



UNDERSTANDING THE NEW LANDSCAPE FOR PUBLIC HEALTH:

A Report to the Maricopa County Department of Public Health

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Table of Contents

Understanding the New Landscape for Public Health

Part I: Introduction	1
Part II: The Impact of the Affordable Care Act (ACA) on Arizona and Maricopa County Populations and Sectors	3
Section 1. A Population View and Equity Initiatives within the ACA	3
1A. Health Insurance Marketplace/Exchange	3
Section 2. Newly Required Coverage and What's Left Out?	11
2A. Preventive Services and the Essential Health Benefits	11
2B. Other Covered Services, Advocacy for Additional Benefits, and Grandfathered Plans	13
2C. What's Missing from the ACA?	17
Section 3. Likelihood of Employers Dropping Health Insurance Coverage	18
Section 4. Implications for Arizona if Medicaid is Not Restored or Expanded to 138 FPL	19
Part III: The Impact of the ACA on Critical Health Sectors and Employers and Opportunities for Public Health	22
Section 5. Primary Care	22
5A. New Demand for Primary Care and Provider Supply	22
5B. Impact of Changes in Primary Care Reimbursement	24
5C. Opportunities to Expand Primary Care Capacity in Arizona	25
Section 6. Safety Net Providers (Non-Health Department)	28
6A. Impact on Community Health Centers	29
6B. Safety Net Hospitals	31
6C. Rural Health Centers	31
Section 7. Triple Aim Initiatives, the Center for Medicare and Medicaid Innovation, and Public Health	32
7A. ACOs	32
7B. Patient Centered Medical Homes (PCMH)	37
7C. Arizona Recovery Through Whole Health Behavioral Health Integration	41
7D. Community Health Teams (CHTs)	44



Section 8. Slowing the Growth of Premium Costs	47
Section 9. Public Health-Health Care Integration: Selected Strategies and Opportunities for Maricopa County and Arizona	49
Section 10. Center for Medicare and Medicaid Services (CMS) Innovation Center Funding Opportunities for Community Integrated Health Care	54
Section 11. Implications of the ACA for the Public Health and Healthcare Workforce	58
Section 12. Employers and Public Health	64

Part IV: Directions and Roles for State and County Health Departments 73

Section 13. Public Health as Chief Health Strategist: Health Information Technology, Informatics, and Planning	73
Section 14. The Prevention and Public Health Fund	76
Section 15. The Impact of Cuts to Public Health	83
Section 16. Health Departments as Providers and Payers of Last Resort	84
Section 17. Education, Assurance and Advocacy	92
17A. Policy Work to Assure Continued Strong Health Care Safety Net	93
17B. Assurance of Preventive Services	97
17C. Education and Outreach: Helping Residents Find, Enroll in, and Remain on Health Insurance and Use Care Appropriately	100

Notes 104

Appendices:

Appendix 1: Comparison of AZ Benchmark Plan to Federal PPO Basic Plan	118
Appendix 2: MA State Quality Advisory Committee Recommended Indicators	123
Appendix 3: The National Public Health Workforce Strategy Roadmap 2012	131
Appendix 4: Public Health Workforce Provisions Summary and Funding Status	132
Appendix 5: Example: How to Prepare for Billing	136



Part I: Introduction

The Maricopa County Department of Public Health (MCDPH), like large health departments across the country, is preparing for major changes to its role after the Patient Protection and Affordable Care Act (ACA) — known as health reform — is fully implemented. This report attempts to answer a series of technical questions from MCDPH, alongside larger questions, about how to navigate the channels and shoals that the ACA will create and/or exacerbate.

A significant number of people, estimated at 30 million nationally, are expected to gain coverage as a result of the ACA.¹ If Arizona expands Medicaid eligibility to 138% of federal poverty levels (FPL), an estimated 300,000 (minimum) people will join the Arizona Health Care Cost Containment System (AHCCCS) either as newly eligible members, former members who lost coverage after the Proposition 204 (sales tax renewal) freeze, or currently eligible people who will join as a result of promotion of health coverage and new requirements.

An additional 570,000 Arizonans will be eligible for new health insurance premium tax credits, 364,800 or 64% of whom are eligible for special low-income tax subsidies for people earning between 200–400% FPL. The Arizona Governor’s Office estimates that 496,000 people will enroll in the individual marketplace and 510,000 in the Small Business Health Options Program (SHOP) small business marketplace. These new options will provide coverage for an estimated 1.3 million of the currently uninsured Arizonans, but not for all of them. By 2016, approximately 10% of the population, or 650,000 people, will still be uninsured.²

Arizona state and local health departments are already suffering as a result of deep state cuts. And pressure to cut public health funding at the national and state and level will only grow as the concomitant pressure rises to pay for new coverage. Simultaneously, funding streams for some traditional public health services appear to be decreasing, or at least changing.

Additionally, what will happen when people who have been seeking certain services through MCDPH are insured and can go to their primary care provider for most of the same services, including many preventive services with no deductible or co-pay?

As the ACA is implemented fully, the crucial question becomes how can Arizona’s health departments position themselves to be a critical partner to health care providers and engage in new models of care? What roles can health departments play in joint grant applications? And what health department services merit contracts and reimbursement in this new environment?

In short, the ACA creates ample opportunity for public health departments and for moving towards a health system that is more focused on prevention. One of the central features of the ACA in support of clinical prevention is the requirement that expanded Medicaid plans and Marketplace plans cover certain preventive services as one of the Essential Health Benefits (EHB). Essential Health Benefits are categories of coverage detailed further in Section 2A. For plans that must provide EHBs, a range of preventive services must be provided at no cost to the patient that encompasses:

- **Evidence-based screenings and counseling.** Services that receive an “A” or “B” rating from the U.S. Preventive Services Task Force, including screenings for obesity, cancer, HIV, and cholesterol, and drug and tobacco cessation counseling;
- **Routine immunizations.** Routine immunizations recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices;
- **Preventive services for children and youth.** A variety of preventive services specified by evidence-based guidelines, such as behavioral and developmental assessments and screening for autism and certain genetic diseases; and,



- **Preventive services for women.** Evidence-based preventive services for women as specified by the Health Resources and Services Administration (HRSA), including, among other things, annual well-woman visits, STI and HIV testing, and breastfeeding support. FDA approved contraception methods prescribed by a physician are also covered, although certain plans are exempt.³

The Prevention and Public Health Fund (PPHF) will direct \$10 billion dollars through 2020 toward prevention oriented activities that will help slow the growth of health care costs. PPHF has already invested over a billion dollars to improve the public health workforce capacity, develop evidence-based guidelines for community prevention, modernize health department infrastructure, develop systems to track environmental health indicators, and dramatically increase local community based prevention through the Community Transformation Grants (CTGs). However, the PPHF is jeopardized as a result of budget cuts and political disagreements about its value.

The Center for Medicare & Medicaid Innovation (CMMI) is fostering the creation of models of care that include a role for public health, such as in Patient Centered Medical Homes, Community Health Teams, linking patients to community services, and partnering to accomplish measurable improvements in the health of specific populations.

There are channels of opportunity available to Arizona health departments via such means as improving planning and informatics capacity and leadership; proactively marketing strategic skills and services to health providers and payers; taking steps to bill AHCCCS, MCOs, and private plans for all eligible services; and, deepening collaborative chronic disease and other systems change prevention efforts. Understanding some of the new landscape in which potential partners find themselves will help lead to more strategic and effective partnerships.



Part II: The Impact of the Affordable Care Act (ACA) on Arizona and Maricopa County Populations and Sectors

The Patient Protection and Affordable Care Act (ACA) will expand free (for states that choose to expand Medicaid eligibility) and low-cost health insurance options for low-income Americans; improve the quality of health coverage; and, invest in health care quality and innovation in addition to prevention and public health infrastructure.

For states that choose to expand Medicaid, eligibility will increase for all adults up to 138% of the Federal Poverty Level (FPL). Health Insurance Marketplaces, or Exchanges, will be established to allow individuals and small businesses to buy affordable insurance that must meet higher standards for affordability and coverage of EHBs. Individuals and families with incomes up to 400% of FPL will be eligible for tax credits and subsidies to purchase Marketplace health insurance plans.

The first section of this report answers specific MCDPH questions about populations that will gain coverage and those that will likely remain uninsured; changes in required coverage; and, gaps that remain. Additionally, this section addresses how all of these changes affect public health's partners in the health care sector, with an eye to key opportunities in relation to health care systems and employers.

Section 1. A Population View and Equity Initiatives within the ACA

1A. HEALTH INSURANCE MARKETPLACE/EXCHANGE

Who Benefits from Expanded Coverage

In Arizona in 2010, the following populations had the highest rates of uninsurance⁴:

- Young adults ages 18 to 24 (32%)
 - » Uninsurance for this age group may have already dropped some as a result of the 2010 ACA provision allowing children up to the age of 26 to remain on their parents' healthcare plan.
- Those with low levels of education (38% of individuals who did not complete high school);
- Low-income individuals with a household income of less than \$15,000 (25%);
- Members of households with incomes between \$15,000-\$29,999 (34%) as they earn too much to qualify for Medicaid, but are working in jobs that do not provide insurance benefits;
- Those who have never been married (29%), are separated from a spouse (31%), or are living with an unmarried partner (28%);
- Lesbian, gay, or bisexual individuals (24%)
- Hispanic Arizonans (37%); and,
- Arizonans living in Maricopa (21%), likely due to the fact that it is the most populous region of the state.

These differences are significant, as those without health insurance are less likely to receive preventive care, are more likely to have undiagnosed or untreated medical conditions, and thus are at greatest risk of having serious and expensive health problems.⁴



In Arizona, 27% of adults did not have a Primary Care Physician (PCP) in 2010, and there was a 46% difference between insured (19%) and uninsured (65%) people who did not have a personal doctor. Those without a PCP were more likely to be male (32% vs. 21% female), younger (42% adults ages 18–28 vs. 6% of adults 70+), of Hispanic/Latino origin (45%) or Native American/American Indian origin (41%). Furthermore, 39% of Hispanic/Latino adults, 1/3 of Black or African-American adults, and 1/4 of Native American or American Indian adults have not seen a doctor once in the last 12 months, compared to non-Hispanic White adults (16%).⁵

The Remaining Uninsured Under the ACA

Overview. Under the ACA, the composition of the uninsured will likely shift due to the mandate that most Americans must have health insurance coverage that meets certain minimum requirements. Exemptions are made if affordable insurance coverage is unavailable and for Native Americans, prisoners, individuals with religious objections, and undocumented immigrants who are not eligible for Medicaid or any federal subsidies.⁶ In Arizona, 650,000 people are projected to remain uninsured by 2016.⁷

Massachusetts (MA) experience. There are lessons to be drawn from the MA experience, where health reform efforts preceded, and helped shape, the national ACA. It is worth noting that at 6.4% in 2006, uninsurance rates in MA were quite lower even before health care reform than those in Arizona.⁸ In MA, insurance coverage increased most significantly for non-elderly adults, and particularly for low-income adults under health reform.⁹ However, while MA boasts the highest health insurance coverage rates in the nation, a small proportion of the population still remains without health insurance. This percentage decreased from 6.4% in 2006 to approximately 6% the year following reform to 2% in 2010.¹⁰ The remaining uninsured were more likely to be young, single, male, non-elderly low-income adults, and/or those of Hispanic/Latino ethnicity.⁹ Among non-elderly adults, the uninsured rate dropped from 10.9% in 2006 to 5.5% in 2007. However, there was a slight increase in

the number of uninsured in 2010, likely due to a near doubling of the state's unemployment rate from 2008 to 2010.¹¹ This may indicate a relationship between health care coverage and the state of the economy and job market.

Access to health care and preventive services increased overall, and the number of unnecessary emergency department visits and hospital inpatient stays decreased, following reform. However, affordability continued to be an issue, with nearly half of the uninsured reporting having access to employer coverage but still not enrolling due to cost. Furthermore, one in five adults reported problems finding a doctor who would see them because providers weren't taking new patients or did not accept the patients' insurance.¹¹

ACA Projections for the U.S.. Populations that will remain outside of the newly expanded insurance coverage systems will include: undocumented immigrants, those still without affordable coverage options available to them, those choosing to pay tax penalties instead of enrolling in coverage, and those eligible for subsidized coverage but who do not enroll in it for a variety of reasons.¹²

Impact of ACA on Special Populations

Maricopa County and Arizona. Projections from the ACA and MA's experience indicate that a significant proportion of Arizona's diverse population may remain uninsured and/or face barriers to care. In particular, Arizona's Hispanics/ Latinos, non-citizen immigrants (including legal permanent residents and undocumented immigrants), and low-income individuals will face additional barriers. The health departments' roles as safety net provider, especially of preventive services, will be especially important for these populations that are excluded from the benefits of subsidized coverage.

Hispanic/Latino population, non-citizens, individuals with limited English proficiency (LEP) and the ACA. In Arizona, where 1/3 of the population identifies as Hispanic/Latino, the uninsurance rate for those identifying as Hispanic (37%) was three times higher than for non-Hispanic white individuals (12%).⁴



In Maricopa County, 30% of the population is of Hispanic or Latino heritage.¹³ At the national level, many uninsured Hispanics are in low-income working families; thus, nearly all would be in the income range to qualify for the Medicaid expansion or premium tax credits (if Arizona passes the Medicaid expansion).¹⁴ However, in the U.S. overall and in Arizona, a high proportion of uninsured Hispanics/Latinos are non-citizens (including both lawfully present and undocumented immigrants), limiting their ability to obtain health insurance within provisions of the ACA, and thus access to preventive services and clinical care.¹⁴

Arizona as a state ranks 10th among all states for the largest number of legal permanent residents with 614,978 individuals expected to become legal permanent residents from 2007–2011.^{15,16} Nearly 16% of Maricopa County's population is foreign born, predominantly immigrating from Latin America.¹⁷ Many of these residents are legal immigrants. In Arizona, lawfully present immigrants are subject to eligibility restrictions for Medicaid and Children's Health Insurance Program (CHIP), including a five-year waiting period and the exclusion of some categories of immigrants.¹⁸ These eligibility restrictions remain in place under the ACA.¹⁴ While legally present immigrants can purchase coverage through the Marketplaces and receive tax credits without a waiting period, the five-year delay for Medicaid and CHIP eligibility creates barriers for access to coverage and often can be cost prohibitive for low-income families.

Arizona also ranks eighth among states with the largest undocumented immigrant population, with an estimated 400,000, comprising 6% of Arizona's total population and 45% of the state's foreign born population.^{13,19} Under the ACA, undocumented immigrants are ineligible for Medicaid and premium tax credits as well as purchasing exchange coverage at full cost.¹⁴

Finally, of Maricopa County residents who speak a non-English language in the home, 10% of individuals speak English "less than very well".¹⁷ Low English Proficiency (LEP) individuals also face many of the aforementioned challenges in obtaining health insurance due to their immigration status and their income, which will be addressed in the next section.

Low-income individuals and the ACA. In 2014, the ACA provides extended eligibility for Medicaid coverage for adults to 138% of the FPL; Arizona legislators are debating whether to implement this expansion. Also in 2014, states independently, or via a Federally Facilitated Exchange, as in Arizona's case, will create new health insurance exchange marketplaces. Advance premium tax credits will be available for individuals between 100% and 400% of the FPL who are not currently eligible for Medicaid and do not have access to affordable health coverage through an employer to help purchase insurance through an exchange.²⁰

Lesbian, gay, bisexual, and transgender (LGBT) population and the ACA. In 2010, approximately 3% of Arizona Health Survey respondents identified themselves as lesbian, gay, or bisexual. They were more likely to be uninsured than their heterosexual counterparts, more likely to be on Arizona's Medicaid (the Arizona Health Care Cost Containment System/AHCCCS) or Medicare, and less likely to have employer coverage.⁴

In the ACA, only one provision explicitly mentions the LGBT community, referring to people of "different genders and sexual orientations" in mental and behavioral health education and training programs.²¹ However, many of the ACA provisions benefit the LGBT community directly. For example, because LGBT people and their families can experience discrimination in employment, relationship recognition and insurance coverage, the ACA can ensure that the majority of LGBT individuals can now receive coverage.²¹ Also, the ACA prioritizes the development of cultural competence standards and training in order to remove barriers to health care services, improve the quality of care, build a strong and diverse workforce and support community health centers. These provisions will be very helpful to promoting the health of the LGBT community and helping them access health care services that are culturally competent and sensitive. Additionally, the ACA prioritizes collecting health and health disparities data (including health status and outcomes data of the LGBT community) and supporting new research. Such data will assist in better understanding the needs and concerns of this population.



While disparities will likely continue to exist within this population, these provisions and many others within the ACA will serve to improve health outcomes.

American Indians. Arizona is home to 21 federally recognized Native American tribes and 250,000 Native Americans.^{22,23} Compared to the U.S. average, Maricopa County has more than twice the percentage of American Indians (2.7% MC, 1.2% U.S.).¹³ While nine of the fifteen AZ counties have a higher percentage of American Indians than Maricopa County, there is a larger absolute number of American Indians in Maricopa County (~107,000) than in any of the other AZ counties.¹³

American Indian/Alaska Native (AI/AN) populations in the U.S. face poor health outcomes when compared to other racial and ethnic groups. For example, AI/AN populations have a life expectancy that is about 4 years less than the U.S. population overall (74 years vs. 78 years), and they die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher), and suicide (74% higher).²⁴

In Arizona, almost half of the American Indian population is on the state's Medicaid program. Furthermore, 35% of this population reported to be in fair or poor health, more than twice as likely as the White, non-Hispanic population, and 41% reported that there was no one whom they thought of as their doctor (compared to 19% of non-Hispanic White).⁵ Additionally, one-in-four American Indian adults had not seen a doctor in the last 12 months, compared to non-Hispanic Whites at 16%.⁵

The ACA does the following to address the health disparities of the AI/AN population directly²³:

- Reauthorizes and makes permanent the 1976 Indian Health Care Improvement Act (IHCA) that expired in 2002, which established a structure for the provision of healthcare services to the AIAN population through the Indian Health Services (IHS);
- Enhances the IHS Director's authority, including

responsibility to facilitate advocacy around Indian health at the federal level;

- Authorizes new programs and expands the accessibility to services delivered by the Indian Health Service. These include:
 - » Hospice, assisted living, long-term, home- and community-based care.
 - » A comprehensive behavioral health, prevention and treatment program (including community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living, emergency shelter, case management, and diagnostic services).
- Extends the ability to recover costs from third parties to tribally operated facilities;
- Enables tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries;
- Authorizes IHS to share medical facilities and services with the Departments of Veterans Affairs and Defense; and,
- Designates Arizona as a Contract Health Service Delivery Area to allow American Indians residing off of Arizona reservations to access healthcare services through IHS.

However, many tribal members may not be able to access IHS services due to ineligibility and/or location; thus, AI/AN populations also utilize private or employer-sponsored health insurance, Medicare, Medicaid, community health centers, and the Veteran's Administration. The ACA's overall provisions apply to AI/AN populations, such as increasing access to and quality of care and promoting prevention. Within these overall provisions are also some American Indian-specific provisions. Public health will need to educate patients, providers (Indian and general), tribal organizations, and other providers on these new provisions and regulations, as well as find ways to accommodate the increasing demand for services at non-American Indian health provider facilities. These include²³:



- *Marketplace.* The Marketplace will be required to provide for special monthly enrollment periods for American Indians and no cost-sharing will be required for American Indians with incomes at or below 300% of the FPL. Also, cost-sharing will be prohibited altogether for American Indians enrolled in any qualified health plan in the individual market through the exchange;
 - *Individual responsibility.* American Indians are exempt from tax penalties for failure to maintain minimum essential coverage;
 - *Insurance eligibility.* Enrollment in Medicaid, Medicare, and CHIP is made easier for American Indians by making IHS, tribes, tribal organizations, and urban American Indian organizations with authority to operate under presumptive eligibility for American Indians seeking services from American Indian providers;
 - *Indian Health Service facilities.* Updates the laws around reimbursements from Medicare, Medicaid, and CHIP by Indian health facilities, and allows facilities to develop new and innovative ways to address healthcare facility deficiencies;
 - *Maternal and child services.* Sets aside 3% of the annual funding for home visiting programs for Tribes, tribal organizations, and urban Indian organizations, and provides funding for education on abstinence, contraception, and adulthood preparation topics. Five percent of the Personal Responsibility Education grants are required to be dedicated to Indian tribes and tribal organizations;
 - *Prescription drugs.* Decreases the “donut hole” for Medicare Part D for older AI/AN adults, thus making prescription drugs more affordable;
 - *Prevention and public health.* Allows states to work with Tribes to promote prevention and health promotion outreach and education campaigns for Medicaid recipients; allows CDC to award grants directly to Tribes to carry out five-year pilot programs to provide public health community interventions (e.g. screenings); and, allows epidemiology-laboratory capacity grants to tribal jurisdictions to assist public health agencies in improving surveillance for, and response to, infectious diseases;
 - *Revenue provisions.* Health insurance or HMOs purchased by tribes for members is not considered income by the IHS for tax purposes or for eligibility in any social security program;
 - *Federal employees health benefits program.* Allows Tribes, tribal organizations and urban American Indian organizations to purchase coverage for their employees from the Federal Employees Health Benefits Program; and,
 - *Workforce.* Establishes a Community Health Representative program for urban American Indian organizations to build the healthcare workforce and strengthens scholarship and loan programs to attract health professionals to IHS facilities and tribal sites.
- Health Disparities.** The ACA aims to reduce health disparities by making key improvements, including²⁵:
- *Preventive services.* Providing individuals with improved access to clinical preventive services by removing cost as a barrier, promoting workplace wellness initiatives, engaging communities in promoting prevention specifically targeted to address health disparities (e.g. Community Transformation Grants), and elevating prevention to a national priority²⁶;
 - *Coordinated care.* Investing in community health teams to manage chronic diseases which disproportionately impact racial and ethnic minority communities;
 - *Diversity and cultural competency.* Increasing racial and ethnic diversity in the health care workforce, strengthening cultural competency training for health care providers, and using language services and community outreach in underserved communities;
 - *Healthcare providers for underserved communities.* Increasing funding for community health centers which nationally serve approximately one-in-three low-income individuals and one-in-four low-income racial and ethnic minority residents;



- *Banning insurance discrimination.* Providing access to individuals with pre-existing conditions and funding to collect information on how women and racial and ethnic minorities experience the healthcare system to lead to improvements to benefit these groups; and,
- *Affordable insurance coverage.* Creating health insurance exchanges guaranteeing that all people will have a choice for quality, affordable health insurance, and providing tax credits to help Americans pay for insurance.

Public health departments and advocates will have a key role to play in assuring that efforts to implement the ACA also promotes health equity and reduce disparities, from data monitoring to workforce capacity efforts to outreach strategies. Public health in particular will have a role to play in keeping an eye on the social, physical, and economic determinates of inequitable health outcomes and promoting policy and systems change to ameliorate these conditions.

New marketplace plans. Layered around the expanded coverage option of increased Medicaid eligibility to 138% of the FPL* are the better quality, and for some low-income residents, affordable plans that will be available in Health Insurance Marketplaces, also commonly referred to as Exchanges. Health Insurance Marketplaces were created in the ACA as a centralized source for the uninsured, small employers, and individuals to enroll in private health insurance or public health benefits.

Subsidies and cost-sharing will be available to citizens and legal U.S. residents with incomes below 400% of FPL who are not eligible for any other source of minimum essential coverage, and who do not have employer-sponsored insurance. Subsidies are available in the form of tax credits that accrue monthly to cover the difference between the premium charged and how much premium is allowable by income (based on a sliding scale). For example, for a family between 201-250% FPL, premium affordability is established between 6.3-8.05% of income. If an individual's premium was 10% of their income, the monthly tax credit would be approximately 2-3% of their income.²⁷ The other form of subsidy is a sliding scale cap on allowable co-pays and deductions for low-income

families. The Congressional Budget Office (CBO) estimates that by 2019, 81% of individuals purchasing their own coverage through the exchanges will receive federal sliding scale subsidies.²⁸

Under the ACA, there are two types of health insurance exchanges: the American Health Benefits (AHB) Exchanges for individual markets and the Small Business Health Options Program (SHOP) Exchanges for small group markets. It is estimated that 746,000 Arizonans will obtain health insurance through both of these exchanges and will receive various levels of subsidies to support their insurance purchase.²³

The rate at which people purchase insurance is described as the “take-up” rate, in order to distinguish from people eligible and those who actually enroll. Historically, some percentage of people eligible for insurance do not enroll, or take up coverage, because of affordability issues, lack of awareness about eligibility, or other reasons.

Profile of AHB Enrollees in the U.S. National data can help inform the profile of likely Marketplace enrollees. The CBO estimates that approximately 24 million people will purchase coverage through the AHB Exchanges by 2019 in the U.S..²⁸

The projected 2019 Marketplace population in the U.S. is relatively older, less educated, of lower income, and more racially diverse than current privately-insured populations.²⁸ The following are specific characteristics of this population in 2019, as estimated by CBO, which may shed light on the newly insured covered by the Marketplace plans in Arizona:

Age, Race/Ethnicity, & Language

- Eighty-four percent of individuals in the Exchange will be between the ages of 19-64;
- The population will be more racially and ethnically diverse (58% white, 11% Black, 25% Hispanic/Latino) than other privately-insured populations. There is likely to be a higher percentage Hispanic/Latino in Arizona; and,

**Commonly referred to as 138 % FPL, when taking into account new methods of calculating income, the minimum expansion amount becomes 138% FPL. In this report we will use 138 % FPL.*



- One-in-four Marketplace enrollees will speak a language other than English at home (23%); again, likely to be a higher percentage in Arizona because of state demographics.

Income

- Median income is projected to be 235% of FPL;
- Marketplace enrollees are likely to be higher income than the current uninsured population (median income: 175% FPL) but poorer than those currently covered by an employer (median income: 423% FPL) or a non-group plan (median income: 337% FPL). This is simply an effect of most lower-income uninsured being eligible for Medicaid expansion.

Education

- Those covered by Marketplace plans will more likely have less education than those covered by an employer (77% of with a high school diploma or less vs. 55%).

Employment

- Four out of five enrollees will be employed (80%);
- Nine out of ten enrollees will have at least one employed person in the household (93%).

Health Care Access

- One-in-three individuals will have gone more than two years without a check-up (37%);
- Nearly two-in-five are projected to have no usual source of care (39%);
- More than one-in-four will have had no interaction with the healthcare delivery system during the year at all (29%); and,
- Those enrolled in the Exchange are more likely to utilize outpatient services, office visits, dental visits, and prescription drugs than those who are uninsured, but less likely than privately-insured adults.

Health Care Outcomes

Adults projected to enroll in Marketplace plans report that they are in worse health but have fewer diagnosed chronic conditions than currently privately insured populations:

- Thirteen percent of adults report that they are in fair or poor physical health (in comparison to 6-7% of currently privately insured individuals, but not statistically different than the current uninsured population at 12%);
- Eight percent report that they are in fair or poor mental health condition, which is significantly greater than privately insured individuals (4%) but not statistically different from the currently uninsured (7%);
- On average, Exchange adults have fewer diagnosed chronic conditions (12% of new adult Exchange enrollees have 3+ conditions) than adults with employer coverage (15%). This may be due to the fact that Exchange adults were previously uninsured and may not have been diagnosed with a chronic condition; and,
- The most commonly diagnosed chronic conditions among Exchange plan eligible adults are hypertension (15%), high cholesterol (9%), and depression (9%).

Individual AHB Marketplace Take-up (Enrollment)

Rates in AZ. In Arizona, it is estimated that 496,000 individuals will participate in the AHB Exchange. *Table 1* estimates the range of take-up rates between 2014–2016. By 2016, it is estimated that 90–95% of individuals participating in the AHB Exchange will have enrolled, with 5–10% of those eligible choosing not to enroll. Coverage expansions historically have been absorbed incrementally, with more and more eligible people enrolling each year as they learn about coverage. Projections below for Arizona enrollment show a multi-year transitional period.



TABLE 1. PROJECTED ENROLLMENT RANGES FOR AZ'S INDIVIDUAL MARKETPLACE

Year	Take-up Rate	# of Enrollees
2014	60-70%	297,600-347,200
2015	75-85%	372,000-421,600
2016	90-95%	446,400-471,200

SHOP Marketplace/Exchange Enrollment

Profile of SHOP Enrollees in the U.S. Small businesses of less than 50 full-time equivalent (FTE) employees traditionally offer insurance coverage to employees at a relatively low rate. In 2011, only 48% of firms with 3-9 workers and 71% of firms with 10-24 workers offered health insurance, compared to 99% of firms with 200 workers or more.²⁹ Particularly, small employers with predominantly low-wage workers, such as restaurants and landscaping businesses, tend not to offer health insurance, as such businesses would need to increase their total compensation dramatically. Also, because small-group insurance markets are traditionally based on risk, coverage for employers with older, lower income, and less healthy employees or in occupations with predictably high-risk can be very expensive or unaffordable.

This pattern is seen in Arizona, where only 29% of private sector firms (or 23,119 firms) with fewer than 50 employees offer health insurance benefits, versus 95% of firms (or 33,787 firms) with 50 employees or more.³⁰ As the majority of private sector firms in AZ resides in Maricopa County (64% or 84,520 firms), for the purposes of this report, it is estimated that AZ's Employer Sponsored Insurance (ESI) coverage patterns are similar to that of the Maricopa County level.³¹ In Maricopa County, over 80% of businesses (or 67,616 firms) have fewer than 20 employees, with more than half of these having fewer than five employees.³² Thus there are a significant number of small employers in the county, the majority of which do not provide ESI.

The SHOP exchange reforms the health insurance market by making it less expensive for small firms to provide coverage for their employees. As of January 1, 2014, no premium rating can be based on health status, claims history, industry, group size, duration of coverage, and other factors. Furthermore, employers with fewer than 25 FTEs and with average annual salaries of less than \$50,000 – and that contribute at least half of the cost of employees' health insurance – will be eligible for tax credits to assist them in purchasing health insurance.³³

Employers of more than 50 employees must pay a "Free Rider" surcharge penalty, or employer responsibility assessment, if their workers are receiving premium subsidies through Marketplace plans.

The smallest firms of fewer than 25 employees have the most to gain and are most likely to participate in the SHOP exchange. These firms are not subject to the employer responsibility assessments and benefit from tax subsidies. Small firms with fewer than 100 employees that offer insurance to employees (offer rates) are estimated to increase by almost 10% under the ACA. The largest increases in offer rates are expected in the smallest firms of <10 employees (14.2%) because they will benefit the most from tax credits.³⁴ However, offer rates are predicted to be unchanged for employers with 25 or more employees, who don't benefit from tax credits. See *Table 2*.

