

A STATE POLICYMAKERS' GUIDE TO
FEDERAL HEALTH REFORM

PART I: ANTICIPATING HOW FEDERAL HEALTH
REFORM WILL AFFECT STATE ROLES

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EXECUTIVE SUMMARY

Many critical aspects of federal health reform will be implemented by the states. Through program design, regulations, policies and practices, state decisions and actions already play a profound role in shaping the American health care system. Much of the ultimate effect of federal health reform will rest on the degree to which federal reform supports and supplements existing state efforts, assumes responsibilities currently held by the states, or conflicts with existing state policies. How states will actually implement health reform must be considered as federal health reform legislation is crafted and federal regulations are developed.

Leaders in state health policy have been working for decades to improve the health care system. They have toiled using the tools at their disposal while sometimes lamenting the barriers federal policy creates and sometimes appreciating the support federal policy provides. Both the House and Senate health reform proposals would dramatically change the federal structure within which state health policy operates. Part I of this State Policymakers' Guide provides a high-level view of existing state roles in the health care system and how federal reform will affect those roles.

In our work with state health policy leaders, we have identified five themes around which current state reform efforts focus. For each of these themes, states have a broad array of tools that they do or could employ to attain their goals. This brief first describes those tools. It then examines how national health reform expands, contracts or modifies the array of tools. Part I of the State Policymakers' Guide looks at federal health reform squarely through the lens of the state policymaker, asking the question: Will reform support or impede progress toward existing state health system improvement goals?

These five themes, which interact to support the overarching goal of improving health, are:

- **Connect people to needed services.** We find, not surprisingly, that federal reform proposals would take significant steps toward the goal of providing people with financial access to care. States would continue to have primary responsibility for converting that financial access into real access to services. Federal health reform proposals provide some significant new tools—such as funds to increase payments for primary care providers and support for state efforts to design and test alternative payment and service delivery models.
- **Promote coordination and integration in the health system.** Federal reform proposals contain a number of important opportunities for improving system coordination and integration by supporting a stronger role for primary care and improving care for people with chronic conditions. Even as these federal initiatives would provide support, states will continue to have primary responsibility for integrating the disparate parts of the health system to improve overall systems of care.
- **Improve care for populations with complex needs.** Federal reform proposals provide states with financial support for initiatives that improve care for people with complex needs. These proposals also open the door to improvements in coordination between Medicare and Medicaid. Yet, two primary barriers to improvements in this area—the limited base of evidence to improve care and the limited infrastructure to spread best practices once they are identified—remain largely unaddressed.
- **Orient the health system toward results.** Provisions throughout federal health reform legislation to improve accountability for results attest to the need for change in this area. Although federal legislation continues the federal government's focus on the Medicare program, it also includes tools that will allow states to continue making payment reforms in the private, Medicaid, and CHIP arenas. Alignment of federal and state initiatives in this area will be important if they are to have their intended effects.

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- **Increase health system efficiencies.** Federal reform proposals include funding for a series of prevention, workforce, comparative effectiveness, and other initiatives designed to make the health system more efficient. States will need to align these initiatives with work already underway in these critical areas.

This review of federal health reform proposals and state tools to support health system improvement leads us to five conclusions.

- States already have many tools available to them to improve the health system. While each of these tools is used by one or more states, some are used by only a few and some are not used as effectively as they might be. This reflects a combination of varied state priorities, capacity, and the limitations of what can be accomplished in the face of competing resource demands.
- The major health reform proposals will provide states with many additional tools to address the issues they have identified as most important for health reform. The tools are not all as robust as states might prefer, but the general direction of many provisions within the reform bills is consistent with the direction many states are already moving.
- The details of federal reform will have a profound effect on whether or not states ultimately view the tools it provides as being helpful or not. In general, states will want to integrate new federal provisions into their ongoing efforts, not have federal law negate those efforts or force them to move in a completely different direction. This is particularly important at the design level; for example, federal and state “pay for performance” initiatives can work together only if they are designed in conjunction. States must be brought into the implementation phase of health reform to assure that provisions that seem consistent actually end up supporting each other in practice.
- States will need a tremendous number of new resources if they are to achieve the promise of health reform. States are struggling under the burden of financing existing programs and they anticipate having new financial responsibilities in the reform legislation—particularly associated with the expansion of Medicaid eligibility. States also anticipate having many new administrative responsibilities. We have attempted to capture state needs related to implementation in a companion document: “Supporting State Policymakers’ Implementation of Federal Health Reform.” The sources of support for states’ implementation work have not yet been identified. Federal health reforms will not yield their potential benefits if states are unable to perform the roles expected of them. If resources are too tight, states may comply with federal minimum standards but be unable to innovate and improve.
- The many existing and potential new state roles should serve as a reminder that federal reform will not eliminate the differences in health care that exist around the country. Some important disparities will be eliminated or substantially diminished—most notably the variations in Medicaid eligibility and in the proportion of the population without health insurance. Yet, the availability of providers, the organization of the health care delivery system, the financing and cost of care, and many other factors will continue to vary substantially around the country. Ultimately, supporting state leadership in utilizing the many tools available to shape the health care system will remain critical to improving the performance of the health care system.

INTRODUCTION

Many critical aspects of federal health reform will be implemented by the states. Through program design, regulations, policies and practices, state decisions and actions already play a profound role in shaping the American health care system. Much of the ultimate effect of federal health reform will rest on the degree to which federal reform supports and supplements existing state efforts, assumes responsibilities currently held by the states, or conflicts with existing state policies. How states will actually implement health reform must be considered as federal health reform legislation is crafted and federal regulations are developed.

