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Chapter 2: Using Federal Reform to Accomplish State Goals

For states, 2010 was defined in many ways by the Patient Protection and Affordable Care Act (Affordable Care Act or ACA): debating its merits, watching its final passage, and then trying to absorb its many provisions. In some states, the legislation was met with cheers, as it was well-aligned with efforts already underway. For officials in other states, it looked like a federal imposition of a new set of priorities that may not have been similarly high on the state's agenda.

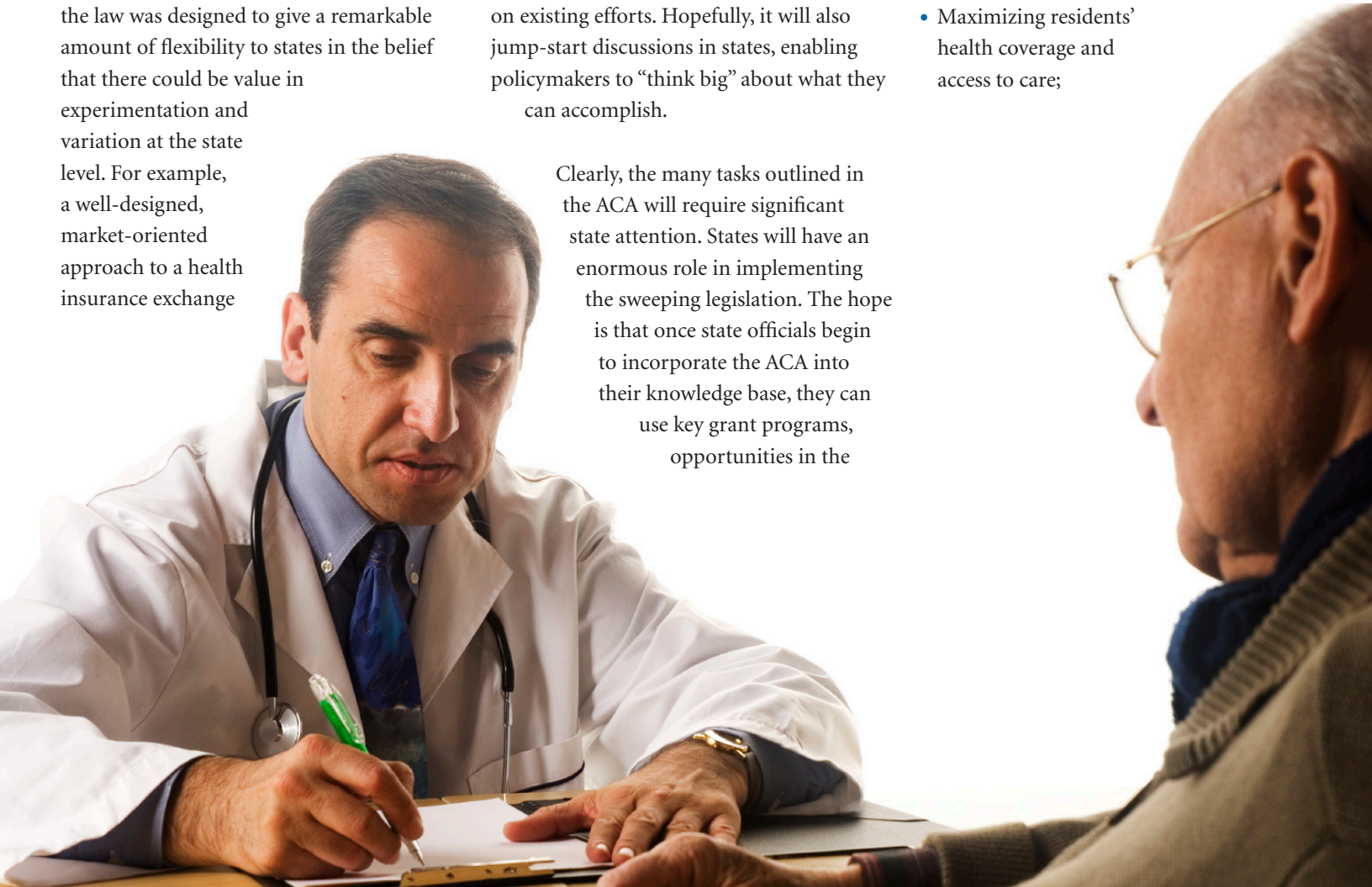
The challenge for states is to understand not only what is included in the federal law, but also how policymakers can use aspects of the law to accomplish their goals. Indeed, the law was designed to give a remarkable amount of flexibility to states in the belief that there could be value in experimentation and variation at the state level. For example, a well-designed, market-oriented approach to a health insurance exchange could teach us much about the merits of that approach, just as a well-executed regulatory approach could do the same. Community-based efforts to redesign the delivery and payment systems to provide better care and improve health will be the engine of reform across the country as successful strategies are incorporated across the system.