TABLE 2. CHANGES IN ESI OFFER RATES, BY FIRM SIZE³⁴

Firm Size	Without Reform	ACA	% Difference
All small firms, (<100)	43.3%	47.6%	9.7%
<10 employees	35.3%	40.3%	14.2%
10-24 employees	64.3%	66.9%	4.0%
25-49 employees	77.5%	77.7%	0.3%
50-99 employees	86.7%	86.7%	0%

SHOP Exchange Take-Up Rate in Arizona. In Maricopa County, 80% of firms overall have fewer than 20 employees; thus, they meet the profile of firms that will benefit the most and likely participate in the SHOP Exchange. Approximately between 484,000 and 510,000 additional lives statewide will be covered through the SHOP Exchange in both 2014 and 2015. However, it is also predicted that enrollment will decrease slightly in 2016 when the small business health care tax credit expires. With the recent postponement of the full implementation of the SHOP Exchange from January 2014 to 2015, it is unclear how these take-up rates will be affected.³⁵ It is also possible that some small businesses that currently offer insurance will stop and will direct their employees to enter into the individual Marketplace to buy coverage.

Section 2. Newly Required Coverage and What's Left Out?

2A. PREVENTIVE SERVICES AND THE ESSENTIAL HEALTH BENEFITS

Starting on January 1, 2014, the ACA will require that all non-grandfathered individual and small group health insurance plans, including those offered through an Exchange, cover certain essential health benefits (EHB). These EHBs include:

- Hospitalizations
- Emergency services
- Ambulatory patient services
- Maternity and newborn care
- Mental health and substance use disorder services (including behavioral health treatment)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management; and,
- Pediatric dental and vision care.

Currently, the U.S. Department of Health and Human Services (HHS) estimates that 62% of health plan enrollees in the individual market do not have coverage for maternity services, and almost one-fifth of enrollees lacks mental health service coverage.³⁶

The benchmark plan defines the standard set of benefits that must be covered by plans in the state, where insurers will need to offer plans with benefits “substantially equal” to those found in the benchmark plan. However, the benchmark plan does not specify what the cost-sharing levels will be; carriers will develop co-pay and deductible features based on the actuarial values (expected cost to them of use of the benefit) for the different level plans as defined by the ACA.³⁶

Arizona's Essential Health Benefits Benchmark Plan: Coverage, Gaps, and Implications

Overview. As a result of the ACA, states could either select their own benchmark plan or default to the state's largest small group plan by enrollment. The state of Arizona has selected the *State of Arizona Self-Insured Plan* (administered by United), *Exclusive Provider Organization* (EPO) plan as its Essential Health Benefits (EHB) benchmark plan. Arizona, Utah, and Maryland are the only three states that selected the state employee plan as their benchmark.^{36,37} Arizona's benchmark plan was selected by Governor Jan Brewer, but stakeholders — including consumer and patient groups, insurers, and specialty providers — were highly engaged in the selection process.³⁸ For example, specialty providers in AZ gave considerable feedback regarding the particular diseases they treat.³⁸

The selection of a Federally Facilitated Exchange does not change the benchmark plan. Arizona's selected state employee plan will still apply. For the essential benefits not covered by Arizona's state employee plan, the Center for Medicare & Medicaid Services (CMS) lays out options for identifying alternative benchmarks.³⁹ As of October 2010, CMS required state Medicaid programs to cover tobacco cessation for pregnant women, inclusive of counseling and prescription medications, without co-pays. There were no other overall benefit changes to traditional (non-expansion) Medicaid plans. ACA Section 2001 provides that newly-eligible (expansion) Medicaid enrollees receive “benchmark or benchmark-equivalent coverage.” Section 1302 establishes essential health benefits for qualified private health plans. And Section 2713 requires that private group or individual market plans must cover preventive services.⁴⁰



Nothing in the ACA applies EHB or preventive service requirements to pre-ACA Medicaid plans. Thus Arizona Health Care Cost Containment System (AHCCCS) traditional plans are not currently required to include benchmark plan benefits.

However, there are two caveats. The Center for Medicare & Medicaid Services (CMS) will provide a one percentage point enhanced match to states that change their standard Medicaid plans (whether fee-for-service or managed care) so that they cover all A or B clinical preventive services identified by the U.S. Prevention Services Task Force (USPSTF) without co-pay or deductible.⁴¹ In a November 2012 letter to state Medicaid directors, CMS Deputy Administrator Cindy Mann noted that “we intend to propose that the definition and coverage provisions for EHBs... generally apply to Medicaid. However, because of the role of the states in defining Medicaid benefits and existing Title XIX statutory provisions, we will propose through regulation some modifications that will apply when furnishing these services to Medicaid beneficiaries.”⁴² (Note: Title XIX refers to grants to states for medical assistance programs). This may merit advocacy on the part of public health leaders to urge CMS to require traditional Medicaid to cover all USPSTF Grade A and B Preventive Services and all other EHBs.

Services not covered by the Arizona Benchmark Plan. Appendix 1 details the AZ state employee plan’s (hereafter referred to as the State Plan) covered and non-covered benefits, along with limitations to coverage organized by the EHB categories. Currently, both the State Plan and the FEHBP provide nine out of ten of the EHB categories; only pediatric dental and vision services are not fully covered.

As previously mentioned, the ACA requires that benefits for all benchmark plans include services in the ten essential health benefits categories at minimum, and these benefits must equal the scope of benefits covered in a “typical employer plan”.⁴³ If a benchmark plan does not include one or more of the ten categories, HHS requires the state to supplement the plan with the appropriate categories of benefits from another benchmark plan option.⁴³

Many EHB benchmark plans do not include services in all the ten required benefit categories and thus require supplementation.^{36,43}

In Arizona’s case, along with almost every other state, pediatric dental and pediatric vision services will need to be supplemented. For both services, HHS allows states to supplement with benefits from either the federal employee insurance plan or from the state’s Children’s Health Insurance Program (CHIP).⁴³ Arizona will supplement this gap with the Federal Employees Dental and Vision Insurance Program (FEDVIP) making it the state with the largest national enrollment.^{44,45}

Also, habilitative services (services that support people with cognitive or physical functions that are not performing at a normal level, as opposed to rehabilitative services which support the re-establishment of functions that have been lost or impaired) are typically not covered in private plans and are poorly defined.⁴³ If the state’s benchmark plan does not include habilitative services, HHS permits states to determine which services fall into this category; however, if a state does not define these services, then the plan may provide the same coverage as provided for rehabilitation services or can separately define habilitative services and report that definition to HHS.⁴³ In Arizona, the State Plan covers rehabilitative and habilitative services and devices comparable to the FEHBP, with the exception of orthopedic services and acupuncture.⁴⁵ Thus, no additional supplementation is technically necessary.

Addressing other public health gaps. As previously mentioned, HHS’s final rule specifies that benchmark plans must cover the ten EHB categories. However, this does not specify the extent to which an EHB issuer must cover all medically necessary items or treatments falling within these categories.⁴⁶ Other than the mandated preventive and pharmaceutical services, plans have broad discretion to determine the level of treatments and services that they will cover and pay for as well as the amount, duration, and scope of coverage.

Some of the services and devices that are uncovered in AZ’s benchmark plan are of public health significance.



While HHS does not mandate any of these services as a part of the Essential Health Benefits, MCDPH may want to consider finding ways to assure that these services are available to those who need them.

Podiatry. In addition to assuring access to podiatric specialty services, because podiatric services are often utilized to address complications due to diabetes, addressing diabetes prevention strategies and promoting self-management strategies for diabetics will prevent some of the need for care. Furthermore, public health can work with primary care physicians and other members of community health teams to promote diabetes screenings and educate the population on prevention and self-management strategies as well as promote healthy eating, active living, and wellness visits to a primary care physician can help prevent the development of diabetes and/or lead to early detection of the disease.

Orthopedic services. In the State Plan, the provision of foot orthotics, corrective orthopedic shoes, and arch supports are excluded from the benchmark plan unless provided in the Diabetic Service and Supply provision.⁴⁷

Developmental testing. Developmental testing within mental health and substance abuse services includes addressing developmental disorders such as developmental reading disorders (i.e. dyslexia) and developmental arithmetic, language, and articulation disorders.⁴⁷ It also excludes counseling for educational activities; borderline intellectual functioning; occupational problems and consciousness raising; I.Q. testing; psychological testing on children requested by or for a school system; and, other similar services.⁴⁷ As education (including access and disparate outcomes) is a social determinant of health, public health should take a role in ensuring that these services can be accessed elsewhere in the community, if not through the healthcare system.

Crisis assessment/community stabilization & peer/recovery support service. This refers to services such as any court ordered treatment or therapy or treatment or therapy ordered as a condition of parole, probation, or custody or visitation evaluations; residential treatment (unless associated with chemical

or alcohol dependency); and, occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.⁴⁷ As the populations requiring services such as these are often high-need, vulnerable populations with complicated health issues, MCDPH ought to take a role in identifying where individuals can access these services elsewhere.

Respite services. Respite care programs ought to be coordinated systems of accessible, community-based services for family caregivers of children and adults with special needs. By providing such services, caregivers can be provided with physical and mental relief, assuring that those being cared for will receive higher quality, sustainable care in the long term. From 2012–2014, Arizona’s Department of Economic Security Division of Aging and Adult Services received a federal grant to develop the state’s Lifespan Respite Care Program (LRC).⁴⁸ MCDPH can partner with the Lifespan Respite Care Program to ensure that these efforts are coordinated amidst other public health efforts to create a long-term, sustainable system for providing respite services to the population.

2B. OTHER COVERED SERVICES, ADVOCACY FOR ADDITIONAL BENEFITS AND GRANDFATHERED PLANS

Chronic Disease Self-Management Programs (CDSMP)

The State Plan offers disease management programs to all members regardless of their selected networks around the following health conditions:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Pregnancy/maternity
- Coronary artery disease⁴⁹

Such programs educate members and their dependents about these health conditions, aim to improve self-management skills, and help make lifestyle changes that promote healthy living.



Because they are a required benefit for eligible Marketplace plan and newly eligible expansion population AHCCCS members, there will be a **significantly increased demand** for CDSMPs.

MCDPH has staff trained in the Stanford CDSMP and provides community CDSM groups in coordination with Arizona's Living Well Institute (AZLWI) and ADHS's AZ Living Well Program. Together, these groups offer the Healthy Living: Self-Management of Chronic Conditions workshops throughout the state of AZ. This includes *Tomando Control de su Diabetes*, a self-management curriculum for the Spanish-speaking population. MCDPH and AZLWI could identify joint and unique opportunities to contract with health plans to provide CDSMPs for health plan members with specific conditions or in distinct racial, ethnic and/or geographic groups that MCDPH with whom has expertise to serve.

Nutrition Services in the ACA

Nutrition services are woven throughout a number of provisions in the ACA. The following sections describe the provisions that have the potential to directly or indirectly involve nutrition services:

Emphasis on Prevention Overall

Through the establishment of the U.S. Preventive Services Task Force — which issues best practice clinical and community guides — as well as through the Prevention and Public Health Investment Fund, there will be increasing opportunities to address nutrition to prevent chronic diseases such as obesity and diabetes.

Workforce

The ACA is analyzing the current health care workforce to identify gaps in delivery of care, particularly for underserved communities.⁵⁰ This analysis includes registered dietitians (RDs).

Workplace Wellness

One of the three major prevention provisions of the ACA is the creation of workplace wellness programs. These programs include motivating employees to engage in health promotion behaviors such as healthy eating, and creating a healthy workplace environment that supports healthy decision-making.

School-Based Health Clinics

The ACA established grants to launch school based health clinics that include nutrition counseling as one of the optional services.⁵⁰

Child Obesity Demonstration Project

In 2011, the Centers for Disease Control and Prevention (CDC) awarded \$25 million in grant funding to build on existing community efforts and identify effective health care and community strategies to support children's healthy eating and active living to combat childhood obesity.⁵¹

Patient Centered Medical Homes (PCMH)

Within the PCMH, nutritionists and registered dietitians are listed as eligible providers that can serve on a PCMH team.⁵² For health homes to qualify for funding, states must develop a model that focuses on beneficiaries with at least two chronic conditions, one existing condition and at-risk of developing another, or at least one serious and persistent mental health condition. Eligible chronic conditions that directly pertain to nutrition include diabetes, heart disease, and overweight/obesity.⁵³

Home Health

As studies have shown that both home and community based care can lead to better health outcomes, the ACA established the "Independence At Home" Demonstration program which encourages primary care practices to provide home based care to chronically ill Medicare patients.⁵⁴ Under this program, RDs are listed as eligible providers. Arizona received a Maternal, Infant, and Early Childhood Home Visiting Program grant that brings a team of providers to the homes of at-risk families. These providers work with families to promote the health of their child(ren), including addressing nutritional health.⁵⁵

Healthy Aging: Preventive Services for Adults 55–64

The ACA established a grant program for public health interventions, community preventive screenings and referral, and treatment for chronic diseases for individuals between the ages of 55–64. With the increasing attention on obesity, diabetes, and other chronic diseases, emphasized intervention activities include improving nutrition and increasing physical activity.^{50,56}



Medicaid Nutritional Services

Under the ACA, Medicaid for the expansion population (should Arizona extend Medicaid coverage to adults up to 138% FPL) will cover preventive services recommended by the U.S. Preventive Services Task Force, including “intensive nutrition behavioral counseling” for adults with “other diet-related chronic diseases”.⁵⁶ Such services will be free to newly eligible Medicaid beneficiaries.

Medicare Nutritional Services under Medicare

Under the ACA, medical nutrition therapy (MNT) services are now covered under Medicare for people with kidney disease (but who are not on dialysis), for people who have had a kidney transplant, and for people with diabetes. MNT services, which include a nutritional assessment, one-on-one counseling, and therapy can be provided by an RD or a Medicare-approved nutrition professional.⁵⁷

Nutrition Labeling at Chain Restaurants

The ACA established national labeling requirements for vending machines and chain restaurants with 20 or more outlets to post calories on menus, menu boards (including drive thru’s), and food display tags, with additional information (fat, saturated fat, carbohydrates, sodium, protein, and fiber) available upon written request.⁵⁰ This provision requires national uniformity to ensure the consistency of information; state and localities cannot require additional nutrient information on menus.

Advocacy for Additional Public Health Benefits

The ACA represents great strides forward in assuring that critical services are covered from a public health perspective. The inclusion of first-dollar coverage (no co-pays or deductibles) for preventive services, women’s contraceptive coverage, and the prevention of exclusion for pre-existing conditions are ground-breaking changes.

In addition to continuing to monitor and assure needed uncovered services for vulnerable populations, health departments can play a role in identifying gaps as well as advocating to address them. There may be particular gaps in Arizona that are important.

The EHB gaps identified above may merit advocacy for coverage if the health department and community groups identify signs that trending worse health outcomes could be prevented by covering particular services. In addition, public health leaders have often advocated for more coverage of case management, home-based services, and the work of Community Health Workers (CHWs).

One of the best ways for public health departments to contribute to improving the coverage of these and other important preventive services often innovated in health departments, which are not driven by the limitations of reimbursement, is to demonstrate value and ROI of comprehensive, culturally appropriate, community based prevention and treatment services. By working with partners to measure the impact on reduced use of costly medical services of evidence-based interventions such as CHW supports and Healthy Eating and Active Living system change, health departments can convince ACOs and innovative health plans of the value of these and other services. At the same time, they will be building the evidence base that the USPSTF uses to determine Grade A or B preventive services that must be covered.

For example, the Boston Public Health Commission (BPHC), Boston’s health department, working with Boston Children’s Hospital and other community partners, developed a model of a primary care linked home visiting pediatric asthma self-management intervention. Hospital asthma clinic patients with the worst outcomes and emergency department use were prioritized for home-visiting services provided by the health department. A study of the program found significant medical savings.⁵⁸ Advocates, the health department, and the hospital worked together to convince legislators to pass language requiring the state Medicaid program to establish a demonstration pilot, and currently the health department and hospital are having conversations with private insurers about the program which has shown impressive cost-savings. Health departments and partners can be entrepreneurial and innovate effective services for priority costly health problems, prove their worth, and then work with health plans and advocates to obtain coverage.



Going forward, as the health care system likely changes from paying for care to paying for better health outcomes, health departments that can demonstrate the cost-effectiveness of population preventive services may then be successful in ensuring that such services are covered in a bundled payment, or other financial structure that supports appropriate care for vulnerable, high-risk populations. It will be important for health departments, public health leaders, and allies to advocate for private coverage and traditional Medicaid program coverage of effective public health services. Additionally, as mentioned earlier, there is an important role for public health to advocate that AHCCCS cover EHBs and Preventive Services in all plans.

People Who Won't Benefit from Essential Health Benefits: Grandfathered Plans

Grandfathered plans

Under the ACA, an employer or insurer offering health insurance coverage can elect to have the plan grandfathered, so long as it was in effect on March 23, 2010 and has covered at least one person continuously from that day forward.^{59,60} These plans include self-funded employer sponsored plans and insured group and individual health plans.⁶¹

Grandfathering exempts a plan from some, though not all, of the ACA's requirements. Regardless of whether a plan is grandfathered or not, all health plans⁵⁹:

- Are prohibited from applying lifetime dollar limits to essential health benefits;
- Are not permitted to cancel their insurance coverage when people get sick or if an employer or employee has previously made an unintentional mistake on the employee's insurance application; and,
- Must extend dependent coverage to adult children until they turn 26 years old. However, until 2014, grandfathered group plans are exempted from covering dependents if a young adult is eligible for group coverage outside of their parent's plan.

Grandfathered plans are not required to:

- Comply with the ACA's preventive care mandates and can keep the same preventive care benefits that were in place on March 23, 2010;
- Offer the EHBs package required of other plans;
- Follow the ACA's limits on out-of-pocket costs for participants;
- Offer new protections when appealing claims and coverage denials; and,
- Protect choice of health care providers and access to emergency care.

Grandfathered individual plans that are not offered through work are not required to:

- Phase out annual dollar limits on key benefits; and,
- Eliminate pre-existing condition exclusions for children under 19 years old.

A plan can lose its grandfathered status by doing the following: eliminating benefits for a particular condition or for services essential to treat that condition; increasing member coinsurance by any percentage amount; increasing the fixed dollar cost-sharing (co-pays, deductibles, and out-of-pocket limits) beyond allowed amounts; and, decreasing a plan sponsor's contributions toward the cost of coverage by more than 5%.⁶¹ These changes are measured against the benefits that were in place on March 23, 2010.

Prevalence of grandfathered plans in the U.S.

In 2010, estimates that health insurance plans that were likely to lose their grandfather status over the next several years ranged from 50% to 90%.²³ A 2012 Kaiser Family Foundation national survey found that 48% of individuals who receive health insurance coverage through their jobs are enrolled in a grandfathered health plan, down from 56% in 2011.⁶² This difference was statistically significant.



Demographics of those providing or enrolling in grandfathered plans

When looking at the types of firms that had at least one plan grandfathered under the ACA, there was no statistically significant difference between small and large firms (58% for firms between 3–199 workers, and 57% for firms with 200 or more workers), or regions of the U.S.⁶² However, while most industries were also statistically insignificant from one another, one exception was the transportation/communications/utilities sector where 78% of such firms have at least one plan grandfathered under the ACA.⁶²

Grandfathering in Arizona

While no Arizona data is publicly available on the number of employers that offer plans that will be grandfathered, it can be estimated that overall data might reflect that of the U.S. since there were few significant differences under the ACA by size of firm, region of the U.S, or industry type. Where possible, firm data specific to the Western region of the U.S. will be used to estimate the number of people covered under and businesses providing grandfathered plans.

In 2010, it was estimated that 54% of Maricopa County adults, or 1,280,000 people, were covered under employer insurance.⁴ In 2012, 63 % of employers overall offered health benefits in the Western region of the U.S..⁶² Applying that to Maricopa County, approximately 41,612 employers offer health benefits to their employees.

Taking into account that 57% of firms in the Western U.S. offered at least one grandfathered plan in 2012, a rough back-of-the-envelope estimate approximates that 23,719 employers offer health benefits that will be grandfathered from providing the essential benefits package as part of their insurance coverage. This will affect 48% or approximately 614,400 of the workers in Maricopa County who are covered under employer insurance. This number is predicted to drop relatively quickly over the following years, as plans change in a way that triggers the loss of grandfathered status. Based on national predictions of the percentage of grandfathered plans that will drop over time, as few as 6,347 to as many as 23,719 employers will offer grandfathered plans in the near future, affecting anywhere between 128,000 to 614,400 employees in

Maricopa County.⁶³ The variation is due to the variety of estimates about how quickly grandfathered plans will lose their grandfather status.

2C. WHAT'S MISSING FROM THE ACA?

From a public health point of view, the ACA is missing full and equal consideration of public health, primary prevention, and the role of health departments in improving population health. While the ACA represents a leap forward in integrating prevention and total population health into the health care system, it is still a major initiative aimed at health care access and not directly at health improvement. This tension will continue until the public health and health care sectors are able to work as partners with joint priorities and measures and health improvement strategies informed by public health that are fully inclusive of primary prevention and community-based and policy and systems change strategies.

For MCDPH, what is not fully addressed in the ACA is how the health department will finance its transformation as public health funding shifts and the workforce needs change. Sustainable, stable financing is necessary for the public health system to evolve into what is necessary to meet population health goals that will allow the country as a whole, and individual states, to continue to afford expanded coverage.

From an integrated population health point of view, looking beyond public health's role, there are some health care related issues excluded from health reform that are relevant. First of all, though it makes great strides, the ACA will not provide health coverage for all people, and MCDPH will want to continue to play a role in assuring access to screenings and preventive interventions such as immunizations and care for these populations at the very least.

In Arizona there will be significant populations that remain uninsured under the ACA expansion. Undocumented residents and those legally present less than five years will not have new coverage options and will be increasingly isolated as the remaining uninsured population will be largely comprised of these groups.



Being more isolated from legal residents may make them more visible, and thus more hesitant to find or seek out care, because of fear of exposing that they are uninsured, which will be the practical equivalent of illegal presence. There will be other subpopulations that fall off of subsidized insurance as they change income levels. The affordability of insurance will continue to be an issue for people just over 400% FPL and others, as deductibles and co-pays rise, since that population is low-income but ineligible for the federal subsidies. The ACA did not include a public option, which was a lost opportunity for a more affordable, high quality plan for low-income residents.

Portability of health insurance was not addressed, which would have mandated that health insurance coverage continuity would not be tied to a particular employer.⁶⁴ Ideally, individuals could have continuous coverage that would not be disrupted when they lost or changed jobs, which compels individuals and families to enroll in new and different coverage and often change providers. Portability would allow for stability, which would improve steady access to care and management and prevention of chronic conditions.

Additionally, the ACA does not attempt wholesale payment reform to tackle the health care system determinants of preventable medical costs such as changing the way health care is paid for, though it does encourage steps in that direction. While the Center for Medicare & Medicaid Innovation (CMMI) is seeding innovative payment and care structures, these will remain the exception to the fee-for-service rule. This means that as the cost of care and coverage rises, and financial pressures on government and health care grow, the focus of the health care system and government will increasingly be on reducing medical costs. This is true in Massachusetts, which turned its attention quickly to payment reform legislation after passing health coverage reform expansion.

The increased and intense focus of public and private health care payers on innovative solutions to reduce preventable medical costs creates a window of opportunity for public health leaders. Public health departments and public health strategies are essential

to solutions that reduce costs, but public health leaders must make this case convincingly. MCDPH should position itself to be part of these discussions and proactively approach public and private health care decision makers with Return on Investment (ROI) evidence for the most effective strategies to improve population health in ways targeted to reduce medical costs. MCDPH could analyze the top costly preventable chronic health conditions in Maricopa County to determine what is being spent now on (avoidable) health care for these conditions, and demonstrate how specific public health and total population health strategies can reduce those conditions and costs.

For example, MCDPH could identify the evidence for primary and secondary community and clinical prevention strategies that have a measurable result in reducing cardiovascular disease; determine and advocate for laws and policies limiting tobacco use; promote environmental systemic changes to reduce sodium in the food supply; promote greater access to and consumption of heart-healthy food; establish clinical support tools and health information exchanges with health departments to increase blood pressure screening and monitoring; and, establish patient EHR-linked prescriptions for physical activity and healthy food.

Section 3. Likelihood of Employers Dropping Health Insurance Coverage

The ACA is often criticized as a threat to American business and the survival of employer based health insurance. Over time, studies have shown mixed results, but it is predicted that employers will not drop the provision of employee insurance coverage because of the full implementation of the ACA. Some studies conducted by business consulting groups have demonstrated that while the majority of employers do not intend to drop health benefits coverage, a small percentage plan to do so or are undecided.^{65,66} According to a Deloitte study, 9% of companies

(representing 3% of the workforce) anticipate dropping coverage in the next 1–3 years and 81% of companies (representing 84% of the workforce) plan to continue.⁶⁶ Ten percent of companies representing 13% of the workforce are uncertain, where cost becomes the primary consideration for employers' decisions.⁶⁶

However, other studies have shown that rather than dropping coverage, employer sponsored insurance (ESI) will likely increase.^{67,69} While the Deloitte survey and others may measure employer sentiment towards the ACA today, they are not necessarily based on economic decisions that employers will make when the time comes to actually make them.⁶⁹ Instead, these studies assert that employer decisions will ultimately be most influenced by whether employers continue to see their employees as valuing ESI over the alternative created by the ACA. Under the terms of the ACA—and the pressure of a competitive market place—these studies predict that employees will value ESI.^{67,68}

A RAND study used the Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model to make this prediction for small firms. In a scenario which assumes that the baseline ACA provisions have taken effect and that most employers have lost grandfathering status, the estimated share of firms offering coverage rises from 62% to 68%.⁶⁸ This is driven by the individual mandate that increases workers' demand for insurance. Another analysis by the Urban Institute found that had the ACA law been in effect in 2012, ESI coverage would have increased by 2.7% (from 151.5 to 155.6 million people in the U.S.), largely attributable to the higher participation rates as employees seek coverage in response to the introduction of tax penalties for remaining uninsured.⁶⁷ Increases in coverage occurred across the board regardless of business size, with the largest relative coverage increase of 6% occurring among workers in small firms, with 100 or fewer employees.⁶⁷

The findings that ESI will not decrease — and in fact, will likely increase — is consistent with the Massachusetts health reform experience. In 2011, ESI was the dominant source of health insurance coverage at 79% for MA's population overall, and there has been no evidence of subsidized coverage “crowding out” ESI.⁹ This was true even during the economic recession when enrollment in MassHealth (Massachusetts'

public health insurance plan) increased in response to the near doubling of the state's unemployment rate from 2008 to 2010.¹¹ Yet, between 2005 and 2010, ESI offer rates grew from 70% to 77%, with firms of 50 or fewer employees that offer ESI growing from 45% to 66%, and firms of 51 or more employees that offer ESI growing from 80% to 92%.⁹ The percent of MA working age adults with employer-sponsored coverage has grown from 64% to 66%.

Ultimately, while it is plausible that some employers may seek immediate cost-savings through benefit reduction as markets adjust to new circumstances, over time, coverage reductions may cause their most valuable workers to seek employment elsewhere, as health insurance is seen as a critical benefit.⁶⁷ Following this logic, it is unlikely that large numbers of employers currently providing insurance coverage will change their decisions to offer it.

Section 4. Implications for Arizona if Medicaid is Not Restored or Expanded to 138% FPL

The combination of Proposition 204 Medicaid restoration and adult Medicaid eligibility expansion to 138% FPL in Arizona is estimated by the Governor's Office to provide expanded eligibility for approximately 300,000 people. But what would happen if the Legislature chooses not to approve the Governor's proposal?

A study published in the *New England Journal of Medicine* reported a significant reduction in all cause mortality in states, including Arizona, that had recently made meaningful expansions to adult Medicaid eligibility.⁷⁰ A new report on Oregon's Medicaid program showed that within two years, people enrolled in Medicaid had better mental health, especially witnessing a decrease in rates of depression, and received more preventive services than their unenrolled peers. Based on these studies, if Medicaid is not extended, Arizona could expect, at the very least, higher rates of depression than if Medicaid had been restored and expanded, and also potentially higher mortality rates for low-income, uninsured Arizonans than if Medicaid eligibility increased to 138% FPL.



An Arizona Senate proposal — the primary alternative to Governor Brewer’s proposal — would only maintain Medicaid coverage for those currently on Medicaid, leaving 300,000 people who would be covered under Governor Brewer’s plan uninsured. The only alternative for people over 100% FPL would be to purchase subsidized plans from the Health Insurance Marketplace (or Exchange). It is likely that many in the 100–138% FPL range would be challenged to afford purchasing plans, even with subsidies, and thus they would likely continue to be uninsured or drop off coverage.

The Senate proposal to avoid the ACA Medicaid expansion would continue the Proposition 204 freeze, maintaining coverage for the approximately 82,000 currently insured Proposition 204 adults up to 100% of FPL.^{71,72} However, CMS recently clarified that it will not approve the Proposition 204 — or any state’s — expansion with a freeze, meaning that Arizona would not receive any federal Medicaid reimbursement and would have to bear the entire cost of insuring this population using state funds.⁷³

If the Senate plan were to prevail, it also raises a serious question as to whether Arizona would be able to afford maintaining coverage for the 57,000 currently covered Proposition 204 residents without federal reimbursement. Even if AZ were to continue providing AHCCCS to these residents, the coverage would be precarious. Because the program has a freeze, members who lose coverage because of income change or for any reason would not be able to re-enroll.

If Arizona does not expand and restore Medicaid coverage, many adults between 100–138% FPL who could not buy or remain enrolled in subsidized Marketplace plans would remain uninsured. Those who did buy Marketplace plans would add more medical expense to their budget (compared to if they could enroll in AHCCCS). Because some people would remain or become uninsured, they would continue to be a burden on the health care system and not be able to access preventive services and primary care. Without fully expanding Medicaid, health care expenses for these low-income individuals would be a much bigger burden, as would the cost of care for the uninsured for the state, the health care system, and employers.


Without participating in the ACA Medicaid expansion, Arizona would miss the opportunity of \$2 billion in federal Medicaid match funds as well as incur the actual loss of tens of millions of dollars of Disproportionate Share Hospital (DSH) payments to cover the care of the uninsured between FY2014–FY2021. But hospitals and health centers will still be faced with the financial burden of providing care to the uninsured; a cost that will be borne by the state and by the health care sector and passed along to all Arizonans. Currently, it is estimated that Arizona hospitals subsidize care for the uninsured by passing along that cost to Arizonans at about \$200 per family per year.⁷⁴

For health departments, the most significant outcome will likely be further, deeper cuts to discretionary funding as the state is forced to redirect dollars to health care institutions to address the unreimbursed health care to the uninsured. If additional Arizonans are not insured, overall health would likely be comparable to what it is currently, although worse than what it would be with the expansion. However, the pressures on public health could intensify as the health care system is squeezed harder financially and fewer people get the care they need in a timely way, including current safety net services. This has the potential for increased incidence of preventable diseases and worsened health conditions, placing greater pressure on public health to meet population health problems through prevention and through safety net services without the resources.

