makes up over 50 percent of the membership in the Arizona Long Term Care System (ALTCS) program.[4] Arizona has tried to align the delivery of care for its dually eligible members by requiring its ALTCS health plans to either become a SNP or establish a relationship with a Medicare Advantage plan. Despite these efforts, providing an integrated and well-coordinated system of care to dual eligibles continues to be an ongoing challenge in Arizona.

Unfortunately, the Act's provisions overall will have only a minimal impact on how Arizona delivers care to dual eligibles. The one exception is if Arizona is able to draw upon this renewed federal commitment to improve the systems of care for dual eligibles and obtain federal approval to implement a more fully integrated care model for dual eligibles through modifications to its current Medicaid 1115 demonstration project waiver.[5]

Improved Coordination for Dual Eligible Beneficiaries

With regard to the dual eligible population, the Act's primary focus is the exploration of strategies for moving national healthcare policy toward a service delivery system that will:

- Promote well coordinated care
- Streamline the administration requirements associated with management of these dual systems of care

Responsibility for this effort is assigned to the federal Department of Health and Human Services (HHS). Specific requirements of the law include the following:

- Immediate establishment of the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services (CMS). The purpose of this Office will be to integrate benefits under the Medicare and Medicaid programs and improve the coordination between the federal government and states for dual eligibles. Along with specifically prescribed goals and areas of responsibilities that address quality and access, coordination of care, simplification of processes and elimination of cost shifting, CMS is required to submit an annual report to Congress containing recommendations for legislation that would improve care coordination and benefits for dual eligible beneficiaries.
- Need for consultation and coordination on the impact of Medicaid and Medicare program policies on dual eligibles between the recently established Medicaid and CHIP Payment and Access Commission (MACPAC) and the longer standing and highly influential Medicare Payment Advisory Commission (MEDPAC). In carrying out their duties, MACPAC is required to regularly solicit input from the states as well as coordinate and consult with the Federal Coordinated Health Care Office.
- Testing of payment and service delivery models for the Centers for Medicare and Medicaid Innovation that is to be established within CMS by January 2011. Potential models this new Center may test include state-operated models that provide fully integrated care to dual eligible individuals or include an all-payer payment system for medical care provided to state residents, including dual eligibles.
- Completion of two studies by the HHS Inspector General: one on the availability in Medicare Part D formularies of drugs commonly used by dual eligibles, and the second on the prices of drugs under Medicare Part D compared to the Medicaid program, including the impact price discrepancies have on dual eligibles.

At the state level, the Act provides the opportunity for individual states to apply for five-year Medicaid waiver demonstration program for dual eligible members, including programs (such as AHCCCS) that also serve non-dual eligibles. Through these demonstration programs, which are included as part of the current federal waiver processes (1115, 1915(b), 1915(c)), states would be able to obtain waivers from certain Medicaid requirements.

Arizona's Medicaid program, which currently operates under 1115 demonstration project waiver, includes both dual and non-dual eligibles. However, at this time Arizona does not have any specific waivers that are aimed at specifically addressing issues of care coordination for dual eligibles. Within the constraints of the current Medicaid and Medicare program frameworks, Arizona has laid a foundation for enhancing coordination for dual eligibles through the use of SNPs. (See following page.)

Despite these efforts, Arizona continues to face many of the same service delivery issues identified by national experts[6] – consumer confusion in navigating multiple systems, inability to manage all of individuals' care needs, lack of financial incentives to manage care effectively, inability to mandate enrollment for dual eligibles in the SNP, and misalignment of administrative, operational and regulatory processes. Given that the Act suggests a willingness by the federal government to look at new models for improving delivery of care to dual eligibles, this current environment may afford Arizona the opportunity to obtain certain waivers from CMS in order to further integrate the delivery of care to dual eligibles under a single entity (e.g., sharing in Medicare

savings attributable to integration, minimizing duplicative reporting requirements for the health plans, allowing mandatory enrollment in the same plans (ALTCS health plan and the companion SNP).[7]

KEY TAKEAWAYS:

- Arizona should identify strategies for improving the delivery of high-quality, well-coordinated care to dually eligible members enrolled in AHCCCS/ALTCS and, as part of the waiver demonstration renewal process, seek the approval needed from CMS to implement these strategies.
- Arizona should take an active leadership role in the national efforts to develop solutions for managing the care of the dual eligibles by providing input to the MEDPAC and working with those MEDPAC commission members who have working knowledge of Arizona and its unique Medicaid program.