The key is for states to be active and engaged. Federal reform should not derail states from previous goals related to market reform, coverage expansion, or delivery system changes. In fact, the law can be a tool to help achieve those goals. It provides additional resources for states to build on existing efforts. Hopefully, it will also jump-start discussions in states, enabling policymakers to "think big" about what they can accomplish.

Clearly, the many tasks outlined in the ACA will require significant state attention. States will have an enormous role in implementing the sweeping legislation. The hope is that once state officials begin to incorporate the ACA into their knowledge base, they can use key grant programs, opportunities in the law, and the new power they have been given to improve the health care system in ways that fit the economic, social, and political climates of their states.

In order to help state officials accomplish their goals, State Coverage Initiatives (SCI) worked with Stan Dorn of the Urban Institute to develop a report titled: *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*.[1] It was designed to help state officials understand how the federal law applies to them and how they can use it to accomplish the following goals:

- Maximizing residents' health coverage and access to care;



- Helping health care and coverage function more like a traditional, consumer-driven market;
- Holding insurers accountable for providing high-quality coverage at a reasonable cost to the consumer;
- Reforming the health care delivery system to slow cost growth while improving quality; and
- Limiting state general fund spending on health care.

STRATEGIES TO MAXIMIZE RESIDENTS' HEALTH COVERAGE AND ACCESS TO CARE

States can use three mechanisms to increase access to care, depending on income level:

- Help eligible individuals enroll in and retain subsidized health coverage;
- Improve affordability and continuity of coverage for low-income adults who are ineligible for Medicaid; and
- Increase access to care within Medicaid.

Help eligible individuals enroll in and retain subsidized health coverage

Several state strategies will be important to maximizing eligible residents' enrollment and retention in both the Medicaid program and the subsidized plans that may be part of an exchange. Among them are: 1) public education and facilitated enrollment; 2) streamlining application forms and procedures for Medicaid, the Children's Health Insurance Program (CHIP), and subsidies for private coverage purchased in the health insurance exchange; 3) streamlining the eligibility determination and enrollment process; and 4) creating an efficient eligibility determination infrastructure.

Improving affordability and continuity of coverage for low-income adults who are ineligible for Medicaid

Coverage may still be out of reach for certain low-income people, even after the new system of subsidies in the exchange is fully implemented. Not only may the subsidies be too low to make coverage fully affordable, but low-income people can end up shifting between Medicaid and the exchange as their income fluctuates.

To make coverage more affordable for residents with incomes too high for Medicaid, states have two options: 1) to implement the Basic Health (BH) program option outlined in the ACA; or 2) to supplement federal subsidies in the exchange. BH would be available for citizens and legally resident immigrants with incomes at or below 200 percent of the federal poverty level (FPL) who are ineligible for Medicaid and CHIP. Since per capita federal payments through this option will equal or exceed the average cost of Medicaid coverage for adults, beneficiaries could receive Medicaid- or CHIP-style coverage, with very low premiums and out-of-pocket costs. However, because Medicaid and CHIP provider payment rates are lower than those of private plans in many states, beneficiaries might not have access to the broader provider networks that are likely to be in the exchange. States could lessen this problem by using any excess of federal BH payments over current Medicaid or CHIP premiums to raise rates.