Impact on Safety Net If Medicaid Expansion Does Not Go Through

In recent years, the Arizona safety net has been under considerable pressure. Demand for safety net services has increased since the recession began in 2009. Many people who did not use safety net providers in the past are now using these services and more people who get care from the safety net have no coverage.⁷⁵ Medicaid expansion carries with it the likelihood that the newly insured population will have an increased demand for some services that they did not seek when they were uninsured. But, importantly, it brings a significant opportunity for safety net providers, who will be able to bill Medicaid for many services that were previously uncompensated.





An additional concern related to Medicaid expansion is the future of the waiver for Proposition 204, which provides Medicaid coverage to all Arizona adults up to 100% of FPL. The waiver expires on December 31, 2013, and it is estimated that 50,000 childless adults will remain enrolled at that time. This group could become uninsured if Arizona's request for an extension of the waiver is not approved.⁷⁶ If this group becomes uninsured, it increases the number of people who are likely to seek uncompensated care from safety net providers.

Beginning in 2014, the amount of Disproportionate Share Hospital (DSH) funding that will be available to safety net hospitals will decrease significantly based on the premise that fewer people will receive uncompensated care due to insurance expansion in other parts of the ACA.⁷⁷ DSH funding to safety net hospitals will significantly decrease as a result of provisions in the ACA that will cause fewer people to receive uncompensated care. It possible that the decrease in DSH funding will be offset by the ability of safety net providers to bill Medicaid if Medicaid expansion takes place. CMS recently announced that it would adjust its rule on reducing DSH payments so as not to penalize states that do not expand Medicaid, so Arizona disproportionate share hospitals are no longer likely to face as dramatic a reduction



Part III. The Impact of the ACA on Critical Health Sectors and Employers and Opportunities for Public Health

in these funds.⁷⁸

Section 5. Primary Care

If accepted, the Medicaid expansion from 100% to 138% of FPL will add coverage for 57,000 adults in Arizona who were not previously eligible for Medicaid. The expansion will also restore coverage for 240,000 adults covered under Proposition 204, which established coverage for all adults at 100% of FPL. Eligibility was frozen in 2010 and eligible Arizonans have been dropping off of — and locked out of — Medicaid coverage since then.⁷⁹ This will have a big effect on the health care and public health system.

5A. NEW DEMAND FOR PRIMARY CARE AND PROVIDER SUPPLY

Nationally, the ACA's expansion of insurance coverage is expected to increase demand for primary care services by 10%. It is estimated that the increase in demand for services will require 7,200 additional primary care providers across the country, or almost 2.5% of the current supply.⁸⁰ Medicaid expansion will affect all patients. For example, increased waiting times in primary care visits could lead to more people seeking non-urgent care in emergency departments.

The greater demand is likely to be manageable in most states with relatively small adjustments in the delivery system. For this report, we reviewed two studies that examined the existing primary care base and expected increase in the insured in slightly different ways. In a study that ranked states with potentially the largest

primary care access gaps after Medicaid expansion, based on the size of the state's Medicaid expansion and the state's primary care capacity, Arizona ranked 34th in the country. Its anticipated expansion relative to primary care capacity is roughly in the middle compared to other states.⁸¹ A bigger challenge than overall primary care capacity for Arizona is the low ratio of primary care providers to individuals in rural areas.

Some analyses suggest that demand for primary care services, when expanded through Medicaid to the currently uninsured, may be unlike demand by currently insured populations. An analysis from the Medical Expenditure Panel Survey suggested that after controlling for age, the uninsured are sicker than those who are insured. They are in poorer health than the current privately insured for most age groups and medical conditions.⁸² This study suggests that differences in the health status of the currently uninsured will be associated with physician use rates about 20% higher than current privately insured rates, mainly driven by use of services by 45-to-64 year olds.⁸² It concludes that expanded coverage will roughly double the physician requirements for the currently uninsured.⁸²

It is difficult to predict how increased demand for care will result from the aforementioned Medicaid expansion as well as expansion under Proposition 204.⁷⁶ The previously uninsured may have delayed seeking care in the past until a health problem became too severe to avoid care. As they learn to utilize primary care, they are likely to seek care in a Community Health Center (CHC) setting where one is available rather than urgent care facility, hospital, or private

practice. The previously uninsured are likely to have more undiagnosed chronic and other conditions that will emerge as they seek care once insured. Similar to the U.S. population overall, Arizona residents have a significant chronic disease burden.

More than half of adults live with chronic conditions: 27% have one chronic condition, 17% have two, and 14% have three or more. Hypertension is the most common chronic condition, followed by arthritis. Utilization of office visits is considerably higher for people with chronic conditions. For instance, people with hypertension and arthritis have approximately three times more office visits per year, compared to people with no chronic conditions.⁸³

People with chronic diseases use emergency departments (ED) more often than those who do not have these conditions. A 2008 study of Arizona ED use showed that half of ED visits could be classified as “non-emergent and emergent-primary care treatable.” This study suggested that many of these services could have been provided in the primary care setting, and that 101 additional primary care physicians would be needed to provide these services.⁸³ This study demonstrates that shifting care from the ED to a primary care setting may be appropriate and cost effective, yet will create an additional demand on primary care access.

Supply of Primary Care Physicians.

In 2008, Arizona’s primary care workforce was comprised of 60% MDs, 11% DOs (Doctor of Osteopathic medicine), 22% NPs (nurse practitioner), and 7% PAs (physician assistant).⁸³ Data from the 2005 Arizona Physician Workforce Study showed that approximately 75% of Arizona physicians are in private practice, and 41% are in primary care specialties, compared to the national average of 38% in primary care.⁸⁴

In 2010, Arizona had 68.1 active primary care physicians per 100,000, compared to the national average of 70.4. At that time, it was estimated that an additional 757 primary care physicians (PCPs) were needed to meet projected population needs.⁸⁵ PCPs are distributed unevenly in Arizona. Pima County has 117 PCPs per 100,000 while Maricopa County has 102/100,000. The distribution of PCPs is much lower in rural parts

of the state. Arizona will need to add an additional 2,206 PCPs by 2020 to maintain a consistent patient/PCP ratio.⁸³

Data from all sources indicates that rural areas in Arizona have significant access issues. A study conducted by the Center for Rural Health in the Mel and Enid Zuckerman College of Public Health at the University of Arizona identified a considerable range in access based upon geography. Overall, Arizona has an average of 231 physicians of all kinds per 100,000. This varies from 250 physicians per 100,000 for some urban areas to 70 physicians per 100,000 for some isolated, small rural towns. Because the expansion of patients into Medicaid will occur statewide, access issues in rural areas is likely to be particularly exacerbated.⁸⁶

Rural Arizona is not the only area with shortages. Maricopa County has several Health Professional Shortage Areas (HPSAs), including in Glendale, Phoenix Central, Phoenix South Central, and Avondale/Tolleson.⁸⁷ ADHS estimates that an additional 300 primary care physicians are needed to eliminate the HPSAs statewide.⁸⁷ Community health centers provide much of the health care services to uninsured, underinsured, or AHCCCS enrollees in the HPSAs.

Another pressure on the future primary care workforce is the aging workforce, with 51% of Arizona’s practicing physicians over 50 years old.⁸⁸ This requires long term planning to draw physicians to Arizona to establish practice in the state. Of Arizona’s workforce, 9.8% completed undergraduate medical education (UME) in-state compared to the national average of 28.6%. Seventeen percent of physicians in Arizona completed their residency programs in Arizona.⁸⁹ Because of Arizona’s relatively small number of UME and residency training spots, it seems likely that Arizona will continue to need to attract physicians to practice in Arizona after their training is completed. In a study of newly licensed MDs in Arizona in 2005, 95% had completed UME out-of-state, and 86% completed their residency out-of-state. In a survey regarding new physician decisions related to where they chose to practice, the most important features indicated by respondents included characteristics of the community, adequacy of the health care facilities, and the quality of the work environment.⁸⁹ Issues about UME are discussed further in the Workforce Section.



Of the 19,000 allopathic physicians licensed in Arizona, more than 9000 practice out of a state. In a study conducted in 2008, reasons identified by physicians include being closer to family and friends and better reimbursement or salary elsewhere. Other top reasons include physicians being unable to find a position in his or her field in Arizona, a career/education opportunity for spouse, to continue postgraduate training, and the quality of children's school(s). Approximately 9.4% of physicians reported that high malpractice premiums are a reason why they practice outside of Arizona.⁹⁰

Nurse Practitioners and Physician Assistants

NPs have a broad scope of practice in Arizona, one of 22 states where NPs can practice independently without physician collaboration or supervision. In Arizona, the annual estimates of licensed NPs grew from 2,351 NPs in 2001⁹¹ to 4,188 in 2013, according to the Arizona State Board of Nursing.

However, reimbursement rates often discourage Arizona NPs from setting up independent practices. Medicaid and Medicare reimburse NPs at 85% of physician fees. However, some private insurers pay at a considerable lower rate than physicians.⁹² In addition, NPs wanting to establish independent practice may encounter challenges in gaining acceptance into health plan panels. In one Arizona NP's opinion, this is not due to credentials, but rather because health plans do not believe that there is an unmet primary care need, and the burden is placed on the applicant NP to prove the need. This creates a time consuming process that may become a barrier to NPs setting up practice.⁹³ In general, more NPs are interested in practicing in team settings such as primary care practices, health centers or clinics, than in setting up independent practice.⁹³

Arizona is currently utilizing PAs as part of the primary care team, as well. There are 1,688 PAs certified to practice in Arizona, with 900 practicing in the state, and approximately 35% working in specialties with a primary care focus. A PA must hold a valid Arizona PA license, possess an approved notice of supervision, and have an approved supervising physician "available" while performing healthcare tasks.⁹¹

5B. IMPACT OF CHANGES IN PRIMARY CARE REIMBURSEMENT

The ACA specifies Medicaid primary care provider payment enhancements, with a federally funded increase to bring rates for primary care providers equal to Medicare rates for a two-year period, beginning January 2013 through December 2014.⁹⁴ The increase applies to 150 different primary care services provided to Medicaid enrollees by family medicine, general internal medicine, and pediatric physicians. To qualify, physicians must prove that they are Board certified and that at least 60% of their Medicaid services in the previous year were eligible primary care services. The enhanced Medicaid rates apply to services provided by nurse practitioners and physician assistants under the personal supervision of a qualified physician. The Medicaid fee increase applies in managed care organizations as well as fee-for-service, and the health reform law requires that qualified physicians in Medicaid plans directly receive the enhanced rates.⁹⁵

The ACA also increases Medicare Part B payments for primary care services by 10% between January 1, 2011 and December 31, 2015. In addition to receiving regular Medicare payments for services provided during this period, PCPs can recover 10% of the cost of providing certain primary care services, further increasing potential primary care reimbursement. This incentive is available to physicians specializing in family, internal, geriatric, or pediatric medicine for whom primary care services account for at least 60% of their allowed charges.⁹⁴ Because the ACA will result in a significant expansion of Medicaid, most of the information reviewed thus far has focused on the impact of the expansion of the Medicaid rates. Changes in Medicare rates will provide additional revenue to primary care providers, but seem unlikely to result in significant capacity to expand.

Provider willingness to accept Medicaid patients. In Maricopa County, much of the Medicaid population receives services from community health centers (CHCs). However, some CHCs have witnessed a large increase in demand for services from uninsured patients, and have fewer patients covered under Medicaid or other insurers. In some cases, CHCs must put uninsured patients on a waiting list, because the CHC has inadequate funding to balance the cost of uncompensated care.⁹⁶



Nationally, it is estimated that that only 41% of PCPs accept all or most new Medicaid patients.⁹⁷ HRiA was unable to obtain the number of primary care providers in Arizona who do not accept Medicaid patients; however, the Arizona Department of Health Services Bureau of Health Systems Development conducts routine phone surveys of physician offices across the state, and estimates that up to half of the offices in Health Professional Shortage Areas do not accept Medicaid patients. No information is collected in these surveys about the reasons for not accepting Medicaid patients.⁸⁷

Studies show that some PCPs do not accept Medicaid because of difficulties in obtaining referrals and other administrative functions in addition to concerns about fees. New models of care, such as Patient centered Medical Homes and Accountable Care Organizations, focus on coordinated care and may result in improved administrative processes. This could mitigate some of the problems and decrease some PCPs' hesitations to accept Medicaid patients.⁹⁷ It is worth noting that AHCCCS is thought to be a relatively easy agency with which to deal. One person said that Medicaid is a good payer relative to paying on a timely basis and to other administrative matters.⁹⁶

Anecdotally, specialist access can be an issue for uninsured patients who receive primary care services through a CHC and are referred for specialty services such as oncology. It can be hard to find specialists who will treat the uninsured. Access is less of a problem for a Medicaid patient requiring specialty services, and CHCs often have established referral patterns to specific specialists who accept Medicaid patients. It is not yet known how referrals to specialists will be impacted if Medicaid is expanded.⁹⁶

Impact of Medicaid rate increases on provider participation. To measure the impact of the Medicaid fee increase, there have been a number of studies attempting to understand the magnitude of fee increases. One study focused on Medicaid-to-Medicare fee indices to understand the potential impact of the rate change in each state. Arizona's Medicaid-to-Medicare fee index for 2012 was .82 for all services (meaning that Medicaid reimbursement rates were 82% of Medicare rates), and .75 for primary care

services. The national average index for primary care services for 2012 was .58. Therefore, primary care providers in Arizona will see a less dramatic shift in their payment under the ACA than primary care providers in other parts of the U.S.. However, the fee index for primary care services in Arizona has decreased significantly in recent years, from .97 in 2008.⁹⁵ This is likely due in part to the AHCCCS reduction in payments to providers in 2009, as part of the budget cuts taking place at that time.⁹⁸ The Medicaid rate increase will restore some funding for services that were previously covered at a higher rate.

An additional incentive to treat Medicaid patients is the opportunity to participate in the Arizona Medicaid Electronic Health Record (EHR) Incentive Program.⁹⁹ The Arizona Medicaid EHR Incentive Program provides incentive payments to eligible professionals and hospitals as they adopt and implement certified EHR technology. Eligible providers include physicians and nurse practitioners. To participate, providers must attest to a number of criteria, including volume of Medicaid patients.⁹⁹ New payment models may also be adopted by Medicaid managed care plans, such as performance-based incentives, and these may provide additional incentives to primary care providers to accept Medicaid patients. While various studies attempt to measure the impact of the fee increases, one can only speculate about the impact they will have on primary care providers' willingness to open their panels to Medicaid patients. Some providers may be adding new patients from the insurance Exchange to their panel, so this (and other) factor(s) may influence their decisions.

5C. OPPORTUNITIES TO EXPAND PRIMARY CARE CAPACITY IN ARIZONA

New Models of Care

An important strategy for expanding primary care capacity will be changing how primary care services are provided within a practice. Implementation of the Patient Centered Medical Home model provides significant changes to the roles on a treatment team, and while the focus is to improve patient quality, it also allows the practice to manage patient care in a more flexible manner. Additionally, proactively and creatively addressing health disparities will be an important consideration in care.



Utilizing data to inform program development; identifying culturally competent staff, outreach in communities and homes; targeting high-risk patients for supportive care and ancillary services such as transportation; and, providing appointment reminders are important issues to be addressed.

Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs) discussed further in Section 7, focus on active management at the primary care site. However these models are based on a team approach, which can include nurse practitioners, physician assistants, health educators, and care coordinators, so the effect of these models may shift some of the demand directly from primary care physicians to other providers. The PCMH model, which is being widely implemented around the U.S. and in Arizona, redesigns care with an emphasis on care coordination and integration across the spectrum, aiming for enhanced access to care through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and other practice staff.¹⁰⁰

Nurse Managed Health Clinics (NMHCs) are community based primary care clinics that are led by an advanced practice nurse. With their focus on health education, health promotion, and disease prevention, and experience serving underserved populations, NMHCs offer an important model.¹⁰¹ Arizona has at least four NMHCs. NP Healthcare Grace (Phoenix) poses an interesting model, as a federally and state funded organization that partners with an academic institution, Arizona State University, and a faith-based organization.⁹³ NMHCs, for which the ACA has authorized funding, exemplify partnership opportunities at the community level.

Primary Care Extenders

Another key to addressing the demand for primary care is the use of primary care extenders, such as community health workers (CHWs). CHWs can help increase health knowledge, support, education, and referrals, all of which can lead to more effective use of primary care. The role of CHWs is discussed more fully in Section 9. Helping to address the need for primary care can draw on the skills of professionals in a variety of roles.

Primary Care Medical Training and Career Pipelines

The limited number of residency training spots in the state, and the impact this has on the availability of physicians, remains an important issue in Arizona. Arizona eliminated state funding for graduate medical education (GME) spots in 2010 as part of state budget cuts. In 2010, Arizona had 21.7 residents per 100,000, compared to the U.S. average of 35.8 per 100,000, ranking Arizona 37th in the country.⁸⁵ While hospitals have funded their own residency programs, it can be costly and is likely not sustainable.⁸⁵ Location of residency programs is important, as well. Seventy-five percent of Arizona graduates who complete a residency in Arizona stay in-state to practice, while only 28% of Arizona graduates who complete a residency in another state return to practice.⁸⁵

The Arizona Department of Health Services (ADHS) Bureau of Health Systems Development oversees the National Health Services Corps (NHSC) and the Arizona Loan Repayment Programs which provide scholarships and loan repayment programs for primary care physicians, NPs, and PAs practicing at CHCs and other safety net sites in Health Professional Shortage Areas. ADHS outreaches to new sites that qualify to encourage them to participate. ADHS also convenes trainings for CHCs and rural health clinics on provider recruitment strategies and tools.⁸⁷ While it is too soon to measure the impact of the expansion of the NHCS by the ACA, there were approximately 420 sites in Arizona and approximately 250 participants as of Fall 2012.¹⁰²

Additional programs encourage residents and other practitioners to explore practicing in underserved locations in Arizona. The Arizona Association of Community Health Centers offers loan repayment programs through the SEARCH (Student/Resident Experiences and Rotations in Community Health) program for students and residents to encourage the practice of medicine in an underserved primary care setting. This program is available to physicians, NPs, PAs, and others.⁸⁵ Other programs have established individual loan repayment programs, as well.



The ACA provided funding for teaching health centers in the Teaching Health Center Graduate Medical Education program, a five-year program designed to increase the number of primary care medical and dental residents trained in community based settings. Eleven grants were made in 2011, none in Arizona.¹⁰³ While no additional funding is currently available, it would be worth monitoring future funding opportunities from this program.

Other collaborations to encourage medical students and residents to gain experience in community health centers are taking place with the hope of increasing students' interest in safety net services. For instance, A.T. Still University School of Osteopathic Medicine offers a curriculum that provides for medical students to have three-year placements at North Country HealthCare, a community health center in northern Arizona.¹⁰⁴ One person interviewed for this report noted that the University of Arizona College of Medicine is looking at residency needs at a statewide level, at least in part stemming from St. Luke's Health Initiative's report, *Graduate Medical Education in Arizona: Growing the Physician Pipeline*.⁸⁷

Nurse Practitioner Clinical Training

The CMS Innovation Center's Graduate Nurse Education Demonstration provides reimbursement for the cost of providing clinical training to advanced practice registered nursing (APRN) students at a number of pilot sites, including Scottsdale Healthcare. Training is provided at Scottsdale Healthcare hospitals in partnership with the nursing schools at Arizona State University, University of Arizona, Northern Arizona University, and Grand Canyon University, and a broad range of community-based care organizations across the state. This pilot helps address the barrier of the clinical cost of training APRNs, and is expected to train more than 400 APRNs to serve as part of the Arizona workforce.¹⁰⁵

Another funding opportunity comes from the Robert Wood Johnson Foundation (RWJF) and the American Association of Colleges of Nursing, which jointly established a program to help address the nursing shortage and increase the diversity of practicing nurses. Additional awards may be made in future years, and

opportunities like this should be monitored.¹⁰⁶ In any nurse training partnership, MCDPH could help assure that training incorporates population health competencies.

Use of Mid-Level Practitioners. One way to meet the increased demand for services for the newly enrolled population will be expanded roles for mid-level practitioners, namely nurse practitioners and physician assistants. A body of research demonstrates that NPs and PAs perform as well as physicians on a number of clinical measures, and that there is a high degree of patient satisfaction with care provided by them.¹⁰⁷ NPs are well positioned to provide services to the newly expanded population. Primary care NPs work in many settings that are likely to treat the newly insured population such community health centers, school-based clinics, nurse-managed health clinics, as well as physician practices. NPs are the fastest growing segment of the primary care workforce.

An important issue for NPs is credentialing and reimbursement issues. Many managed care plans do not credential NPs as independent providers, and often reimburse at a considerably lower rate than primary care physicians.¹⁰⁷ It is important to examine Arizona Medicaid and managed care organization (MCO) credentialing and payment policies to ensure that they provide incentives for NPs to practice in the state.

Health Department Roles

Connect residents with primary care access. The Boston (Massachusetts) Public Health Commission (BPHC) — the city's health department — expanded the services of its Mayor's Health Line after health coverage expansion in the state resulted in limited access to PCPs. The BPHC Mayor's Health Line assists residents in finding and enrolling in health coverage and accessing a range of services. After health care reform, the Health Line added capacity and systems to help callers seeking primary care providers. The Mayor's Health Line also conducted targeted outreach in Boston emergency departments to connect with newly insured residents who may not yet have a primary care home



Contribute to relevant planning efforts. Public health should be directly involved in planning the state's approach to expanding access and assuring that access is comprehensive of all needed primary care services, is culturally competent, and quality preventive services are available. In Massachusetts, the Boston Public Health Commission participates on the state's Primary Care Medical Home Coordinating Council.¹⁰⁸ As referenced elsewhere, in other states, PCMH and workforce planning efforts are led by or include health departments.

Recognize Excellent Models. The BPHC established the Mayor's Task Force on Primary Care to focus on important issues of access to quality care and preventive services for low-income residents. The Task Force released a report identifying major primary care issues and recommendations, and then established a Mayoral Prize for Innovation in Primary Care to recognize outstanding achievement in improving access to and the quality of primary care through innovations in health care delivery systems, the workplace, and the community. In recent years, awards were presented to: a community health center for developing a system for tracking and coordinating care for patients in need of breast, cervical, and colon cancer screening; another community health center for its partnership with the Boston Housing Authority to improve the health status of public housing residents and connect them to community services; a large Boston employer for creating a comprehensive employees wellness program that has incentivized healthy lifestyle choices and reduced health care costs; and, a family foundation for a large investment in five Boston community health centers to standardize and coordinate diabetes care.¹⁰⁹ Paired with other initiatives, a recognition program such as this highlights the important role that municipal leadership can take in providing primary care access in the community.

Monitor Access and Related Health Outcomes.

As the ACA is implemented, it will be important to monitor the way that primary care access plays out in the community using a variety of metrics. The ADHS Bureau of Health Systems Development monitors trends in primary care physician availability. Examining trends regarding the ratio of primary care providers to enrollees is one metric. Because there are other factors in primary care service availability, such as

services provided by community health centers, NMHCs, and independent practice NPs, it may be helpful to gather data from all of these sources to understand overall trends and potential gaps. In addition, population surveys will assist in understanding associated health outcomes and in monitoring rates of preventive screening by population.

Section 6. Safety Net Providers (Non-Health Department)

OVERVIEW

The Institute of Medicine report, *America's Health Care Safety Net: Intact but Endangered*, describes the safety net as providers who offer care to patients regardless of their ability to pay and for whom a substantial proportion of their patients are uninsured, underinsured, or enrolled in Medicaid. This can include public and teaching hospitals, community health centers, local health departments, free clinics, special service providers, and some physician networks and school-based clinics.¹¹⁰ The impact of the ACA on safety net services is still uncertain, but it is likely to have a profound effect.

As previously discussed, many of the low-income adults newly insured under Medicaid are expected to be in fair or poor health, with many complicated medical and behavioral health issues.¹¹¹ There is likely to be a significant increase in demand for services, as people who were previously uninsured seek care they may have needed and did not seek. This could increase the already existing shortage of primary, specialty, mental health, and oral health care providers, especially those with expertise in treating vulnerable populations.¹¹² Safety net providers are expected to remain an important source of care for vulnerable populations under the ACA.¹¹³ Based on the experience of Massachusetts, safety net providers are likely to continue to care for many of the same populations they currently see, including the chronically ill and people with multiple conditions.¹¹⁴ In Massachusetts, use of some safety net providers increased after health reform. For example, the number of patients served by community health centers increased by 31% from 2005 to 2009.



The share of uninsured patients at CHCs decreased during this time, from 36% of CHC caseload to 19%.¹¹⁴ Services for patients who had previously received uncompensated care could now be billed to MassHealth, the state Medicaid program.

That Massachusetts safety net providers saw an increase in patients demonstrates the important role that safety net providers continued to play, especially as wait times for access to care from private primary care practices increased.¹¹⁴ In the 2009 Massachusetts Health Reform Survey, patients who received care from safety net providers reported the most common reason chosen to receive care through these providers was because safety net service was convenient and affordable. Respondents also said that safety net sites provided other useful services in addition to health care and had staff who spoke their language.¹¹⁴

There has been considerable concern about access to safety net providers in Phoenix as far back as 2004. At that time, physicians and dentists were in short supply in the Phoenix metropolitan area, resulting in access problems for uninsured and underserved patients. Section 11 discusses areas in Maricopa County that have Health Professional Shortages and the impact on use of CHCs. Arizona's safety net has already lost substantial funding due to AHCCCS's freeze on coverage for childless adults at 100% of FPL in 2011, the elimination of the catastrophic coverage through Arizona's spend down program in 2011, and the reduction of provider fees in 2009.⁹⁸ The elimination of tobacco tax funding for CHCs to provide primary care services for the uninsured who did not qualify for benefits, was an additional loss.⁹⁸

CHCs have seen a significant increase in uninsured patients, many of whom were likely frozen out of eligibility for AHCCCS. CHCs' ability to provide uncompensated care is offset by revenues from Medicaid and other payers. Thus as they began to experience a decrease in AHCCCS revenues, CHCs have had less capacity to provide uncompensated care. In some cases, uninsured patients now have to be placed on waiting lists to receive CHC services.⁹⁶

6A. IMPACT ON COMMUNITY HEALTH CENTERS

While CHCs are already strained in their ability to provide uncompensated care, there are funding streams in the ACA that should help support them through the transition and until many more of their uninsured patients have insurance. There are several provisions of the ACA that address the need for expanded CHC capacity and will help increase CHC revenues:

- Increased Medicaid revenues as a result of Medicaid expansion;
- Expanded coverage for low- and middle-income people through the insurance Exchanges;
- Increased Medicare rates; and,
- An increase in federal health center grants.¹¹⁵

Essential Community Providers and Participation in Marketplace Health Plans. The ACA has several requirements related to Federally Qualified Health Centers (FQHCs) and FQHC look-alikes related to their participation in Marketplace health plans, and their reimbursement by these plans. An important issue for FQHCs is their designation as “essential community providers”, which will enable them to participate in qualified health plans and make them available to patients who access coverage through an insurance exchange.

HHS proposed to define essential community providers as only those groups suggested in the ACA, including those named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act.¹¹⁶ Eligible entities under Section 340B(a)(4) include:

- Health centers (including FQHCs and FQHC look-alikes; Tribal and Urban Indian Health Centers; Ryan White HIV/AIDS Program Grantees);
- Hospitals (including children's hospitals, critical access hospitals, disproportionate share hospitals (DSH), free standing cancer hospitals, rural referral centers, and sole community hospitals); and,



- Specialized clinics (including Title X family planning clinics, sexually transmitted disease clinics, and tuberculosis clinics).¹¹⁷

There are some ambiguities regarding the interpretation of the definition of essential community providers as they pertain to FQHCs. For example, the ACA specifies that nothing in the essential community provider statute requires “any health plan to provide coverage for any specific medical procedure.” This could be interpreted to mean that health plans need not contract with FQHCs to cover all of their services, but instead use FQHCs for limited specific services. If health plans utilize limited services at FQHCs and send patients to other providers to receive services that FQHCs are capable of providing, it would limit the potential benefit from Medicaid expansion.¹¹⁸

Health departments are also a critical part of the safety net, and to the extent that they provide primary care services and run specialized clinics included as essential community providers, they could be considered essential community providers. Public health advocates could recommend that HHS include both CHCs and health departments as essential community providers.

Reimbursement. The ACA requires a new prospective payment system for Medicare-covered services furnished by FQHCs, including preventive services, beginning October 1, 2014.¹¹⁸ The Medicare list of preventive services — which includes services like abdominal aortic aneurysm screening, bone mass measurements, and Glaucoma Screening¹¹⁹ — is broader than the benefits covered under the preventive service in the Essential Health Benefits requirements. Additionally, the ACA requires qualified, or Marketplace, health plans to pay FQHCs no less than Medicare Prospective Payment System rate for “any item or service” covered by the plan.¹²⁰

Funding Opportunities for CHCs

Recognizing that CHCs will be an important site of primary care for newly covered patients, the ACA includes a number of provisions that expand CHC capacity. Many of these may represent opportunities for MCDPH to partner with local CHCs.

The ACA also provides opportunities via the Community Health Grants for FQHCs to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. This is a significant opportunity for MCDPH to explore.

KEY ACA PROVISIONS THAT SUPPORT CHCs

Section 10503(c)	Authorized \$11 billion for CHCs starting in FY 2011. Of these funds, \$9.5 billion were directed toward expanding operational capacity and \$1.5 billion to fund the expansion and improvement of existing facilities. ¹²⁰	
Section 5208	Authorized new nurse managed health centers for the period of 2010 through 2013 ¹²⁰	
Section 4101	Provided new authorizations for school-based health centers through the School-Based Health Center Capital (SBHCC) Program to address capital needs in school-based health centers. Available for the period of 2010 through 2013 ¹²⁰	Three Arizona SBHCs funded in 2012; none in Maricopa
Section 5508	Authorized funds to qualified teaching health centers to support the expansion of primary care medical and dental residency training in community based ambulatory settings. Available for 2011–2015. ¹²¹	
	CMS Innovation Center FQHC Advanced Primary Care Practice Demonstration, beginning in 2011. Participating FQHCs are developing patient centered medical home models. This demonstration runs through 2014.	Eleven sites in Arizona, including Sun Life Family Health Center in Maricopa ¹²²



6B. SAFETY NET HOSPITALS

In a 2004 study at St. Joseph's Hospital and Medical Center, approximately 22% of emergency room visits that did not result in admission were non-emergent, and 23.2% were for conditions that were emergent but could have been treated in a primary care setting.¹²³ Many of these ER visits were likely by uninsured patients whose numbers will diminish, but not disappear under the ACA.