EXTENSION OF SPECIAL NEEDS PLANS

Medicare Advantage Special Needs Plans (SNPs) are healthcare plans that have contracted with CMS and are focused on delivering Medicare benefits to the most vulnerable individuals, including dual eligibles, institutionalized individuals or individuals with severe or disabling chronic conditions. Under the health reform law, SNPs were authorized for another three years (until 2014), requiring any SNP serving dual eligibles to have by 2013 a fully-capitated contract with the state Medicaid agency to provide all Medicaid services, including long-term care. As part of the SNP extension, the Act also made two additional changes to the current operation of SNPs that include the following:

- Beginning 2011, the law allows CMS to pay frailty adjusters (increased payments based on health status) to SNPs for those dual eligible members if the SNPs have a fully-capitated contract with the state. However, recently CMS announced that it will not make this adjustment in 2011 due to lack of sufficient data to accurately determine frailty level. CMS expects to have a larger sample size to calculate these frailty levels for contract year 2012.[8]
- Beginning 2012, the law requires SNPs to be approved by the National Committee for Quality Assurance (NCQA) based on standards established by the Secretary of HHS. Since 2008, NCQA has been contracted with CMS to develop a strategy to evaluate the quality of care provided by SNPs. This phased assessment process utilizes defined Healthcare Effectiveness Data and Information Set (HEDIS) measures[9] as well as measures that evaluate structure and process requirements. All contracted SNPs are required to currently report annually their performance on the prescribed measures.

The overall extension of SNPs is positive for Arizona, which has successfully used SNPs as a mechanism for bridging the two separate systems of care for dual eligibles for the past four years in the ALTCS program. As part of its contract, AHCCCS requires the ALTCS health plans to either 1) become a Medicare Advantage SNP or 2) develop a formal relationship with Medicare Advantage Plans or Medicare Advantage SNP. Currently, five of the nine ALTCS plans offer a SNP option to their members.[10] Approximately 40 to 50 percent of the dual eligibles in ALTCS/AHCCCS are enrolled in a Medicaid plan and SNP that are managed by the same health plan.

The two additional SNP provisions (frailty adjusters and NCQA approval) have the potential to positively impact the quality of care delivered to dual eligibles in Arizona. However, depending on how they are implemented, they also have the potential to impact the continual viability of SNP plans for dual eligibles in Arizona. Since the national trend is to ratchet down the payment to Medicare Advantage plans, the frailty adjuster is critical to ALTCS health plans that financially struggle under the current Medicare payment schedule to cover the costs associated with providing care to this more expensive Medicare population. Additionally, concern has been raised by some of the current SNP plans in Arizona over requirements to meet NCQA approval standards (e.g., will there be additional administrative requirements, and will the standards target caring for dual eligibles as opposed to caring for Medicare Advantage beneficiaries in general?).

KEY TAKEAWAYS:

- Arizona should continue to monitor the implementation of changes to SNPs, making sure the proposed solutions will appropriately support Arizona's service delivery system and the future viability of SNPs for dual eligibles in Arizona.
- Arizona should work in partnership with its current ALTCS health plans to make sure they are prepared to become NCQA-approved SNP plans in 2012.

ELIMINATION OF MEDICARE PART D CO-PAYMENTS FOR CERTAIN DUAL ELIGIBLE BENEFICIARIES

For the dual eligibles, Medicare pays for most of the prescription drugs that they need under the Medicare Part D program. Under healthcare reform, beginning in January 2012, dual eligibles that are at risk of institutionalization (i.e., receiving home and community-based services) will no longer be required to pay co-payments for drugs covered under Medicare. Previously this exemption only applied to low-income individuals who were residing in an institution, with all other dual eligibles being required to pay the following co-payments depending on income:

- For those with income at or below 100 percent of the Federal Poverty Level (FPL), the co-payment was $1.10 for generic and $3.20 for brand name drugs.
- For those with income above 100 percent FPL, the co-payment was $2.40 for generics and $6.00 for brand names.