Alternatively, states could supplement federal subsidies in the exchange. This option would offer access to the provider networks in the exchange, but unlike with the BH option, state general fund dollars would be needed.

To help people whose incomes fluctuate and are being shifted between Medicaid and subsidized coverage in the exchange, states can learn from the Massachusetts experience and encourage Medicaid plans to participate in the exchange (or BH, if the state implements this option). In this way, as household income rises or falls, a family could stay in the same plan and continue to see the same doctors, even as the applicable premium payments and out-of-pocket cost-sharing rules change. The BH option would also help with continuity of coverage and care as incomes fluctuate below 200 percent FPL.

Increasing access to care within Medicaid

The ACA increases funding for Medicaid to raise payment rates to Medicare levels for primary care providers furnishing "evaluation and management" services in calendar years 2013 and 2014. To further increase low-income consumers' access to care, the law increases funding for community health centers, school-based health centers, and other infrastructure that can potentially serve Medicaid beneficiaries. Other options to help encourage provider participation (other than increasing Medicaid rates) include expediting Medicaid claims payment, increasing the use of tele-medicine to serve rural Medicaid beneficiaries, and changing state licensure laws to increase the range of services that non-physicians (and non-dentists) are allowed to provide within the Medicaid program (and potentially outside it as well, depending on state politics surrounding this issue).

HELPING HEALTH CARE AND COVERAGE FUNCTION MORE LIKE A TRADITIONAL, HEALTHY MARKET

One of the most important aspects of a healthy market is for consumers to understand their options so they can make informed decisions. Currently, consumers do not have access to a wide range of both price and quality information about providers and insurance plans, making it difficult for them to choose plans that meet their needs. To address these problems, the ACA provides new tools that state officials can use to move the health care system toward a more competitive market-based system.

To that end, state policymakers can focus on:

- Price transparency for both providers and plans;
- Quality information for both providers and plans; and
- Implementing health insurance exchanges in a manner that increases the role played by consumer choice.

Price transparency is an important first step in helping consumers make informed decisions. The exchange will offer—in many cases, for the first time—an ability for consumers to compare premium prices on products with similar actuarial values. Exchanges can also offer additional information about plan quality, along with price and quality information about providers.

Since Medicare already collects performance data on hospitals and to some extent on physicians,[2] and the ACA further strengthens the current system for evaluating quality and efficiency for these providers, states can work with the Department of Health and Human Services (HHS) to make quality reporting easily accessible to consumers. In addition, states can build an all-payer claims database (APCD) that gives consumers access to information about real prices paid to providers. The federal law opens the door for Medicare participation in state-based APCDs, and some states are already receiving those data. Since performance data need to be risk-adjusted to provide an accurate picture, rather than reinventing the wheel, states can apply methodologies that HHS is developing for Medicare to address this issue.

To present the information in a user-friendly manner, states may:

- Make all price and performance information available in a single place, such as a consumer health information website, perhaps as a part of the exchange web portal.
- Present basic information; additional information can be made available for those who want to dig deeper.
- Organize the information to show risk-adjusted costs and outcomes for provider teams' treatment of particular conditions, throughout the full cycle of care.
- Consider—if all qualified plans are allowed to offer coverage—(a) designating which plans are recommended by the exchange, so that consumers are not overwhelmed by available choices or (b) providing consumers with decision tools to help narrow options to those that best fit the particular consumer's needs.
- Provide other useful information about insurance options in the exchange, such as whether particular drugs are included in health plan formularies.