Part I of this State Policymakers' Guide provides a high-level view of existing state roles in the health care system and how federal reform will affect those roles. It represents a snapshot taken in the midst of the health reform debate and discusses some important provisions but does not seek to capture all issues or options in all of the bills.¹ Subsequent sections of the guide will provide more detail on existing state policies, more specific analysis of federal legislation once it takes final form, and analysis of the implications of the many choices states will face.

Leaders in state health policy have been working for decades to improve the health care system. They have toiled using the tools at their disposal while sometimes lamenting the barriers federal policy creates and sometimes appreciating the support federal policy provides. Both the House and Senate health reform proposals would dramatically change the federal structure within which state health policy operates.

State reform efforts are shaped by an overarching goal—a goal certainly shared by those pursuing federal reforms as well. The goal was stated well more than a decade ago by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry: "The purpose of the health care system must be to continuously reduce the impact and burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States." In the decade since that report, concerns regarding the cost of health care have grown dramatically. Today's state reform efforts also are guided by a sense of urgency regarding the need to improve the efficiency of the health care system and to make the financial burden associated with supporting that system manageable for families, businesses, and taxpayers.

In our work with state health policy leaders, we have identified five themes around which current state reform efforts focus. These themes interact to support the overarching goal of improving health. The five themes, described in more detail in the companion document "State Policymakers' Priorities for Improving the Health System," are:

- Connect people to needed services
- Promote coordination and integration in the health system
- Improve care for populations with complex needs
- Orient the health system toward results
- Increase health system efficiencies

For each of these themes, states have a broad array of tools that they do or could employ to attain their goals. This report first describes those tools. It then examines how national health reform expands, con-

¹At the time of writing, the House had passed the Affordable Health Care for America Act (H.R. 3962). The Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee had approved their bills, but the combined version for introduction on the Senate Floor had not been released.

tracts or modifies the array of tools. Part I of the State Policymakers' Guide looks at federal health reform squarely through the lens of the state policymaker, asking the question: Will reform support or impede progress toward existing state health system improvement goals?

CONNECT PEOPLE TO NEEDED SERVICES

An effective health care system begins with connecting people to the services they need. The most visible aspect of this connection is financial access through public or private insurance that covers the health care needs of enrollees. Identifying and enrolling people into public programs for which they are eligible, and maintaining their enrollment so long as they are eligible, is a critical part of the connection. Ultimately, the connection is dependent upon assuring that high quality health care professionals, facilities, equipment, supplies and medications are actually available when people need them. States play a vital role in all of these areas.

EXISTING STATE TOOLS

At the most basic level, states facilitate access to services by participating in federal programs like Medicaid and the Children's Health Insurance Program (CHIP), creating their own state health insurance programs, and establishing financial eligibility standards designed to make public coverage available for those who cannot afford private coverage. State-defined eligibility standards have increased steadily over time. Sometimes this has been a result of federal incentives such as the enhanced matching rate in the CHIP program; sometimes through waiver negotiations that converted other sources of federal funds into increased levels of coverage; and sometimes simply because states that saw a growing need made expanded coverage a priority, as occurred with the creation of the Washington Basic Health Plan, Minnesota Care, and the significant eligibility expansions states made during periods of strong economic growth such as the late 1990s. In current tight fiscal times, state coverage expansion efforts have slowed down. However, they have not completely stopped, especially for children.

States have a great degree of control over the eligibility processes for public programs, and the nature of these processes has a significant effect on whether or not people in need actually obtain coverage. State efforts to simplify enrollment are long-standing. Those efforts received a significant boost in the years following the enactment of the CHIP program when many states simplified their eligibility standards and then began to apply those simplifications to the much larger Medicaid program. States are increasingly relying on technological improvements and web-based applications to simplify enrollment and renewal processes.

Public health insurance programs share a history with welfare in passively awaiting applicants to show up at the county or local office to apply. As attention has increased in recent years on the large number of people—particularly children—eligible for coverage but going without, states have made a more significant effort to identify and solicit applications from those who are eligible. A key aspect of this process is working with community based organizations that not only identify needy applicants but also assist them in navigating the application process.

The benefit structures of public and private insurance programs have a significant effect on whether or not people actually obtain the services they need. Within federal guidelines, states have significant control over the services covered in Medicaid and CHIP, and even more control over how those services are delivered and what limitations are placed on their use. States have tailored the Medicaid and CHIP benefit packages to meet the needs of specific groups of people: elders and people with disabilities requiring home and community based services; children and adolescents with special health care needs; people needing hospice services at the end of life; and children and pregnant women. Some states are designing benefits to encourage the use of preventive services or medications required to control

chronic conditions. States also have broad authority to define the terms of private insurance coverage. Yet, states must balance efforts to assure that coverage is comprehensive against concerns that coverage will be made unaffordable. In addition, employers may choose to self-insure, in which case they are no longer subject to state coverage rules and their employees are not included in state-defined consumer protections.

States have substantial control over the private health insurance market and their choices can affect the availability and nature of coverage. States regulate the rating and underwriting practices of insurers in the small-group and individual insurance markets. Tighter rating bands and restrictions on underwriting can make coverage available to older and sicker people, but those who are younger and without identified health conditions pay higher premiums when risk pools are broader. States also operate high-risk pools, which provide subsidized coverage for people who the private market considers to be “uninsurable.” A few state programs—most notably Healthy New York—have experimented with innovative approaches in which the state assumes some of the risk, thereby reducing health insurance premiums.

Private health insurance is sold primarily through agents and brokers. Massachusetts established a health insurance “connector,” and other states, like Maine, Utah and Washington, are setting up insurance exchange models. These approaches are designed to increase competition across carriers and increase comparative information for purchasers. These recent examples follow on various efforts over the past two decades to create purchasing pools for small businesses and individuals.