Many hospitals rely on federal and state DSH funds to help cover the cost of care for the uninsured. While the basic structures of the Medicaid and Medicare DSH programs will not change, the amount of DSH funding will decrease significantly beginning in FY2014 as fewer people are expected to need uncompensated care as a result of expanded insurance coverage. DSH payment will be reduced by over \$14 billion during 2014 to 2019.⁷⁷

The methodology of the reduction, which has not yet been published, results in the largest percentage reductions on states with the lowest percentage of uninsured individuals or those that do not target their DSH payments to hospitals that have high Medicaid volume or high levels of uncompensated care. It will also impose a smaller percentage reduction on low DSH states, and will take into account the extent to which DSH allotments have been used to expand coverage under a Section 1115 demonstration project.⁷⁷ The uncertainty about DSH funding may be of concern to safety net providers, especially those that have a disproportionate share of uninsured or undocumented patients. It is not yet clear if revenue gained from expanded coverage will balance the decrease in DSH funds.¹²⁰

Section 3025 of the ACA established the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The readmission measures apply to patients who were admitted for acute myocardial infarction, heart failure, and pneumonia, and who are readmitted within 30 days of discharge.¹²⁴ There is some concern about the impact that this will have on safety net hospitals which treat patients with more complex needs and fewer social supports post-discharge, which could be factors that increase the likelihood of readmission.

Based on Massachusetts' experience, rates of ED use may not change significantly after Medicaid expansion. A study that compared use of EDs in 2006 to 2008 showed a 4% total increase. The study found a 2.6% decrease in ED use for "low severity" visits by people who had previously been uninsured or underinsured.¹²⁵ Another study focused on use of care by safety net patients (both insured and uninsured) compared to other low-income adults and the overall Massachusetts adult population. For most services except ED use, there was no significant variation in utilization. However, safety net patients were more likely to use EDs than others, and 33% of low-income safety net patients used EDs for non-emergency situations, compared to 14.7% of all adults.¹¹⁴ This suggests that overuse of EDs is not necessarily a matter of insurance status. Efforts to change ED use could require education on accessing care in the appropriate location, and looking for ways to make primary care more accessible, e.g. expanded office hours.

DSH has been a significant source of revenue for Arizona safety net hospitals. In 2012, more than \$9 million was received in DSH funds by 43 hospitals.⁹⁸ While the specific change in federal DSH funds to Arizona is not yet known, it will most certainly have an impact. As the new method of DSH funding (supposedly) takes into account the percentage of the state's population that is uninsured, current levels of DSH spending, and the use of DSH funding in Medicaid waiver programs, Arizona's DSH reduction may not be too dramatic if the state continues to have a large number of uninsured.¹²⁶

6C. RURAL HEALTH CLINICS

The ACA in §5601(b) permits community health centers to engage in contractual collaboration with rural primary care providers that agree to accept health center patients without discrimination and prospectively discount their charges in accordance with the health center's fee schedule. Eligible rural providers include rural health clinics, critical access hospitals, low-volume hospitals, and community hospitals.¹²⁰



If Medicaid expansion occurs, rural health providers will be particularly stressed by the increased demand for services. Arizona has a very uneven distribution of primary care providers, with significant shortages in rural parts of the state. While Maricopa County is predominantly urban, there are several areas of the county, such as Wickenburg and Gila Bend, that are more isolated and where residents face significant barriers in access to care. Rural health centers will have an important role in helping expand access in parts of the state where primary care access is low.

Many of the current efforts to expand access in rural areas focus on encouraging health care providers to practice in rural settings, often in health centers. Programs like the National Health Services Corp and the Arizona Alliance for Community Health Center's SEARCH program (described in Section 10) help place and provide incentives to providers to serve in Health Professional Shortage Areas (HPSAs). The Arizona 3RNet program also helps health care providers find positions in rural Arizona. The program is run by the Mel and Edith Zuckerman College of Public Health Center for Rural Health at the University of Arizona, working with the Arizona Department of Health Services, Bureau of Health Systems Development, and the Arizona Alliance for Community Health Centers.¹²⁷ In addition, the Arizona Department of Health Services Bureau Health Systems Development provides support and resources to providers who would like to work in HPSAs, including rural areas.⁸⁷

Rural areas will be most stressed for adequate capacity because of a workforce shortage. One of the greatest needs, and which may be more acute in rural settings with fewer community based organizations, will be for Navigator support for newly-insured individuals to help them navigate the process of identifying, enrolling, using, and maintaining enrollment in health insurance.

Education for safety net providers. To address workforce issues, the ACA provides funding opportunities to support training and education to safety net providers which can help to improve access. Expanded funding for scholarships, loan repayment, and training are available to safety net primary care providers in underserved areas. There are also opportunities for faculty loan repayments for physician assistant and nursing education programs.

The Health Resources and Services Administration (HRSA) is also authorized to provide funding for teaching health centers that allow training of more primary care residents and dentists in ambulatory settings, including FQHCs, community mental health clinics, and rural health clinics.⁷⁷ These will be further discussed in the Workforce Section 10.

Section 7. Triple Aim Initiatives, the Center for Medicare and Medicaid Innovation, and Public Health

The CMS Center for Medicare & Medicaid Innovation (CMMI) is focused on encouraging alternative care and payment structures that accomplish the Triple Aim goal of reduced medical cost, improved clinical quality, and better population health. Just as the National Prevention Strategy guides public health agencies and the spending of the PPPHF, the National Quality Strategy guides the work of CMMI and other national Triple Aim efforts.¹²⁸ Health departments have a wealth to offer in partnering and contracting with the health care system to accomplish all three aims through population health strategies, and would do well to be familiar with the National Quality Strategy and CMMI initiatives.

This section explores several health models supported by CMMI: Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and Community Health Teams (CHTs), highlighting examples from the experiences of other states that may give Maricopa County and Arizona ideas for designing integrated models of care and public health. Section 9 explores this question more fully, responding to MCDPH questions about how to collaborate with health care providers and payers.

7A. ACOs

As described by CMMI, ACOs are groups of physicians, hospitals, and other health care providers that work together voluntarily to provide coordinated high quality care to their patients.



Participating providers are collectively responsible for the care of an enrolled population and may share in savings associated with improvements in the quality and efficiency of the care they provide.¹²⁹ The specific financial models of ACOs vary, either based on capitation or fee-for-service reimbursement. The ACO model was originally used in pilots with the Medicare population, but is now used by many commercial payers, and is being implemented in many states.

In ACOs, coordinated care aims to ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. Although ACO models vary, they always involve use of quality metrics focused on patient centered care, increased coordination of care, and incentives designed to reward performance (i.e. improved outcomes).¹²⁹ ACOs provide strong incentives to keep patients healthy, treat illness efficiently, manage chronic conditions effectively, and focus on population based rather than episodic care. These foci are highly aligned with public health core competencies.

ACOs are intended to address concerns of both cost and quality through several mechanisms, including: encouraging better care coordination; providing incentives for prevention and management of chronic diseases; and, reducing over utilization. By using performance measures, the ACO model is intended to ensure that cost savings come from improving the quality of care rather than limiting needed care.¹³⁰

ACOs, supported by other new health care systems such as global health budgeting, should focus on population health to improve health and lower costs. As ACOs are developing, they should be encouraged to incorporate community based prevention and public health into their systems. Integrating prevention and public health with the larger health care system can be achieved in a variety of ways, including through coordination with health care providers and with existing public health programs and departments.³

While much ACO development originally focused on serving Medicare members through Pioneer or Shared-Saving ACOs, the model is rapidly expanding across the country to serve other populations including

Medicaid populations in many states. While ACO development often occurs as a result of discussions among payers, hospital systems, and provider networks, public health agencies offer a range of relevant services related to prevention and population health, and public health departments should explore such opportunities.

Example: Oregon Coordinated Care Organizations

Oregon's development of Coordinated Care Organizations (CCOs) provides an example of public health partnership with coordinated care in an accountable care model. In early 2012, CMS approved a Section 2703 health home State Plan Amendment for Oregon Medicaid enrollees with chronic conditions, building on Oregon's existing Patient Centered Primary Care Home Program. This led to the development of the CCO program, which began enrolling patients in November 2012. Fifteen CCOs have been established.

A CCO is a network of all types of health care providers (medical care, addiction and mental health care, and sometimes dental care providers) that have agreed to work together in their local communities to serve people who receive coverage under the Oregon Health Plan, the state's Medicaid plan. There is no change in the benefits that patients are entitled to in a CCO. An important focus is the integration of medical care and mental health care that patients receive.¹³¹ CCOs receive a capitated budget (rather than fee-for-service, they receive a per patient payment), covering medical care and mental health care, and dental care will be added eventually. CCOs are accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.¹³¹

As the CCOs were established, the Oregon Health Authority (OHA) took a strategic approach and did not create any extensive requirements about how CCOs would be set up locally. Each CCO has a Community Advisory Council, and among the Council's responsibilities is to conduct a community assessment. In some cases, local public health staff may serve on the council, or provide support to the council as needed.¹³²



The CCO works at the local level to determine key issues that need to be addressed, and the local health departments often have key roles in helping to identify these issues. Such recently identified issues include lowering smoking rates in pregnant women and addressing mold problems in low-income housing.¹³³

OHA has the authority for the initiative, and within OHA, the Public Health Division serves as a resource to CCOs, helping to identify evidence-based public health practices that can be implemented at the local level. The Public Health Division is currently developing the infrastructure to provide training, technical assistance, and learning collaboratives for the CCOs, supported in part by a CMS State Innovation Grant.¹³² OHA is currently establishing a Transformation Center that will disseminate best practices among CCOs and other health plans, and spread the model across payers and into the qualified health plans of the health insurance exchange.

The Oregon Health Authority (OHA) and the Department of Human Services support Living Well and Chronic Disease Self-Management Program workshops in Oregon by providing opportunities for leader training and networking, programming and the development of statewide infrastructure in Oregon. The Living Well Program is part of the Health Promotion and Chronic Disease Prevention Section in the Center for Prevention and Health Promotion.¹³⁴ Local community programs that choose to offer this program would have a participant attend one of these trainings, which are provided by OHA. In addition, OHA provides a number of resources to Living Well Programs, including tools for approaching funders and marketing the program, and a business planning initiative to help support the sustainability of the program.

The average cost for someone to attend the six-week program is \$375.¹³⁵ The Living Well programs are supported in a number of different ways including by partner organization budgets, fee-for-service payments, and other forms of reimbursement, participant fees and donations.¹³⁶ Partnering organizations are typically hospitals, employers, health insurers, including commercial health plans, Medicaid managed care organizations, Medicare Advantage plans, and aging service providers.¹³⁵ Some programs charge participant fees which vary by program.

The course can be a useful resource to CCOs which are incentivized to help patients with chronic conditions manage their health more effectively. CCOs can use this resource by covering the course fee for enrollees with chronic conditions; providing referrals to the course; offering incentives to enrollees to participate; and, training community health workers to become course leaders. “Living Well” is an example of the flexibility the CCO has in developing programs and practices that work locally with guidance and support of OHA.

The Public Health Division has prepared communications that can be used by local public health at the CCO level. Such communications support the importance of implementing evidence-based standards to prevent, detect, and manage chronic diseases; focus on promotion of health screenings, tobacco cessation; and, coverage of disease self-management and weight loss programs. Messages focus on:

- Working with CCOs and local partners to connect people to prevention programs that support the goal of keeping people healthy and reducing the need for health care, including tobacco prevention, worksite wellness, policy development coalitions, and home visits to asthma patients and pregnant women;
- Providing CCOs with guidelines on injury and illness prevention, health promotion, prevention models, and appropriate standardization levels;
- Guiding CCOs in addressing health disparities and improving health equity; and,
- Making available data that public health routinely collects, such as formal health assessments of communities and the state.¹³⁷

While Oregon’s CCOs have been operating for only a short time, OHA’s Public Health Division has been working for some time to identify how it can be most useful in the current ACA environment. One staff person noted that an important strategy for creating a strong public health presence in this model is by creating a broad base of partners.¹³²



Example: Accountable Care Communities in Akron, Ohio

In 2011, the Austen BioInnovation Institute (ABIA) in Akron, OH convened a range of groups to launch an Accountable Care Community (ACC). The ACC focuses on improving the health of the community and creating incentives for the health care system to reward improved health while delivering cost effective care. Success is measured by factors including the improved health of the whole community, cost effectiveness and cost savings in the health care system, improved patient experience, and job creation in Akron.¹³⁸ To support the initiative, the ABIA received a capacity building Community Transformation Grant of \$500,000 per year for five years in 2011.³

The ACC focuses on health promotion and disease prevention, access to quality services, and healthcare delivery. ACC builds on initiatives encompassing health care providers, the public health system, and community stakeholders.³ Collaboration between public health and the health care system are an important aspect of the model, including:

- Development of integrated medical and public health models that deliver clinical care in tandem with health promotion and disease prevention efforts;
- Utilization of inter professional teams including medicine, pharmacy, public health, nursing, social work, mental health, and nutrition; and,
- Collaboration among health systems and public health to enhance communication and planning efforts.³

The ACC focused initial health improvement activities on Type 2 diabetes, which is widespread in Akron. The diabetes population is fairly evenly spread among privately insured, publicly insured through Medicare and Medicaid, and uninsured people.¹³⁸

The first project that the ACC involved a group of people with diabetes who were linked to care and services within the ACC. Each person could receive, based on his or her needs, augmented medical care, programs and initiatives for self-management, and secondary and tertiary prevention. These included education for self-care, nutrition, physical activity, and mindfulness for social and emotional wellness.

The ACC's next project focused on a diabetes self-management program that was an educational and experiential program in a small group setting with participants drawn from diverse practice sites.³

The ACC fostered a collaborative in order to leverage the resources and collective thinking of a multi-sectoral and diverse representation of organizations, including the major hospitals and health care providers, employers, the Chamber of Commerce, universities, housing groups, transportation groups, economic developers and planners, a range of faith-based organizations and many others. In addition to activities directly related to education and care for disease, others have included community gardens, fresh food preparation, and fit-minute exercise.¹³⁸

The initiative has demonstrated positive results. The average cost per month of care for individuals with diabetes was reduced by more than 10%. The ACC is planning to expand to focus on additional health problems such as asthma.¹³⁸

Accountable Care Organizations in Arizona

One of the primary ACOs in Arizona is Banner Health Network, one of the 13 Pioneer ACOs funded by CMS in 2012. Banner Health Network is a partnership between Arizona Integrated Physicians, the Banner Medical Group, the Banner Physician Hospital Organization, and Banner Health, with more than 2,600 Banner affiliated physicians in the Phoenix metro area.

The agreement between Banner Health and Aetna covers technology support for population health management functions for more than 200,000 patients, including the 50,000 Medicare fee-for-service patients covered under the Pioneer ACO shared savings program and members in Aetna's ACO relationship (Aetna Whole Health) with Banner.

The agreement includes implementation of the following capabilities from Aetna subsidiaries:

- Health information exchange technology to enable the secure, two-way exchange of health information across a patient's care team, including hospitals, physicians, labs, pharmacies and other ambulatory services;



- Access to Aetna’s point-of-care clinical decision support services and a desktop-based workflow tool to track, monitor, coordinate and report on patient health outcomes; and,
- Smartphone and online appointment setting and pre-registration services for patients.¹³⁹

Aetna’s technology will connect with Banner’s existing systems by creating a technology overlay that doesn’t require replacement of the systems. Aetna’s software will rely on Banner’s systems to collect patient data and present the information to physicians in an easily accessible way, while also conducting analytics to identify patterns and trends. Identification of those patterns and trends should help the organization cut costs and raise the quality of care.¹⁴⁰ Banner is planning to develop an ACO arrangement in commercial markets in 2014.¹⁴¹

Other ACOs have been established or are in development. For example, a new affiliation between John C. Lincoln Health Network and Scottsdale HealthNetwork was recently announced. The new nonprofit system will include five hospitals and 3,700 affiliated physicians, a large primary care physician network, urgent care centers, an ACO, and extensive community services.¹⁴² In AZ there are four ACOs in the Medicare Shared Savings Program: Arizona. Care Network, LLC (a collaboration between Dignity Health and the Arizona State Physicians Organization), GPIPA ACO, Yavapai Accountable Care, and Yuma Connected Community¹⁴³ Abrazo Health Care has also established an ACO.

Arizona Connected Care is a collaboration of independent health care providers in Tucson and Southern Arizona, including more than 150 physicians, three Federally Qualified Health Centers, and Tucson Medical Center.¹⁴⁴ These providers intend to achieve the three-part aim of improving the patient experience and population health while helping control costs. As an original Brookings-Dartmouth pilot site, Arizona Connected Care will help develop and prove new care technologies and methods.

While building on Patient Centered Medical Home methods to improve access to team based primary care services, Arizona Connected Care will also align the efforts of specialists and institutions to assure that patients throughout the community have access to necessary services in a supportive and education-based health care environment. Engaging patients directly in their own care should lead to improved decision-making, quality of life, and better use of community health resources.

Public Health-ACO Example: Learning Collaboratives in Vermont

The Vermont Blueprint for Health is a state led program that aims to integrate a system of health care for patients, improve the health of the overall population, and improve control of health care costs by promoting health maintenance, prevention and care coordination, and management. Described in more detail later in this report, the Blueprint has become a learning health system aiming to meet the needs of providers and improve the health outcomes of all Vermonters. The Vermont Department of Health (VDH) plays an important role in supporting the training needs of the Blueprint. Specifically, VDH assists PCMHs with meeting their learning requirements, particularly around quality improvement, which are required as Blueprint participants and also for National Committee for Quality Assurance certification (QI).

While each PCMH has a quality improvement facilitator, he or she may not have the depth of knowledge on topics related to chronic conditions or adequate training related to the QI cycle.¹⁴⁵ To address this need, VDH established learning collaboratives based on the Institute for Health Improvement model. To set up the collaborative, QI facilitators helped identify primary care practices that could benefit from participation, and each practice assembled a multi-disciplinary team. The collaborative involved a series of three all-day learning sessions over a six month period, and between sessions the teams worked on data collection and QI projects. There was no charge to participants and continuing medical education credits were provided.¹⁴⁶ The first learning collaborative was focused on asthma management.¹⁴⁶

At the end of the collaborative, each group made peer presentations and was able to demonstrate some measures of improvement. The collaborative resulted in changes at primary care sites such as:

- Better identification of the asthma panel
- Development of asthma visit templates
- Planned visits for asthma management
- Workflow redesign to include assessment of control and completion of asthma action plans
- More patients prescribed controller medications, based on severity
- Spirometry in office
- Adding an asthma educator to the practice¹⁴⁶

Additional learning collaboratives related to obesity and tobacco are being considered. When developing a collaborative, the health department may want to write them into the state's federal grant.¹⁴⁵

According to a staff person, the VDH was less involved in the overall development of the Vermont Blueprint for Health than the Department of Vermont Health Access (Medicaid), which manages the Blue Print. The VDH has been more involved in supporting public health functions, such as described here.¹⁴⁵

7B. PATIENT CENTERED MEDICAL HOMES (PCMH)

Section 2703 of the ACA created a new state plan option under which states can establish a health home model for Medicaid enrollees with chronic conditions. Under this option, states can receive a federal match rate of 90% for health home services for the first eight fiscal quarters that a state's health home State Plan Amendment (SPA) is in effect.

Under the ACA, eligible individuals for health homes have one of the following: two chronic or more conditions; one chronic condition and at-risk for a second; or, a serious and persistent mental health illness. Specific conditions include mental health conditions, substance abuse disorders, asthma, diabetes, heart disease, and overweight. In addition, states can expand the list of conditions that can be included.

The health home's main function is to coordinate the patient's medical and behavioral health services in order to ensure integrated care. While the health home can provide services, this is not required. Health home provider arrangements can include a designated provider, a team of health care professionals that links to a designated provider, or an interdisciplinary, inter professional health team. Teams of professionals can be freestanding, virtual, or based at a hospital, community health center, clinic, physician's office or group practice, or academic health center.¹⁴⁷ Health homes are required to provide specific services to each enrolled member, including comprehensive care management; care coordination and health promotion; transitional care from inpatient to other settings; patient and family support; referral to community and social support services; and, use of health IT as feasible and appropriate.

Because integration of behavioral health and medical care is an important focus, states are required to coordinate with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as appropriate in addressing issues regarding prevention and treatment of mental health and substance abuse for individuals with chronic conditions.¹⁴⁷

Lastly, states have flexibility in how they structure payment for health home services. This can include a tiered payment structure based on the severity of each enrollee's conditions and the specific services provided within the arrangement, or it can be on a fee-for-service or capitated basis.¹⁴⁸

Example: Community Care of North Carolina

Community Care of North Carolina (CCNC) was officially launched in 2001; however, CCNC evolved over time into the program that it is today.¹⁴⁹ In the 1960s, clinics were integrated into networks of practitioners through the Office of Rural Health and the Area Health Educations Center (AHEC). Today's CCNC is a statewide, regional network based medical home model designed to improve the quality and cost-effectiveness of care, retain physician support and participation, and achieve lasting improvements in care and health outcomes.^{150,151} Key elements include:



- *Network formation.* Physicians are encouraged to work together locally and with other health organizations in community networks to plan cooperatively for meeting recipients' care needs;
- *Population management tools.* Evidence-based programs and protocols, disease management programs, care management tools, pharmacy management tools, and practice based improvements;
- *Primary Care Medical Homes.* Goal is to be accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally effective. Care teams include community health workers, social workers, and nurses who work with patients at home as needed;
- *Patient case management and support.* Support and coordination for chronic care patients with complex needs as well as patient education, help to navigate the system, and self-management skills; and,
- *Data and feedback.* To provide timely and relevant information on how patients and interventions were faring and highlighting opportunities for improvement; includes electronic linkage among practices, hospitals, Department of Social Services, health departments, and care team.

Community Care Networks. CCNC is structured around 14 Community Care Networks (CCN) that cover all 100 counties in the state, with more than 3,500 physicians and 1,200 practices serving more than one million enrollees.^{150,152} CCNs are local nonprofit organizations that facilitate a partnership among local physicians, hospitals, county health departments, and departments of social services, all of which are required partners.^{152,153} They are also encouraged to include other health care providers and health support agencies to build the local health system. CCNs hire local case managers to work with primary care physicians and patients to implement care and disease management interventions. Because of the statewide CCN structure, the state can tap into the network to respond to state and local health needs such as mental health and substance abuse issues, and extend the network to additional populations as it has for the aged, blind, and disabled population.¹⁵²

Connection with NC's Division of Public Health. The North Carolina Office of Rural Health and Community Care (ORHCC) serves as the central program office for CCNC under the sponsorship of the state's Department of Health and Human Services (DHHS).¹⁵³ North Carolina's Department of Public Health (DPH), also under the direction of DHHS, was not a founding member of CCNC. However, DPH currently is listed as a partner for CCNC and is engaged in CCNC initiatives including:

- Care Coordination for Children. Serving children from birth to five years of age who meet certain risk criteria¹⁵⁴;
- Pregnancy Medical Home. Improving the quality of perinatal care given to Medicaid recipients, thereby improving birth outcomes and reducing Medicaid spending¹⁵⁵;
- Data analysis; and,
- Funding support. DPH has provided funding to hire staff such as a full time data analyst to assist CCNC with their Community Transformation Grant.

Funding. Under federal Medicaid regulations, CCNC is structured through the NC state plan as an enhanced primary case management model. Designated medical homes receive a fee-for-service payment and additional per member per month (pmpm) payments to compensate for key access and population management activities, allowing networks to do things such as hire case managers and care coordinators.¹⁵²

Reduced Health Care Utilization and Cost-Savings. Inpatient and ER utilization rates of CCNC enrollees from 2007–2010 were consistently lower and primary care visits and pharmaceutical prescriptions consistently higher when compared to the unenrolled Medicaid population.¹⁵⁶ This resulted in estimated Medicaid savings in the millions, and nearly \$1 billion over four years from mid-2006 to mid 2010.¹⁵⁷ Furthermore, while enrolling aged, blind, or disabled members into medical homes cost an additional \$82 million in the state's FY 2006, it resulted in net \$53 million in avoided costs by the 2010FY.¹⁵⁷



Lessons Learned. Overall, the CCNC model demonstrated that regional multi-partner public-private networks:

- *Can be effective across urban and rural settings;*
- *Combine scaled-up impact of a statewide model with regional specificity.* As a statewide structure, CCNC ensured maximum population impact.¹⁵⁸ However, it also relied on regional networks to ensure that implementation was locally appropriate for quality of care and health outcomes and improved access;
- *Create joint public-private accountability for shared goals.* CCNC created a community based infrastructure that increased the investment of diverse providers to assume responsibility and accountability for the target population and outcomes; and,
- *Leverage shared infrastructure to expand impact of small practices.* NC Medicaid recipients are typically seen in small practices that lack the economies of scale to facilitate purchasing and to maintain core aspects of the medical home model (e.g. EMRs, interdisciplinary teams for care coordination).¹⁵⁸ CCNC established the shared care management infrastructure.

Health Homes after ACA Implementation

Missouri

Missouri was the first state to set up health homes under Section 2703, effective January 2012. Prior to that, Missouri had implemented a health home for patients with serious mental illness. Under its SPA, Missouri established two health homes. The first was for patients with a serious mental illness. Designated providers are CHCs.¹⁵⁹ For patients without a regular primary care provider, medical care is integrated at the CHC by a nurse liaison that works with behavioral health staff to identify signs of medical conditions. Care coordination is provided at the CHC, and integrates adherence to medical treatment along with mental health treatment and addressing social issues.¹⁶⁰

Missouri's second health home was for patients with two or more chronic conditions, and the designated providers were FQHCs, rural health clinics, and primary care clinics.¹⁵⁹ Missouri pays a capitated payment to health homes for clinical care management, delivery of health home services, data reporting, and other administrative functions. Medical and behavioral health services are paid on a fee-for-service basis.¹⁵⁹ Prior to the implementation of the health home model, Missouri had begun to adopt payment for services that led to integration of care. For example, Missouri reimburses for telehealth, and implements use of Screening, Brief Intervention, Referral and Treatment (SBIRT) which is recognized as an effective tool for identifying behavioral health issues in the primary care setting.¹⁶¹

Rhode Island

Effective October, 2011, Rhode Island Medicaid established two health homes, one for Medicaid enrollees with serious mental illness and one for children and youth under 21 with special needs. Health homes for enrollees with mental illness are based in nine community mental health organizations. These organizations receive a direct capitation from the state. Managed care organizations (MCOs) continue to have a role in managing care for these patients, and the state breaks out the funds that the MCOs will receive based on services that they provide.

Oregon

Oregon introduced its health home in March 2012 for Medicaid enrollees with two chronic conditions, with one condition and at-risk for a second, or a serious mental illness. The state allows a variety of providers to serve as Patient Centered Primary Care Homes, including physicians, certified NPs, clinical practices, FQHCs, tribal clinics, or community mental health programs. Interested providers submit information to the Oregon Health Authority about their capacity to provide health home services, and the Authority determines which providers meet the minimum standards and then tiers them based on their capabilities. Oregon pays a capitation to the health homes, and payments are based on the health home's tier. Capitation is paid directly to the health home for patients who are not enrolled through an MCO, or through an MCO, which can retain payment only for those services it provides; the rest is passed on to the health home.¹⁶²



New York

New York's health home, which was implemented in 2012, focuses on enrollees with two or more chronic illness, HIV/AIDS and at-risk of another chronic condition, or a serious mental illness. Providers that can serve as health homes include primary care practices; hospitals; medical, mental health or substance abuse clinics; FHQCs; and, home health agencies. To become a health home, providers first apply, and New York selects health homes based on services available, geographic spread, as well as the ability to meet health home functions. The state provides a capitation directly to the health home. In New York, many of the people who qualify for health homes are enrolled through MCOs which are required to contract with health homes, and to pass through all funds for the services they provide.¹⁶²

Challenges

Many states are facing major implementation challenges in preparation for Medicaid expansion in 2014, such as establishing insurance Exchanges and upgrading IT systems. Balancing priorities such as the establishment of a health home along with other ACA related initiatives can be an added challenge. Resources required to implement these programs are significant and can compete with one another.¹⁶²

Additional challenges that states are likely to face include:

- Fee-for-service reimbursement systems may not cover the time and services required for providers to coordinate care for patients, meaning that developing alternative reimbursement models may be needed;
- Exchange of patient information to the care team is critical, but implementing this exchange of information can be complex; and,
- Workforce shortages for primary care and behavioral health services can be an obstacle in developing integrated care models.¹⁶¹

Role of MCOs

The appropriate role for health homes in the context of other evolving care delivery and payment arrangements is an issue for states that want to implement health homes. This is especially true in states like Arizona where the majority of Medicaid members are enrolled through a managed care organization (MCO). There are a variety of possible arrangements relative to an MCO's role; it can delegate all services, have a shared model with health homes for care coordination functions, or assume all health home functions.¹⁶³ States implementing the health home model should work closely with MCOs to establish roles and understand the impact on flow of funds.¹⁶² For functions that the MCO will maintain, MCOs will need to determine how they will relate to other entities on the care team. For instance, there is growing evidence that face-to-face care management is most effective at improving quality and controlling cost. If an MCO is to take on that role, it will need to look at ways to provide these services on-site.¹⁶³

Health Home Structure

In their SPA, states establishing health homes are required to collect quality, utilization, efficiency, and patient experience measures. States can identify outcomes of importance to specific populations, such as disparities in care, burden and outcomes; develop measures to capture those outcomes; and, establish regular reporting mechanisms. Medicaid can also include these requirements in contracts with providers and health plans.¹⁶⁴ In addition, health homes can create financial incentives for providers, such as Pay for Performance incentives or a shared savings model.¹⁶⁴

Sustainability

Long-term sustainability is important to plan for, since funding at 90% applies only to the first two years of implementation. Important considerations include:

- Focusing on enrollees with the greatest potential to improve outcomes and reduce costs, such as pre-diabetic or pre-hypertensive patients, which can allow states to make the business case for pushing savings back into the programs once regular federal matching rates apply, and/or expanding to serve additional populations; and,



- Incorporating health homes into similar multi-payer efforts can enable states to leverage shared infrastructure, build on existing provider efforts, and use resources more efficiently. Demonstrating a return on investment (ROI) will help position states to request additional funds from policymakers.¹⁶⁴

Tools are available for calculating ROI, such as the ROI Calculator for Asthma and the web-based ROI Forecasting Calculator for Health Homes and Medical Homes which was created with funding from the Robert Wood Johnson Foundation and the Agency for Health Research and Quality (AHRQ).

Other Considerations.

Importance of Medicaid — Department of Mental Health relationship

One of the features of the model in Missouri that administrators of the health home cited as important is the relationship between the state's Medicaid agency and the Department of Mental Health. Sharing patient data through a web portal allows case managers and clinicians to track chronic conditions and plan appropriately. These administrators note that building a strong relationship between the two agencies takes time, and should begin early on in planning a health home initiative.¹⁶⁰

Lack of leadership and planning role for health departments

Of note, the leadership role of public health agencies was not highlighted in any of the materials reviewed about state health home efforts. While health departments are sometimes engaged to perform a specific function or service, they do not appear to be an equal player at the planning table. Most planning activity seemed to involve state Medicaid agencies, provider networks, and managed care organizations. This suggests that health departments have serious work to do to get at the table given the critical role they can and should play in health home and health system planning efforts. Public health's experience with primary prevention and population based health, wraparound services, and promoting best practices and policies are directly relevant to the health home model. Likewise, other relevant state agencies, such as Arizona Child and Family Services, should be at the

table to plan wraparound services. Public health leaders have a role to make the case that these models and the partners should extend beyond the usual suspects.