To increase competition in the market, states can employ the following strategies:

- Encourage insurers to offer a broad variety of plans in the exchange, at each available actuarial value.
- Encourage one or more insurers to offer plans with limited provider networks that allow lower premiums.
- Consider the creation of new carriers, such as a member-owned co-op or a state-administered plan that can operate in the exchange. The goal is to increase competition among carriers, especially in states where a small number of insurers dominate the market.
- Let brokers and agents sell exchange plans, and give medium-sized firms—those with 100 or fewer workers—access to the exchange to increase the number of residents using the exchange. Brokers would receive the same fee regardless of the health plan in which a consumer enrolls.
- Collaborate with employers to design an exchange that works well for them.

HOLDING INSURERS ACCOUNTABLE TO CONSUMERS

The ACA establishes a multitude of reforms for health insurance markets and provides states with tools they can employ to increase insurers' accountability to consumers. The strongest measures go into effect on January 1, 2014.

One of the most important tools in ensuring compliance with legal requirements is having access to data that can potentially flag violations. Until now, insurance commissioners have had limited access to such data. The ACA changed this by requiring insurers to provide substantial new amounts of data on such topics as claims payment and denial, enrollment, disenrollment, and provider participation. This information can help spot possible legal violations, such as failure to provide services included in the minimum benefits package, that could be detected if a plan has unusually high denial rates for certain claims. Along similar lines, a very low volume of paid claims in a particular geographic area and specialty could indicate a gap in a plan's provider network.

A state can take additional steps and require other data elements that could be useful to determine plan performance. For example, a state could require detailed information about the number and nature of complaints and appeals filed by consumers (if such information is not required by HHS). To provide an incentive to insurers to comply with the additional data requests, a state can make licensure or access to the exchange contingent upon compliance with the data request. Making insurer performance data publicly available and searchable would let journalists, purchasers, and nongovernmental organizations supplement the efforts of state regulators and identify potential problems.

State officials can authorize state agencies to bring claims under the False Claims Act and educate the public and insurers about the potential application of the Act to insurers that knowingly offer unqualified plans in the exchange. False Claims Act recoveries may be enormous, as they will be based on the volume of federal subsidies wrongfully received by an insurer. In addition, states can tap into the $30 million the ACA appropriates for the establishment of a consumer assistance program and partner with community-based legal services offices that already furnish similar services. These actions can increase consumer protection and further deter insurers from violating legal requirements, including those that apply to the exchange.

States can use several mechanisms to supplement current enforcement dollars. For example, a state insurance department can contract with the exchange to certify plans as qualified. Funds for the administrative activities for the exchanges do not require state general fund appropriations. Until 2015, they can come from federal grants. After that, exchanges must be self-supporting. (The Massachusetts exchange, for example, surcharges insurance premiums in the exchange, which allows federal subsidies to pay most administrative costs.)

Other funding mechanisms for insurance enforcement include using federal grants to build capacity for rate review, working with health consumer assistance programs, and using "whistleblower" awards obtained from pursuing False Claim Act claims.

Finally, states can increase insurers' accountability to consumers by introducing new competitors into the health insurance market. To recruit providers without paying exorbitant reimbursement rates, such an insurer would need a large number of enrollees. A publicly-administered health plan, such as SustiNet in Connecticut, could achieve a critical mass of enrollees by enrolling, at plan start-up, Medicaid and CHIP beneficiaries as well as public employees and retirees. An added benefit is that, with such a large number of enrollees, such a plan has the potential to galvanize a change in the state's health delivery system, to help implement the reforms described next.

