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MANAGING HEALTH REFORM

ARIZONA: ROUND 1

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**

March 2014

**Rockefeller Institute of Government
State University of New York**

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University of Pennsylvania**

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With the assistance of Thomas Holland

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MANAGING HEALTH REFORM

ARIZONA: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

A number of decisions helped set the stage for Arizona's implementation of the Affordable Care Act (ACA). These decisions and the dynamics that led to them reflect a complex mix of intergovernmental political calculation and pragmatic public policy, past and present, which frame the state's capacity for implementing ACA in Arizona.

Mixing National and State Politics: Arizona as a Leader in the Fight to Overturn "Obamacare"

Arizona political leaders were at the forefront of opposition to national health reform even before the ACA became law and in the stormy days thereafter. Many Arizona public officials, including some members of the state's congressional delegation, opposed what many conservatives were calling "Obamacare" from its inception. The most visible Arizona actors in this drama were Governor Jan Brewer and Attorney General Tom Horne, who promoted and actively participated in the multistate U.S. Supreme Court suit, *NFIB v. Sebelius*.

On the political level, Arizona policymakers' active opposition to Obamacare can be explained by intergovernmental and party politics. Arizona is a "red" state that has, with the exception of endorsing Bill Clinton in 1996, voted for Republican candidates in every presidential election since 1952. A majority of voters are

registered Republicans; both chambers of the state Legislature have Republican majorities; and many state elected officials are Republicans. Against this backdrop, Brewer and former State Senate President Russell Pearce vaulted into the national political spotlight by championing state versus federal power to set and enforce immigration policy, in some ways a precursor to the politics of “states’ rights” 21st century style, as it played out in health care reform in Arizona.

Following Politics to Policy: Arizona Declines to Operate its Own State Exchange

In keeping with the view that states should and could do a better job running their own health insurance exchanges, Brewer and key staff decided to explore development of a state-run exchange. In September 2010, the Governor’s Office of Economic Recovery received a state planning grant from the Centers for Medicare & Medicaid Services (CMS) for almost \$1 million. The planning grant was seen by key staff as necessary for Arizona to perform “due diligence,” to explore potential development of an exchange in a time of high political tension and uncertainty, as well as a very tight deadline for implementation. This resulted in what was described as something of a “sense of panic.” Contributing to the uncertainty was the desire by the governor and several key Republican legislators to kill the ACA. And at the time, Brewer was waging a fierce re-election campaign against Democratic former Attorney General Terry Goddard. Before the campaign, Brewer wanted Goddard (as the state’s attorney general) to join other states in the suit to block the ACA. Goddard refused. But Brewer persisted and, with the help of Horne, became viewed as a national leader in the effort to have the Supreme Court “throw out the whole law.”

Much of 2011 was spent working with consultants and experts on various aspects of planning information technology (IT) integrations and Web site design for the state exchange. According to state officials, uncertainty remained high during this period, mainly because of delays in rules and clarifications from CMS. Draft exchange rules were made available in early 2011, but much ambiguity remained. In November 2011, CMS awarded the Arizona governor’s office an additional \$29,877,427 for Level 1 exchange planning. Most of the money was targeted for IT integration (exchange and Medicaid systems). The governor’s principal advisor for health affairs, Donald Hughes, headed all planning for a state exchange. He and others close to the process reportedly believed at this stage that Arizona would choose the state-run exchange option, and that Hughes would likely be the CEO of the state-run exchange.

In 2012, the Supreme Court decision and the presidential election cemented the status of the ACA. On November 15th following the election, Brewer decided against a state-run exchange and chose to participate in a federally facilitated exchange. She said it

was impossible for Arizona to plan its own exchange, citing uncertainty about future costs to the state due to lack of reliable fiscal information, federal delays in issuing rules, and the lack of sufficient written guidelines and a specific timeline. This development was seen by many as part of an ongoing political battle between the governor and President Obama, and politics were no doubt part of it. Ultimately, her positive decision on Medicaid expansion, combined with the decision to have a federally facilitated exchange for Arizona, reflected a political compromise.

Following Policy to Politics: Arizona Chooses to Expand Medicaid

“One of the first governors to push back against the Medicaid expansion was Arizona Governor Jan Brewer. Brewer vigorously opposed Obamacare for nearly three years. However, after the Court upheld the law, and gave states the option to opt into the Medicaid expansion, Brewer pulled a 180, and supported joining Obamacare.”
– Blogger Josh Blackman¹

In June 2013, Brewer emerged as the key actor in the decision to expand Medicaid. She was reinforced by polling results indicating a state majority favored Medicaid and was the target of an intense political effort, including from a well-known Republican lobbyist hired to help persuade her to support expansion. A very powerful coalition of businesses, hospitals, and community groups eventually convinced Brewer that expansion would have fiscal benefits and advance the economic recovery. Supporters also cited the state’s responsibility to support KidsCare and to restore Medicaid benefits to those in need who had been receiving them before recent budget cuts.