While this change will expand the pool of dual eligibles who will be able to avoid out-of-pocket costs for Medicare drugs, those who are not at risk of institutionalization will continue to be required to pay for their Medicare Part D co-payments.

In Arizona, the majority of dual eligibles who are at risk of institutionalization (i.e. ALTCS) reside in home and community-based settings. Prior to the recession, ALTCS health plans paid the small co-payment for all Part D prescriptions. However, beginning in early 2009, these dual eligibles became responsible for making these payments for Medicare drugs (there is no co-pay requirement for any of the limited drugs a dual eligible may receive through Medicaid). In addition to benefiting these low-income members, this provision will also simplify the requirements for dual eligibles by eliminating the differences in prescription co-pay requirements between the Medicaid and Medicare programs. Unfortunately, those dual eligibles enrolled in AHCCCS health plans (those not at risk of institutionalization) will need to continue to pay for their Medicare drug co-payments.

KEY TAKEAWAYS:

- In 2012, ALTCS dual eligibles residing in a home or community-based setting will no longer need to pay co-payments for Medicare covered drugs.

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Linda Huff Redman, PhD is an independent healthcare consultant with 14 years of experience advising organizations that serve low income populations on a broad range of healthcare related issues. Her expertise includes Medicaid program and provider organization restructuring, redesign of programs serving special need populations, federal fund maximization, managed care Medicaid RFP submittals, performance reviews, and federal waiver and strategic plan development. Previously, Dr. Redman spent eight years with Arizona's Medicaid agency (AHCCCS) as the Deputy Director.

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5 Under §1115 of the Social Security Act, the Secretary of Health and Human Services can allow states to "experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid statute." The statute authorizes the Secretary to waive compliance with any state Medicaid plan requirements, to develop plans that suit states' health-care needs and goals. Since Arizona began providing Medicaid on October 1, 1982, AHCCCS has been exempt from specific provisions of the Social Security Act, pursuant to a 1115 research and demonstration waiver.

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10 Except for Pima Health System which formed a partnership with a SNP operated by Bridgeway Health Solution the county-operated ALTCS plans and the state-operated ALTCS plan for persons with developmental disabilities have not become SNPs. Paul Saucier notes that small provider organizations or counties may not be well suited to become a SNP due to administrative burden, financial reserves and the political hazard of passing financial risk on to county tax payers. Saucier, P., & Burwell, B. (2007, January). The impact of Medicare special needs plans on state procurement strategies for dually eligible beneficiaries in long-term care. Cambridge, MA: Thomson Medstat. Retrieved July 30, 2010 from http://muskie.usm.maine.edu/Publications/MeicareSNP.pdf

IMPACT ARIZONA

INDIAN HEALTH

Beverly A. Russell

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Act). The new law reauthorizes and makes permanent the Indian Health Care Improvement Act (IHCIA), demonstrating the federal government's commitment to honoring its trust responsibilities to Indian tribes. It also authorizes new programs and expands the accessibility of services delivered by the Indian Health Service so that it can accomplish its mission of raising the health status of American Indians and Alaska Natives to the highest level.