7C. ARIZONA RECOVERY THROUGH WHOLE HEALTH BEHAVIORAL HEALTH INTEGRATION

Integration and coordination of primary, acute, behavioral health, and social support is a common thread among many ACA provisions. The Centers for Medicare and Medicaid Services (CMS) has funded one model to achieve this through ACA Section 2703, providing support for health homes for patients with serious mental illness or other chronic conditions. SAMHSA is collaborating with CMS in this area, and has awarded grants to 64 community based health agencies to build partnerships and infrastructure to initiate or expand the integration of primary care services for people in treatment for serious mental illness.¹⁶⁵ Grants focus on providing services such as:

- Facilitation of screening and referral for primary care prevention and treatment;
- Ensuring that primary care screening, assessment, treatment, and referral be provided in a community based behavioral health agency;
- Developing and implementing a registry/tracking system to follow primary health care needs and outcomes;
- Offering prevention and wellness support services; and,
- Establishing referral and follow-up processes for physical health care requiring specialized services beyond the primary care setting.¹⁶⁵

There is great need for integration of mental health and health care in Arizona. Residents with serious mental illness (SMI) die more than 30 years earlier than the average state resident. These deaths are often related to obesity, smoking, asthma, and lack of regular medical care.¹⁶⁶ Nationally, 85% of the high cost Medicaid members had a mental health diagnosis and 60% of highest cost beneficiaries had chronic disease and mental health co-morbidities.¹⁶⁷



In March 2011, AHCCCS and the ADHS Division of Behavioral Health Services received a planning grant from CMS to explore the feasibility of a Regional Behavioral Health Authority (RBHA) with expanded responsibility for adults with serious mental illness. This RBHA model is referred to as “Recovery through Whole Health”.¹⁶⁸ With this planning grant, AHCCCS and ADHS designed a program that goes beyond CMS’s health home model. The state’s model is thought to be one of the most integrated models of care in the U.S..¹⁶⁹

In 2012, AHCCCS and ADHS submitted a Section 1115 Medicaid waiver to create this authority which was approved in January 2013. With it, they created the Maricopa County Integrated Regional Behavioral Health Authority, and awarded Mercy Maricopa Integrated Care (MMIC) a grant to administer the Authority.¹⁷⁰ MMIC is a locally owned and operated nonprofit health plan sponsored by Mercy Care Plan and Maricopa Integrated Health System. Mercy Care is a 28-year old Arizona Medicaid Plan managed by Schaller Anderson, an Aetna company. Maricopa Integrated Health System (MIHS) is a county wide public health care system with a long history as a safety net provider.¹⁷¹

The contract will begin on October 1, 2013 and allows two one-year extensions. Two other organizations that bid on the RFP for the RBHA contract have filed protests regarding the awarding of the contract to MMIC. Magellan Health Services, the current vendor for the Maricopa RBHA, and Arizona Physicians IPA both have submitted protests.¹⁷² While ADHS continues to plan for an October 1 effective date, the protest could impact the start date if a stay is issued.¹⁶⁹

Under the contract, MMIC will oversee treatment for approximately 12,000 individuals with serious mental illness through a network of local providers and clinics. If Arizona expands its Medicaid coverage, an additional 7,000 people with serious mental illness will qualify.¹⁶⁶ MMIC will be responsible for all behavioral health and medical services for the SMI population. MMIC will also manage mental health and substance abuse treatment for an additional 52,000 adults and children, and this number will increase if Medicaid expansion takes place.¹⁶⁹ For this population, the RBHA will be responsible for coordinating behavioral health services, and medical care will continue to be managed through AHCCCS.¹⁶⁹

Care has been fragmented for the SMI population under the current model, in which mental health and medical care are not integrated. There is often little communication between the various providers treating patients, and services may be covered by more than one payer (e.g., Medicaid and Medicare). As a result, several problems can occur:

- Patients may experience medication interactions;
- The patient’s family may be left trying to navigate multiple issues;
- The patient may access higher levels of care for preventable issues; and,
- Unnecessary funds are expended.¹⁷³

The “Whole Health” approach focuses on connecting all of a patient’s providers, and MMIC is also introducing an Electronic Medical Record (EMR) portal to support the effort. The RBHA will be responsible for care management, working with providers’ across the patient’s care team. The care management team will focus on combining physical health, mental health, and social support in a holistic way. In addition, the RBHA will provide enhanced case management and improved care coordination.¹⁷⁰

Priorities and Challenges

Network Sufficiency. Ensuring an adequate network to meet patients’ mental health and health care needs is a priority. MMIC is actively working on network development at this time.¹⁶⁹

Many patients who are covered under the RBHA will want to continue relationships with their current providers. Under the new contract, patients will be able to continue to see their existing providers for the first 90 days and then will be transitioned to providers that have contracted with MMIC.¹⁷⁰ MMIC is currently working on enhancing its network to try to accommodate as many providers as possible that currently treat the target population. Currently MMIC has contracts with 91% of the network treating the SMI population, and is working to expand the network further with full contracts or single case agreements.¹⁶⁹



Transferring Patient Data. The exchange of patient data will be very important for a smooth start-up of the program, as well as for ongoing operations that create connections between behavioral health and medical care providers. This includes transfer from Magellan and current acute care providers for the program start-up. The program will also require some providers to change EMRs and will also have an effect on AHCCCS and ADHS’s electronic systems. Implementing the needed technology is a significant challenge, and extensive work is underway at ADHS to ensure that IT systems are prepared for the program’s implementation.¹⁶⁹

Communication with Patients, Families, Providers, and the Public. Another important focus over the coming months is working with patients, families, and the public to make sure that they understand how the “Recovery through Whole Health” program will work, its significance, and its benefits. Such communication is most effective on a person-to-person basis.¹⁶⁹ To this end, the ADHS Office of Individual and Family Affairs has begun outreach to key organizations in the community. They want to include non-traditional providers, and have been reaching out to first responders, such as EMS and fire fighters, and plan to include information about the program in law enforcement programs in the future.¹⁶⁹ Navigators have begun to provide community outreach and will continue this work in coming months.¹⁶⁹

Opportunities for MCDPH

AHCCCS and ADHS have been the lead organizers in developing MMIC. Possible areas where MCDPH could add significant value include:

- **Become a MMIC provider for homeless clients through the Health Care for the Homeless clinic;**
- **Provide outreach, enrollment, and education functions.** MCDPH might identify and refer people into MMIC as well as educate partner organizations and clients about the Whole Health approach. The Health Care for the Homeless Clinic could support enrollment in the initiative. Disseminating information about the “Whole Health” program to community agencies, patients, families, and the public in general will be important for a smooth transition;
- **Share relevant population health data.** MCDPH monitoring and reporting on health data relevant to the MMIC population may provide useful context and guidance for needed supports and interventions. For example, identifying community level challenges and resources for sub populations by race, ethnicity, sexual orientation and gender identity, neighborhood, and homeless status would be an invaluable exercise. MCDPH might also provide recommendations to MMIC as to relevant population information to capture in its information system;
- **Provide Prevention, Wellness, and Chronic Disease Management**
 - » *Primary Prevention.* MCDPH could recommend population and community strategies for MMIC to support health and wellness of members such as increasing access to healthy food and opportunities for physical activity, social connectedness, and tobacco and violence-free environments. Two examples include:
 - Promote tobacco-free behavioral health housing.
 - Promote Community Connectedness Activities. Programs that enhance strong and connected neighborhoods are shown to improve community mental health
 - » *Chronic Disease Self-Management (CDSM).* An important focus of the “Whole Health” program will be to provide tools and support to patients to help them prevent and manage chronic conditions. Other county health departments collaborate with RBHAs in this area and MCDPH could contract with MMIC to train people in chronic care self-management and help design a system to promote access to CDSM.
 - » *Chronic Disease and Preventive Care Quality Improvement.* MCDPH could develop a program to support MMIC providers to institutionalize routine protocols for key preventive care and chronic disease management, such as routinely asking about tobacco use and establishing a referral mechanism for the Arizona Smoker’s HelpLine and also to CDSM programs.



- **Address housing needs.** Housing can be a significant issue for much of the population that MMIC will be managing. People who have difficulty obtaining housing because of drug use or criminal records can end up living on the street, where their health conditions can worsen. RBHAs have some ability to provide housing support through funding allocated by ADHS. “Housing First” programs, which are willing to accept patients with criminal records and/or who are not sober, can help address this problem.¹⁶⁹

Through MCDPH’s Health Care for the Homeless Clinic, MCDPH might support MMIC coordinated care teams in housing assistance. Because of their experience, MCDPH could contract to train coordinated care teams in supporting homeless clients with housing assistance or contract to provide assistance directly to MMIC clients who may not be Health Care for the Homeless Clinic patients.

7D. COMMUNITY HEALTH TEAMS (CHTs)

Section 3502 of the ACA allows states to establish community health teams (CHT) to support patient centered medical homes (PCMH). Specifically, the section mandates a new grant or contract program to establish health teams that support primary care practices to help coordinate and manage care. Under the ACA, local health departments can receive funds to organize CHTs and partner with local primary care providers, including FQCHCs.¹⁷⁴

A primary care provider that contracts with a care team must:

- Provide a care plan to the care team for each patient;
- Ensure access to participant’s health records; and,
- Meet regularly with the care team to ensure integration of care.

Primary care is defined as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”¹⁷⁵

To obtain a grant or contract, a CHT must:

- Establish contractual agreements with primary care providers for support services;
- Support PCMHs;
- Collaborate with local primary care providers and existing state and community based resources to coordinate disease prevention and chronic disease management;
- Develop and implement interdisciplinary and inter professional care plans with local health care providers;
- Incorporate health care providers, patients, caregivers, and authorized representatives in the design and oversight of the program; and,
- Provide coordination and support to local primary care providers so that they can provide access to high quality health care services, preventive services, specialty care and inpatient services, culturally appropriate patient and family centered health care, and pharmacy services.¹⁷⁶

Support must be provided so that local primary care providers can:

- Coordinate complementary and alternative services;
- Promote strategies for treatment planning, as well as monitor health outcomes and resource use, share information, and organize care to avoid duplication of services;
- Provide local access to individuals implementing patient care;
- Collect and report relevant data that allows for evaluation of the success of the collaborative efforts on the patient’s health;
- Establish a coordinated system of identification for children at-risk of developmental or behavioral problems;



- Provide 24/7 care management and support during transitions in care settings (e.g. discharge planning and counseling support, referrals for mental health and behavioral health services); and,
- Serve as a liaison to community prevention and treatment program.¹⁷⁶

CHTs can establish contractual relationships with a number of physicians and networks of providers, or can be established by a provider group to support their clinicians. CHTs are connected to health homes and can be a model for providing care coordination within the health home.

Example: Vermont Blueprint for Health

Vermont has the most established structure for utilizing CHTs to support primary care. The Vermont Blueprint for Health (Blueprint) was launched in 2006, and is a statewide, public-private initiative to support the delivery of coordinated, high quality health services to the general population and achieve the triple aim of improving healthcare and population health, and controlling healthcare costs.^{177,178}

The program calls for advanced primary care practices to serve as PCMHs for the patients they serve with comprehensive support from CHTs, along with a health information technology infrastructure that supports guideline based care, population reporting, and health information exchange.^{178,179} While it began as a pilot program in 2009 serving three communities, by the end of 2012 (and as required by law), the Blueprint was in all 14 Vermont Health Service Areas, with 106 primary care practices successfully undergoing the National Committee of Quality Assurance PCMH recognition process.¹⁷⁹

Community Health Teams (CHTs). In the Blueprint, CHTs are intended to be the link between primary care and community-based prevention of chronic disease. Services provided by CHTs include: individual care coordination; outreach and population management; and, counseling and close integration with other social and economic support services in the community.¹⁷⁹ CHTs enhance patient care directly through individual services performed on the patient's behalf, and indirectly through their support of individual providers

and practices.¹⁷⁸ CHTs and providers communicate via electronic health records and meet regularly to discuss patient care.¹⁸⁰

Core CHTs. Five full-time equivalent employees that serve a population of approximately 20,000 staff each CHT. CHTs typically include members such as:

- *Nurse coordinators* who performs clinical duties, supervise the team, track patients who are overdue for appointments or tests, manage short-term care for high need patients, check that patients are getting their prescriptions and taking their medications appropriately, and following up with patients on their personal health management goals;
- *Social workers/community health workers* who help patients fill out insurance applications, follow treatment plans, manage stress and work toward their personal wellness or disease management goals, and accompany patients to appointments and help them find transportation or child care;
- *Behavioral health counselors* work in primary care practices and help providers identify patients with untreated depression or substance abuse, and intervene quickly when necessary; and,
- *Public health specialists* who coordinate efforts between the CHT and public health initiatives to reduce common health-risk behaviors and contribute to large-scale preventive efforts.

The composition of each CHT is determined locally with input from area practices and hospitals.^{178,179} When assembling the CHT, the planning group considers the demographics of the community, services and programs communities have and need, and gaps in available services. CHTs also reduce barriers to primary care by providing patients with direct access to an enhanced range of services and more individualized follow up at no charge to patients or practices regardless of health insurance status or type (i.e. no co-payments, prior authorizations, or billing for CHT services).¹⁷⁹

CHT Extenders. Many communities also engage CHT Extenders to find harder to reach subpopulations (e.g. the elderly who want to live in their home).¹⁸⁰



In addition, patient self-management classes are available, including:

- Healthier Living Workshops
- Blueprint run tobacco cessation
- Wellness Recovery Action Planning (WRAP) for people living with depression and anxiety
- Diabetes Prevention Program that targets people at-risk for developing type 2 diabetes.

Functional CHT and the role of public health. The Blueprint recognizes that the community is rich in human resources and services, and thus the “functional CHT” refers to community health and human service programs, including local nonprofit organizations and local and state public health departments to better address health needs in a more coordinated way. By coordinating with these groups and resources, the core CHTs can leverage enormous resources to help provide expanded services for their patient population and support the development of new services in their community.¹⁸⁰ While the role of state and local public health is still under development, the inclusion of public health specialists in the CHT has led to Blueprint clinicians’ increased awareness about the social determinants of health, an example of the critical role public health can play in functional CHTs.¹⁸⁰

Electronic Medical Records. The Department of Vermont Health Access (Medicaid) created the IT infrastructure needed to collect information for electronic medical records (EMR). As healthcare providers use EMRs, data can be used to create a health information exchange (HIX). The HIX interfaces with a central clinical registry that can provide data back to healthcare providers, CHTs, and public health services, enabling visit planning, care coordination, more accurate reporting, and a learning health system to continually monitor, evaluate and set new goals.

Funding. The Blueprint requires all major commercial insurers, Medicare, and Medicaid to pay into a system for provider incentives and to fund CHTs.¹⁸⁰ Primary care practices serving as PCMHs receive fee-for-service payments from insurers and Medicaid, as well as a per person per month payment based on the

National Committee for Quality Assurance score against PCMH standards.¹⁷⁸ The CHT budget for each community is proportional to the total population served by the recognized PCMH practices in a Health Service Area. In 2012, this amount was \$350,000 per year for a general population of 20,000 served by the practices (\$17,500 per year for every 1,000 patients).¹⁷⁹ Decisions about money allocation are made at the local level.

Impact of the Blueprint. Evaluation of the Blueprint indicated:

- *Improved healthcare.* Trends in hospitalization rates were generally more favorable and heading downward for Blueprint study groups from 2007–2011. From 2010–2011, all groups increased their use of hospitals; however, Blueprint groups increased at a slower rate than the comparison group. This trend was unclear for emergency department utilization data;
- *Mixed results on preventive services.* Favorable trends were seen for patients with diabetes for HbA1C testing. However, there was a downward trend in the rate at which patients with diabetes had eye exams, and received breast and cervical cancer screening. These downward trends could indicate room for improvement or an intentional change in clinical best practices; and,
- *Improved control over healthcare costs.* From 2007–2011, growth in total healthcare expenditures slowed across all groups (Blueprint and control), and in 2011, both Blueprint study group (BSG) showed the first downward trend in per capita healthcare expenditures, while the comparison group trended upwards. The Medicaid population across all study groups had a reduction in per capita health expenditures from 2007–2010, with a slight uptick in 2011; however, the rate of increase in the non-Blueprint group was higher.



Gaps and Lessons Learned

- *Engage public health in central planning.* While the benefits of engaging the public health field are discussed among Blueprint administrators and CHT members, there could be additional enhancements to the partnership among PCMHs, CHTs, and public health. Currently, the field is engaged as the “functional CHT;” however, from a population health point of view, it would be beneficial for public health partners to be at the planning table providing data and developing policies and strategies to promote health;
- *Allow time for training and buy-in for CHTs and PCMHs.* In VT, collaborations between the multidisciplinary CHTs and PCMHs were reported to be very successful by both patients and providers. This was attributed to the time taken for training and relationship building among CHT members themselves with support from coaches and practice facilitators¹⁸¹;
- *Establish multi-sectoral buy-in at the leadership and administrative level.* The Blueprint engaged multi-sectoral partners at the administrative and leadership level as well as at local provider level. This included collaboration among CHT members, clinicians, all VT’s insurers, hospital leadership, and non-medical communities and organizations, allowing for greater buy-in for the Blueprint overall¹⁸¹;
- *Allocate time for buy-in and culture change.* VT Blueprint implementers recognized that the concept of interdisciplinary PCMHs and CHTs was a major shift from the traditional primary care practice model. Thus, buy-in from primary care offices and practitioners may be slow, and it is important to take the time to cultivate relationships and allow for partners to become comfortable with a new model;
- *Develop the Workforce.* Workforce development should focus on inter professional education to enable trainees to work together on interdisciplinary teams; and,

- *Strong Information Technology infrastructure is essential but difficult.* While developing a health Information Technology infrastructure to coordinate care was central to the Blueprint, challenges have been faced during implementation. For example, in one HSA, 19 different clinics were engaged as PCMHs which utilized seven different electronic health record systems. VT is currently looking for ways to create a central clinical registry so that CHTs can work from an integrated health record.

Community Health Teams in Other States

While Vermont is leading the development of CHTs, other states have implemented a version of this model on a smaller scale. Community Health Innovations of Rhode Island (CHI-RI) received a grant from Blue Cross & Blue Shield of Rhode Island to form community health worker teams and establish a center for community directed health solutions. While this initiative is not on the scale of Vermont’s, it is a part of a strategy to support the state’s PCMH initiative.¹⁸²

Section 8. Slowing the Growth of Premium Costs

From a public health point of view, the best way to slow the growth of premium costs is to make targeted population health changes that result in health plan members with less and better managed chronic disease and fewer preventable hospital costs. Generally, chronic diseases represent over 75% of health care expenditures, and much of it is preventable.

But health care payers do not have expertise in population based strategies, are unfamiliar with the evidence base and ROI for these approaches (which is still emerging), and so they are actively pursuing new models of care. These models include using incentives, negotiating new contracting arrangement with providers, and other approaches more in their traditional purview to stabilize insurance premiums. While acknowledging that these approaches are mostly necessary, but not sufficient, to achieve the goal of slower premium growth, listed here is a brief summary of strategies that payers are using or exploring, particularly those with a population health or prevention focus.



Reimbursing for Quality

Pay for Performance. Under a “pay for performance” (P4P) arrangement, a payer compensates physicians based on performance. Evaluation is based on physician performance data, which are usually administrative or claims data measuring the quality and/or cost of care. Patient satisfaction data may also be used as a measure. These data are used to determine if physicians have met the payer’s performance criteria; those who meet the criteria are eligible for a bonus or fee-for-service compensation.¹⁸³

Blue Cross Blue Shield of Massachusetts (BCBSMA) was a leader in implementing a broad P4P model. In 2009, BCBSMA implemented a modified global payment plan with large provider networks around the state. These arrangements established a fixed cost for the care of patients during a specific period and bonus incentives for achieving quality goals. According to a 2012 study in Health Affairs, health spending for patients covered under this arrangement was 1.9% lower in the first year and 3.3% lower in the second year than for patients covered via fee-for-service programs, and the 4,800 doctors in the global payment program also scored higher on measures of quality care.³

Another model being widely utilized by payers are ACOs, described earlier in this report.

In 2008, Medicare implemented a policy in which it would not pay for costs associated with ten preventable errors, including certain types of hospital acquired infections.¹⁸⁴ Evaluations of this policy have not indicated a decrease in hospital infection rates, but have yielded an increase in hospital planning related to decreasing infection rates.¹⁸⁵

Section 3025 of the ACA built on this program by establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective beginning on October 1, 2012. This program applies to patients with specific conditions who are readmitted within 30 days of a discharge.¹⁸⁶ Because this is a relatively new program, it is unclear if this policy will be replicated among commercial payers.

Reimbursement for mid-level practitioners such as Nurse Practitioners and Physician Assistants. Some payers are considering credentialing and reimbursement policies for less costly, qualified health care providers as part of the care team, including NPs and PAs. A recent RAND study using Massachusetts specific data estimated that NP and PA visits are 35% less expensive than physician visits and could yield significant savings to the state.¹⁸⁷ Reimbursement policies vary by payer. Reimbursements for Community Health Workers (Minnesota) and through credentialing and certification programs (MA, Texas, Ohio), are also being explored.

Insurance benefit designs. Many payers have developed new health plans designed to increase the share of cost that the enrollee bears or incentivize healthy behaviors. For example, many payers have developed high deductible health plan options or tiered options based on the providers that an enrollee chooses to utilize. Payers have also implemented programs that include use of incentives for enrollees to participate in targeted wellness programs such as tobacco cessation, weight loss, exercise, and diabetes management. Discussed further in Section 8, this is an area for health departments to monitor and determine whether it has the intended or unintended impacts. Health departments have many programs worthy of contracting with health plans to provide wellness and disease management programs.

Improving population health and care coordination. Payers are developing enhanced care management programs for people with chronic conditions, large drivers of health care costs.³ Public health may be in a position to work with health plans to identify evidence-based public health interventions in these areas. For example, Vermont brought all health payers to the table to help underwrite care coordination under the Blueprint and then study its effectiveness. Similarly, state and local public health departments in MA are working with the state Medicaid plans to reimburse for asthma home visiting programs, with an environmental assessment and intervention. The Sinai Health Systems are also receiving private and public reimbursements for the use of CHWs in addressing home-based asthma care. Aetna is also examining the implementation of this model. Some payers are reimbursing others, and other health plans are providing the services directly to their members.



There is also the potential to expand private insurance coverage of community prevention programs. Private insurers must also increase support for community based prevention programs so their beneficiaries and the larger community they serve have the opportunity to take part in effective, evidence-based programs to support them in their communities.³ Some payers are expanding coverage to include prevention-focused programs. For instance, the National Diabetes Prevention Program (NDPP) is a 16-week lifestyle improvement program for individuals at high-risk for diabetes. This program engages individuals in group education with a trained lifestyle coach, focusing on improved eating habits, increased physical activity, and other behavior modifications. United Health Group began partnering with the YMCA in 2010 to replicate this program, working with pharmacist led education and behavioral intervention initiatives within the pharmacy setting.³

Government is the biggest health care payer and also has the ability to establish policies that can limit the growth of premiums. Many states have an insurance rate review process, though it is rare that states exercise their authority to significantly limit premium increase through this means. In Massachusetts, payment reform legislation enacted in the summer of 2012 included a measure to limit the annual per capita increase in health care costs to that of the state's economic growth. In 2010, the Massachusetts Division of Insurance rejected 235 out of 274 health plan rate increase filings for being too "excessive".¹⁸⁸

Section 9. Public Health-Health Care Integration: Selected Strategies and Opportunities for Maricopa County and Arizona

A whole new field is emerging to explore how public health can integrate with the health care system. Public and private organizations are analyzing this question, including the Institutes of Medicine (IOM), the Centers for Disease Control and Prevention (CDC), Center for Medicare & Medicaid Innovation (CMMI), the Robert Wood Johnson Foundation (RWJF), the

American Public Health Association (APHA), Trust for America's Health (TFAH), the National Association of City and County Health Officers (NACCHO), the Association of State and Tribal Health Officers (ASTHO), the American Medical Association (AMA), the National Association of Community Health Workers, The Prevention Institute, the Kresge Foundation, and many more. They all agree that the work to be done to accomplish integration is both internal (needed transformations to public health and health care) as well as external (dependent on the partnerships health departments forge with other government agencies and health care entities).

This section is not an exhaustive presentation of the issue, but rather a sampling of highlights from HRIA's research that aims to partially answer MCDPH's questions about opportunities to partner with the health care sector. Part IV of this report more fully explores the central data and planning role that health departments have great potential to fulfill. The forthcoming recommendations report will also attempt to more fully consolidate and describe opportunities.

Market Expertise and Services. The most immediate role that MCDPH can engage in is to familiarize ACO and health care leadership with the data, analysis, and planning skills, as well as the population health services, that MCDPH can provide. With ACOs, these conversations should take place early in their development so that potential public health roles can be imagined and incorporated from the beginning.

In approaching ACOs, health care leaders, and health plans, it is important to demonstrate the value of public health as an investment with measurable results. While in the past public health has not needed to create a business case for specific interventions that were grant funded or financed through operating funds, it is important to present opportunities related to financing, resource constraint tradeoffs among objectives, and how specific interventions can add value to the ACO.¹⁸⁹ Walk in the door with data about the ROI from health department services and population health approaches. Learn to speak in the language and through the lens of health care priorities.



As described in this report, health care payers and providers are looking for public health contributions to problems such as reducing preventable readmissions, extending primary care, care coordination, and case management for patients with complex health and social needs, connecting clinical services to wellness resources, and preventing and managing chronic disease among of their clients. Health departments need to frame their expertise and partnership potential in ways that will communicate their ability to help accomplish those goals.

Leaders in hospital and provider networks may be more familiar with programmatic and direct service elements of health departments, such as disease management programs and immunization, and less familiar with the planning, surveillance, and policy development expertise that MCDPH can provide, such as introduction of evidence-based public health guidelines and policies. It will be important to ground any conversation in a full understanding of health department competencies and capacities. For example, explaining that surveillance, her, and claims data can be used to track vulnerable “hot spots” could enable health departments to assist ACOs in targeting services more effectively to geographic neighborhoods. Health departments should consider how to finance these services, whether through contract, a pool of funding established by an ACO, multiple health systems, or payers to develop the needed infrastructure to contribute population health planning skills.

Join forces to plan and take responsibility for health improvement. The greatest impact will be accomplished if health departments and other government agencies — along with the health care system — collaborate to determine common measures, assess community needs from a combined point of view, and agree on population health priorities and goals. There are many possible models and scales on which to base this, from small working groups up to comprehensive city- or county-wide joint Community Health Assessment/Community Health Needs Assessment (CHA/CHNA) planning and Community Health Improvement Plan (CHIP) development (more fully discussed in Section 13). Vermont offers another promising innovation for planning. The Department of Public Health and the newly formed Green Mountain Care Board, the entity charged with achieving the

triple aim in Vermont, are exploring the establishment of a new cross-departmental Population Health Working Group. Linked to Vermont’s CMMI State Innovation Model grant, the goal of the group is to develop actionable recommendations in such areas as Hospital Community Benefit/Community Needs Assessment policy and practice and better alignment of state spending with prevention to improve population health outcomes.¹⁹⁰

Advise on Population Health Measures for Health System Quality and Performance. Many state governments are looking at how to align quality and performance measures across public and private health care systems. The states of Massachusetts and Vermont are exploring health system metrics that incorporate population health outcomes, and in the case of Vermont, measures related to the social, physical, and economic determinants of health. The Massachusetts Statewide Quality Advisory Committee (SQAC) includes an (unfortunately) non-voting member of the MA Department of Public Health. The SQAC invited the Executive Director of the Association of State and Territorial Health Officers (ASTHO) to recommend population health measures, some of which are included in the Statewide Measure Set Recommendation (*Appendix 2*). Both the ASTHO recommendations for MA and recommendations for the Vermont Green Mountain Care Board have basis in part in the County Health Rankings framework of indicators. Vermont is exploring adding new population health indicators into its Green Mountain Care Board dashboard.¹⁹¹

Public health leaders in Arizona could formally make recommendations to the Governor, AHCCCS, ACOs, health plans, and hospital systems that aligned measures include population health and social, physical, and economic determinants of health. Health departments can lead the way to recommend measures most appropriate to target cost driving population health issues in Arizona.

Advocate for an All Payer Claims Database and a Population Health Role for it. Most states in the U.S. have included — or are in the process of including — within their payment reform activities an *All Payer Claims Database* (APCD). *Arizona is not one of them.*



APCD is one system comprised of medical, pharmacy, and dental claims, as well as information about member eligibility, benefit design, and providers for all payers covering their residents. The database streamlines required data submissions for payers and also affords a deep understanding of a state's health care system by providing access to timely, comprehensive, and detailed data. While these databases are focused more on tracking health care quality and cost, unfortunately public health fails to use it as an important mechanism for population health surveillance — especially at a more granular level than is currently available to them, such as the BRFSS. ADHS has an important opportunity to investigate how an APCD can be adopted in the state of Arizona as an important tool for monitoring health care quality and population health.

Share Evidence-based Best Practices. Public health can be an important source of evidence-based guidelines, especially related to primary prevention and chronic disease management. Oregon Health Authority's Division of Public Health has become a source of information on guidelines for work being done at the local level by Care Coordination Organizations, and is able to share lessons learned by CCOs to others across the state.¹³² Some state health departments are strengthening their own capacities relative to evidence-based public health planning. By expanding their own capacity and sharing it with local health departments, public health then has the capacity to expand into the communities and health systems in which they work.

For example, the Missouri State Department of Health (MSDH) sponsored an Evidence Based Public Health course, led by faculty from the Prevention Research Center in St. Louis (PRC-StL), for state leaders in 2010. In 2011, the course was expanded to local public health districts, and emphasized the importance of evidence-based community interventions and the role of the health department in community assessment, interventions, and policy. Soon after, MSDH repeated the course, taught by MSDH staff. MSDH included the EBPH model in grant applications to the Coordinated Chronic Disease Program and the Community Transformation Grants program. MSDH offered \$15,000 to \$26,000 mini-grants to local health departments

to support the development of evidence-based action planning in such areas as physical activity, joint-use agreements, smoke-free municipalities, and healthy corner stores.¹⁹² This example is cited to demonstrate that creating an emphasis on evidence-based practice for local health departments will enable staff to then incorporate the approach when working with others.

As described above, an important skill that the Oregon Health Authority offered to the Coordinated Care Organizations was as a resource on evidence-based guidelines and practice, as local initiatives are planned at the community level. In this example, the ability to stay abreast of current developments regarding best practices is performed at the state level, and then disseminated locally, where resources may not exist to track the information.

In a similar fashion, MCDPH could orchestrate learning collaboratives on evidence-based chronic disease prevention and management strategies.

Partner to Improve Quality of Preventive Services and Connection to Community Health Resources. CMMI and Community Transformation Grant (CTG) funds provide opportunities for health departments to partner with clinical sites to deploy public health expertise with clinical quality improvement efforts. The first round of CTG funds called for applicants to include in their plan efforts with providers to increase clinical preventive screenings indicated by the Million Hearts Initiative, as well as develop models to help providers connect patients to community resources for healthy eating and active living or other wellness support.