REFORMING THE HEALTH CARE DELIVERY SYSTEM TO SLOW COST GROWTH WHILE IMPROVING QUALITY

The ACA includes a number of provisions aimed at reforming the health care delivery system to slow cost growth and improve quality. Those provisions offer a range of options for states to consider in restructuring care delivery and reimbursement. For example, states can:

- Implement Medicaid demonstration projects to test new reimbursement methods that reward value, rather than volume;
- Use new Medicare methods to base payment on provider performance for public employee coverage;
- Incorporate Medicare, Medicaid, and private coverage into multi-payer initiatives that implement reimbursement and delivery system reforms;
- Help high-cost, chronically-ill patients in Medicaid, public employees, and the privately insured participate in the "patient-centered medical home" model of coordinated care;
- Implement initiatives to prevent costly rehospitalization, improving health status and saving money for public and private payers alike;
- Use the results of comparative effectiveness research to encourage public employees to avoid costly procedures and treatments that do not contribute to patient health, while permitting private employers to give their covered employees similar incentives; and
- Apply for federal grants and participate in demonstration projects to combat obesity, smoking, and other risk factors among Medicaid beneficiaries, in low-income communities, and with other residents.

Implement Medicaid demonstration projects to test new reimbursement methods that reward value, rather than volume

The fee-for service payment system provides incentives for providers to increase the volume of services and perform high-cost procedures, rather than incenting the provision of high-quality care in an efficient manner that focuses on improving consumer health. Over the years, concerns about the pitfalls of the fee-for-service payment system have led policymakers to consider a variety of options including:

1) *Bundled Payment.* This is a payment methodology through which all hospitals, doctors, and post-acute care providers participating in an episode of care join together to receive a single payment for that episode, from three days before hospitalization through 30 days after discharge, for example.

2) *Accountable care organizations (ACOs).* ACOs allow teams of physicians (and potentially other providers, including hospitals) to share in the cost savings that result when these providers' patients incur fewer health care costs than is typical for similar patients while meeting certain quality standards. The analysis of cost savings takes into account all services, not just those furnished by the ACO.

3) *Global Payments.* Large safety-net hospitals or networks could be paid on a global or capitated basis rather than fee-for-service.

The first two models also offer the hope that, if implemented, they would achieve both cost savings as well as better care in the form of increased care coordination across all treatment settings. The ACA includes opportunities for Medicaid to test some of these innovative payment methodologies.[3]

Use new Medicare methods to base payment on provider performance for public employee coverage

The ACA includes a number of mechanisms aimed at reforming the Medicare reimbursement system. Some, such as pay-for-performance mechanisms, focus strictly on either hospitals or physicians. However, other provisions included in the ACA try to increase

coordination across all treatment settings—for example, through bundled payment or ACOs.

The health reform law also includes provisions that encourage Medicare beneficiaries to take a more active role with regard to the care they receive. Beneficiaries who select high-value providers would either experience lower costs or receive additional benefits.

States may want to apply some of these reforms to public employee coverage. However, state officials would need to monitor the implementation of these reforms, as they could lead to unintended consequences. While a pay-for-performance system could lead to better and more efficient care, there is some concern that it could worsen racial and ethnic disparities and change providers' behavior so that they focus primarily on the measures used to determine payment levels. States would also need to ensure that the ACO-provider groups would develop in a manner that increases care coordination without creating entities whose leverage in contract negotiations would extract excessive payment levels from private insurers.

Incorporate Medicare, Medicaid, and private coverage into multi-payer initiatives

Multi-payer initiatives could help ease providers' administrative burden resulting from getting different or contradictory messages about expectations related to quality, cost, and care coordination. Such initiatives could include Medicare, either by applying Medicare reimbursement reforms to other payers or by applying state payment innovations to Medicare. To take the latter approach, states would need to propose a demonstration project to the Center for Medicare and Medicaid Innovation (CMMI).[4]

Help high-cost, chronically-ill patients participate in the "patient-centered medical home" model

Another way to increase coordination across treatment settings is to create patient-centered medical homes (PCMHs). Beginning in January 2011, states can implement the new Medicaid option for PCMH services and use federal grants to provide PCMH services to certain chronically ill beneficiaries. During the first eight quarters of a state's implementation of this option, the federal government pays 90 percent of the cost of the PCMH services.