Insurance provisions are complex and meaningful access to care depends upon enrollees having appropriate information regarding the terms of their coverage and, in some instances, someone to help them advocate their position to the insurer. States have established grievance and fair-hearing requirements in instances where coverage is denied. Some states also have an independent ombudsman—often focusing on Medicaid, long term care or private insurance—to help their residents navigate the health system so they can receive needed care and the care they are legally entitled to under the terms of their coverage.

Consumers can quickly lose access to care if their insurance company fails or it prices its enrollees out of the market. Stemming from a long-standing consumer protection role, some states carefully scrutinize insurance premiums before products can be marketed and have regulations that protect consumers from unfair insurance prices, and all have solvency requirements to ensure that health plans have funds in reserve to pay claims. States analyze insurer and broker market conduct to make sure insurers are following the state’s rules for offering and pricing products. States assist enrollees with their transfer to new coverage when an insurer exists the market or in the rare instances that an insurance company fails.

Many critical services are provided to state residents directly through mechanisms other than health insurance. Beyond the large Medicaid and CHIP programs, states receive numerous targeted grants that enable them to deliver particular services. Some of the larger of these federal grants include the Preventive Health and Health Services Block Grant, Maternal and Child Health Services (MCH) Block Grant, Community Mental Health Services Block Grant, Substance Abuse Prevention and Treatment Block Grant, and the Ryan White HIV/AIDS Program. States (along with localities) also fund school-based health centers, emergency, poison control and trauma systems, and community safety net and public health clinics.

Some people’s needs are so profound that traditional health insurance benefits are of limited value. For decades, states have operated mental health institutions, institutions for people with developmental disabilities, veteran’s homes, and the like. Even in the wake of efforts to move many of these residents into the community, many large residential facilities remain and continue to be operated by states. States are also responsible for providing medical care to their large and growing prison populations.

HOW MIGHT NATIONAL REFORM AFFECT THESE STATE TOOLS?

The House and Senate health reform proposals would both significantly expand Medicaid coverage. A new eligibility category based solely on income (not on family structure) would overcome a long-standing barrier to state coverage expansions: that adults without custodial children or who are not disabled are ineligible for Medicaid no matter how low their incomes. Federal reform also likely will affect states' options for Medicaid coverage—potentially adding new optional groups such as low-income people with HIV, newborns who have no other form of health insurance, and family planning services for certain low-income women.

A cornerstone of the pending reform proposals is significant new funding to subsidize private health insurance for those who cannot afford it. While their precise levels have not yet been determined, these subsidies would certainly support and extend (and in some instances replace) existing state efforts. How they are ultimately structured will determine the degree to which they actually expand the availability of insurance coverage to firms, individuals, and families.

The mechanism for delivering these subsidies is a new insurance “exchange,” which could be national, state-based, or formed on a regional basis. The precise structure and roles of the exchanges have not yet been defined. States are keenly interested in how exchange-based coverage will interact with the existing state individual and small group markets. Whether the exchange model will be an effective mechanism for actually connecting people to the coverage that most suits their needs is not yet known.

The House and Senate bills require most individuals to purchase health insurance, but provide exemptions to those for whom insurance premiums remain unaffordable. Who is covered by the mandate and the size of the penalties for those who violate it will be critical in determining how many people obtain coverage and whether some people will wait to purchase coverage until their health deteriorates. These factors will have a significant effect on premiums. It remains to be seen how effective the individual mandate as ultimately structured will be in supporting the goal of expanding coverage.

The House bill requires states to work with the federal government to review annually private health insurance premium increases. The bill provides grants to states to help them conduct these reviews and to plan and implement health insurance reforms and consumer protections. Depending upon how these reviews actually are conducted, these resources could support the state goal of assuring that health insurance premium payments support meaningful access to care.

A significant step forward from the state perspective is the wholesale shift out of the welfare model when it comes to determining eligibility for public programs. While welfare reform broke the formal link between welfare and Medicaid eligibility more than a decade ago, income eligibility policies in Medicaid remain extremely complex, usually requiring substantial paperwork and documentation on the part of the applicant. The overall approach set forth in health reform is to dramatically simplify these rules, enabling subsidy determinations to be made, for example, based on prior year income tax returns. Medicaid eligibility also would be based on an adjusted gross income determination—aligning policies with those already in use in the tax code and moving away from the highly variable income disregards and assets tests states currently use. Changes in eligibility of this sort comport nicely with state efforts to simplify and streamline eligibility processes with the goal of more effective outreach, enrollment and retention. Yet, the task of aligning state-based and potentially new federally-based eligibility determinations will pose a large new coordination challenge. Most state administrative systems will require substantial modernization to make these changes. States will confront a new challenge of helping families navigate transitions in coverage between Medicaid, CHIP and the exchange.

The provisions in health reform relating to benefit design are very much in flux. States that cover without cost-sharing the services recommended by the United States Preventive Services Task Force would receive modest increases in their federal Medicaid match rate. Depending upon how subsidies and affordability standards are defined, and how those provisions interact with decisions made by employers and families, states could find themselves with a significant increase in the number of people with financial access to needed services, but they also could find a new cadre of people with coverage insufficient to meet their needs. This latter group could create new needs for addressing “underinsurance,” such as figuring out how to pay for the uncompensated services this group receives or how to wrap state-based benefits around an insufficient base of coverage. Much of the statutory language related to benefit design speaks in broad actuarial terms, but the benefit package is likely to require the offer of preventive services and to prohibit cost-sharing for these services, which is consistent with many states’ goals of emphasizing prevention.