This was not an easy sell, particularly to some influential Republican legislators who strongly opposed expansion. To counter this opposition, Brewer called a special session and threatened to veto every bill until the state Legislature approved Medicaid expansion. Ultimately, the Legislature gave Brewer what she sought. It has been suggested that this was a very effective example of using a tea party tactic to defeat the tea party.

But Brewer had to pay a high political price for her stand. She came under intense criticism from the blogosphere and from conservative media, including prestigious outlets such as *The Wall Street Journal* and *The National Review*. Local columnist Robert Robb claimed the governor’s threat to veto all bills until the Medicaid expansion was passed was excessive and beyond the intent of the veto power: “It is not illegal. But it is an abuse of power. And does smack of an imperial governorship.” The decision certainly changed her image among some former conservative allies at home: “Jesus had Judas. Republicans have Governor Brewer,” Maricopa County GOP Chairman A.J. LaFaro said after Brewer decided in January 2013 to pursue expansion.²

And the firestorm lingered in state court. A lawsuit by the conservative Goldwater Institute asked the court to decide whether disgruntled lawmakers and potentially affected taxpayers had standing to fight the method used by legislative leaders to finance Medicaid expansion. The suit, rejected in 2014 by the court, argued that expansion enabling legislation involved a tax and therefore requires a two-thirds majority of the Legislature, which would likely be unattainable. But supporters say the measure delegated authority to the Brewer administration. Plaintiffs claim they are not seeking to block expansion, just the funding mechanism.³

Brewer's efforts to expand Medicaid were seen by some as fickle, given her earlier efforts to defeat Obamacare, and by others as remarkable statesmanship. On the other hand, various observers perceived her rejection of a state-run exchange as inconsistent with her general position supporting states' rights and determinations rather than relying on federal management. But the politics of this decision in Arizona and other Republican-dominated states seems at least partially influenced by the desire to see the exchange experiment fail, label that failure as a matter of poor federal management, and thereby damage the ACA, particularly the exchange component.

For Implementation and Outreach, Arizona Looks Toward the Community

Following these major ACA decisions, Brewer directed that no state agency be involved in promoting or developing the exchange. The exception is the state Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), which is naturally involved in outreach for Medicaid expansion.

The outreach vacuum is being partially filled by community action. An influential state-based health and community development foundation, St. Luke's Health Initiatives (SLHI), is serving as convener and partner in a statewide coalition of Arizona Community Health Centers (ACHC) and allied community organizations to persuade uninsured individuals to enroll in affordable health insurance or, if eligible, in Medicaid. This coalition, called "Cover Arizona" (www.coveraz.org), is funded in part by CMS to provide umbrella navigator and outreach services.

In early October, CMS was still "clarifying" expectations of the enrollment system. By the end of October, much remained unknown and untested. There was enormous uncertainty about IT and the quality of new integrated systems. Would AHCCCS and the federally facilitated exchange ultimately link effectively to other federal and state systems? Timing was a major concern for outreach counselors as well as potential enrollees, as appointments and counseling sessions were postponed.

Yet the important point may prove to be one of developing human capacity within this grassroots network and among potential new recipients of health care. Cover Arizona had invited more than 200 potential counselors, navigators, and other community

outreach participants from around the state to an initial CMS-led training effort in late August 2013. Participants were engaged and very enthusiastic about the promise of the ACA and represented significant, largely self-organized potential for implementation. In a little over a month later, that group had grown to more than 600 community partner organizations.⁴

1.2. Goal Alignment

Arizona has simultaneously taken both partially affirming and partially oppositional responses to major goals of ACA. At this point, the state appears to be consciously avoiding active involvement in the development and trajectory of the federally managed exchange. Yet the reverse is true for the Medicaid expansion, where the state is aligned with ACA policy.

How do we explain this apparent paradox? Many observers would suggest it is the result of historical patterns of politics and political culture, and they would be partially correct. Beneath that sweeping explanation, however, are important public policy determinants that apply to ACA implementation in Arizona:

1. *Goal alignment over time in a dynamic intergovernmental system is often part of a shifting policy dialectic, sometimes resulting in agreement and/or mutually acceptable compromise, sometimes resulting in goal displacement or failure to accomplish the goal.*
2. *“State behavior” in a dynamic pluralism is normally dispersed, seldom unified.*

Arizona was the last state to adopt Medicaid, but after a long and contentious legislative debate over the merits of federal aid, the risks of state dependency, and other issues, decisionmakers came to understand that state fiscal pressures were on a collision course with ideology. They compromised and finally agreed to accept Medicaid funds in 1981.⁵