Numerous other Indian-specific provisions are included in the Act. This section provides an overview of some of the Act's most significant implications for Arizona's 21 federally recognized tribes and 250,000 Native Americans.[1]

KEY REFORM CHANGES

- **The Indian Health Care Improvement Act has been permanently authorized.**
- **American Indians and Alaska Natives who purchase health insurance on the individual market through an exchange do not have to pay co-pays or other cost sharing if their income does not exceed 300 percent of the poverty level.**
- **Members of American Indian and Alaska Native tribes are exempt from individual responsibility requirements such as the mandate to purchase health insurance.**
- **The value of health services/benefits from IHS-funded health programs or tribes will be excluded from an individual's gross income so that it cannot be taxed starting with benefits and coverage provided after the date of enactment.**
- **Designates the state as a contract service area.**
- **Requires the Secretary of Health and Human Services to conduct a study on the feasibility of the Navajo Nation administering its own Medicaid, CHIP and Medicare programs.**

OVERVIEW OF INDIAN HEALTH

The provision of health services to American Indian and Alaska Natives (AI/ANs) grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship was established in 1787, through Article I, Section 8 of the Constitution.[2] The federal responsibility of health care for American Indians and Alaska Natives has been reaffirmed over the last 200 years by several laws, treaties, settlements, agreements, court decisions, executive orders and legislation.

A significant advancement in Indian health care came in the form of legislation known as the Snyder Act of 1921. The Snyder Act of 1921 provided written affirmation of the federal responsibility for the health care for American Indians and Alaska Natives.[3] The Indian Health Care Improvement Act (IHCIA) was enacted by Congress in 1976 to address the deplorable health conditions in tribal communities. The IHCIA established the structure for the provision of healthcare services to American Indians and Alaska Natives. Along with the Snyder Act of 1921, the IHCIA formed the legal foundation for the delivery of health care to AI/ANs by the Indian Health Service (IHS).[4] Unfortunately, despite repeated attempts to reauthorize, the IHCIA expired in 2002.

Today, the IHS is the principal federal healthcare provider for American Indian and Alaska Natives. The IHS is an agency within the Department of Health and Human Services responsible for providing health services to federally-recognized tribal members.[5] The

goal of this health system is to raise the health status of Indian people to the highest possible level. The IHS provides healthcare services to American Indians and Alaska Natives on reservations, in rural communities and in urban areas. This healthcare system is comprised of various types of health delivery models including hospitals, clinics, and health stations. IHS services are delivered through direct (IHS) services, tribal services and contracts with non-IHS service providers.

MAJOR CHANGES FOR INDIAN HEALTH IN THE ACT

The impact of healthcare reform in Indian country is multi-fold. Although the IHS is the federal agency responsible for Indian health care, tribal members may not be able to access these services due to location and/or ineligibility. As a result, many American Indians and Alaska Natives utilize other sources of health care, such as private or employer-sponsored health insurance, Medicare, Medicaid, community health centers and the Veteran's Administration. Thus, the Affordable Care Act is applicable to American Indian and Alaska Natives because they are a part of the U.S. healthcare system.

The Act provides American Indians and Alaska Natives – and Americans – more choices and access to health care. More people will be eligible for Medicaid beginning 2014. American Indians will be able to benefit from more affordable, subsidized private insurance options through the exchange. Other provisions of the new law, including those aimed at promoting prevention and improved quality, will also benefit American Indians and Alaska Natives as members of the overall U.S. health system.

Nonetheless, there are many provisions in the Act that specifically benefit American Indian and Alaska Native individuals, tribes and Indian health facilities.

Indian Health Care Improvement Act

Healthcare reform reauthorizes and makes permanent the Indian Health Care Improvement Act (IHCIA). This is significant because it makes the provision of health care for American Indians and Alaska Natives law. In essence, it codifies existing treaty obligations to Indian tribes, legally confirming the federal government's commitment to providing health care for American Indians and Alaskan Natives.

The Act also includes many major changes and improvements to IHCIA to facilitate the delivery of healthcare services, such as:

- Enhancement of the IHS Director's authority, including responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within the Department of Health and Human Services.
- Authorization for hospice, assisted living, long-term, and home- and community-based care.
- An extension of the ability to recover costs from third parties to tribally operated facilities.
- Current law updates regarding collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities.
- Ability for tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries.
- Authorization for IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services.[6]
- Authorization of a comprehensive behavioral health, prevention, and treatment program. This will include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living. emergency shelter, case management, and diagnostic services.