However, states are not limited to implementing PCMH services in Medicaid. They can implement these services with public employees and retirees and encourage (or even require) private insurers to do likewise, particularly in areas of the state that have an infrastructure suited for this model of care.

States can support the PCMH model with community health teams, health information technology (HIT) implementation plans tailored to meet the needs of the PCMH model, and primary care extension centers (or other mechanisms to help providers transition to new models of practice). To do so, states would need to seek funding from the CMMI in case federal grants authorized for these purposes do not become appropriated. This funding could also be used to evaluate the effects of the PCMH model on quality, clinical outcomes, cost, and patient and provider satisfaction.

Implement initiatives to prevent costly rehospitalization

States can also follow Medicare's lead, for example by implementing in Medicaid the Medicare ban on reimbursement for care related to health-care-acquired conditions. The ban can apply to both Medicaid fee-for-service and Medicaid managed care. Likewise, a state can apply to dual eligibles Medicare innovations such as the Community-Based Care Transitions and the Independence at Home demonstration project. The Community-Based Transitions Program involves hospitals furnishing evidence-based care transition services such as active post-discharge engagement to patients who might be at high risk for hospital readmission. The Independence at Home demonstration program is intended to improve care coordination for approximately 10,000 chronically ill Medicare beneficiaries nationwide both in the home and across treatment settings. There is no reason why these initiatives could not focus on dual eligibles, potentially yielding gains for states as well as the federal government and beneficiaries.

Use the results of comparative effectiveness (CE) research

The ACA increases funding for comparative effectiveness research, which can assess the strengths and weaknesses of possible treatments for particular health conditions. Public employee coverage could incorporate the results of CE research so that only the least costly service that provides known medical benefits would be covered. Two safeguards would need to be implemented to give consumers the opportunity to receive more expensive treatments when necessary: 1) allowing patients to pay the extra cost of more expensive treatments; and 2) paying for the more expensive procedure if the physician can show that the more costly service is more likely to achieve its therapeutic goal or avoid harmful side effects for a particular patient.

On the private market side, states could authorize health plans to implement similar policies. However, because one safeguard involves patients paying extra to obtain more expensive services, applying CE research to Medicaid, CHIP, or subsidized coverage in the exchange should be avoided, at least until this policy establishes a track record.

Apply for federal grants and participate in demonstration projects to combat obesity, smoking, and other risk factors

The ACA provides a variety of funding mechanisms to support both primary prevention and secondary prevention. Primary prevention refers to population-based efforts to prevent the development of health problems. Such efforts include eliminating environmental toxins, improving nutrition, increasing exercise, and reducing the use of tobacco and other addictive substances. Secondary prevention involves providing screenings and tests to spot potential health problems and allows for early diagnosis and treatment that prevents the development of serious illness. The health reform legislation appropriates funds to support grant programs and demonstration projects that promote healthy behaviors and wellness, such as smoking cessation and healthy eating to prevent obesity. The ACA also gives Medicaid a small increase in the applicable federal matching percentage if the state covers certain qualifying preventive services, free of cost-sharing. State officials can also take advantage of discounted rates to purchase adult vaccines.

LIMITING STATE GENERAL FUNDING SPENDING ON HEALTH CARE

While many state officials have voiced their concerns over how much the ACA will increase the burden on state budgets, much less emphasis has been placed on the potential savings it can generate. For example, states can achieve savings by:

- Implementing mechanisms to save on the health coverage for public employees and retirees;
- Substituting federal Medicaid dollars for state and local dollars;
- Moving Medicaid beneficiaries into subsidized coverage that is fully federally funded;
- Slowing health care cost growth within Medicaid; and
- Increasing state revenue.