The Department of Health and Human Services approved the AHCCCS, a “Medicaid waiver experiment,” also the name for the cabinet-level agency formed solely to run the program. Despite the initial opposition to accepting Medicaid in Arizona, the AHCCCS experiment over time became a source of pride. Its “cost containment” approach of prepaid capitated services won national accolades and attempts to imitate. The AHCCCS agency was viewed as something of a public policy model of oversight. Elements of the program were celebrated locally; yet, not by accident, the term “Medicaid” was seldom mentioned. It is said that to this day there are state legislators who believe that Arizona does not participate in Medicaid. Over time, AHCCCS expanded coverage to quell the program’s one significant criticism that it did not include significant numbers of people in need of health care, and in 2000 Arizona voters in a referendum election agreed to extend health care to qualified adults without children. AHCCCS has become popular in Arizona.⁶

Against this backdrop, it is clear that something very similar happened in 2013 when Arizona accepted Medicaid expansion. Fiscal pressures were about to collide with ideology; Medicaid was seen as a bad word, but AHCCCS was viewed more positively and a business and health industry-led coalition made a case for the fiscal and ethical need for Medicaid expansion. No such effort was developed to promote state management of the health insurance exchange, although there was much agreement with the philosophy of state leadership and management authority. When the decision to defer the exchange to federal management was made, issues such as dispersion of power, skepticism about federal intentions, and perceived long-term state costs and obligations trumped the states' rights philosophy.

The greatest degree of goal alignment appears to be between local outreach efforts statewide, described in 1.1, and CMS. Arizona's community outreach coalition is assembled, trained, and (with the help of grants from CMS) ready to provide enrollment assistance and implement of the ACA.

Part 2 – Implementation Tasks

2.1. Exchange Priorities

As a federally facilitated exchange, Arizona has experienced many of the same information systems challenges and frustrations that are the focus of national media attention. These included delays in going live with the state's new enrollment information system, Health-e-Arizona Plus (HEAplus); developing and using new paper enrollment and screening tools; cancellation and re-scheduling of application appointments until late November; and so forth.⁷

Substantial time and effort has been devoted to reaching groups judged to be in need of counseling and navigation assistance. This has been a bottom-up effort with members of the Cover Arizona coalition forming around various "vulnerable populations" and difficult-to-serve groups such as homeless people, ex-prisoners, veterans, and so forth.⁸ There is a genuine commitment among members of the Cover Arizona coalition and CMS to the ACA's goals of affordable, accessible quality medical care.

Community participants report recent improvement in CMS outreach and support efforts, including hiring additional outreach recruiters, sponsoring community events and providing additional training. IT glitches have led to delays in enrollment through the exchange, but do not seem to have slowed down counseling, organization, and other implementation efforts. And leaders of the coalition of ACA facilitators point with pride to successful enrollment of approximately 8,000 applicants in Medicaid expansion by mid-October 2013.

Largely because of political considerations, state officials have had minimal impact in setting exchange priorities. Yet by the end of October 2013, some areas of state-federal

cooperation were apparent. To prepare for ACA implementation, representatives of the governor's office and the insurance commissioner had many meetings and other interactions with federal officials. A major topic was the Qualified Health Plans (QHP) selection process. Also, an interagency committee has been meeting every six weeks, with representatives of the AHCCCS, the insurance commissioner, the Department of Health, and the Governor's Office to share information and ensure coordination. Despite these efforts, the important federalism fact is that the actual success or failure of the Arizona exchange is, by intent, left principally to the federal government and its community partners.

2.2 Leadership – Who Governs?

As a result of Arizona's relatively late and somewhat surprising decision to defer to federal management of the exchange, and as a function of larger forces of a dynamic federalism, formal leadership of the state's exchange became the responsibility of federal officials. Brewer designated Don Hughes, her health care policy advisor, as the "primary point of contact" for HHS on exchange issues, and Tom Betlach, director of the Arizona Health Care Cost Containment System, as the "primary point of contact on eligibility determination and coordination for the Medicaid Program and the Children's Health Insurance Program."⁹ Subsequently it was also made clear that state agencies and employees were generally not to be involved in the implementation of the exchange.

The dynamics of this choice, the pressures of time, and the complexity of the ACA have empowered federal staff and leaders of the Cover Arizona coalition to work informally and collaboratively to achieve the goals of the exchange.

Federal management of the exchange is the responsibility of the Department of Health and Human Services, led by Herb Schultz, regional director of HHS Region IX. As for Cover Arizona, a steering committee of representatives from approximately twenty-five organizations throughout the state is leading efforts for the coalition. There are also regional leads for four different geographic regions of the state.¹⁰

At this time, major players in the Arizona exchange include:

Federal Officials:

- Herb K. Schultz, regional director, HHS Region IX
- Ken Shapiro, executive officer, Office of the Regional Director, HHS Region IX
- David Sayen, regional administrator, CMS
- Kaihe Akahane, CMS Regional Office
- Kimberly Will Broadie, state program director, Arizona Field Office, Corporation for National and Community Service

Major Arizona Players include:

- John McDonald, CEO, Arizona Alliance for Community Health Centers (AACHC)
- Allen Gjersvig, director of Healthcare Innovation, Arizona Alliance for Community Health Centers
- Tara McCollum Plese, senior director for external affairs, AACHC
- Kim VanPelt, director, Arizona Health Futures, St. Luke's Health Initiatives (SLHI)
- Don Hughes, governor's health care policy advisor
- Tom Betlach, director, AHCCCS
- Germaine Marks, director of insurance

2.3. Staffing

Much of the federal management to date has involved training, some financial and programmatic assistance, and updated explanations of rules and procedures for outreach and navigator functions. This effort is led by a cadre of federal staff, including those officials listed above. Naturally, the IT work so essential to development of the exchange is the focus of intense federal effort, although state agencies, particularly AHCCCS, the state Department of Economic Security, and the state Department of Health Services have been heavily involved in developing a new integrated information system, Health-e-Arizona Plus, to replace the state's old legacy system, Arizona Training & Evaluation Center (AZTEC). The new system is designed to connect to the federal marketplace and upgrade application and enrollment for Medicaid and related services.¹¹

The actual delivery of outreach and enrollment services is highly decentralized, but linked by the steering committee of the Cover Arizona coalition. The advantage of this model is that grassroots organizations throughout the state are engaged in the effort to assist and recruit uninsured people into either the expanded Medicaid system of the AHCCCS or the exchange.¹² But there are disadvantages to the decentralized approach. Some fragmentation of central authority may lead to mixed signals to potential clients. Case workers from the state's social service agency, the Department of Economic Security (DES), may be less than fully informed about the operational requirements of the ACA. Most navigators and other certified "assisters" are generally not public employees or insurance representatives. They often have had only twenty hours of online training, coupled with high expectations about enrollment. One close observer of the ACA implementation felt that the Cover Arizona deserved kudos for developing this dynamic squad of hopeful, experienced, and interested participants. But he worried: "Will their expectations be met? He then asked, "How will that work?"

2.4. Outreach and Consumer Education

Outreach is seen as one of the main parts of the Cover Arizona coalition's broad strategy to:

- Maximize enrollment of individuals and families in the new insurance marketplace and Medicaid.
- Identify and assess outreach efforts to build on coalition successes

As noted above, St. Luke's Health Initiatives, a public foundation focused on Arizona health policy, community development, and capacity building, has joined with the AACHC to convene and coordinate outreach, education, and navigation efforts of the Cover Arizona coalition. SLHI and its director of the Arizona Futures program, Kim VanPelt, have led development of the coalition's Web site, www.coveraz.org, a coordinating and information resource for coalition members and the state's best educational tool for potential participants and observers of the ACA in Arizona. Many of the nonprofits and community health centers that are part of Cover Arizona have developed strong bonds and a high level of trust as a result of their work over the years on health issues such as earlier Medicaid expansion and KidsCare.¹³ Staff of these organizations are both receiving from CMS, and providing to other community organizations, training for outreach, enrollment, and navigation.

SLHI staff has devoted substantial time and effort to critical coordination functions, supported by a \$1 million annual budget contributed by the foundation. While this is a significant sum, organizers point out that it pales in contrast to multimillion dollar investments in outreach by other states.

Operationally, Cover Arizona activities are directed at four main strategic targets:

- Community awareness/media
 - a. Nationally funded media efforts
 - b. Local events, presentations, and media efforts
- Outreach
 - a. Demographic-based efforts
 - b. Geographic-based efforts
 - c. Targeted grassroots-like efforts
- Enrollment assistance
 - a. Training
 1. Navigators
 2. Certified enrollment assistance
- Evaluation

The Cover Arizona coalition has organized outreach and assistance efforts based on constituencies, organization types, and geography. Coalition subgroups, in partnership with community health centers, hospitals, clinics, and various other community-based organizations, are developing and conducting training for

outreach and educational activities aimed at the following categories:

By demographics, organization type, or issue¹⁴

- Low income families with kids under nineteen
- Young adults, eighteen to thirty-four
- Diversity
- Older adults, fifty to sixty-four
- People with chronic health conditions
- Community health centers
- Hospitals
- Incarcerated, re-entry population
- Homeless providers, consumers
- Behavioral health providers, consumers

By geographic area

- Central Arizona
- Western Arizona
- Southern Arizona
- Northern Arizona

In addition to outreach and education provided by Cover Arizona, CMS has contracted with national organizations to conduct events, outreach, and enrollment assistance in Arizona. These organizations include Cognosante, SRA, and Weber Shandwick. The coalition is just beginning to work with each of these groups.

In September, the national nonprofit Enroll America began a yearlong campaign to sign up eligible Arizona residents in Medicaid or health insurance through the exchange. Enroll America is collaborating with local health care and social service agencies, including many members of Cover Arizona, to locate uninsured people using mapping technology and political campaign-style organization. Trained volunteers are being deployed to answer questions and get eligible individuals signed up.