Formalized support and improvements to Indian Health Service made through the Indian Health Care Improvement Act are important to ensuring healthcare access for Arizona's 250,000 American Indians. A high percentage of the American Indian population in Arizona relies on the federal government for health care.

Contract Health Service Delivery

Another important new provision in the IHCIA is the designation of the State of Arizona as a Contract Health Service Delivery Area (CHSDA). In the past, each of the three IHS service areas in the state had specific funding set aside in contract health services, which allowed the local service unit to contract out those health services that fell outside the scope of their local capacity. Currently, many Indian people who move away from their home reservations in Arizona are frequently not eligible for Contract Health Services, since they would be moving away from the CHSDA in which they have eligibility. The permanent status of the state of Arizona as a CHSDA will now allow American Indians the freedom to move about the state and still qualify to receive health care under Contract Health Services, should it be needed. Arizona tribes must now work to obtain an increase in federal dollars allocated to Contract Health Services to meet the existing need and the anticipated increased number of covered patients.

Navajo Nation Feasibility Study

The Act also includes a provision directing the Secretary of Health and Human Services to conduct a study to determine the feasibility of treating the Navajo Nation as a state for purposes of administering Medicaid, CHIP and Medicare services to American Indians living within the boundaries of the Navajo Nation. If the study eventually leads to the Navajo Nation administering its own Medicaid program, the impact on both the Navajo Nation and the State of Arizona could be profound. Arizona would no longer have to process the paperwork for Navajos living on the reservation; the government should save money because the rules could be made simpler and easier to process with Navajo rules for eligibility instead of three different state standards. The Navajo Nation, in turn, would likely be able to better serve its citizens.[7]

During the healthcare reform debate, concerns existed that Indian Health Service would be eliminated. The resulting health reform law does quite the contrary. The Act not only permanently authorizes the IHS, but it expands access to IHS services. This legislation contributes to the transformation of the healthcare system, making health care more affordable and accessible for American Indians and Alaska Natives.

KEY TAKEAWAYS:

- Permanent authorization of the Indian Health Care Improvement Act (IHCIA) makes the provision of healthcare services to American Indians and Alaska Natives through the IHS law, further cementing the federal government's commitment to provide health care for American Indians and Alaskan Natives.
- Changes to IHCIA resulting from healthcare reform will allow American Indians residing in the state of Arizona who do not reside on reservations greater access to healthcare services.
- More federal dollars and new or expanded contracts with non-Indian healthcare providers will be needed if American Indians not living on reservations are able to take advantage of their new ability to access contract health services.
- A feasibility study related to the Navajo Nation administering its own Medicaid, Medicare and CHIP programs could have a big impact on both the Navajo Nation and AHCCCS, if the findings eventually result in the Navajo Nation administering these programs.

OTHER CHANGES AFFECTING AMERICAN INDIANS

The healthcare reform legislation is organized into 10 different titles that, among other requirements, establishes a mandate for most residents of the United States to obtain health insurance. It establishes state insurance exchanges through which individuals and families can receive federal subsidies, substantially reducing the cost of purchasing health coverage. The legislation expands Medicaid eligibility considerably and reduces the growth of Medicare's payment rates for most services. The new law will also impose an excise tax on insurance plans with high premiums and make various other changes to the federal tax code, Medicare, Medicaid and other programs.

The Act also includes some American Indian-specific provisions:

Exchange

- Authorizes the Secretary of Health and Human Services to require the exchange to provide for special monthly enrollment periods for American Indians, thus giving them more time to enroll in insurance plans offered through the exchange.
- Specifies that no cost sharing will be required for American Indians with incomes at or below 300 percent of the federal poverty level enrolled in coverage through a state exchange. Cost sharing will be prohibited altogether for American Indians enrolled in any qualified health plan in the individual market through the exchange.

Individual Responsibility

- Exempts American Indians from penalties for failure to maintain minimum essential coverage that can be assessed against a member of an Indian tribe. The law exempts members of Indian tribes on the basis of the federal trust relationship.