Not surprisingly, most of what federal reform is designed to do is provide people with financial access to care. Yet, states put a tremendous amount of their effort into converting that financial access into real access to services. That effort involves activities such as increasing the supply of providers—especially primary care providers—and improving their distribution, negotiating with health plans around access and quality standards, seeking to overcome linguistic and cultural barriers to receiving care, and analyzing racial and ethnic disparities and seeking to reduce them. Federal health reform proposals provide some new tools—such as federal funds to increase payments for primary care providers and support for state efforts to design and test alternative payment and service delivery models. Despite these provisions, states will continue to have primary responsibility for connecting state residents to needed services.

PROMOTE COORDINATION AND INTEGRATION IN THE HEALTH SYSTEM

Many of the problems in the American health system trace their roots back to fragmentation and a lack of coordination. Fragmentation is a source of medical errors, adverse drug interactions, duplicate procedures, and administrative waste. Chronic conditions require management and maintenance and ongoing care in contrast to the episodic and acute orientation of our current health system. A great deal of state-level effort currently is focused on coordinating and integrating the disparate components of the health system.

EXISTING STATE TOOLS

States purchase health care services for a broad range of people: Medicaid and CHIP enrollees, active state employees, retirees, and sometimes for local governments or colleges. Only a handful of states actively coordinate the purchasing and payment policies across these programs, despite the potential for such efforts to yield efficiencies and send consistent signals to the health care system regarding performance expectations.

Within each program, states can—and some do—promote health system coordination in their purchasing policies. Contracts with providers, or managed care companies when they are relied upon to coordinate care, can include performance standards tied to measures of system coordination and integration. Such measures can include clinical measures that reflect a systemic approach to delivering care, patient satisfaction measures tied to system coordination, and process requirements that reflect a coordinated system. Some states require Medicaid managed care organizations to have memoranda of understanding with critical partners such as local public health departments or community health centers.

States have a direct effect on system integration when they decide how to structure their managed care contracts. It is common to “carve-out” service categories such as mental health or oral health. These carve-out contracts may place care management for some services in the hands of an organization with greater expertise, but they also create opportunities for fragmented services and a lack of accountability for outcomes. States also sometimes contract with private health plans to provide a core set of Medicaid benefits, but then “wrap-around” benefits for services like EPSDT. These approaches raise similar issues regarding coordination and accountability.

More than a dozen states are working directly with health care providers to promote coordination through the patient centered medical home model. This model provides enhanced payments to support an expanded role for primary care practices to coordinate the patient’s care across the range of services they need. State roles include financing, working to gain the participation of multiple payers, organizing assistance with practice redesign, and other supports.

The variety of health and social programs with which many people interact creates another risk of fragmentation that some states have worked hard to overcome. Some states are integrating eligibility for health coverage with other human services programs—such as juvenile justice, foster care, child protection and food assistance—to make it easier for people to apply for and receive the benefits they need. States are attempting to coordinate not just across multiple programs but also across multiple funding streams, including various federal grants. For example, states provide medical and social services to pregnant women through “braided funding streams” that combine funds from the MCH Block Grant, Temporary Assistance for Needy Families (TANF), and Medicaid, and may also draw upon state, local, or private funds to deliver comprehensive services.

Health Information Technology (HIT) is viewed as a critical tool to support coordination and integration. While the federal government is providing substantial financial support for HIT and Health Information Exchange (HIE), the responsibility for making it work—deciding on the appropriate level of privacy and security; ensuring interoperability between systems; developing and analyzing datasets for practice patterns and variability—generally rests with the states. States roles in HIT and HIE can include supporting statewide planning efforts, convening stakeholders, and implementing coordinated activities.

Patients or health care consumers are taking an increasingly active role in coordinating their own care. This is particularly important for people with chronic conditions, for whom self-management is critical to their own health, and people with complex conditions who out of necessity interact with a broad range of health care providers and who are often better able to integrate their care than anyone else. Many states integrate self-management and self-direction provisions in their Medicaid and public employee programs.

HOW MIGHT NATIONAL REFORM AFFECT THESE STATE TOOLS?

The House and Senate health reform proposals reflect some of the momentum built by states working to integrate care. They include additional funding and resources for the expansion and continuation of many promising programs that states can employ to promote coordination and integration in the health care system.

For example, both House and Senate bills include funding for medical home demonstration projects in Medicare and Medicaid. The Senate Finance Committee bill goes farther, making it a Medicaid state plan option to offer medical homes to those with chronic conditions and providing enhanced federal funding for Medicaid enrollees with chronic conditions who designate a health home. Many states have already begun to implement medical homes initiatives; the reform legislation provides additional support for this innovation.

The reform proposals recognize the importance of primary care providers as entry points and coordinators for the health care system. The House bill would invest in primary care and care coordination by increasing Medicare and Medicaid payments for primary care providers.

Each of these provisions offers important opportunities for improving system coordination and integration. States will have new tools to promote coordination, but still will be working with an extremely complex system. Even as these federal initiatives provide important support, states will continue to have primary responsibility for integrating these efforts with the rest of the health system.

IMPROVE CARE FOR POPULATIONS WITH COMPLEX NEEDS

The category of “complex populations” is incredibly heterogeneous. It includes: people of all ages with multiple chronic and/or acute health conditions or with severe and/or degenerative physical or mental disabilities due to congenital condition, injury or disease; young people interacting with the juvenile justice and/or foster care systems; the frail elderly; and those approaching the end of life. Despite their many differences, this group shares important characteristics. People with complex health care needs often interact with a broad range of health professionals. They may experience frequent moves between care settings – from hospitals, to nursing homes or rehabilitation facilities, to the community, to residential facilities, and back. They may have undiagnosed or untreated conditions—particularly in mental health. They may have significant social and supportive service needs that are not medical in nature. They may have parents, spouses or children intimately involved in their care who need support as well. People with complex needs may have health care paid for by multiple payers—including Medicare, Medicaid, private insurance, and other targeted programs (such as Ryan White funds for people with HIV/AIDS and Title V funds for children with special health care needs).