Enroll America's reasons for targeting Arizona reflect the state's outreach challenges and strengths. On the challenge side, the state has a relatively large number of uninsured residents (approximately one million out of a total population of approximately 6.5 million), no state based health exchange, and no state-supported outreach efforts. Despite this, there is grassroots outreach capacity. In choosing to work in Arizona, Enroll America acknowledged that the state has a "... network of community groups that have cooperated in the past on health-related issues, including outreach for the KidsCare health-insurance program."¹⁵

2.5. Navigational Assistance

As described above, outreach, education, and navigation are closely linked in Arizona. Many members of the Cover Arizona

coalition view these activities as interrelated and are engaged in each activity. Community organizations throughout the state have expanded to learn about and engage in navigation for the ACA, particularly for the special groups and geographic regions they serve.

Major Navigator Grants for Arizona:

Arizona Association of Community Health Centers

Service area: Statewide

Anticipated grant amount: \$1,344,096

The Arizona Association of Community Health Centers has served as Arizona's primary care association since 1985 and continuously strives to fulfill its mission of promoting the development and delivery of affordable and accessible health care. The Arizona Association of Community Health Centers navigators will coordinate outreach opportunities throughout Arizona.

Sub-Grantees/Partner Organizations:

- Arizona Association of Community Health Centers
- Kids Health Link
- Nuestra Salud
- Pima Community Access Program (PCAP)
- Pima County Health Department
- St. Elizabeth of Hungary Clinic
- United Way of Tucson & Southern Arizona¹⁶

In addition, the AACHC and many members of Cover Arizona receive other federal funds that have, to some degree, been allocated to outreach and navigation. The Health Resources and Services Administration (HRSA) has made important contributions to AACHC and some of its allied community health centers.

Arizona Board of Regents, University of Arizona

Anticipated grant amount: \$190,268

Service area: Pima County

The Center for Rural Health at the University of Arizona aims to reduce the numbers of Asian American and Pacific Islander uninsured in Pima County, and implement a comprehensive outreach strategy. They intend to use the Southern Arizona Asian & Islander Health Coalition to reach out to these populations and inform them of new coverage options.¹⁷

Greater Phoenix Urban League, Inc.

Anticipated grant amount: \$523,773

Service area: regional navigator entities statewide

The Greater Phoenix Urban League aims to equip disadvantaged people with tools to achieve economic and social equality, including through improving their health and well-being. Greater Phoenix Urban League's navigators will provide a comprehensive,

statewide public awareness campaign aimed at identifying and assisting uninsured individuals across Arizona to access and navigate the health exchange marketplace.¹⁸

- Sub-Grantees/Partner Organizations:
- Greater Phoenix Urban League (lead applicant)
- Arizona Family Health Partnership (AFHP)
- Empact-La Frontera (ELF)
- Coconino County Health Department (CCHD)
- Tucson Urban League (TYL)
- Women's Health Coalition of AZ (WHC)

Campesinos Sin Fronteras, Inc.

Service Area: Yuma County

Grant Amount: \$71,386

Campesinos Sin Fronteras provides services to farm workers and low-income Hispanics, while serving the general population as well. The Campesinos navigator program will provide enrollment assistance to uninsured individuals in Yuma County.¹⁹

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. As described earlier in this report, state agencies were directed to be passive in implementing the ACA following the decision to adopt a federal marketplace. However, some coordination of major agencies has been necessary and carried out in the form of meetings among representatives of the AHCCCS, the Insurance Department, the Department of Health, the Department of Economic Security, and the Governor's Office. Major topics requiring interagency coordination included:

- Development and implementation of the new Health-e-Arizona Plus integrated information system to link data and interactions among consumers/assistors and state agencies of DES, DHS, and AHCCCS.
- QHP certification process
- Eligibility determination

The state's interagency committee has shared information and raised issues of general concern to develop effective management tools for use in Arizona's Medicaid efforts, related social and health care services, and the federal marketplace. Staff from each state agency mentioned has had to work more closely, particularly on data and IT issues, in part because of requirements of the ACA.

2.6(b) Intergovernmental Relations. Relations between the federally managed Arizona exchange and other governmental entities vary greatly. There are relatively weak ties between state agencies and the exchange, not surprising given Brewer's directive described above. We are aware of significant working relationships to solve problems, particularly those of IT, and eligibility. Finally, the exchange and the community outreach

coalition, which includes local public and nonprofit organizations, are focused on the same outcomes and are, at this very preliminary point, working well together on the development and deployment of training, outreach, and navigation around the state.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). The following insurance companies are participating in the exchange in Arizona. Each has been certified by appropriate federal (Medicare’s Center for Consumer Information and Insurance Oversight) and Arizona (Department of Insurance) officials and each has multiple QHPs in counties throughout the state.