Streamlined Insurance Eligibility

- Makes enrollment in Medicaid, Medicare and CHIP easier. Under the new law, IHS, tribes, tribal organizations and urban Indian organizations are considered "Express Lane Entities," allowing for presumptive eligibility under Medicaid, Medicare, and CHIP for American Indians seeking services from Indian providers.

Indian Hospitals and Other Healthcare Facilities

- Extends permanently creditable service definitions for Medicare, allowing Indian hospitals to bill Medicare for outpatient and doctor services.
- Allows IHS and tribal health facilities to develop new and innovative ways of addressing healthcare facility deficiencies. It also authorizes the development of new health programs providing care in alternative settings or outside regular clinic operating hours.

Maternal and Child Health Services

- Requires the Secretary of Health and Human Services to create guidelines for Indian tribes, tribal organizations, or urban Indian organizations for early childhood home visiting programs. Sets aside three percent of the annual federal funding for home visiting programs for Indian tribes, tribal organizations, or urban Indian organizations.
- Provides funding to educate adolescents on abstinence, contraception and adulthood preparation topics. Five percent of funding for Personal Responsibility Education grants is required to be dedicated to Indian tribes and tribal organizations.

Prescription Drugs

- Decreases the "donut hole" for Medicare Part D for older adult Indians, making prescription drugs more affordable. Allows all drugs dispensed by IHS, tribal or urban Indian pharmacies to be counted as "true out-of-pocket" costs incurred by individual Indians enrolled in a Part D drug program.

Prevention and Public Health

- Allows states to enter into arrangements with Indian tribes for prevention and health promotion outreach and education campaigns for Medicaid recipients.
- Allows the CDC to award grants to Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age (Healthy Living/Aging Well grants).
- Allows epidemiology-laboratory capacity grants to tribal jurisdictions to assist public health agencies in improving surveillance for, and response to, infectious diseases.

Revenue Provisions

- Does not require health insurance or HMOs bought by tribes for members to be deemed as income by the IHS for tax purposes or for eligibility in any SSA program.
- Exempts programs established by federal law to provide care (other than through insurance policies) to members of Indian tribes from fees dedicated to the Patient-Centered Outcomes Research Trust Fund.

Federal Employees Health Benefits Program

- Allows a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for their employees from the Federal Employees Health Benefits Program.

Workforce

- Authorizes establishment of a Community Health Representative program for urban Indian organizations to train and employ American Indians to provide healthcare services.
- Strengthens scholarship and loan programs to attract health professionals to IHS facilities and tribal sites. Supports scholarship programs to recruit American Indian students into psychology and behavioral health professions.

State Implementation, Needed Coordination

As outlined above, there are many provisions and exemptions in the new law designed to protect American Indians and improve their access to health care. State agencies and tribal organizations will need to work together to ensure that the needs and protections offered to American Indians are addressed as part of reform implementation.

Significant efforts will be required to educate patients, individual providers, Indian hospitals, tribal organizations and other entities that interface with Indian patients on these protections and exemptions. For example, consumers and providers will need to be educated about presumptive eligibility for Medicaid for American Indians and exemption from cost sharing through the exchange for Indians with income at or below 300 percent of poverty.

IHS will play a vital role in health reform implementation. The majority of health care for American Indians and Alaska Natives in Arizona is provided directly at one of 53 IHS facilities ranging from ambulatory facilities to hospitals. Care is also delivered through 10 tribally-operated “638 Health Programs” and three urban Indian health centers in the state.[8]

New Demands on Non-Indian Health Providers

Health reform will place new demands on non-Indian health providers. American Indians living off reservations will have greater access to IHS contracted services. Expanded eligibility for Medicaid and subsidies for private health insurance offered through the exchange may mean that more Indians have health insurance – increasing demand for services at non-Indian health provider facilities.