States have a dominant role in organizing, purchasing, and financing health, family supports, and long term services for persons with complex needs. Forty-two percent of Medicaid spending is associated with people with disabilities, and another 28 percent is for elders. Historically, many of these populations were served in institutions that provided health care as well as assistive services. More recently, states have worked to enable persons with complex needs to receive physical health care, mental health services, and assistive supports in community settings.

EXISTING STATE TOOLS

Due to its sheer size, the Medicaid program dominates states’ activities in this area. The Medicaid program provides an entitlement to nursing home care for eligible recipients. For many years, states have been seeking a better balance between institutional and community based care. All states use Medicaid home and community based services (HCBS) waivers to provide long term supports in the community. Older people, people with physical and developmental disabilities, persons living with AIDS, persons with traumatic brain injuries, and children with complex medical conditions are some of the populations states serve through their Medicaid HCBS waiver programs. In addition, some states provide optional state plan services to low-income persons who need some assistance but do not require an institutional level of care. Some states supplement their Medicaid-funded programs with services financed exclusively with state funds or with federal grant funds from programs like the Maternal and Child Health or Social Services block grants.

For each component of a state’s home and community based services delivery system, states define the benefits to be provided, the population that will financially and functionally qualify for services, the types of providers permitted to participate in the program, the community and residential settings in which supports will be delivered, and the payment rates for all of these services. In addition to making these policy decisions, states put in place a set of administrative processes to support program operations such as collecting data on consumer characteristics and needs, designing quality management systems, and managing provider payment systems. While the specific manner in which states organize their HCBS delivery systems varies, they usually designate a local entity to assess eligibility for programs, develop a tailored service plan for each enrollee, and coordinate and monitor the delivery of services.

States administer the survey and certification process for nursing homes, which allows these facilities to obtain payment from Medicaid and Medicare. This process has evolved from a strict compliance approach to incorporate perspectives of residents and measures that address quality of life as well as quality of care.

A number of states are operating initiatives designed to coordinate care for people with multiple chronic conditions. Recognizing that traditional care guidelines for common conditions such as diabetes or heart disease may be ineffective or even counterproductive for people with multiple conditions, some states are working with leaders in health delivery to determine how to reduce the burden of disease for these complex populations.

Finally, persons with complex needs often require services provided by multiple delivery systems—primary care, behavioral health, chronic care, and long term care, and financed by different programs—particularly Medicaid and Medicare. Individual states are developing delivery systems reforms to better integrate care for persons across these systems, but major challenges remain.

HOW MIGHT NATIONAL REFORM AFFECT THESE STATE TOOLS?

The major health reform proposals provide states with additional policy tools for making community supports for persons with complex needs more readily available. The Senate Finance Committee bill provides states with increases in Medicaid federal financial participation for community based services as an incentive to take on new policy options. Specifically, enhanced federal matching rates are available to states for adopting a new optional state plan attendant service; making structural changes to their Medicaid home and community based services systems; and implementing a new medical home state plan option. In addition, states participating in the existing Money Follows the Person demonstration would be eligible for enhanced matching rates for Medicaid home and community based services provided to persons who are transitioning to community living following an institutional stay of 90 days or more, instead of 180 days under current law.

Health reform bills also address one of the states' most persistent challenges: achieving better integration of financing and service provision for persons eligible for both the Medicare and Medicaid programs. Both the House and Senate bills establish a new office in the Centers for Medicare and Medicaid Services (CMS) charged with improving coordination between the two programs. Some of the office's new responsibilities include: providing states, special needs plans, physicians, and other relevant entities with tools to better align the two programs' benefits; supporting state efforts to coordinate health and long term care services for dual eligibles; and providing support for coordination of contracting and oversight by states and CMS related to integrated Medicare and Medicaid programs. In addition, special needs plans are reauthorized and the Secretary of Health and Human Services is given authority to establish improved risk-adjusted payments for plans serving dual eligibles.

New requirements aimed at improving the quality of care provided in nursing homes are included in the health reform bills. Nursing homes would be required to disclose additional financial and staffing information; the CMS Nursing Home Compare website would contain more detailed information, including links to state survey and certification agencies' websites that post facility-specific inspection information; and states would be required to implement a new resident complaint resolution process. In addition, the House bill requires HHS and states to implement a criminal background check system for all direct service workers in nursing facilities, ICF/MRs, assisted living facilities, and providers of personal care services, home health services, and adult day care.

The health reform bills create a voluntary, federally-administered insurance program financed by individuals' premium payments made through payroll deductions. The program would make cash benefits available to eligible individuals for the purchase of long term care services and supports. Individuals could use their cash payments to purchase the types of services developed by state Medicaid programs. State disability determination agencies, under contract with the Social Security Administration, will establish individuals' eligibility for benefits based on measures of functional ability. These provisions could increase opportunities for coordination and, in the longer run, reduce the financial burden on the Medicaid system.

Finally, with the creation of a new eligibility category that includes low-income adults without children, a large number of people with chronic conditions will be entering the Medicaid program. With Medicaid coverage, they may gain access to services that will prevent their conditions from becoming more severe and costly to treat.

Despite these new opportunities for improving services and supports for persons with complex needs, two fundamental barriers to advancing care are not addressed: the limited base of evidence to improve care for people with complex health needs, and the limited infrastructure to spread best practices once they are identified. Evidence-based practices and measures for addressing differing combinations of multiple chronic conditions are difficult to develop. For example, traditional performance measures examine care for each condition separately (e.g., diabetes, high blood pressure, depression). This approach is insufficient to measure care quality for persons with multiple conditions. Likewise, more refined measures need to be developed for assessing the outcome of various approaches to providing long term services and supports. Given the high personal and financial burdens associated with the many conditions that present themselves among populations with complex needs, a significant national investment in developing evidence-based practices and spreading their adoption could have tremendous yield. This sort of endeavor is beyond the scope of what any individual state can do.