- Aetna (www.aetna.com)
- Blue Cross Blue Shield of Arizona, Inc. (www.azblue.com) – AACHC
- Cigna Health and Life Insurance Company (www.cigna.com)
- Health Choice Insurance Co. (www.healthchoiceaz.com) – Adelante
- Health Net of Arizona (www.healthnet.com) – AACHC
- Health Net Life Insurance Company (<https://www.healthnet.com>)
- Humana Health Plan, Inc. (www.humana.com) – AACHC
- Meritus Health Partners (www.meritusaz.com) – Adelante
- Meritus Mutual Health Partners
- University of Arizona Health Plans (www.uamarketplace.com) – University Healthcare Marketplace

The list of QHPs by county with cost comparisons is available at <https://www.healthcare.gov/health-plan-information/>.²⁰

Arizona has an estimated 107 QHP plans covering the state. One study found that Arizona and Florida stand out as “hotbeds of competition”²¹ with several counties boasting 80 to 170 plans. This is attributed, in part, to the fact that several insurers have been selling Medicare Advantage plans in Arizona and Florida, making those states logical places for aggressive sales on exchanges. The sheer number of plans available in Arizona, combined with apparent diversity of types of plans, rates, and predicted demand from uninsured people, suggests a robust, competitive QHP environment for most Arizona residents. Just how well the competition will play out is an important question for our next report in the spring of 2014.

2.7(c) Program Articulation. There is a reasonable degree of confidence that future IT systems will be made reliable and that navigators, assistors, counselors, etc., will increasingly be able to assure that clients enroll in appropriate programs. There seems to be less certainty about the ability to make speedy adjustments

based on changes in eligibility. Two types of “churn” trouble state Medicaid and exchange officials:

1. Within Medicaid: Before the ACA, there was a six month gap to reapply if client became ineligible, then eligible. The ACA streamlines redetermination so that those who become eligible don't have to go through the full reapplication and wait period.
2. From Medicaid to exchange and vice versa: A few plans will target churn and improve care coordination for those who move back and forth. Some state officials believe this will be more difficult because of federal administration of the exchange than if the state were running the exchange.

2.7(e) Government and Markets. We haven't seen any evidence of institutional/ regulatory change but will monitor legislation and regulation with this possibility in mind.

2.8. Data Systems and Reporting

In late 2010, Arizona began work on its new integrated information system (HEAplus) for use in implementing the ACA.²² Most of the two exchange planning grants from CMS described earlier, totaling almost \$30 million, were invested in IT systems and development to manage the complex needs of the ACA. Originally, the Governor's Office spearheaded this effort, but refinement and completion of the new system migrated to the AHCCCS after the decision to defer to federal management of the exchange.

Importantly, IT has been a major focal point of sustained interaction over critical implementation issues such as eligibility, churn, access to a range of plans, and so forth among the Governor's Office, AHCCCS, the Department of Economic Security, Department of Health, and the Cover Arizona coalition. In this sense, IT issues are not just a barrier to implementation, but may eventually be catalysts generating communication and collaboration, leading to greater coordination and innovation. This hypothesis will be tested in future rounds of our research.

HEAplus did experience some technical difficulties in early October, which did not surprise system developers. There was unanimous agreement that coordination with all agencies, state and federal, was complicated, the time frame for implementation unrealistic, and testing of full capacity not possible prior to October 1. HEAplus did not go live until October 19 after necessary testing and repair. Current operations appear to be relatively smooth within AHCCCS, but problems remain with system interface with www.HealthCare.gov. Presently AHCCCS does not have any Medicaid applications that started from www.HealthCare.gov. As a result, no one has been made AHCCCS-eligible if they applied on the federally facilitated exchange, and CMS is not able to transfer applications that screen eligible. Well into December 2013, federal

officials did not have a date when they expected this capability to be functioning. So if the marketplace screens an applicant as AHCCCS eligible, the applicant must apply for AHCCCS directly. This can be done on HEAplus, but is a second step. Sometime in the future, the marketplace will automatically transfer Medicaid applications to AHCCCS. But for now, that can't be done.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

The SHOP in Arizona is a part of the federally facilitated exchange. Special advice and information for small businesses and potential SHOP enrollees is available on www.HealthCare.gov and <http://coveraz.org>. Both sites have 1-800 phone numbers and will accept paper as well as electronic applications.