Implementing mechanisms to save on the health coverage for public employees and retirees

- Use federally funded reinsurance to cover claims incurred by early retirees available to employers who implement measures to reduce spending on the chronically ill.
- Implement delivery system reforms, which have the potential to slow cost growth. Particularly promising candidates for cost savings include home care for high-risk patients after hospital discharge, and exercise and diet interventions aimed at pre-diabetic individuals to delay or prevent the onset of full Type II diabetes.
- Lessen the need for local aid if local governments achieve savings by enrolling their employees and early retirees in the exchange.

Substituting federal Medicaid dollars for state and local dollars

Currently, states spend resources to provide physical and mental health care to adults with incomes at or below 138 percent FPL, including uncompensated care for the uninsured and mental health services. Federal matching funds through Medicaid can substitute for these state and local expenditures. With newly eligible adults, state savings will be particularly pronounced since the federal government will pay 100 percent of all costs during 2014-2016, then gradually scale back to cover 90 percent of costs in 2020 and beyond.

Moving Medicaid beneficiaries into subsidized coverage that is fully federally funded

Currently, Medicaid pays for the care of some adults whose income exceeds 138 percent FPL, including pregnant women. This coverage can be terminated, with the adults shifted to the exchange (or the Basic Health program, in states adopting that option). In addition, states can achieve savings on the medically needy, whether they receive coverage as newly eligible Medicaid adults (for whom the federal government pays enhanced match), Basic Health, or the exchange. The medically needy are people who have incurred, within a state-defined period between one and six months in length, medical bills that reduce their disposable income below medically needy income levels. When they receive full-scope coverage, their out-of-pocket costs will decline substantially, thus lowering the amount Medicaid must spend to cover their remaining expenses.

Slowing health care cost growth within Medicaid

Although many of the reforms included in the new law can save Medicaid dollars, the most promising may involve the establishment of the new Coordinated Health Care Office within CMS, which is tasked, among other things, with integrating both dollars and care for dual eligibles. Since these are the most frail and costly consumers—accounting for nearly half of all Medicaid costs nationally—coordinating care among these funding streams may be able to eliminate redundant and inconsistent care and result in savings while improving care.

Increasing state revenue

According to the CBO projections, once the exchanges are available, some small employers will drop coverage, resulting in a two-percent decline in employer-sponsored insurance (ESI). Labor economists believe that employers will share much of the resulting cost savings with workers in the form of higher wages. This, in turn, will lead to an increase in revenue from income taxes and (to a lesser extent) sales taxes. Also, in states with taxes on insurance premiums, revenues will increase as health coverage expands.

CONCLUSION

Health care reform remains a hotly debated issue. While state officials may not soon agree on every provision of the federal legislation, there is no question that they have been given considerable flexibility to put their stamp on the direction of the health care system under their jurisdiction. They can use the tools in the bill to accomplish long-held state goals and to foster conversations about new objectives for the future. States will not only have a role in determining the success or failure of the ACA, but, much more importantly, they will help decide if the larger goals of the health reform effort —higher quality and increased access to care while reducing costs—are achieved.

ENDNOTES

1 Dorn, S. (2010, September). State Implementation of National Health Reform Harnessing Federal Resources to Meet State Policy Goals. State Coverage Initiatives. Retrieved January 18, 2011, from www.statecoverage.org/node/2447.

2 Beginning in 2007, the Centers for Medicare and Medicaid Services (CMS) implemented a voluntary individual reporting program, called the Physician Quality Reporting Initiative (PQRI), which provides an incentive payment to physicians who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries.

3 The ACA provides an opportunity for states to establish demonstration projects for pediatric ACOs.

4 PPACA Section 3021 establishes the new Center and appropriates $10 billion through 2019 to fund demonstration projects. Starting in 2011, the Center will test innovative payment and delivery arrangements to improve quality and slow cost growth in Medicaid, CHIP, and Medicare, without regard to normal budget neutrality requirements. HHS is authorized to expand successful models to nationwide scale, after appropriate certification by the CMS Actuary.

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