ORIENT THE HEALTH SYSTEM TOWARD RESULTS

The overwhelming majority of payments made in the health care system as currently structured are for services performed or products supplied, without regard to quality or outcomes. States are at the forefront of the movement to reorient the health system by building ways to measure health system performance and reward good results. States are working to develop metrics to more accurately assess quality and value, and are seeking to use evidence to drive payment reforms that enhance the quality of health care services and improve the performance of the health system.

EXISTING STATE TOOLS

States can orient the health system toward results through the ways in which they contract for and pay for health services for their employees as well as for publicly-insured populations. In addition, states set requirements for reporting data and outcomes both to regulatory agencies and to the public. States are using these tools to move away from simply paying for inputs and procedures and toward paying for better care processes, and, as measures become available, better outcomes as well.

For example, states have developed quality standards for managed care organizations contracting with Medicaid and CHIP programs, and with their state employee health benefits plans. While managed care contracts vary in structure and scope, all states' contracts now include quality assurance and outcome reporting elements. Some states take quality metrics into account when selecting which plans to contract with and/or assigning enrollees to a plan. Contracts may contain a number of quality measures and reporting requirements, such as emergency room utilization, HEDIS measures, and indicators that assess access to care. States often require consumer satisfaction surveys as a part of overall quality improvement strategies. In Medicaid and CHIP, states are required to engage an external review entity to study and report on the outcomes achieved by a contracted managed care entity. States may condition payment incentives on quality measures. Similarly, states are changing the way they contract with and reimburse providers in their fee-for-service systems to also support accountability for outcomes. Often, contracts require submission of data on health outcomes or units of services. Several states are using quality and cost information to create "tiers" of cost-sharing in which state employees who choose higher-cost or lower-quality providers pay more out of their own pockets.

Payment reforms such as pay for performance, accountable care organizations, bundled payments, and episode-based payments are additional tools being piloted or used by states to encourage accountability for results. Payment agreements in these sorts of arrangements may include language that defines expected outcomes, such as a reduction in hospital admissions, or may provide for a higher reimbursement rate for practices that consistently achieve specified objectives. States play a critical role in these efforts—convening interested parties, developing standards, and reporting on progress.

States also strive to orient the health system toward results through collecting and reporting data. Currently, most public reporting is limited to hospital-based care. However, many states are expanding public reporting to include other settings, such as outpatient practices and the long-term care system. Publicly reported measures may relate to patient safety, overall quality, or costs. States use public reporting requirements to drive accountability and improvement. Some states are attempting to coordinate the numerous public and private reporting initiatives, both voluntary and mandatory, by compiling information from multiple sources and helping consumers understand and use these data. Several states have built,

and many others are in the midst of building, “all-payer” databases, which enable analysis and comparison that is impossible when data remains fragmented and proprietary with each payer. A strong health information technology infrastructure is invaluable in these endeavors.

States are also engaging directly in quality improvement initiatives that span from the institutional level to the physician level—from changing practice in hospital and nursing home facilities to system-wide primary care initiatives like developing medical homes or the use of primary care case management in state Medicaid programs. States also have a role in improving physician practice by participating in initiatives such as Assuring Better Child Health & Development (ABCD), which facilitates the delivery of developmentally appropriate care for children.

Finally, states are using a focus on health disparities as a lens through which to view gaps in performance. Medicaid agencies can leverage their purchasing power by placing requirements in managed care contracts that encourage reduction of disparities, establishing new contracts for services that will help reduce disparities, and providing financial or other incentives for contractors to undertake activities to reduce disparities. In addition, state grants awarded by health departments and other health agencies can require that recipients target populations or communities with high rates of disease, that grantees conduct targeted outreach to minority groups, or that health outcomes are reported by race and ethnicity.

HOW MIGHT NATIONAL REFORM AFFECT THESE STATE TOOLS?

Provisions throughout federal health reform legislation to improve accountability for results attest to the need for change in this area. Though federal legislation continues the federal government’s focus on the Medicare program, it also includes tools that will allow states to continue making payment reforms in the private, Medicaid, and CHIP arenas.

Federal reform provides authority and funding for states, along with the federal government, to implement and evaluate various alternative payment models. The House bill includes Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, as well as pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient centered medical homes. Similarly, the Senate Finance Committee bill includes provisions for a pediatric accountable care organization demonstration project in Medicaid and CHIP; a Medicaid global payment demonstration project for safety net hospitals; and a Medicaid bundled payment demonstration for acute care provided in a hospital or nonhospital setting. Both House and Senate bills create an “Innovation Center” within CMS to develop, test, and expand innovative payment and delivery arrangements to improve care and reduce costs for Medicaid and Medicare beneficiaries.

The federal legislation under consideration also contains provisions to improve the use of quality measures. The Senate Finance Committee bill establishes a Medicaid quality measurement program in which the Secretary of HHS, “in consultation with states,” will develop an initial set of health care quality measures for adults eligible for Medicaid (the CHIP reauthorization legislation already created a pediatric quality measures program). The bill also prohibits federal financial participation in Medicaid payment for health care acquired conditions. Similarly, the House bill provides for the development of Medicaid and CHIP quality measures for maternity care and adults, and establishes other national quality measures. Finally, both the House and the Senate HELP bills establish federal entities charged with developing, evaluating, and disseminating best practices for performance improvement and quality.