Part 4 – Summary Analysis

4.1 Policy Implications

“You know what’s relatively easy? Fixing a website. You know what’s really hard? Ensuring access to affordable, quality health care for every single American and improving our broken health system in the process.”²³
– Columnist Sally Kohn

A complex mix of management and policy is required to make the ACA work. This will take time. The brief first chapter of the ACA implementation story in Arizona compels us to continue our focus on federalism as it actually operates and to look beyond rhetoric. To recap, here is what we know and are beginning to learn more about, after just one month of formal implementation:

- Governor Jan Brewer suffered significant losses serving as a national leader of opposition to the ACA. The Supreme Court decision and presidential election of 2012 effectively sank this opposition.
- The governor was viewed by some as a winner, some as a loser because of her decision to expand Medicaid, a move favored by a powerful coalition of state private and public sector leaders, mainly for general economic recovery and state budget reasons. But the decision did not play well with members of the governor’s strong conservative base. They saw it, and to a lesser degree her choice of a federally facilitated exchange, as betraying the states’ rights, antifederal government rhetoric that she had used in past policy debates. Some credit the governor with helping develop the lobbying coalition that helped her influence reluctant legislators of the wisdom of Medicaid expansion.
- The Arizona Health Care Cost Containment System was a clear winner. As a cabinet-level agency that runs the state’s Medicaid program, AHCCCS was a strong and respected

proponent of Medicaid expansion. AHCCCS estimates 300,000 people will be added to Medicaid and \$2.5 billion restored to the state budget. Many of these people were previous Medicaid recipients whose incomes had moved above 100 percent of the federal poverty level and will now be covered under the expanded 133 percent level.

- So far, the Cover Arizona coalition and its members are winners. With little external funding and only very recent experience working on this policy issue, Cover Arizona is making impacts around the state and with many different population groups. Day-to-day implementation of the ACA in Arizona, given the state government's leadership reticence, would be hard to imagine without Cover Arizona and its rapidly expanding membership.
- Conservative moderates and liberals, including those powerful interests who lobbied for expanding Medicaid, are winners. The tea party and its oppositional counterparts, the state's small left wing, are the losers. Arizona has been characterized as heartless for stances on other social policies, and many thoughtful state leaders believed that view would be magnified if the state rejected Medicaid expansion while cutting other basic state services. The business/medical lobby saw that as bad for the economy and for business; the more socially conscious lobby apparent in the membership of Cover Arizona saw it as bad for human development. The ACA led to state government implementation decisions that gave these often diverse interests the opportunity to collaborate as winners in this early process.

4.2. Possible Management Changes and Their Policy Consequences

At the end of each interview for this project, we asked: "When it comes to ACA implementation in this state, what keeps you awake at night?" Some of their answers highlighted important management issues and possible responses for the future, including:

- *Reduce intergovernmental tension* associated with federally facilitated exchange status, IT problems, slow responses for clarifications and interpretations of rules, and general state-federal relationships. Some of this friction may diminish with time. Yet by deferring exchange management to the feds, the state also shed some measure of responsibility and authority, which will no doubt persist as a point of conflict in Arizona unless another exchange is proposed by the state (unlikely in present political setting).
- *Improve coordination, training, and resources for state employees:* They will need to be more involved in ACA implementation. Despite the enthusiasm and promise of the Cover Arizona coalition, employees of state agencies

other than AHCCCS work daily with potential ACA clients and should receive training and information necessary to provide this critically important health care resource to clients.

- *Improve understanding of fiscal consequences of the ACA:* What will this long-term effort cost the state? How will health providers adapt to ACA changes? Who will provide and pay for training?
- *Consider public funds for outreach, awareness, and organization:* States running exchanges are spending much more for these activities than federally facilitated exchange (FFE) states. California, for example, is spending \$25 million on these functions, whereas Arizona has no money allocated for printing outreach material. SLHI has spent about \$1 million for enrollment assistance effort and is devoting substantial professional time to convening and training functions of Cover Arizona
- *Manage expectations:* There are roughly one million people who may qualify for insurance, yet technical IT problems, overloaded navigators and assisters, etc., may dampen enthusiasm, particularly among uninsured “young invincibles,” whose enrollment is needed to make the insurance system cost effective. Providers and the public need to receive frequent, clear, and objective messages about operations, changes, and performance of ACA systems to stay interested and enroll.
- *Implement the promised “one stop” shop:* “Just do it!” is the admonition of one principal player in the Arizona ACA process. He looks to ACA implementation and optimistically points out that Arizona has made it through the great debate (over the ACA) and the Great Recession. He sees the future as one of restoration and expansion, the key being implementation, which requires sustained leadership and grassroots effort.
- *Seize the opportunity – American Indians, affordable care, and culture change:* There are twenty-two Indian tribes in Arizona and 50 percent are enrolled in AHCCCS Medicaid. Commercial coverage is a big culture shift for American Indians. Under the ACA, many low-wage uninsured Indians would qualify for exchange subsidies and be introduced to commercial insurance. Many Navajos occupy reservation land in the adjacent states of Arizona, New Mexico, Utah, and Colorado (the Four Corners area). The Medicaid directors of each state have met and see this as a real opportunity to develop health insurance for the large group not covered by AHCCCS. This will take some time, however, as general skepticism about federal inventions remain among many American Indians.