A funded Massachusetts CTG program brings together the health department, the state CHC Association, and specific health centers for a Quality Improvement and clinical-community connection model. It incorporates Health Information Exchange (HIE) and Electronic Health Record (EHR) technology to use clinician prompts as a reminder to provide needed screenings and automatically generate prescriptions to local gyms and farmer's markets when indicated. In each site, a CHW helps with patient follow-up and also represents the health center at a local wellness improvement coalition funded in part through the grant.



Join or Form Community Health Teams as a Partner to an ACO or Innovating Health Care System. With expertise in assessing community needs and designing comprehensive, community-based case management and wraparound services, health departments can identify and organize the needed regional partners into a CHT that would be part of a new model of care.

Promote and Build Capacity for Community Health Workers. CHWs have the potential to be one of the key points of connection between public health and health care. CHWs have been shown to make care more culturally competent, enhance access, improve chronic disease care, and yield a significant Return on Investment (ROI).¹⁹³ CHWs can help extend health care capacity and ameliorate health care shortages in the primary care work force, as well. The ACA provides new opportunities to accomplish these goals through developing an effective CHW workforce and integrating CHWs into new health system models. Studies that demonstrate the cost-effective result of including CHWs as part of the care team include:

- CHWs in Denver, CO provided case management to increase patients' use of primary and specialty care and successfully reduced use of urgent care and inpatient and outpatient behavioral health care¹⁹³;
- While it is no longer in existence, the Arizona Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) project showed increased physical activity and fruit and vegetable consumption among participants who received provider counseling, health education, and CHW support to target chronic disease risk factors in uninsured, primarily Hispanic/Latina women over age 50¹⁹⁴;
- Bilingual and bicultural CHWs in a Massachusetts program provided enhanced prenatal care for ethnic and linguistic minorities, resulting in significantly increased enrollment in early prenatal care¹⁹³; and,
- Health improvements resulted in a 10% reduction in the number of days in a two-week period with asthma symptoms as a result of Seattle King County health department program that employed CHWs to deliver home-based asthma care and environmental assessments. It also resulted in a 45% reduction in urgent health service use.¹⁹⁵

Health departments can play many important roles in building CHW capacity. CHWs are rarely integrated effectively as a member of the primary care team and are more often used in an “add-on” role. Barriers to CHWs playing a more formal role include lack of provider awareness about CHWs' skills, inadequate training and certification programs, and lack of reimbursement mechanisms for CHW services. A workforce analysis from the Health Resources and Services Administration found that CHW positions tend to be short-term and low-paid, with little recognition from other health care professionals.¹⁹³ To this end, health departments can:

- Initiate CHW workforce development activities, such as developing career paths, training and continuing education and participating in certification efforts underway. The University of Arizona Community Health Worker National Education Collaborative is an excellent local resource for curricula, technical assistance and research on CHWs;
- Lead campaigns to raise awareness about and promote the CHW role. Consider establishing an Office of Community Health Workers as has been done in other states. Use communication collateral and campaigns to explain and promote the role of CHWs. Communicate ROI and efficacy data;
- Partner with healthcare providers to include CHWs in new models, such as contracting with AHCCCS and Marketplace health plans for health department CHWs to provide CDSM programs as well as other wellness supports and linkage to preventive services. MCDPH is well positioned to link CHW prevention services with primary care in CHCs through home visiting or case management for specific populations or diagnoses. Partnering on a demonstration project for CHTs or other innovations could help lay the groundwork for reimbursement and/or contracts with plans. Developing and advocating for policies to promote reimbursement.

The Minnesota Community Health Worker Alliance, a stakeholder consortium that includes state agencies, government officials, academic institutions, nonprofit organizations, health care providers, and CHWs, developed a standardized curriculum for CHWs.



The Alliance also laid the groundwork for ways to reimburse CHWs. In 2008, the state passed legislation that authorizes hourly reimbursement for CHWs.¹⁹⁶ CHWs who have completed the standardized curriculum are eligible to enroll under the Minnesota Health Care Plans. Under the supervision of a physician, advanced practice nurse, dentist, public health nurse, or mental health professional, their services can be billed to Medicaid¹⁹⁶; and,

- Promote and train CHWs as Marketplace Navigators with enhanced skills to support vulnerable low-income populations newly eligible for insurance to enroll, stay on insurance, and access preventive services and care appropriately. See section 17 for more discussion of the Navigator role and health departments.

Plan and provide direct services that reach people where they are. Traditionally, health departments are able to make services available that are more easily offered in the community than in clinical sites, such as:

- Targeted immunization clinics
- Teen pregnancy prevention programs
- CDSM group programs
- Facilitated clinical-community resource connections such as prescriptions to gyms and food markets
- Match vouchers (like BPHC) for farmers markets
- Asthma home visiting programs
- Amoking cessation
- Injury prevention training targeted to seniors and children and those who care for them
- Lead poisoning prevention and testing programs
- Breastfeeding classes through hospitals and workplaces
- Early intervention home assessments
- Legal-medical partnership program providing patient advocacy with lawyers
- Housing inspector training programs to look at environmental conditions in housing that contribute to illness, especially asthma
- Oral health screening and referral programs to alternative community settings.

Health Providers and Payers’ “Skin in the Game”

Health care payers and providers have a vested interest in assuring a robust public health system. In fact, health payers will see reduced health care costs and savings if public health is stronger and better able to assure a healthier population. In emerging health care system models that allow providers to share in the savings from improved outcomes, this is real skin in the game. But historically, health care payers and providers don’t invest in public health departments and programs other than through their charitable giving or community benefits. While new IRS CHNA requirements create an opportunity to better align that giving with public health — potentially including investing in health departments — there are other approaches to health care providers paying for public health services. Analogous to health care providers contributing to a common pool to pay for care for the uninsured, some states have created models whereby health payers contribute to public health common goods. For example, discussed further in this report, Massachusetts has established two such funds, the Pediatric Immunization Trust and the Prevention and Wellness Trust. A portion of all acute care payments is contributed to these funds to reach a targeted amount which goes to invest in the goal of universal pediatric immunization and toward strategic community based prevention activities.



Section 10. Center for Medicare and Medicaid Services (CMS) Innovation Center: Funding Opportunities for Community-Integrated Health Care

Overview of CMS Innovation Center Opportunities

Since the implementation of the ACA, programs that have received the largest share of federal funding are focused on employers and businesses (47% of funding), followed by private insurance and exchanges (22%), Medicaid and Medicare (8%), health centers (8%), public health and prevention (4.3%), maternal health and pregnancy (4%), workforce and training (4%), and health care facilities and clinics (2%).¹⁹⁷ For the public health and prevention category, which consists of funding for initiatives aimed at reducing the prevalence of chronic conditions and improving population health, almost \$517 million was awarded as of 2012. Public health and prevention received significantly less funding in Arizona than any other category, at approximately \$9.1 million.¹⁹⁸

A significant percentage of funding from the CMS Innovation Center and other agencies for initiatives related to ACA was granted in 2010–2011. A new opportunity (second round of CMS Innovation funding) was released on May 15, 2013 that MCDPH should investigate.

The CMS Innovation Center (CMMI) is focused on developing new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Congress has also identified a number of demonstration projects, through the ACA and through past legislation, that CMS is required to conduct.¹⁹⁹ Much of the funding allocated to CMMI was frontloaded and many initiatives have already been funded. By late 2012, CMMI spent almost half of the \$10 billion allotted to it over 10 years under the ACA.²⁰⁰ CMMI is focused on developing and sharing data with partnering organizations to refine models that promote the Triple Aim of Improved Care, Better

Population Health, and Lower Costs. CMS is not interested in continuing to pursue approaches that do not show promise.²⁰⁰

Medicaid Incentives

One area of interest is finding methods that encourage Medicaid enrollees to participate in prevention efforts, and CMMI developed the Medicaid Incentives for the Prevention of Chronic Diseases Model to identify promising practices in this area.²⁰¹ State Medicaid programs in West Virginia, Florida, and Idaho experimented with Medicaid beneficiary incentive programs prior to the ACA. These programs focused on creating incentives for behavior changes, such as smoking cessation or weight loss, using a variety of incentive structures. None of the programs conducted rigorous evaluation, and not much evidence was produced about the impact that the incentives had on improving health outcomes.²⁰² While there is much interest in the use of incentive programs, the lack of evidence on effective practices supported the need for the CMS pilot.

Programs funded through this initiative must contribute to an understanding of the effectiveness of incentive programs for general populations and for Medicaid populations specifically. Some promising practices and concepts that CMS identified for programs to consider included:

- the importance of strong communication;
- providing enough incentive dollars;
- taking into consideration starting points;
- avoiding penalty approaches to incentives;
- including physicians and other providers in the process;
- incorporating boards or panels that function as an independent reviewer and auditor can help with ethical, legal, and practical constraints; and,
- incentives for outcomes may yield the best results, but are difficult to administer and introduce several legal, ethical, and practical issues.²⁰¹

Under this program, three-year grants were awarded to ten states in September 2011. Funded programs focus on tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving diabetes management.²⁰¹



There is no indication on the CMMI website about future funding opportunities in this area. However, promising practices may be identified through this initiative, and it may be useful to monitor the CMMI web portal for information in the future about findings and learning opportunities. CMMI has an easy sign-up process for email updates.

Accountable Care Organizations and Primary Care Focused Initiatives

A major area of focus at the CMMI has been funding development and implementation of ACOs. The Center funded three pilots related to ACOs in AZ:

- Pioneer ACOs, effective January 2012, including Banner Health Network;
- Medicare Shared Saving ACOs, effective January 2013, including four in Arizona: Arizona Care Network, LLC (a collaboration between Dignity Health and the Arizona State Physicians Organization); GPIPA ACO; Yavapai Accountable Care; and, Yuma Connected Community; and,
- Advanced Payment ACOs, none in Arizona.¹⁴³

CMMI has funded other demonstrations that focus on patient/physician access to community resources, and preventive health, including:

- Comprehensive Primary Care Initiative Demonstration: a public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination. Participants in 497 practices in seven states were announced in August 2012;
- The FQHC Advanced Primary Care Practice Demonstration: coordinates payments to FQHCs, enhancing primary care services and improving access. The three-year project involves 500 FQHCs in 44 states. Eleven FQHCs in Arizona are participating; and,
- Multi-payer Advanced Primary Care Practice Demonstration: state-led, multi-payer collaborations to help primary care practices transform into medical homes. This three-year project involves eight states.²⁰³

Other CMS Innovation Center Opportunities

The Health Care Innovation Challenge is another interesting opportunity in CMS Innovation. This is a three-year initiative that is a broad appeal for innovations with a focus on developing the workforce for new care models. The first group of 72 innovation advisers was named in January 2012.²⁰⁴ (Among them was Health Resources in Action; Laurie Stillman is the P.I.). Because it is an on-going initiative, MCDPH should monitor the CMS Innovation Center website to see if additional applications will be accepted in the future.

A new Health Care Innovation Challenge RFP was released on May 15, 2013, with Letters of Intent due June 28. The webinar will be in late May. The RFP seeks proposals for innovations that will focus on four areas:

- 1) rapidly reduced Medicare and Medicaid costs in post-acute settings;
- 2) improved care and outcomes for populations with specialized needs, such as children in foster care, people with Alzheimers, and serious behavioral health problems;
- 3) quick transformation of payment and delivery models for specific types of providers; and,
- 4) improved population health through comprehensive care models that extend beyond the delivery setting into the community. This will focus on improvement for populations defined by geography, socioeconomic class, and diagnosis, such as patients in certain neighborhoods or patients with COPD or asthma.^{205,206}

This is an important opportunity for MCDPH to partner with health care providers and lead facilitation of connection to community services to improve population health.

CMMI is also currently accepting applications is the Comprehensive End-Stage Renal Disease (ESRD) Care initiative which will identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD.



Through this initiative, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with patient centered, high-quality care. Letters of Intent were due on May 15, 2013.²⁰⁷ Additional demonstration programs can be viewed on the CMMI website.

Other Federal Funding Opportunities

A review of federal grant opportunities on April 27, 2013 yielded the following opportunities:

Behavioral Interventions to Address Multiple Chronic Health Conditions in Primary Care (R01) (Funding Number PA-12-024)

This funding opportunity announcement (FOA) seeks Research Project Grant (R01) applications that propose to use a common conceptual model to develop behavioral interventions to modify health behaviors and improve health outcomes in patients with co-morbid chronic diseases and health conditions. Specifically, this FOA will support research in primary care that uses a multi-disease care management approach to behavioral interventions with high potential impact to improve patient-level health outcomes for individuals with three or more chronic health conditions. The proposed approach must modify behaviors using a common approach rather than administering a distinct intervention for each targeted behavior and/or condition. Diseases and health conditions can include, but are not limited to: mental health disorders (e.g. depression), diabetes, smoking, obesity, chronic pain, alcohol and substance abuse and dependence, chronic obstructive pulmonary disorder, cancer and hypertension. Submission dates: February 5, June 5, October 5.²⁰⁸

Improving Health and Reducing Premature Mortality in People with Severe Mental Illness (R01) (Funding Number RFA-MH-14-060)

People with severe mental illness (SMI) die from the same causes as those in the general population (e.g. heart disease, diabetes, cancer, stroke, and pulmonary disease). However, these diseases are more common in people with SMI and lead to earlier death. The modifiable health risk factors that contribute to these diseases are smoking, obesity, hypertension, metabolic disorder, substance use, low physical

activity, poor fitness and dietary which are more common and have an earlier onset in people with SMI. Side effects of psychiatric medications, which may include weight gain and metabolic disorder, add to these health risks. Effective interventions to reduce these common modifiable health risk factors exist for the general population; however, they are generally unavailable to people with SMI and evidence is sparse on how to bring them to this population. This FOA will support R01 grants of up to five years for rigorous effectiveness testing of innovative services interventions designed to reduce the prevalence and magnitude of common modifiable health risk factors related to shortened lifespan in adults with SMI, as well as in children and youth with serious emotional disturbances. Submission date: November 7, 2013.²⁰⁸

ACA SHIP and ADRC Options Counseling for Medicare Medicaid Individuals in States with Approved Financial Alignment Model (Funding Number CMS-1N1-12-001)

The CMMI is authorized to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care furnished to individuals under such programs. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) is charged with more effectively integrating benefits under the Medicare and Medicaid programs and improving the coordination between the Federal government and states. In July 2011, CMS released a letter to state Medicaid directors which discussed two models for integrating care and aligning financial incentives for Medicare and Medicaid as part of CMS. Financial Alignment Initiative, a joint initiative of CMMI and the Medicare-Medicaid Coordination Office, under which states and CMS will collaborate to integrate care and financing for Medicare-Medicaid individuals. Current closing date for applications: August 15, 2013.²⁰⁸

PPHF 2013 Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges

(Funding Opportunity Number: CA-NAV-13-001)
This FOA has been developed to enable recipients to operate as Exchange Navigators in States with a Federally-facilitated Exchange (FFE), as authorized under Section 1311(i) of the ACA.



Any state electing not to pursue a State-based Exchange for benefit year 2014 will have an FFE or a State Partnership Exchange in the case of a State collaborating with an FFE in a Consumer and/or Plan Management Partnership Exchange. To view a current list of States that will have an FFE or State Partnership Exchange in benefit year 2014 see Section VIII. State Reference List. Applications due: June 7, 2013.²⁰⁸

One program, “*Delivery on the promise of diabetes prevention programs*”, which received a CMS Health Funding Innovation Award, may be of interest. The program, which has sites in Arizona and seven other states, received approximately \$11.8 million over a three-year period. As part of this program, the National Council of Young Men’s Christian Associations of the United States of America (Y-USA), in partnership with 17 local Y’s currently delivering the YMCA’s Diabetes Prevention Program, the Diabetes Prevention and Control Alliance, and seven other leading national nonprofit organizations focused on health and medicine, is receiving an award to serve 10,000 pre-diabetic Medicare beneficiaries in 17 communities across the U.S. The intervention will focus on community-based diabetes prevention through a national diabetes prevention lifestyle change program coordinated and taught by trained YMCA Lifestyle Coaches. The goal is to prevent the progression of pre-diabetes to diabetes which will improve health and decrease costs associated with complications of diabetes, hypercholesterolemia, and hypertension.²⁰⁹ This program could be of interest to MCDPH in exploring opportunities to partner with or support.

Because much of the significant funding to date on approaches to integrating care, prevention, coordinated care, and chronic disease management has stemmed from the CMS Innovation Center, it will be important to monitor funding opportunities from this agency. While roughly half of the Center’s funds have been utilized at this time, the Center seems intent on continuing to fund innovative programs. Because the Center’s purpose is to identify promising practices, it will be important to monitor the results of various pilots that have been funded, and to take advantage of any learning opportunities that may become available.

The Alliance for Community Health Centers is applying for Cooperative Agreement to Support Navigators in federally-facilitated and State Partnership Exchanges. Their proposal focuses on two outreach and enrollment coalitions including one in Maricopa County.²¹⁰

The previous Section 9 offers many areas of potential partnership with co-applicants to CMMI RFPs.

Other Funding Opportunities in Community-Integrated Health Care

In addition to funding opportunities from the government, private foundations have taken a strong interest in health reform, and have funded a large range of reform-related initiatives. Grant Makers in Health conducted a survey of 87 foundations across the U.S. about their activities related to health reform over recent years, and survey results showed that major areas of activity for the foundations included:

- Transforming Delivery of Care (56 foundations);
- Strengthening the Safety Net (52 foundations);
- Advocating on Coverage and Access Issues (51 foundations);
- Addressing Public Health and Prevention (49 foundations);
- Enhancing Outreach and Enrollment Strategies (45 foundations);
- Educating and Informing (44 foundations); and,
- Addressing Complex Care Needs (Multiple Chronic Conditions, Behavioral Health) (40 foundations).²¹¹

Key elements of these areas include community integration transforming care delivery, addressing public health and prevention, and addressing complex care needs. While many of these foundations are focused on specific state-level activities, this trend shows an ongoing interest in the integration of health care delivery and its interface with public. This suggests that it is worth monitoring private foundation funding opportunities.

In addition, the Public Health and Prevention Fund dedicates a significant percentage of funding to clinical prevention, and Community Transformation Grants include primary community prevention as well as clinical-community connection components.



While there are no current open funding opportunities, the initiatives of funded grantees point to opportunities for clinical-public health collaboration that Arizona could follow. This will be discussed further in Section 14.

Section 11. Implications of the ACA for the Public Health and Healthcare Workforce

Overview

As described earlier in this report, Arizona and Maricopa County already face gaps in needed healthcare — especially primary and rural care — which will only intensify when the number of insured individuals grows. ADHS Bureau of Health Systems Development estimates that an approximately 300 additional primary care practitioners are needed to address the HPSAs statewide, even before increased coverage resulting from the ACA.⁸⁷ To meet the increased demand for services after implementing the ACA, an additional 750 primary care providers are needed, and the workforce should be redistributed across Arizona to meet geographic differences.⁷

Arizona's public health infrastructure and staffing needs are detailed in the St. Luke's Health Initiative report, *Putting the Pieces (Back) Together: Public Health and Prevention*. State and local public health investments in Arizona have declined rapidly recently; state public health spending dropped 68% between 2008–2011. The Public Health Division of ADHS lost 15% of FTEs in the same time period. In FY 2011, Arizona spent only \$48 per capita (combined state and federal funding) on public health, compared to the national average of \$94 per capita. Maricopa County spent only \$12 per capita.²¹²

In addition, the changing health and health care landscape demands an increase in a new kind of professional with skills to move between the public health and clinical worlds. These should be leaders in both spheres who can make the connections and collaboratively design innovative approaches that combine improved primary care

with population health strategies. There are some provisions in the ACA to address these needs, and there is a great opportunity for MCDPH to play a leadership role in coordinating and assuring that any workforce initiatives also incorporate public health workforce needs.

ACA Provisions to Address the Health Workforce

The ACA includes provisions to strengthen the health workforce through a number of programs focused on education and building a pipeline for primary care and needed public health specializations. Some of these provisions include mandatory appropriations while others include authorizations of appropriations, making funding dependent on the federal budgeting process.²¹³ They merit continued monitoring and advocacy at the federal level and can also serve as models for state level efforts.

The ACA also recognized the need for planning at the national level and created the National Health Care Workforce Commission to include planning for the public health workforce as well. Members of the panel were appointed in 2010, but the panel has not yet met, due to lack of funding.²¹⁴ In 2011 CDC launched the Public Health Workforce Development Initiative to analyze and address the changes to resources and workforce needs in public health. Through the Scientific Education and Professional Development Program Office, CDC recently hosted a Public Health Workforce Summit and has developed a preliminary National Public Health Workforce Strategy Roadmap (see *Appendix 3*).²¹⁵

In addition to health workforce analysis and planning provisions, other measures included in the ACA include:

- **Health Workforce Education, Training, and Pipeline.** Established loan forgiveness to practice in underserved areas and at safety net institutions, including health departments; fellowships in needed areas such as Public Health Informatics; primary care training, including for nurse practitioners and primary care extension program; and, CHW workforce grants;



- **New Models of Care.** CMMI grants incubate new models of care that enhance primary care access through a coordinated team approach such as PCMH and CHTs that include nurses, CHWs, and others in order to better extend the quality of care and not rely exclusively on physicians;and,
- **New Public Health Infrastructure and Programming.** ACA provisions increase the size of the public health workforce, such as eliminating the cap on Commissioned Corps and establishing a Ready Reserve Corps, Epidemiology and Laboratory Capacity, and School-Based Health Centers. Community Transformation Grants fund additional public health personnel and also extend the reach of public health by requiring multi-sector partnerships and environmental change.

See *Appendix 4* for a complete summary of provisions in the ACA that are intended to increase the public health and healthcare workforce through educational support, capacity expansion, or training. Many of these have not received funding yet, however. Those that had funds allocated have used Prevention and Public Health Fund dollars.

New Critical Public Health and Health Care Competencies Needed

Public health and health care providers are facing many major changes right now, including how care is being delivered. While health promotion, prevention, and chronic care management are not new to primary care providers, these functions have taken on a bigger role, as more health systems are moving into accountable care models and patient centered medical homes. Public health practitioners are now faced with the need to speak the language of health care financing, billing, return on investment, and health system design, as well as policy and informatics.

For health care providers, some of the new skills that have become increasingly important include:

- **Working in a team model to treat patients effectively.** This means involving all members of the team, including the physician, mid-level providers, care coordinators/case managers, and office staff, and developing systems to treat a patient proactively effectively in a team context. This includes skill in working with CHWs as well as skilled CHWs themselves;
- **Understanding primary prevention and population health strategies.** With the advent of ACOs, primary prevention is likely to become an important focus for primary care providers, and dissemination of effective, evidence-based strategies will be needed. Health departments and schools of public health can play a key role in supporting the integration of these competencies into clinical education, residencies and fellowships;
- **Patient engagement.** To help patients become more effective at managing their health, it is important to be able to work with them in a way that assists them in understanding and following their treatment plans. To do this, providers may need to strengthen their cultural competency skills, have a better understanding of health literacy issues, and develop new skills like motivational interviewing and running group sessions. They will also need to make time in the office visit to provide chronic disease self-management education;
- **Working with non-clinical community partners.** Providers need to be able to work with health departments, community health workers, wellness coalitions, YMCAs, or others in the community that can provide support and assistance to patients. These may be new partners for some health care providers, so providers will need to learn what services these partners offer, priorities of the partners and how to work effectively together;
- **Awareness of community resources.** Management of some conditions can require increased physical activity, improved nutrition, and other lifestyle issues. Providers need familiarity with community services that can provide related services and a process to refer to them. Case managers can fill this role;



- **Use of technology.** The role of technology is important for ensuring communication among the patient’s team. In addition, patient registries and other systems to help proactively track care and measure outcomes are more common. Skill at using EHRs, registries, decision support and other technology has become increasingly important. Tracking health disparities amongst vulnerable groups, is recommended; and,
- **Quality improvement processes.** Many primary care practices are implementing major changes to adapt to new models of care. Being able to plan and implement changes and measure outcomes is important, and is key to success in many ACO and Pay-for-Performance contracts. This is required by the National Committee for Quality Assurance (NCQA) to gain recognition as a Patient Centered Medical Home.

For the public health workforce, skills that are needed to successfully lead, thrive, and integrate into the larger health system include:

- **Increasing accountability.** Public health should develop capabilities to assume greater accountability for the design and development of the overall plan for improving health in their communities. This means they must be able to establish their value and role in the identification, implementation, coordination, and evaluation of cost-beneficial prevention programs and activities²¹⁶;
- **Mobilizing communities and forging partnerships.** Public health is increasingly moving to the role of convening and building collaboration with multi-sector partners. While this not a new skill for public health, partnership and collaboration building is increasingly important in order to find ways to integrate health care and public health functions. In addition, mobilizing communities with the tools of change is critical to accomplishing environmental, policy and systems changes²¹⁷;
- **Ability to partner with the health care system and build new models that integrate clinical and population health.** Many public health departments may have not had an opportunity to collaborate with health care systems and may be unfamiliar with

the services they offer, the language they speak, and the constraints with which they are faced. Public health leaders must better understand the health care and health care financing system — from MCOs to ACOs — and be able to formulate and propose strategic partnerships, points of leverage and intersection.²¹⁸ In order to accomplish this, public health departments must market their services and expertise to health systems and health plans.

- **Working with non-traditional partners to champion health.** An important role that public health can play is to promote health in all policies (HIAP) to promote conditions that lead to good health. This can include working with transportation and environmental planners, land use decision-makers, school administrators, business owners, real estate, parks and recreation officials, and housing authorities to help them understand what public health can offer to their work, and to find opportunities for collaboration.^{216,217} Within the area of HIAP, experts have identified the below specific competencies needed by public health professionals²¹⁹:
 - » Building key staff skills and knowledge about and ability to “speak the language” of other governmental divisions (housing, transportation, community development, education, planning);
 - » Understanding political agendas and administrative priorities of other sectors;
 - » Growing the toolbox and evidence base of potential policy strategies;
 - » Assessing comparative health consequences of different policy options through Health Impact Assessments (HIAs) or more informal analysis;
 - » Establishing ongoing meetings for collaborative learning and work with other sectors; and,
 - » Working with different government sectors that affect health to accomplish their priorities that will help improve population health, such as increasing funding for efforts to increase high school graduation rates or for new affordable housing.



- **Demonstrating value.** In working with health care providers and other new partners, it is important to demonstrate the value that public health and prevention bring. That means collecting the data, sharing the evidence base, and telling the stories that illustrate the value of public health in people's lives. Along with demonstrating how public health efforts can lead to better health and longer lives, public health needs to demonstrate how these efforts reduce medical spending and prevent unnecessary hospital care.²¹⁷
- **Identifying ways to incorporate disease prevention into health care system redesign.** The aging of the U.S. population underscores the need for finding ways prevent or delay the onset of age-related illnesses like cancer, diabetes, and heart disease. These diseases are major drivers of health care expenditures and are associated with modifiable risks that public health interventions can influence.²²⁰ Public health has a long history of focus in these areas, and this work can be more connected to health care delivery efforts. Finding ways to connect these prevention services with delivery sites is a new focus for public health;
- **Stronger communications skills, including social media.** Public Health must have the capacity to frame issues and strategically communicate its messages through the media, communications plans, and use of social media. Public health professionals need to become proficient with tools such as posting video, blogs, and tweeting to strategize how they can help reach different communities and audiences^{217,221};
- **Developing informatics skills.** New technologies, such as electronic health records, provide vast opportunities for sharing information in new ways. These technologies can result in large amounts of data being accessible to public health departments. Developing capabilities to utilize this data to create opportunities for better health outcomes and quality care is an important priority and requires sophisticated informatics skills.²¹⁷ In addition, public health should have the capability to share population health data with health care systems as well monitor other data that are drivers of community health such as educational attainment and employment which impact health outcomes²¹⁶;
- **Monitoring, voicing, and recommending solutions to issues of equity.** The ACA focuses on improving health care access and quality to all Americans. Public health has a long history of working to address health care disparities and inequities. The ability to convey the need for addressing inequities is something important and unique that public health brings to the current environment, and it is important to find ways to help the health care system monitor impact on different populations, identify inequities, effectively communicate this message, and advocate for solutions.²¹⁷
- **Developing policy related skills.** Competence around policy development is a critical area of focus as public health increasingly targets the determinants of chronic disease through environmental, systems and policy change^{216,217}; and,
- **Working with payers.** Public health professionals will need competencies to understand health insurance systems and the point of view of payers as well as the ability to build and negotiate relationships. Many public health services merit contracts and reimbursement and scaling up to broader usage. Under the ACA landscape of more health insurance coverage the adage, what doesn't get paid for, doesn't get done should be heeded. If public health concepts are to be embraced by health care systems, then the time it takes to proactively incorporate cost-saving population health activities needs to be paid for up front. Public health needs to be at the table shaping payment reform activities which support primary and secondary prevention activities.

Strategies for Arizona and Maricopa County to Address Health Workforce Needs

The most effective strategies and partnerships to address healthcare workforce issues in Arizona will also incorporate public health workforce issues and solutions and aim for better integration across clinical and population health providers and systems. There is broad agreement and momentum among hospitals, health centers, health plans, and providers to expand primary care capacity to meet the forthcoming demand of newly insured residents.



While there is not yet that kind of agreement and momentum in the health care community about the system's need for a robust public health workforce, the opportunity exists to make the case and lead efforts to weave the two together.

The public health workforce's experience in prevention and population and public health are ultimately very important to the health care workforce's goals. Public health has an understanding of preventable diseases and their determinants as well as evidence-based interventions, and investments in public health reduce preventable disease and death. One analysis showed that increases in the number of FTEs at local health departments per capita was associated with lower rates of death from cardiovascular disease.²²²

While health care professionals have been addressing preventable health challenges such as diabetes, obesity and smoking-related diseases on an episodic basis historically, the implementation of accountable care organizations and other health delivery system redesign shifts the perspective to population health. This will require some reorganization for health care providers, and public health may be able to provide useful resources and guidance.

Many health care systems may not have had knowledge of the services and resources that MCDPH offers. Providing health care and health payer medical directors with a presentation of evidence-based services related to health promotion, management of chronic conditions, health literacy, efforts to reach hard-to-reach populations, along with other functions such as health assessment, would be a practical starting place. They are used to referring to peer-reviewed literature and demonstration projects for new promising practices. In states without limitations on pharmacy and medical device marketing to physicians, providers are used to dinners and presentations and giveaways to promote particular products. Public health can rely on honest strategies of demonstrating the evidence for services through peer-reviewed publications and concise, targeted presentations in short, half-hour meetings aimed at beginning relationships. Developing coordinated health improvement plans with the health care sector, through their community benefit programs, can

help coordinate activities within localities, and focus resources on the most important issues.

There are a number of ways that public health can work with the health care workforce, many of which are detailed in Section 9. Below are additional ways public health and the health care system can collaboratively address workforce needs.