The House and Senate Finance Committee bills include measures to encourage improved data collection on health disparities and attention to cultural competency in health care. For example, the House bill

creates grant programs to support cultural and linguistic competence training for health professionals and to community partnerships providing services to reduce health disparities. The Senate bill creates uniform categories for collecting data on race, ethnicity, gender, and language. It also requires CMS to collect and report health outcomes data on racial and ethnic subgroups of Medicaid and CHIP beneficiaries. Some states may need to adapt their data collection protocols to comply with these new requirements; all states will ultimately benefit from the insights these new data can provide.

This collection of new and expanded federal initiatives provides states with many useful tools to promote an agenda of accountability. Alignment of federal and state initiatives in this area will be a challenge. States need the participation of Medicare in their local efforts, but also do not want to be held back by the federal government as they develop new initiatives.

INCREASE HEALTH SYSTEM EFFICIENCIES

Tightly constrained resources at the state level have moved efforts to improve efficiency to the top of the agenda. The cost of the American health care system is extremely high by international standards. There are significant opportunities to save resources by eliminating the provision of unnecessary or ineffective care, reducing medical errors, preventing illness and disease, and reducing administrative costs. In the midst of ongoing health reform discussions that include debates about waste in the health care system, there are many tools that states already are employing to increase health system efficiencies.

EXISTING STATE TOOLS

States view public health and prevention as critical priorities in their own right and as key tools for reducing the burden that disease places on the health care system. Public health interventions work at the population level with communities, neighborhoods, schools, and in other settings. States support public health by creating healthy environments for active living, setting school physical education requirements, providing nutrition standards for school meals, running tobacco cessation campaigns, and educating residents about obesity prevention and substance abuse treatment. States have been active in setting the standards for the types of screening newborns must have. Screening provides epidemiological data and identifies an individual health need that might not otherwise be detected and may lend itself to early intervention or treatment. States develop strategies and operate programs to prevent the spread of communicable diseases, including new strains of flu and viruses. States also operate laboratories to analyze tissue samples, environmental samples, and other items to determine the prevalence of various conditions and the emergence of disease. They maintain registries of people with various conditions. Environmental protection reduces the incidence of disease. States plan for and respond to emergencies and natural disasters to minimize their consequences.

A well-trained and effective workforce is necessary for the efficient provision of health care services. States operate medical, nursing, dental, pharmacy, and other schools that train health professionals. The capacity of those schools and the structure of their graduate medical education have a significant effect on the availability of providers, their choice of practice site, and their degree of specialization. In addition, states oversee ancillary education and credentialing for health care workers, define continuing education requirements, and establish and enforce conduct standards for health professionals. These standards affect the skill set of these professionals and their ability to learn new skills during their careers, such as working in teams or adopting new health information technologies.

States regulate health providers' scope of practice. By regulating which procedures and services health care professionals may perform, state scope of practice policies can have a significant effect on access to care and the cost of care. To address workforce shortages in areas such as primary care, mental health services, and dental care, some states have expanded the scope of practice of nurse practitioners, physician assistants, dental hygienists, psychologists or pharmacists.

States make coverage decisions within their Medicaid and CHIP programs as well as for their state employees. States are increasingly interested in examining the effectiveness of services before they elect to cover them. A handful of states participate in the Oregon Health Sciences University Drug Effectiveness Review Project which compiles the best available evidence on the effectiveness of certain drugs and provides that

information to states to use in their own decision-making processes. States are experimenting with benefit designs that, for example, reduce or eliminate cost-sharing for medications used for the management of chronic conditions.

A number of states engage in comprehensive health planning, and thirty-six states use Certificate of Need (CON) programs, laws, or agencies to avoid capital expenditures that the state determines are not necessary for meeting the health needs of the population. CON standards can target investments to where they will have the largest net benefit for population health.

States seek to use their public coverage funds efficiently. By law, Medicaid is the payer of last resort, so third parties—private insurers, Medicare, employer-based insurance, or workers’ compensation—must cover an enrollee’s cost before Medicaid pays the remainder. All states pursue third-party reimbursement, but some states are particularly active in assuring that Medicaid payments are made only when all other sources of payment have been ruled out.

Rooting out fraud within their health care systems is another state role. States undertake various activities to avoid making overpayments, to recoup overpayments, and to prevent, detect, and prosecute fraud when it occurs. States may impose penalties for fraud and abuse including repayment with interest, fines, corrective action plans, suspension or termination of provider agreements, and revocation of provider or facility licenses. States are required to identify and investigate providers suspected of fraud and abuse in order to receive federal Medicaid funds.

Some states monitor the community benefit provided by non-profit hospitals and nursing homes. These facilities must meet certain standards in order to maintain their tax-exempt status. These monitoring activities are designed to assure that the fiscal benefits of tax-exempt status are not conferred unless warranted by the provision of sufficient public benefit.

The malpractice framework is commonly noted for its inefficiency. Awards are poorly correlated with harm and delays in compensation are extremely long. The degree to which legal liability drives up health care costs through “defensive medicine” is heavily debated. States have adopted a variety of responses including caps on certain forms of damages and efforts to make it easier for health care providers to apologize, which is viewed as a possible mechanism for reducing the likelihood of a lawsuit.

States have a wide range of authority over a variety of special funding sources, and states have worked to make better use of these funds. For instance, states have considerable discretion in how they allocate Medicaid Disproportionate Share Hospital (DSH) funds. A number of states have sought and received federal waivers to use their DSH funds to provide health coverage for people who would otherwise be uninsured. States also receive considerable funds through the tobacco settlement. Some states have used these funds to improve population health—particularly through smoking cessation efforts—but others states have not.

Some efforts to improve system efficiency—such as sharing performance data and developing mechanisms to pay for shared infrastructure such as 24-hour nurse call lines—require cooperation among various actors in the health care system. Concerns regarding anti-trust violations can impede those efforts. With appropriate oversight, states can provide “state action immunity” from anti-trust concerns.