The genius of American federalism is that it promotes experimentation and innovation in different applications of public policy to meet unique governance requirements of states and localities. Arizona has a history of adapting to major challenges with action that is home grown, but greatly stimulated by federal resources and incentives. As is often the case, Arizona leaders and residents bristled at some of the national government “mandates” revealed in the ACA, yet saw opportunity in working toward goals of the law. It is increasingly well known that almost one million uninsured Arizona residents will benefit from full implementation of the ACA. There are challenges to be sure, yet the present situation seems conducive to further ACA development because:

- *The Market:* Arizona has a greater number of qualified insurance plans to choose from than most states, stimulating greater competition and lower rates. Initial indicators such as appointments with counselors, Web site visits, etc., suggest strong interest that can be converted to demand.
- *Medicaid Expansion:* AHCCCS has a national reputation for innovative Medicaid implementation and is focused on the expansion goal. Support for expansion is spread among many state interests, public and private.
- *Grassroots Implementation Capacity:* The Cover Arizona coalition is a large, growing, and dynamic network with community ties throughout the state. Outreach, education, and navigation aspects of the health insurance marketplace have had a head start in response to the decision to avoid state management of the exchange.
- *Increased Collaboration Between CMS and Cover Arizona:* Federal and community partners know each other from past interactions involving community health centers and other health policy issues. Both networks appear eager to work together on agreed-upon goals of the ACA.
- *Arizona’s Governance DNA, the Context for Implementation:* This includes a populist tradition leery of national government policies; skeptical of representative democracy in general; favoring direct community involvement and action whenever possible; believing that public problems should be addressed, not avoided at their geopolitical roots; and a strong emphasis on fiscal prudence.

One month provides only very early clues, and there remains significant dissonance concerning the ACA in Arizona. Yet this is the initial framework for implementation. This is operational federalism more than rhetorical federalism, although the two are always inextricably mixed. These indicators suggest that much is in motion that will have significant consequences for the implementation of this act in Arizona.

Endnotes

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- 3 Kyle Cheney, Medicaid Expansion Challenge Alive in Arizona in "Insurance commissioners fear Jan. 1 health coverage losses - HHS responds to navigator charges - Obama convening tech execs," *Politico Pulse*, *Politico.com*, December 17, 2013, <http://www.politico.com/politicopulse/1213/politicopulse12512.html>.
- 4 For the current list and location of community organizations, see the map at <http://coveraz.org/navigators-and-assisters-map/>.
- 5 John Stuart Hall and Melinda Snook Hollinshead, *Connecting Public Policy and Management: The Arizona Health Care Cost Containment System Experiment* (Albany, NY: Nelson A. Rockefeller Institute of Government, 2000, http://www.rockinst.org/pdf/health_care/2000-connecting_public_policy_and_management_the_arizona_health_care_cost_containment_system_experiment.pdf.
- 6 Cannon & Gills, Inc., for St. Luke's Health Initiatives, *Step by Step: Proposition 204 - Healthy Arizona II, What it is, how it works, and what it means for the future of health care in Arizona* (Phoenix, AZ: St. Luke's Health Initiatives, 2001), http://slhi.org/pdfs/studies_research/Step_By_Step.pdf
- 7 See www.coveraz.org.
- 8 See www.coveraz.org/outreach/.
- 9 Letter from Janice K. Brewer, governor of Arizona, to Gary Cohen, director of Office of Consumer Information and Insurance Oversight, November 28, 2012.
- 10 For list of over 600 health-care organizations, advocacy groups, and social service providers belonging to the coalition, as well as subgroups and geographic regions, see www.CoverAz.org.
- 11 See <https://www.healtharizonaplus.gov/>.
- 12 See the state map of organizations involved at www.coveraz.org.
- 13 Arizona has an estimated 107 QHP plans covering the state. One study found that Arizona and Florida stand out as "hotbeds of competition."
- 14 For more detail on these groups and leaders, see "How to Connect with Marketplace and Medicaid Outreach Activities in Arizona," <http://coveraz.org/how-to-connect-to-arizona-outreach-activities/>.
- 15 Mary K. Reinhart, "Health care reform ramps up in Arizona," *Arizona Republic*, September 5, 2013, accessed September 8, 2013, <http://www.azcentral.com/news/politics/articles/20130905arizona-health-reform-ramping-up.html>.
- 16 See <http://www.providencehospital.org>.
- 17 See <https://localhelp.healthcare.gov>.
- 18 See <http://www.gphxul.org>.
- 19 See <http://www.campesinossinfronteras.org>.
- 20 For additional details about each provider and each plan by county, see <http://coveraz.org/health-plan-information/>.
- 21 Jayne O'Donnell and Paul Overberg, "For some areas, insurance plan choices are paltry," *USA Today*, November 13, 2013, <http://www.usatoday.com/story/news/nation/2013/11/12/healthcaregov-few-plans-some-counties-com-petition-lacking/3499869/>.
- 22 See <https://www.healtharizonaplus.gov/>.
- 23 Sally Kohn, "Patience, Obamacare will work," *CNN Opinion*, October 25, 2013, <http://www.cnn.com/2013/10/24/opinion/kohn-obamacare-exchanges/>.