Convene a Public Health-Health Care (Integrated Health) Workforce Committee. In many states, regional collaborative processes, used in Colorado, Ohio, California, Illinois, Nebraska, New York, Iowa, Maryland, and Wisconsin, bring together government agencies, foundations, and other philanthropic organizations to target financial resources and strategic thinking around creating jobs and career paths related to the healthcare workforce.¹²⁶ A 2010 St. Luke's Health Initiative report, *Impact Arizona: Health Reform Hits Arizona*, noted the need for a statewide effort to focus on workforce planning in Arizona.

Though Arizona does not have one unified state workforce planning effort, there are clearly workforce planning efforts underway within and between organizations around the state. One such initiative is the Arizona Action Coalition which includes four co-lead coalition members: Arizona Nurses Association, Arizona State Board of Nursing, Arizona Hospital and Healthcare Association, and United Health Group. This is part of the *Future of Nursing: Campaign for Action*, coordinated through the Center to Champion Nursing in America, an initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation. The Arizona Action Coalition is focusing on increasing opportunities for nurses to lead healthcare improvement efforts and the establishment of a health care workforce center.²²³ The Coalition is planning future events, and partnering with this group could be an important link to planning around NP practice, as it relates to other workforce planning opportunities.

The Arizona Healthcare Workforce Center is another organization working to understand current Arizona workforce needs. The Center, which is funded by the Arizona Hospital and Healthcare Association, is a collaborative effort with Arizona's health care community, state licensing boards, and ADHS.²²⁴



According to one person interviewed for this paper, the Center is interested in developing a study of demand for primary care services in the state, if funding is obtained.⁹³

What seems to be missing is a coordinated statewide effort that incorporates public health and health workforce needs broadly. ADHS Bureau of Health Systems Development is responsible for many of the same functions, including the monitoring workforce and administering the loan program; however, it is not charged with workforce planning in a focused way. This could be a role for the state, perhaps in partnership with MCDPH. An important role for public health, whether as convener or participant, is to keep an eye on the workforce needs for services that are often neglected, such as oral health providers, a workforce that will maximize population health improvement goals, and those that focus on health disparities, and the need to focus investments in programs that will increase opportunities for underrepresented groups including a CHW workforce. Following are two examples of statewide efforts that may provide models for Arizona.

California Health Workforce Alliance (CHWA). A group of over 100 stakeholders including health care and public health organizations, academic institutions, professional associations, foundations, and community-based organizations came together to form this public-private partnership “dedicated to leadership of coordinated, systematic and transformational strategies to meet California’s emerging health workforce needs and enhance the health and economic vitality of our increasingly diverse communities”.²²⁵ Members jointly fund a staff of two FTEs that convenes quarterly meetings of the full body, with subcommittees carrying out most of the work.

As a neutral convener and broker of multiple interests, CHWA developed inclusive guiding principles and priorities for their activities²²⁶:

- *Geographic Framework.* To assure they are incorporating local and statewide projected demographic trends and addressing needs;
- *Diversity/Cultural Competency.* Framed as “strategic investment in our own California communities”;

- *Beyond Institutional Interests.* A joint commitment to work collaboratively;
- *Community Benefit/Corporate Social Responsibility.* To develop solutions across the public-private line that meet their agreed-on ethical standards;
- *Intersectoral Scope.* Acknowledges that the solutions will involve all sectors, including primary, secondary and higher education, philanthropy, government, employers, labor, and community-based organizations;
- *Collaborative Orientation.* Affirms the need for flexibility, accommodation, shared investment of resources and shared risks, and;
- *Neutral Convening/Evidence-Based Decision Making.* Commitment to collect and use both quantitative and qualitative data to inform planning and decision-making.

CHWA is active in policy as well as programs. Their current priorities include:

1. Strengthen K-12 student readiness and motivation to pursue health careers;
2. Align academic production and employer needs through innovations in delivery system, practice model, and training;
3. Partnership and technical assistance with member workforce initiatives;
4. Leadership of the CA Health IT workforce initiative; and,
5. Short-term and long-term workforce planning and development.

CHWA includes a particular focus on expanding the role, training and use of CHWs, promotores, medical assistants, mental health workers, and other front line workers. They are conducting a statewide assessment of the roles and contributions of CHWs to be released July 2013.²²⁷



Convene training and continuing education opportunities.

Preventive health and population based health are areas for which public health is well positioned to provide training to the health care workforce. For instance, learning collaboratives for primary care practices on chronic conditions such as asthma and diabetes may be a valuable resource. Public health agencies are in a good position to convene multiple practices to participate, enabling cross-organization learning. Vermont Department of Health's experience with learning collaboratives is described in the ACO section. In addition, sponsoring a Community Health Education Center (as did the Boston Public Health Commission) which provides trainings for lay workers, can be valuable in increasing capacity, effectiveness, and reimbursement of CHWs.

Track primary care and other access information and identify gaps.

There are many unknowns about what will be the change in demand for services. Public health can have a role in helping monitor availability of providers, especially in underserved areas, and then work with other organizations to develop strategies to address these gaps. The Boston Public Health Commission collaborated with the Massachusetts Department of Public Health's Health Care Workforce Center in a pilot data collection effort with the Board of Registration in Nursing. The minimum data set that was established will eventually be implemented in the Commonwealth's seven other boards of registration. These data will be used to monitor trends in the availability of primary care providers and the use of interdisciplinary team care, and will inform the development of strategies to address disparities and increase the racial and ethnic diversity of the workforce.¹⁰⁸

Retool the governmental public health workforce.

MCDPH and other county and state health departments should seize the opportunity to retool their own workforces to align with foundational competencies as described in the RWJF Transforming Public Health report, as well as to meet accreditation competencies. Whether this means retraining existing staff and/or reallocating or identifying new funds to hire new staff, it should be a priority to assure a workforce that is aligned with changes and the "new" public health, as is the goal of the CDC's Public Health Workforce Development Initiative.²²⁸

Section 12. Employers and Public Health

Overview

In Maricopa County, as in the U.S., the majority of able-bodied adults under the age of 65 spends a significant amount of time at work and is covered by employer sponsored insurance plans.^{4,32,229} In recent years, employer and employee contributions to health insurance have increased significantly. Thus, reducing health insurance and medical costs is a primary concern of employers; furthermore, employers are increasingly concerned about the impact of absenteeism (typically due to personal illness, family issues, personal needs, entitlement mentality and stress) and presenteeism (i.e. employees who attend work despite personal or family illness or chronic conditions and are not productive and/or risk contagion to others) on productivity in the workplace.³² Thus, workplace wellness initiatives are critical to improve the health of populations and reducing per capita costs of health care.

In one study looking at the direct and indirect costs generated for a single large employer (including medical care/pharmaceutical loss, presenteeism costs, and incidental absences), the health risks of high blood glucose, high blood pressure, poor mental health, and inadequate exercise would reduce healthcare costs most significantly.²³⁰

Beyond reducing direct and indirect costs, investing in workplace wellness initiatives can strengthen an employer's reputation by improving its image, provide employers with leverage for negotiating with insurance and workers compensation carriers, boost employee morale, promote employee retention, and enable workers to remain engaged in the workforce until reaching older ages.³²

While workplace wellness programs require an investment of resources, the overall Return on Investment (ROI) for health promotion is significant. For every \$1 invested in workplace wellness, a return of \$1.40 to \$4.70 was realized over a three year period.²³¹ Furthermore, the ROI for every \$1 invested to increase physical activity, improve nutrition, and prevent tobacco use was estimated at \$5.60 in the U.S. and \$4.20 in Arizona.²³²



In a compiled review of the literature, researchers indicate that for every \$1 spent on wellness and prevention, absenteeism costs were reduced by \$2.73 and medical costs by \$3.27.³² Typically, ROI is realized in one to five years from the initial investment.³²

Prevalence of workplace wellness initiatives. While no data exists estimating the percentage of AZ businesses that offer employee wellness programs, estimates can be made from national data. The following data comes from the 2012 Kaiser Family Foundation's (KFF) Employer Health Benefits Survey.⁶² Wellness programs that the survey asked about were mostly programmatic in nature, rather than policy or environmental strategies, and included:

- Weight loss programs
- Biometric screening
- Smoking cessation programs
- Lifestyle or behavioral coaching
- Gym membership discounts or on-site exercise facilities
- Nutrition classes
- Web-based resources for healthy living
- Wellness newsletters.

Approximately 64% of companies in the U.S. that offered health benefits also offered at least one wellness program, with 60% of these companies also offering wellness benefits to spouses and dependents of employees.^{62,233} Ninety-four percent of employers with 200+ employees offered at least one wellness program, versus 63% of smaller firms (<200 employees). The most common wellness programs offered by large employers included web-based resources for healthy living (77%), smoking cessation programs (70%), gym membership discounts or on site exercise facilities (65%), and weight loss programs (65%). For small businesses, the most common wellness programs offered included web-based resources for healthy living (45%), wellness newsletters (45%), gym membership discounts or on-site exercise facilities (28%), and smoking cessation programs (28%). See *KFF Employer Health Benefits Survey Exhibit 12.3 for graphic breakdown of type of wellness programs.*

The transportation/communications/utilities (94%) and finance (89%) industries were significantly more likely to offer wellness programs than any other industries, and the retail sector was significantly less likely to do so (37%).

In the Western region of the U.S. (including Arizona), 62% of firms offered at least one wellness program. The most common wellness program included providing web-based resources for healthy living (47%) or providing wellness newsletters (62%). Providing gym membership discounts or on-site exercise facilities was the least prevalent wellness program in the Western region was (16%). Interestingly, the Western region was significantly less likely to provide this type of program when compared to the other regions of the U.S..

Prevalence of wellness incentives. Again, while no data exists estimating the percentage of AZ businesses that offer employee wellness incentives, estimates can be made from national data using KFF's Employer Health Benefits Survey.^{23,62} Incentives that the survey explored include:

- Workers pay smaller percentage of the premium;
- Workers have smaller deductibles;
- Workers receive higher Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA) contributions; and,
- Workers receive gift cards, travel, merchandise, or cash.

Of employers that offered at least one wellness program, 11% offered at least one financial incentive to participate in a wellness program. The most common type of incentive provided included gift cards, travel merchandise, or cash (8%)

When broken down by size of firm, 10% of small firms and 41% of large firms that offer at least one wellness program offer employees a specific incentive for enrollment.⁶² The following is the specific breakdown of incentives by firm size:

- Gift cards, travel, merchandise, or cash (30% of large firms; 7% of small firms);
- Lowering worker premium contributions (14% of large firms; 2% of small firms);



- Receiving higher HRA or HSA contributions (7% for large firms; <1% for small firms); and,
- Smaller deductible for workers (3% for large firms; <1% for small firms).

Of large firms that offer health risk assessments, 63% offer a financial incentive to employees for completion, which is significantly higher than the percentage of small firms that do so.

In the Western region, where the rates were low overall, the most common types of incentives offered were gift cards, travel, merchandise, or cash (3%), and having workers pay smaller percentages of the premium (3%). The rate of gift cards, travel, merchandise, or cash is significantly lower than the rates for all other regions of the country.

Opportunities Through the ACA

One of the three major prevention provisions of the ACA's Prevention and Public Health Fund (PPHF) is creating workplace wellness programs. Thus, there will be increased opportunities for employers and health departments to implement and expand such initiatives. HRiA was pleased to work with MCDPH to advise on best practices in workplace wellness, and many of these recommendations are reiterated here.

Recognizing the importance of workplace wellness in reducing health costs and promoting population health, the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury jointly released proposed rules on wellness programs. These rules, effective for plan years starting on or after January 1, 2014, include²³⁴:

- Supports for workplace wellness programs, including “participatory wellness programs” that are generally available regardless of health status (e.g. programs reimbursing for the cost of fitness membership; providing rewards to employees for attending monthly, no-cost health education seminars; or, rewarding employees that complete a health risk assessment);

- Amends standards for nondiscriminatory “health-contingent wellness programs” that require individuals to meet a specific standard related to their health to obtain a reward (e.g. programs that reward those who do not use, or decrease their use of, tobacco, achieve a certain weight or specified cholesterol level, etc.). These standards state:

- » Programs must be reasonably designed, providing individuals with a reasonable chance of improving health or preventing disease without being overly burdensome;
- » Programs must be available to all similarly situated individuals, with reasonable alternative means of qualifying for rewards for individuals with special medical conditions; and,
- » Individuals must be given notice of the opportunity to qualify for the same reward through other means.

- Increases the maximum permissible reward under a health-contingent wellness program from 20% to 30% of the cost of health coverage, and up to 50% for programs designed to prevent or reduce tobacco use.

These proposed rules do not specify the types of wellness programs to offer, providing employers with flexibility to design their programs based on their workplace context.

Best Practices

Assessment, planning, implementation, and evaluation.

Successful workplace wellness initiatives start with an assessment of employees' health needs and status, as well as the policies, promotion, environmental supports, and HR benefits for workplace wellness at the individual, organizational and community levels.³² This assessment asks:

- What are the main health issues that your employees have?
- How will you go about changing the conditions that contribute to them?
- How will you know you made a difference?



Following the assessment phase, a workplace health improvement plan is created, resulting in the implementation of programs, policies, and practices addressing employees' health and risk factors as well as organizational culture and conditions. The implementation phase includes identifying champions at different levels and sites of the organization (including employees and leadership) and establishing a Workplace Wellness Committee with broad based employee participation across departments with support from leadership. Furthermore, policy change is critical to make it easier for employees to make healthier choices. Also, employers should look for establishing community linkages and leveraging community resources to support workplace health, while also helping working families balance work and family commitments.

Finally, evaluation of participation and outcomes, with progress reports shared with leadership and employees, is key to ensuring a sustainable infrastructure.

Comprehensive initiatives. Workplace wellness initiatives range from generic programs promoting healthy eating and increased physical activity to targeted interventions aimed at preventing and managing specific diseases among high-risk individuals. There are more comprehensive approaches aimed at supporting physical and mental health, in conjunction with workplace safety, that does not single out anyone but rather offers tailored guidance and support to all employees, regardless of baseline health status.³² A comprehensive approach focusing on individual and organizational change that is tailored to the population, creatively marketed, embraced by top management, and sustained through workplace policies is deemed most effective.^{32,235}

Environmental strategies and policy. The Health Impact Pyramid establishes that protective interventions and changes in the environment or context of where people live, work, and learn through policy efforts and systems change are the foundation for impacting a population's health. Wellness policies facilitate social norms change by shifting the agreed upon norms in a workplace and allowing norms to be enforced. Policies can be implemented at the employer, community, municipal, and county level.

National and local resources. The following are resources for model workplace wellness initiatives at the national and local level:

National

- ***CDC's National Healthy Worksite Program*** (www.cdc.gov/nationalhealthyworksite). This program is designed to assist employers in implementing science and practice-based prevention and wellness strategies that lead to specific, measurable health outcomes to reduce chronic disease rates.
- ***The Wellness Council of America*** (www.welcoa.org). WELCOA's mission is to serve business leaders, workplace wellness practitioners, public health professionals, and consultants by promoting corporate membership, producing leading edge worksite wellness publications and health information, conducting national trainings that help worksite wellness practitioners create and sustain results-oriented wellness programs, and create resources that promote healthier lifestyles for all working Americans.
- ***U.S. Healthiest Workplace*** (www.ushealthiest.org/viewPage.php?ID=healthy-workplaces). Provides promising practices recommended by the Task Force on Community Preventive Services and also promotes HealthLead, the U.S. Healthiest Workplace Accreditation Program.
- ***Chapman Institute*** (<http://www.chapmaninstitute.net>). Runs the WellCert Program, which is a five level certification training program for worksite wellness professionals intended to prepare individuals to plan, design, implement, manage and evaluate "next generation" or "best practice" Corporate Wellness programs.
- ***The Health Enhancement Research Organization*** (HERO) (www.the-hero.org). National leader in employee health management, including research, education, policy, strategy, leadership and infrastructure. HERO developed the HERO Employee Health Management Best Practice Scorecard.



State and local level

- **Action Communities for Health, Innovation, and Environmental Change (ACHIEVE) Communities (www.achievecommunities.org/index.cfm).** Supported by the CDC, ACHIEVE is a partnership between local communities and national and state organizations to promote policies, systems, and environmental change strategies to promote health and prevent chronic diseases and related risk factors. Located in 149 communities, ACHIEVE communities have generated best practices around a number of efforts, including the adoption of worksite wellness policies. Particular ACHIEVE communities with robust workplace wellness programs include:
 - » *Mecklenburg County, North Carolina Working toward Wellness Program*, which aims to provide business with resources, guidance, and ideas to encourage physical and policy changes to encourage wellness in the work environment. This program provides a Program Coordinator to provide a free workplace wellness assessment and customized recommendations, resources and ideas to encourage wellness; and,
 - » *Cook County's Spring into Health* through the Illinois Department of Public Health, which provides employees with free health education, screenings and social support.
- **Healthy Arizona Worksites (www.healthyazworksites.org),** A partnership among Maricopa County Department of Public Health, Arizona Department of Health Services (ADHS), Arizona Small Business Association, and Viridian Health Management, this website provides information, toolkits, training and technical assistance to help business in Arizona have healthier worksites and healthier employees.

Incentives. While almost all workplace wellness programs are voluntary, employers are increasingly utilizing incentives to encourage employee participation. Some employers utilize gift incentives such as t-shirts, gift cards, or cash. While others are linking participation in wellness programs to employees' costs for health coverage (e.g. reducing premium contributions or reducing the amounts they pay in deductibles and

co-pays). Additionally, employers that offer multiple health plans might allow participation in a comprehensive plan only for employees engaged in the wellness program.²³³ This trend will only continue with the ACA provision of increasing incentives from 20% to 30% of employee premiums.

Disincentives. A 2011 survey found that of 600 large U.S. employers, nearly half already employ or plan to implement financial penalties over the next three-to-five years for employees who do not participate in wellness programs.²³³ Workplace wellness incentives can have unintended consequences of shifting costs to those with greatest health care needs, violate the federal anti-discrimination and privacy laws through HIPAA and the ACA's prohibition on health status rating, and potentially affect which workers remain in employer plans and which end up in the new health insurance exchanges.²²⁹ Some consumer advocates argue that differentiating health coverage costs among employees is unfair and will lead to employers policing workers' health.²³³ Thus, it is important to establish standards at the state and federal level for consumer protections to guard against programs and financial incentives that inappropriately punish workers in poor health and/or are overly coercive.²²⁹ Health departments should play a role in monitoring the impact and unintended consequences of employer financial penalty disincentives.

Currently, the evidence is mixed as to whether incentives result in real improvements in health outcomes or healthcare savings. Incentives prompt workers to participate in wellness programs and may be a first attempt to gain entrée into establishing a healthy worksite program. Yet, there have been no published, independent studies on how changes in premiums or cost sharing affect the health outcomes of workers.²³³ One review found that financial rewards had no impact on the outcomes of participants in smoking cessation programs or on weight loss or maintenance of weight loss for participants in obesity treatment RCTs. Yet, other studies showed positive results associated with a weight loss and smoking cessation program using financial incentives.²³³



One study, which looked at data from a wellness program intervention over a two year period from 2005–2006, even indicated that the health care cost-savings of decreased hospitalizations for targeted conditions due to the wellness program was negated in the short run due to the increased spending for prescription drugs, outpatient care and the cost of the program and incentives themselves.²²⁶ This did not take into account the business case for potential improved employee productivity.

Ethically, incentives are empowering and rewarding for employees who manage to comply, but can be unfair for those who struggle and/or fail.²³⁷ Attainment incentives do not distinguish between those who try but fail, and those who do not try. Incentives are based on the assumption that one can reach health targets through individual effort rather than acknowledging the role the environment plays in shaping health behaviors.

In February 2013, Maricopa County produced a draft Community Health Improvement Plan (CHIP). Specific to the topic of workplace wellness, this plan prioritized the following objectives²³⁸:

- Identifying wellness “champions” for worksite wellness;
- Increasing the number of existing comprehensive worksite wellness policies;
- Increasing employers’ access to best practices/ toolkits to develop a comprehensive worksite wellness model;
- Creating an online database for worksites to share locally used strategies and outcome data; and,
- Making the healthy choice the easy choice at AZ worksites through objectives such as creating a worksite wellness resource webpage, implementing healthy vending programs at worksite buildings, establishing voluntary nutrition guidelines for foods at meetings, events and vending machines, providing trainings to workplaces to promote Chronic Disease Self-Management Program, AZ Smoker’s Helpline, and smoke/ tobacco-free zones, etc.

Healthy Arizona Worksites Program (HAWP), which was developed and funded by MCDPH and ADHS, implemented by the Arizona Small Business Association (ASBA) and Viridian Health Management (the CDC’s National Healthy Worksites Program implementation contractor), provides the infrastructure to support these efforts. HAWP was launched in June 2012 to help employers successfully implement evidence-based healthy worksite initiatives to improve the health, reduce healthcare costs, and increase productivity of their employees and businesses. Participating employers receive free comprehensive training and support in successfully implementing a worksite wellness program and recognition for their leadership and commitment to the health of their employees and state’s business community.²³⁹

The HAWP webpage (www.healthyazworksites.org) provides businesses with information and free tools to help assess their current worksite environment and health-related policies, and develop and implement an effective worksite wellness program for their worksite context. ASBA and Viridian reach out to employers to promote worksite wellness resources and conduct trainings and technical assistance for worksite wellness program implementation at no cost to businesses.

HAWP is based on CDC’s National Healthy Worksite Program curriculum (see page 87) and engages business in creating and/or improving their healthy worksite initiatives. This is done through the following practices:

- An assessment to define employee health and safety risks as well as current health promotion activities, capacity and needs;
- A planning process to develop a workplace health program that includes goal determination, selecting priority interventions, and building organizational infrastructure such as establishing a wellness committee and engaging senior leadership;
- Program implementation involving steps needed to put selected health promotion programs, policies, practices, and environmental supports into place and make them available to employees; and,



- An evaluation of efforts to systematically investigate the reach, quality, and effectiveness of healthy worksite initiatives.²³⁹

With the emphasis of worksite wellness through the ACA and Maricopa County's CHIP, expanding HAWP's reach will be critical in the coming years.

Strategies for Public Health

As the ACA and Maricopa County's CHIP emphasize the importance of employment based wellness initiatives to improve the population's health and reduce healthcare costs, MCDPH is uniquely positioned to promote a culture of worksite wellness within the county and among diverse stakeholders.

The ACA's rules do not specify the types of wellness programs that employer can offer; rather, employers have the flexibility to design programs that fit the culture and context of their worksite environment. Thus, MCDPH should reach out to businesses and workplaces to inform them about the ACA's new workplace wellness provisions and collaborate with them to design evidence-based wellness programs.

The ACA expands employers' ability to reward employees who meet health status goals through workplace wellness program by increasing the limit on the total allowed amount of wellness program rewards from 20% to 30% of employee health benefit costs. As a result, workplaces may be more interested in offering incentives as a part of their programs to increase employee participation and reduce health insurance costs in the long-term. However, because of the mixed evidence surrounding incentives, MCDPH should work with employers to ensure that incentives adopted by workplaces do not unfairly penalize workers or lead to employers' policing of workers' health. Further evaluation of incentive programs would be useful to identify best practices and add to the body of evidence around the benefits and pitfalls of incentive programs.

MCDPH would be well advised to use this new opportunity to make contacts with businesses, by providing positive messaging about new wellness opportunities, and explaining to them the new ACA provisions. The following are strategies that MCDPH

can consider as part of its role in promoting workplace wellness, as was recommended in a report from HRiA to MCDPH.

Building awareness and support through coalitions.

Already, MCDPH has strategically engaged the business sector through the ASBA to promote the HAWP program among ASBA's constituents. Additionally, Maricopa County's CHIP workgroup engaged diverse employers to participate in the development of the county's Community Health Improvement Plan; thus, these employers are likely to be bought into the importance of workplace wellness initiatives. As the CHIP moves into the implementation phase and HAWP expands, MCDPH should continue to play the role of a neutral convener of diverse stakeholders from multiple sectors. By continuing to co-facilitate planning efforts with the business community and other stakeholders, community and worksite ownership can be built, and a culture of worksite wellness efforts can be normalized.

Identifying, engaging, and recognizing individual

organizational workplace wellness champions. Along the theme of engaging diverse stakeholders, MCDPH can work with ASBA and Viridian to identify early adopter individuals and employers that can champion workplace wellness initiatives. Furthermore, MCDPH can contract with them to provide technical assistance and share best practices with other workplaces interested in implementing such initiatives. MCDPH can also consider engaging champions in WellCert training to certify them as worksite wellness professionals.

Calculating and communicating the return on

investment. MCDPH can collect data and craft the message around the return on investment to encourage employers to consider workplace wellness initiatives. Particularly, MCDPH should continue to work with ASBA to message the economic benefits of participating in workplace wellness programs for ASBA's constituency. Once this messaging is finalized, MCDPH can equip Viridian for their trainings with employers.

Be the “go-to” for the “how-to.” The ACA allows for employers to create worksite wellness programs that are appropriate for their worksite culture, and HAWP's website provides general tools that employers can consider using for assessments, program design/ implementation, and evaluation.



While this flexibility ensures a greater likelihood for worksite buy-in and relevance, MCDPH can still support worksites to ensure initiatives are evidence-based.

- *Assessment.* For organizational assessments, MCDPH can work with employers to create standard assessments to collect data on their population's health. For example, MCDPH could provide a standard assessment tool to conduct routine health risk assessments and/or biometric screenings for workers to help workplaces determine what health issues to focus upon.
- *Program development.* Once assessment data is collected and interpreted, MCDPH could support employers to select and implement evidence-based health promotion programs aimed at improving their workers' health. While employers receive training on creating a workplace wellness action plan and receive a toolkit of potential strategies, MCDPH can work with workplaces to determine which strategies are best suited for their context. Furthermore, as the most effective programs provide individualized risk-reduction counseling within the context of a healthy company culture, MCDPH can work with employers to ensure that workplace wellness is promoted both at the individual behavioral level and at the environmental level.⁷
- *Evaluation.* To evaluate efforts, MCDPH can assist workplaces in measuring the impact of their workplace wellness programs to determine whether they accomplish the following: the program identifies employees with specific health risks and targets incentives to address those risks with greater cost-effectiveness than general approaches. Incentives actually induce employees to modify behavior and thereby improve their health while improvement in employees' health leads to cost savings for their employers.⁸ Rigorous evaluation will build the evidence base for the effectiveness of workplace wellness programs, and can set the stage for further expansion of such initiatives by demonstrating stronger data on the return on investment.

Develop and disseminate toolkit materials and model policy. MCDPH can enhance and widely disseminate HAWP toolkit materials to worksites to draw attention to the ease of implementing a worksite wellness program. Furthermore, MCDPH can develop evidence-based, comprehensive workplace wellness model policies that workplaces can use to customize for their own context.

Collect data for surveillance and evaluation. As worksites collect assessment and evaluation data for their workplace wellness programs, MCDPH can support worksites in analyzing collected data and providing broader population data for comparison. Formulating and conducting evaluations is a unique and important role that a public health department can play for an employer. Gaining access to worksite assessment and evaluation data will also benefit MCDPH as they can use it to assess the health of the working population, identify priority areas to address based on the populations' needs, and evaluate the effectiveness of various workplace wellness strategies.

Create a learning community for workplace wellness initiatives. Consistent with the strategic plan, MCDPH can create a website/online database for employers to learn about workplace wellness initiatives occurring around the county and state, share best practices, and talk about lessons learned.

Connect worksites with community-based organizations. As the health of the individual is inextricably linked with the health of the community, it is good business to promote community health via community engagement.²³⁵ MCDPH can play a role in connecting worksites with community initiatives that support their worksite wellness goals. For example, in Detroit, DTE Energy developed a Gardens Project that enlisted help from schools, community, and religious group, to plant and grow fresh produce for community consumption.



Designing incentive programs. The ACA allows employers to have maximum flexibility to design their own programs and incentives. While employers may claim to pursue wellness programs that build a healthier workforce, they also face strong pressure to lower health insurance costs. Thus, with the mixed evidence around the effectiveness of workplace wellness incentives as well as its potential to overburden those who are the most sick, MCDPH should work with employers to design incentive programs that protect consumers while also promoting the health of their workforce. Also, further studies need to be conducted on effective incentive programs nationally.

MCDPH should follow the development of the body of literature and communicate findings to employers through the HAWP website, trainings conducted by Viridian, and through communication through the ASBA. Eventually, a toolkit with evidence-based strategies should be created to support employers in developing effective incentive programs. Finally, MCDPH can collect evaluation data specifically around incentive programs that are or will be established to identify effective and best practices.

Workplace Policy. As part of cost containment health reform legislation in MA, a Prevention and Cost Control Trust Fund was established to ensure that funding was available for primary prevention. The MA Department of Public Health administers this fund, which will go out to communities in the form of grants to implement evidence based prevention programs that will serve to save on healthcare costs. Up to 10% of the funds are designated for workplace wellness activities. The cost containment law also incentivizes businesses by creating a new workplace wellness tax credit program to encourage businesses to implement qualified wellness programs. This will reinforce and leverage federal opportunities. Funding comes from a tiny surcharge on insurances and hospitals.



PART IV. Directions and Roles for State and County Health Departments

Section 13. Public Health as Chief Health Strategist: Health Information Technology, Informatics and Planning

Overview

Public health departments have the challenge and opportunity right now to leverage one of the health department's essential functions and the first domain of accreditation — “conducting and disseminating assessments focused on population health status and public health issues facing the community” — to claim a critical place at the new health system table.²⁴⁰

Numerous recent landmark reports and papers highlight the increasingly critical role of strong data and health information technology systems in public health's role post-ACA.^{241,3,242,189,243} Trust for America's Health powerfully defined the necessary new role for health departments as “the chief health strategist in communities.”³ The report continues, “*Health departments must assume greater accountability for the design and development of the overall strategic plan for improving health in communities. To do this, health departments must clearly establish their value and role in a reformed health system — especially in the identification, implementation, coordination and evaluation of cost-beneficial prevention programs and activities.*”³

The Transforming Public Health project, funded by the Robert Wood Johnson Foundation to develop guidance for public health officials and policy-makers in prioritizing vital public health functions in a shifting political and fiscal landscape, has identified the critical need for health departments to have sharp, data-informed, and evidence-based capacity to prioritize.³

In order to identify the most pressing and costliest health problems and determine evidence-based and locally appropriate population health interventions, health departments need to develop data infrastructure and analytical capacity worthy of a chief health strategist. At the same time, health departments must strategically build effective and enduring community and cross-sector partnerships in order to co-create meaningful collective priorities and an action plan for health improvement that is mutually owned by public health and the health care sector.