A number of health information technology initiatives are expected to yield efficiencies. Health Information Exchange (HIE) permits transfer of health-related data across providers with greater efficiency than paper records. HIE reduces the likelihood physicians will order duplicate diagnostic procedures. Health information technology can reduce the administrative burden small physician practices experience inter-

acting with multiple insurers. Ultimately, a robust health information technology infrastructure integrated with system improvement goals can improve care quality and coordination and reduce health care costs.

HOW MIGHT NATIONAL REFORM AFFECT THESE STATE TOOLS?

The federal reform proposals include additional funding and resources for programs that promote public health and prevention, such as: the expansion of school-based health clinics; home visitation programs for women with young children; community based prevention and wellness programs and research; expansion of the vaccines for children program; increasing the public health workforce and the public health infrastructure; and medication management programs for people with chronic conditions. Grants would be available to implement healthy lifestyle incentive programs, like tobacco cessation, for Medicaid enrollees. New grants would allow states to implement programs to prevent obesity in children. States (and communities) have a wealth of experience implementing these kinds of programs and would need to integrate these new efforts with those that already exist.

Federal reform legislation includes provisions to strengthen the health care workforce. The Senate HELP committee proposal includes a provision that would increase loans for nursing students and create loan repayment programs for public health workers and pediatric specialists. The bill would also expand funding for the National Health Service Corps. Also, the House bill would include provisions to increase training for primary care providers and promote training in outpatient settings. To help balance supply and demand, both the House and Senate bills would establish a workforce commission to assess workforce needs and make policy recommendations.

Both the House and Senate HELP bills establish a new comparative effectiveness research center within the Agency for Healthcare Research and Quality. The new center would conduct and analyze research on the clinical effectiveness of medical procedures and treatments. Similarly, the Senate Finance Committee proposal would establish a non-profit Patient-Centered Outcomes Research Institute, which would also compare the clinical effectiveness of medical treatments. States will certainly be interested in the outcomes of such research and may choose to rely on the recommendations of these centers when making coverage decisions.

Federal legislation also includes provisions to help states address fraud in the health care system. The House proposal would allow provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and require Medicare and Medicaid program providers and suppliers to establish compliance programs. Similarly, the Senate Finance Committee proposal would allow for the exclusion from all federal health care programs of providers who provide false information on applications to participate in Medicare, Medicaid, or CHIP and the development of the “One PI database” to capture and share data across federal and state programs. The bill also authorizes increased penalties for submitting false claims and increased funding for anti-fraud activities.

Federal reform legislation tightens some of the requirements for conferring non-profit status on hospitals. The Senate Finance Committee proposal would impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs. In addition, non-profit hospitals would have to adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to inform patients about the financial assistance policy

before undertaking extraordinary collection actions. States, which often confer their own tax-exempt status in alignment with federal tax status, may decide to follow these new federal rules, or to adopt their own rules for determining the tax status of hospitals.

The Senate Finance Committee bill contains a “Sense of the Senate” provision that health care reform “presents an opportunity to address issues related to medical malpractice and medical liability insurance,” according to a committee summary of the plan. The bill also “would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.”

The House bill would reduce Medicaid DSH payments by \$6 billion in 2019, imposing the largest percentage reductions in state DSH allotments on states with the lowest uninsured rates and those that do not target DSH payments. All states will need to evaluate how this will impact their safety net providers and perhaps reallocate their DSH allotments to preserve access to care.

CONCLUSION

This review of state tools to support health system improvement and how the current federal health care debate interacts with those tools leads us to five conclusions.

- States already have many tools available to them to improve the health system. While each of these tools is used by one or more states, some are used by only a few and some are not used as effectively as they might be. This reflects a combination of varied state priorities, capacity, and the limitations of what can be accomplished in the face of competing resource demands.
- The major health reform proposals will provide states with many additional tools to address the issues they have identified as most important for health reform. The tools are not all as robust as states might prefer, but the general direction of many provisions within the reform bills is consistent with the direction many states are already moving.
- The details of federal reform will have a profound effect on whether or not states ultimately view the tools it provides as being helpful or not. In general, states will want to integrate new federal provisions into their ongoing efforts, not have federal law negate those efforts or force them to move in a completely different direction. This is particularly important at the design level; for example, federal and state “pay for performance” initiatives can work together only if they are designed in conjunction. States must be brought into the implementation phase of health reform to assure that provisions that seem consistent actually end up supporting each other in practice.
- States will need a tremendous number of new resources if they are to achieve the promise of health reform. States are struggling under the burden of financing existing programs and they anticipate having new financial responsibilities in the reform legislation—particularly associated with the expansion of Medicaid eligibility. States also anticipate having many new administrative responsibilities. We have attempted to capture state needs related to implementation in a companion document: “Supporting State Policymakers’ Implementation of Federal Health Reform.” The sources of support for states’ implementation work have not yet been identified. Federal health reforms will not yield their potential benefits if states are unable to perform the roles expected of them. If resources are too tight, states may comply with federal minimum standards but be unable to innovate and improve.
- The many existing and potential new state roles should serve as a reminder that federal reform will not eliminate the differences in health care that exist around the country. Some important disparities will be eliminated or substantially diminished—most notably the variations in Medicaid eligibility and in the proportion of the population without health insurance. Yet, the availability of providers, the organization of the health care delivery system, the financing and cost of care, and many other factors will continue to vary substantially around the country. Ultimately, supporting state leadership in utilizing the many tools available to shape the health care system will remain critical to improving the performance of the health care system.

A STATE POLICYMAKERS' GUIDE TO FEDERAL HEALTH REFORM.
PART I: ANTICIPATING HOW FEDERAL HEALTH REFORM WILL AFFECT STATE ROLES

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