Of course, expanded private health insurance coverage through the exchange and expanded Medicaid coverage (which will ostensibly occur as a result of the 2014 eligibility expansion and new presumptive eligibility provisions) will only become a reality if more American Indians/Alaska Natives apply for coverage. Indeed, many Americans Indians are *already* eligible for Medicaid yet remain unenrolled, even though Medicaid coverage provides them with access to some health services otherwise unavailable through IHS and improves the financial strength of IHS facilities. Concerted, cooperative outreach and enrollment efforts (as allowed by the IHCIA) may be needed by AHCCCS and tribes to make the possibility of coverage under AHCCCS a reality.[9]

Arizona must also prepare for an increase in Medicare Part B reimbursement requests from tribal entities, IHS clinics and hospitals now that they have permanent authority to receive reimbursement of some Part B services. The flow of additional reimbursement dollars into these facilities in Arizona will open the door for enhanced health services to Arizona's tribal communities.

New Grants and State Partnerships

The Act includes grants in a wide array of areas from maternal/child health, patient-centered medical homes, quality improvement, regional emergency care systems, trauma care centers, dental, and primary care residency for qualifying communities in Arizona. In many instances, it may make sense for the state to work directly with the 21 federally recognized tribes to apply for this funding, serving as either a pass-through agent or a partner. Such potential partnerships would benefit tribal communities since many of these programs are new to tribal areas. In any case, the state should be prepared to offer technical assistance on implementation.

According to the U.S. Department of Health and Human Services and IHS tribal consultation policies, consultation with tribes should occur when there is a "critical event," such as a new law or policy that may impact tribes. Clearly, the passage of the Patient Protection and Affordable Care Act, which includes the long-awaited reauthorization of the IHCIA, represents a critical event requiring tribal consultation.[10] The IHS is working closely with the U.S. Department of Health and Human Services on health reform implementation. According to IHS Director, Dr. Yvette Rubidoux, "IHS staff have reviewed each provision, and are drafting next steps, timelines, and determining which agencies we need to partner with on implementation of some key provisions."

Due to the many Indian specific provisions in the Act and the reauthorization of the IHCIA, implementation will be a complex undertaking requiring the participation of federal, state and tribal entities. Coordination and consultation will be needed to implement reform successfully.

KEY TAKEAWAYS:

- Healthcare reform implementation will be a complex undertaking requiring participation of federal, state and tribal entities.
- American Indians, government agencies, healthcare providers, and various tribal entities may need to be educated about specific provisions, exemptions and protections in the new law related to American Indians.
- Non-Indian Health Service providers may experience increased demand for services.
- Concerted, targeted outreach efforts may be needed to realize the potential of increased access to health care through AHCCCS among tribal members.
- The state may want to partner with tribes and apply for federal grants in an effort to bring new money, programs and services to Tribal communities.
- The passage of the Affordable Care Act, which included the long-awaited reauthorization of the IHCIA, represents a critical event requiring tribal consultation prior to implementation.

ABOUT THE AUTHOR

Beverly Russell has worked to improve the health of American Indian people for 15 years. She currently serves as the Tribal Liaison for First Things First. Ms. Russell is an enrolled member of the San Carlos Apache Tribe. She has a rich background in Indian Affairs and public policy, serving as the Executive Director for the National Council of Urban Indian Health, as a legislative aide for the U.S. Senate Committee on Indian Affairs, as a Kaiser Family Foundation Fellow, and as Chief of Staff to the Vice Chairman of the San Carlos Apache Tribe.

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APPENDIX

OTHER SELECTED RESOURCES ON HEALTHCARE REFORM

This report covers many important topics related to reform. To gain an even broader understanding of various provisions of health-care reform and their impact, the following additional reading is suggested:

Administrative Simplification

Administrative Simplification. (2010). American Hospital Association. Retrieved September 17, 2010 from http://www.aha.org/aha/content/2010/pdf/10-admin-simplification.pdf

Costs

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Grant/Funding Opportunities

Morgan, R. (2010, May 24). Summary of the state grant opportunities in the Patient Protection and Affordable Care Act: HR 3590. Washington, DC: The National Conference of State Legislatures. Retrieved September 16, 2010 from http://www.statecoverage.org/files/NCSL%20-%20PPACA%20State%20Grant%20Opportunities%20May%202010.pdf

Health Disparities

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Private Health Insurance

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