Aligning Priorities: Joint Implementation of Health Improvement Plans by Health Departments and Hospitals. Perhaps the most powerful tool and process to engage health system partners is through a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). Section 9007 of the ACA established new IRS requirements for nonprofit hospitals to conduct them, every three years, under new ACA rules. The rules require public health expertise in the planning process. Concurrently, state and local public health departments that wish to become eligible for accreditation by the Public Health Accreditation Board must conduct a CHA and CHIP every five years. Coordinating CHA and CHIP efforts and time frames, between public health departments and hospital community benefits programs can become a powerful mechanism for leveraging coordinated resources for improving population health. In the past, there was little accountability or requirements for hospitals to spend community benefits dollars on promoting community health. The vast majority community benefits dollars, in fact, have been historically used to write off hospital bad debt. The ACA IRS hospital rules provide an important opportunity to link primary care and public health practice, and to more concertedly address the important drivers of health and reduce disparities.



MCDPH recently engaged more than 1,000 residents and partners in a CHNA and are currently finalizing a five-year CHIP for 2012–2017. As Maricopa County and partners are going through this planning process, nonprofit hospitals are heading their own separate CHNAs and CHIPs for their catchment areas. To the extent that MCDPH can encourage more collaboration of hospitals in these processes, and ensuring public health and multi-sectoral partnerships, the more efficient and effective population health goals stand to be.

In fact, the Association of State & Territorial Health Officials (ASTHO)'s Primary Care and Public Health Integration Initiative has as one of the five strategies to develop and implement effective measures of population health. In a joint assessment process, public health's contribution to establishing measures and priorities is critical not only to a hospital's community benefits planning, but also to their quality improvement and population health integration.²⁴⁴

There are differences in the health department and hospital requirements, but there are ways to address them and maximize common effort and impact. One difference is the time cycle. Public health standards call for assessment no less than every five years while the IRS regulations call for hospital assessments every three years. This is easily addressed by health departments shifting to a three-year planning cycle to align with the rhythm of hospital assessments. In fact, the state of North Carolina did just that.

Health departments are charged with assembling a broader collection of data points in its CHA than are hospitals, including community assets to address health challenges, whereas hospitals are looking to identify need only. The health department plan must be for the entire community, whether state or county, whereas a single tax-exempt hospital's plan is for its catchment area only.

While it is not specified in statute that hospitals must include state and local health departments in their planning, they are required to take into account input from a broad range of stakeholders, including *those with public health expertise*. States may impose additional requirements on tax-exempt hospitals for their community benefit expenditures. Arizona has no requirements at this time.

An ideal situation is for a health department, with multiple tax-exempt hospitals in its community, to conduct jointly a coordinated CHA/CHNA and CHIP planning process with clear and shared ownership of implementation of the plan. This cooperation would have the greatest population health impact and establish shared measures and target outcomes that could galvanize collective action toward joint community health improvement goals.

Some cities are adopting this emerging best practice coordinated approach, such as Austin and San Antonio Texas and Worcester, Massachusetts. In some cities, a health department is the lead for the multi-stakeholder process, in others it is the hospitals. San Antonio hospitals valued the process so much that they identified funds to staff the coalition that brings together all of the stakeholders, the Health Collaborative of Bexar County.²⁴⁵

Health departments could participate in a range of ways with individual or multiple hospitals' CHNA processes, including voluntarily partnering as a consulted stakeholder or taking a bigger contracted or reimbursed role in planning, designing, and even carrying out the assessment(s). Below are valuable roles health departments can play.^{245,246,243}

- Providing technical expertise to support the design and implementation of a CHNA;
- Identifying key measures for a health assessment that incorporates social and economic determinants of health as well as access and direct health outcomes;
- Sharing local data resources for health access, health outcome, healthy behavior; community assets and social, physical, and economic determinants of health;
- Providing technical assistance with data collection, synthesis, and analysis;
- Serving as the data clearinghouse or central repository for all the measures being monitored;
- Providing expertise on evidence-based population health strategies through both hospital programs and community based efforts, including policy and systems change;



- Coordinating efforts of multiple hospitals to combine resources for a central CHNA or combined health department CHA/hospital CHNA;
- Acting as a neutral facilitator for a joint collaborative effort;
- Providing a broad vision for shared goals of community health improvement and community change that includes a collective impact frame;
- Leveraging community relationships to engage residents and community-based organizations in a CHNA process;
- Providing guidance and input to align hospital CHNAs and Community Benefit Plans with health department CHIPs; and,
- Convening a multi-stakeholder group including hospitals to operationalize meaningful community health improvement, including regularly assessing progress against benchmarks, reviewing new data and jointly adjusting course.

Health Information Technology Infrastructure and Informatics for a Chief Health Strategist

In order to accomplish all aspects of the essential public health services and be a valuable strategic partner to the health care system, health departments must have twenty-first century health information technology. This is essential in order to ensure that health departments are not left further and further behind the major conversations and initiatives about health outcomes, quality, health care costs, and population health improvement.

If health departments can demonstrate to partners such as hospitals and health plans that they offer unique and valuable information about the health of populations and the community determinants of health — as well as the analytical ability to identify patterns, gaps, and issues — and then offer evidence-based strategies for addressing these problems, it will be in the interest of other partners to jointly invest in increasing the infrastructure and informatics capacity

of health departments. Effective data and analytical participation in CHNAs and CHAs is one way to show health care partners the value health departments can add to the effort to improve the health of the population in targeted ways and reduce health care costs.

While the ACA has provisions to help FQCHCs and other health care providers adopt Electronic Health Records (EHRs) and Health Information Exchanges (HIEs), it is not strong in providing funding and mechanisms for health departments or for integrating population health data collection opportunities. NACCHO continues to advocate for federal resources and policies that will help health departments get up to speed with EHRs, HIEs, and informatics.

There are some federal monies, such as through the PPHF, CMS' National Public Health Improvement Initiative, and MCDPH should continue to maximize HIT improvement opportunities through this source. Another option is to explore a state and/or local mechanism for contributions from hospitals and insurers toward a robust public health HIT infrastructure with interoperability with health care providers.

Likewise, health departments might make this area a priority for requests from foundations. Pilot partnerships with CHCs and key hospitals or health care providers around developing interoperable systems — such as on quality improvement efforts to integrate specific clinical preventive services into EHRs and automatic provider reminders that share data with the health department — could help build alliances and make the case for the broader need. In addition, shifting health department use of discretionary funds from providing direct service by either phasing out key services and/or significantly increasing third party reimbursement, could free up funds to build data and analytical capacity.²⁴⁷

At a minimum, health departments should have EHRs for any direct services provided and the ability to receive and exchange data from health care providers through an HIE or a mediating Health Information Organization (HIO). This allows for rich information sources for timely surveillance, sensitive monitoring of the impact of interventions, and analyzing return on investment.



The ability to calculate the return on investment for public health interventions is key to the demonstration of impact and relevance in a health world dominated increasingly by concern about controlling health costs. An electronic billing system is important for efficient billing and can create a flow of financial information to help understand the return on investment for public health direct services. However, it is perhaps even more valuable to have ROI for community-based interventions. “Hot spot” mapping of preventable inpatient and ED admissions before and after geographically targeted interventions could help understand if and how they change the cost of care for residents in targeted areas.

Additional tools, strategies, and systems will add capacity in key areas, such as “hot spot” analysis and planning, Geographic Information Systems (GIS), and electronic billing systems. Given the heightened importance of prioritization and designing interventions that will improve population health in a way that also significantly reduces medical costs, the practice of identifying highly preventable disease, hospital admission and cost “hot spots”, and convening partners to address these identified problems will be an extremely valuable role for health departments. Partnerships with academic and research institutions can also be ways to extend health department capacities in this way.

In Los Angeles County, University of California Los Angeles researchers conducted a community health profile analysis to identify geographic areas that are “hot spots” of preventable disease and hospital admissions and shared with multiple stakeholders, including the Los Angeles County Department of Public Health. By identifying areas with high rates of risk factors and preventable health conditions and then establishing rates of preventable admissions and ED visits for these areas, they were able to identify high utilizers and then add in GIS mapping to understand the physical environment of these neighborhoods, so the health department and hospitals could target the most relevant interventions.²⁴⁸ The state or county health department, or in combination, could convene academic, health and community partners for a hot spot analysis of particular agreed on preventable health conditions.

Several additional tools would strengthen health department’s ability to plan and strategically target interventions for maximum effectiveness. GIS capacity is a useful tool for contextualizing community, policy, and systems interventions. It also provides a powerful communication tool by offering a visual presentation of concepts and data and can be particularly useful for multi-stakeholder conversations. By adding layers on a map such as combining health outcomes, risk factors, and health care access and utilization data with the location of grocery stores, junkyards, schools that serve breakfasts, and parks, health departments can present relevant information — including social, physical, and economic determinants of health — to partners and stakeholders. This is educational, strategic for planning where to direct resources, and for aiming health improvement activities as far upstream as possible.

While health departments don’t have all the answers, they can play a valuable convening role in coordinating population health HIT activities among partners including health care providers. Health departments have the potential to be the central point — the data repository for a broad range of total population health data — along with providing, convening, and coordinating central analytic capacity. Whether convening or joining a table set by others, for health departments to be relevant in the health care world, they must transform HIT, interoperability and analytic capacity.

Section 14. The Prevention and Public Health Fund

Overview

The Prevention and Public Health Fund (PPHF) is a critical source of new funding established in the ACA as part of redirecting health systems towards prevention and strengthening the capacity and impact of the public health system. The American Public Health Association (APHA) christened it “the nation’s first dedicated mandatory funding stream for public health and prevention activities.”²⁴⁹ The purpose as stated in the ACA is to “improve health and help restrain the rate of growth in private and public sector health care costs.”



The PPHF is a landmark accomplishment that has contributed to leveraging important public health and prevention efforts and raising awareness among health care and community-based stakeholders about the importance of prevention. PPHF activities are intended to align with the National Prevention Strategy created by the National Prevention, Health Promotion, and Public Health Council. The four strategic directions of the plan are to:

- Build healthy and safe community environments
- Expand quality preventive services in both healthcare and community settings
- Empower people to make healthy choices
- Eliminate health disparities

The strategy is focused on weaving seven priorities through those strategic directions:

- Tobacco-free living
- Preventing drug abuse and excessive alcohol use
- Healthy eating
- Active living
- Injury and violence-free living
- Reproductive and sexual health
- Mental and emotional wellbeing

In addition, it is a vital stream of funding to help health departments build capacity, transform, and adapt to the “new” public health. PPHF National Public Health Improvement Initiative grants are helping MCDPH make needed changes to improve performance, policy and workforce development and best practice implementation. These funds are essential to improve public health infrastructure and align it with National Prevention Strategies and accreditation requirements in order to make it possible for health departments to play their essential role in transforming the health system.

Vulnerability of the PPHF. The PPHF has been under attack since its inception. It represents less than 2% of what is expected to be spent by the federal government on the ACA, yet it is one of the most attacked and vulnerable components of the bill. Originally funded at \$16.75 billion over ten years, it has been cut and raided for other purposes since the original authorization, so that the total amount is currently down by over one-third of what was originally intended (see *Table 3*). An APHA report lists 11 attempts to eliminate, reduce, or redirect dollars from the PPHF from the passage of the ACA through late spring 2012.²⁴⁹ There have been numerous attempts since then, some of them successful. Most significantly, the Middle Class Tax Relief and Job Creation Act used \$6.5 million from the PPHF to prevent cuts in Medicare payments to physicians.²⁴⁷

Since then, the FY 2013 sequester has lopped another \$50 million off the fund, and the Obama Administration announced that it would use nearly half of the FY 2013 amount for health insurance marketplaces/exchanges. Currently, Senator Tom Harkin, the primary champion for the PPHF, is holding up approval of the new Centers for Medicare & Medicaid Service to protest this use of the fund.

In addition to direct cuts and redirections to non-PPHF purposes, the PPHF has increasingly been used to supplant, rather than supplement, other federal public health discretionary funding (See *Table 4*). Original 2013 Administration budget plans designated over a third of the allocation to supplant other government public health funding.²⁴⁹ With one-third of the Fund being used to supplant other funding and one-half being used for Marketplace/Exchange costs, that leaves roughly 15% for actual new investments, a dramatic 85% cut to the potential impact of the Fund.

FY 2013 sequestration cuts may mean rescissions to funded programs. Arizona receives \$9.4 million in PPHF funds, some of which may be lost as a result of the sequestration cuts, depending on CDC programmatic decisions.²⁵⁰



TABLE 3. PREVENTION AND PUBLIC HEALTH FUND SPENDING WITH CUTS INCLUDING MARKETPLACE/ EXCHANGE FUNDING (COURTESY SARAH KLIFF, HEALTH REFORM WATCH)

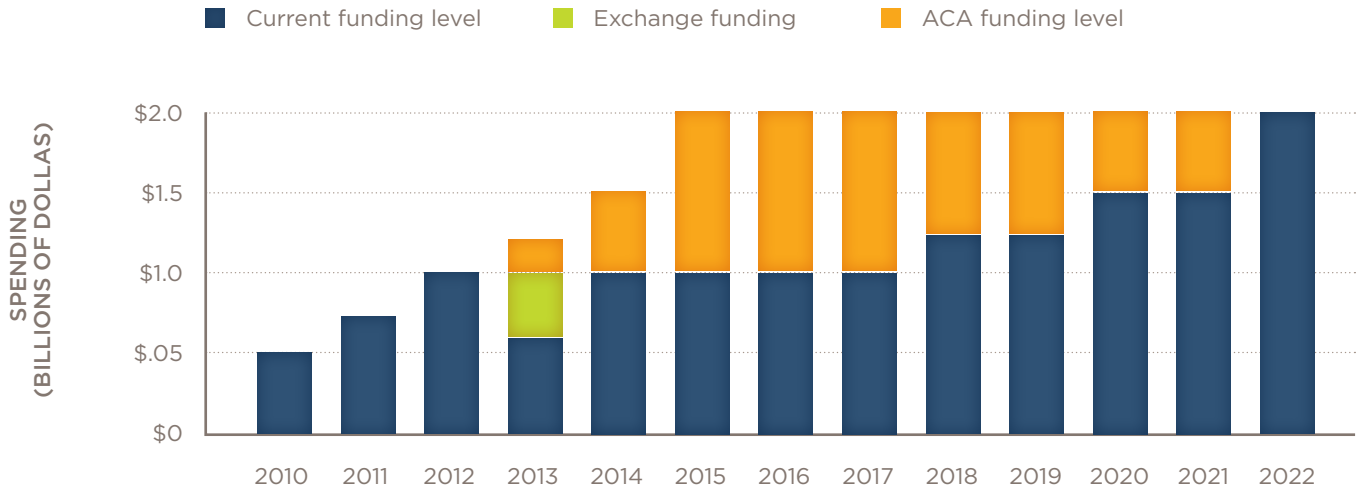
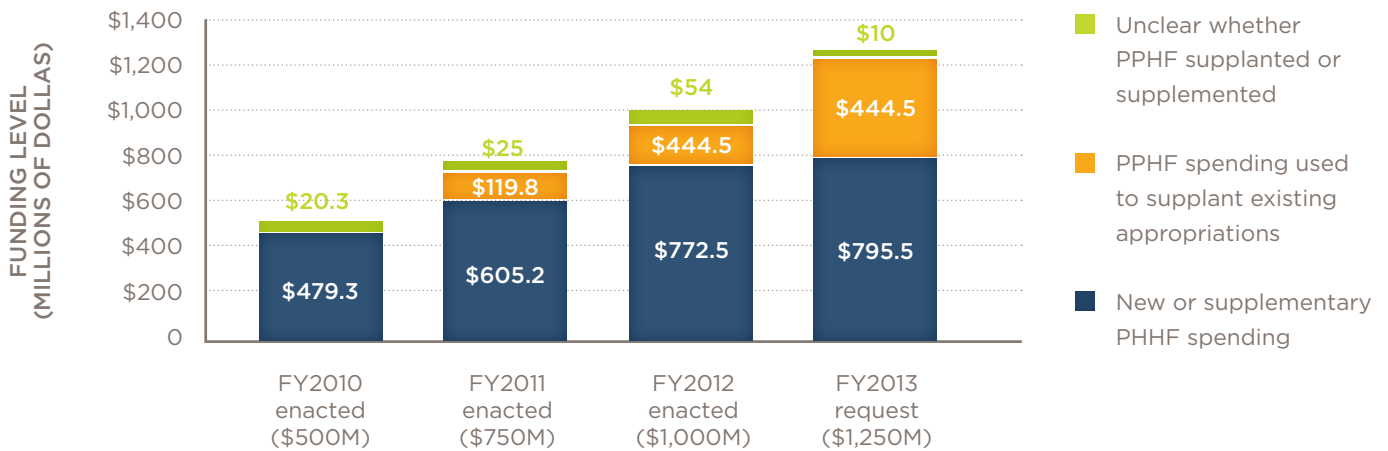


TABLE 4: AMOUNT OF PREVENTION FUND USED TO SUPPLANT RATHER THAN SUPPLEMENT APPROPRIATIONS (SOURCE AMERICAN PUBLIC HEALTH ASSOCIATION)²⁴⁹



PPHF Funded Activities

Notwithstanding these reductions, the PPHF is having a significant impact. In its FY 2012 report to Congress, DHHS reported that since 2010, DHHS invested close to \$2.25 billion from the Fund.²⁵¹ The PPHF has funded programs in four critical priorities: community prevention, clinical prevention, public health workforce and infrastructure, and research and tracking. To date, community prevention programs such as Community Transformation Grants (CTGs) and other chronic disease prevention funding received the largest share of the overall funding (see Table 5).

The CTGs are one of the PPHF's signature contributions, strengthening and leveraging health departments' power by supporting multi-sector collaboratives that create upstream environmental change. These funds are helping to create opportunities for public health approach to shift from siloed disease-focused efforts to more comprehensive chronic disease prevention and health in all policies approaches. The PPHF is making possible public health workforce planning, fellowships and training, something greatly needed but for which few health departments have local resources. And PPHF is supporting the creation and dissemination of evidence-based interventions through the "Community Guide."

TABLE 5. CHART OF PPHF FUNDED ACTIVITIES²⁵²

Agency	Activity or Program	Allocation, (dollars in millions)	Planned Uses of Funds
ACL	Chronic Disease Self-Management Program	7.086	To award competitive grants to selected states to help older adults and adults with disabilities cope with their chronic conditions by providing access to evidence-based chronic disease self-management programs, and also to assist states in developing sustainability plans to continue providing these programs after the grant period ends
ACL	Alzheimer's Disease Prevention Education and Outreach	0.150	To continue education campaigns for people caring for someone with Alzheimer's or dementia, and to operate and update alzheimers.gov website
ACL	Elder Justice	2.000	To assess best practices and interdependencies across sectors engaged in the prevention and intervention of elder abuse, neglect, and exploitation to inform the development of a national adult protective services data system
AHRQ	Clinical Preventive Services Task Force	6.465	To maximize the quality and effectiveness of the U.S. Preventive Services Task Force by providing scientific, technical, and administrative support
CDC	Community Guide	7.378	To provide evidence-based findings and recommendations about effective public health interventions and policies to improve health and promote safety
CDC	Prevention Research Centers	6.456	To help alter the individual behaviors and community environmental factors that put people at risk for the leading causes of death and disability — chronic diseases, such as cancer, heart disease, and diabetes.

Agency	Activity of Program	Allocation, (dollars in millions)	Planned Uses of Funds
CDC	Nutrition, Physical Activity, and Obesity (NPAO) State Programs	8.823	To improve the health of places where Americans live, work, learn, and play by supporting comprehensive efforts to address obesity and other chronic diseases through a variety of evidence-based nutrition and physical activity strategies
CDC	Public Health Workforce	15.609	To help ensure a prepared, diverse, sustainable public health workforce by increasing the number of state and local public health professionals (e.g. epidemiologists, public health managers, informaticians) who are trained through CDC sponsored fellowships and other training activities targeted at the existing workforce
CDC	National Public Health Improvement Initiative	21.663	To systematically increase the capacity of public health departments to detect and respond to public health events requiring highly coordinated interventions to improve and/or sustain the performance (efficiency/effectiveness) of public health organizations, systems, practices, and essential services
CDC	State Healthcare Associated Infections (HAI) Prevention	11.750	To fund health departments in healthcare associated infection (HAI) prevention efforts within their states by expanding state prevention activities and accelerating electronic reporting to detect HAIs at the state level
CDC	Epidemiology and Laboratory Capacity	34.424	To enhance the ability of state, local, and territorial Epidemiology and Laboratory Capacity and Emerging Infections Program grantees to strengthen and integrate capacity for detecting and responding to infectious disease and other threats
CDC	Breastfeeding Promotion and Support	2.500	To fund community initiatives to support breastfeeding mothers and support hospitals in promoting breastfeeding
CDC	Early Child Care and Education Obesity Program	4.000	To support a collaborative effort to promote children's health by encouraging and supporting healthier physical activity and nutrition
CDC	Community Transformation Grants	146.340	To support community level efforts to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes
CDC	Immunization	90.883	To improve the public health immunization infrastructure in order to maintain and increase vaccine coverage among children, adolescents, and adults
CDC	Tobacco Use Prevention	60.302	To raise awareness and shift key attitudes and beliefs about the harms of tobacco use and exposure to secondhand smoke in areas of the country with some of the highest rates of tobacco use prevalence

Agency	Activity of Program	Allocation, (dollars in millions)	Planned Uses of Funds
CDC	Healthcare Surveillance/ Health Statistics	28.514	To expand the availability of data for tracking the provision, use, effectiveness, and impact of primary and secondary preventive healthcare services and to expand the capacity of CDC and its health department partners to use the data for such tracking
CDC	Environmental Public Health Tracking	20.740	To establish and maintain a nationwide tracking network to collect, integrate, analyze, and translate health and environmental data for use in public health practice
CDC	National Prevention Strategy	0.922	To support and implement the National Prevention Strategy which aims to guide our nation in the most effective and achievable means for improving health and well-being
CDC	Million Hearts Program	4.612	To improve cardiovascular disease and stroke prevention by promoting medication management and adherence strategies and improving the ability to track blood pressure and cholesterol controls
HRSA	Alzheimer's Disease Prevention, Education and Outreach	1.847	To expand the work of the Geriatric Education Centers to support outreach and education to enhance healthcare providers' knowledge of the disease, improve detection and early intervention, and improve care for people with the disease and their caregivers
SAMHSA	SAMHSA Health Surveillance	14.733	To support critical behavioral health data systems, national surveys, and surveillance activities
CMS	Health Insurance Enrollment Support	304.000	To invest in health insurance enrollment support specifically through activities that will assist with eligibility determinations which are in need of intervention and activities to make people aware of insurance options and enrollment assistance available to them
CMS	Health Insurance Enrollment Support	148.803	To invest in health insurance enrollment support specifically through activities that will assist with eligibility determinations which are in need of intervention and activities to make people aware of insurance options and enrollment assistance available to them
Total		949.000	

Maximizing Opportunities in the PPHF

The most important strategy to successfully receive funds from the PPHF is to be an active advocate for the critical nature of its intended purpose and continued restored robust funding. The following considerations are offered in order to maximize opportunities for further PPHF grants.

Robust Data and Evaluation Proposal Components and/or Plans. As a result of the PPHF's vulnerability, the CDC is strongly compelled to make a case for the ROI of spending from the fund, particularly chronic disease prevention and Community Transformation Grants. Thus one important strategy for applicants to the fund is to bolster research and evaluation capacity through health department infrastructure and/or partnerships with academic and research institutions. This points to the importance of Health Information Technology and interoperability efforts which have been funded through the PPHF and which would put a health department in an advantageous situation to capture, analysis, and strategically use data and demonstrate effectiveness as well as a leadership role for government health in health informatics. It also suggests the possibility of hiring an evaluator with a strong background in health economics who can be a resource to many health department programs, including the workplace wellness program.

Demonstrate Something Unique. Because the PPHF is borne out of the ACA from visions and goals for a much bigger role for public health and prevention in the health system, many new PPHF RFPs, like CMMI RFPs, are aimed at seeding innovation and learning as well as demonstrating new models, interventions, and promising practices. What can MCDPH develop to address uniquely local challenges employing uniquely local assets to help move forward solutions? Are there collaborations to address border health and rural health? What is the role of public health in states with continued high rates of uninsurance? Are there new, creative uses for HIT and planning with other partners?

Voluntary Policy Change Ready to Go. For CTGs in particular, the CDC is looking for ability to leverage voluntary policy change through multi-sector partnerships. It would strengthen an application to have an already established multi-sector coalition working together on common goals as well as a willing partner or partners already committed to making a policy change, such as private landlords of multi-unit housing, especially low-income and subsidized multi-unit housing, willing to create a policy of no smoking in the housing.

Business Sector Partnerships. In particular, the CDC is looking for successful partnerships that include the business sector. A project with employers that want to build off of their wellness plans to adopt environmental and policy changes — such as healthy cafeterias and vending machines or other partnerships that strongly engage businesses — would strengthen an application. Other sector partnerships that are strongly valued by the CDC include community planning agencies (subsidiaries of the American Planning Association) and nonprofit community development corporations that address commercial and economic issues in low-income neighborhoods.

Align with Cutting Edge Efforts. Look for cues to other funded projects and also at national public health organizations working closely on issues related to the PPHF. Consider the projects highlighted in the recent Trust for America's Health reports. Pursuing voluntary accreditation and quality improvement as Maricopa County is doing is an important step. Track the activities and priorities of the Transforming Public Health Project at www.newpublichealth.org, and position the health department in alignment.²⁵³ The suggested opportunities in this report and consolidated in the forthcoming recommendations report will point to ways that MCDPH can maximize opportunities for funding from the PPHF in future years as new resources become available again.



Section 15. The Impact of Cuts to Public Health

Overview

The Maricopa County Department of Public Health asked several questions about the potential for federal funding cuts to public health programs in light of the ACA. While that was not the intention of the ACA, it is the reality, and it is most likely to get worse.

While the ACA as passed included many strong measures to fund and strengthen public health, including the Prevention and Public Health Fund, it did not establish any public health entitlements or hard funding such as funds dedicated from a soda tax or an assessment on insurers. As the pressures have increased to cut federal spending, public health is higher on the chopping block than federal medical spending or other ACA costs, and has been cut significantly. The political power of health care interests is to this point, stronger than that of public health, and the economic benefits of public health are barely visible to most policymakers and have few federal champions.

One example is the Prevention and Public Health Fund (PPHF) discussed above. Intended for new and expanded investments, it has been cut in half already by a combination of cuts, use to supplant other public health funding, and redirection to more clinical and health insurance related activities. It gives a stark example of the vulnerability of new public health funding in competition with new federal health care spending.

Massachusetts is another example of this phenomenon. After Massachusetts expanded health insurance in 2006, the state's commitment to paying for increased health care coverage, in combination with the down-sized economy, has squeezed out other important government spending, in particular, public health. Programs that have a strong effect on health also have suffered cuts, including education, particularly higher education, environmental programs, including parks funding, and others. In effect, the increases in coverage were paid for by cuts to other public services.²⁵⁴

This phenomenon is a continuation of the historic trend of the political vulnerability of public health funding. Unfortunately, expanded health coverage, especially for preventive services, seems to compound the misunderstanding of policymakers when it comes to the strategic economic, let alone health, value of good public health. Budget making decisions default to simplistic assumptions that since health insurance will cover key services, many health department safety net programs are no longer needed. The truth is more complicated, as the section of this report on public health departments as health service providers details. Indeed, in some cases, insurance access has made it more difficult for low-income people to access needed services, because of deductibles, co-pays and other issues.

In addition to the economic pressures of the recession and new expenses that are increasingly demanded by the ACA, there is a third major federal economic squeeze: the Budget Control Act of 2011 which established sequestration as an automatic set of cuts to enforce budget reduction, and triggered if Congress is unable to agree on a plan to reduce the federal deficit. Sequestration went into effect on March 1, 2013 and included an 8.4% cut to non-defense discretionary spending that must be distributed over seven months of the FY 2013 federal fiscal year. This means \$2.4 billion cut from public health programs, noted by ASTHO as "devastating to the public health infrastructure."²⁵⁵ These cuts are on top of an 8% reduction in federal health spending from FFY 2010-FFY 2012.

While DHHS and the CDC are still determining final cuts and savings for FY13, ultimately they will lead to reduced funds for state and local health departments. The Office of Management and Budget directed CDC to implement 5% cuts to non-defense programs.²⁵⁶

A Fall 2012 ASTHO estimate showed Arizona at risk of losing \$20,224,165 based on an 8.4% cut in nine selected programs, including: WIC, Section 317 Immunization Grant Program, the Preventive Health and Health Services Block Grant, Ryan White/HIV/AIDS Program Part B, the Public Health Emergency Preparedness Cooperative Agreements, the National Breast and Cervical Cancer Early Detection Program, the Environmental Protection Agency State and Tribal Assistance Grant Program, CDC chronic disease



categorical programs, and the Hospital Preparedness Program.²⁵⁵ Applying the OMB directive of 5% cuts to CDC, the actual amount of cuts to Arizona will vary by program, but should total less than the projected \$20.2 million and be more in the \$12 million range.

Arizona will have received some of these cuts by the time this report is complete. Many of them won't take effect at the state and local level until the next time a grant payment is expected with FY 2013 funding.

As described in the previous section, the Prevention and Public Health Fund has been subject to cuts and raiding and is slated for further cuts. Sequestration sliced \$51 million off the Fund, which may mean rescissions and reductions to any remaining FY13 payments of the \$9.4 million in PPHF grants Arizona has received. Arizona PPHF grants such as Community Transformation, Tobacco Use Prevention, Clinical Prevention, Public Health Infrastructure and Training and Research and Data Collection.^{257,250}

The President's FY2014 budget would avoid further sequestration cuts but would also cut public health funding disproportionate to other health and human service funding, including the elimination of the Preventive Health and Health Services Block Grant and significant cuts to the Community Transformation Grants.²⁵⁸ It is not likely that the House and Senate compromise budget will be better for public health allocations, especially if entitlement programs like Medicare and Social Security are held mostly harmless and more of the burden of cuts falls to other discretionary programs, including public health.

The ACA does not directly cut public health program funding, nor does it explicitly protect any existing funding streams. It does create new pressures and perceptions about what is covered now and thus what may be unnecessary for public health to continue doing. Arizona should anticipate continued cuts in federal and state traditional public health funding for all categories of public health funding, but particularly funding for programs that will be increasingly seen as provided by the health care sector, such as screening, immunization and laboratory services. When this happened in Massachusetts, a lot of advocacy was needed to restore these services that were initially done away with by the legislature.

The PPHF will help support health departments to evolve and may continue to supplant some traditional funding, at least temporarily, but it will not make up the difference. Funds for these services will increasingly flow to health plans and health care providers, requiring health departments that continue to provide any direct services to establish themselves as providers and maximize billing and reimbursement for services. Health departments will have to work to educate federal health officials about the need for continued public health funding — at the very least for a transition period — for safety net clinical services to vulnerable special populations of the uninsured and underinsured.

Section 16. Health Departments as Providers and Payers of Last Resort

Overview

One of the main concerns of health departments across the country, and a question for this report from MCDPH, is what role should health departments play in the provision of direct services. This is one aspect of much larger and important question about what should be the role of health departments in the health landscape post ACA.

Two major changes establish the context for this question: the major public health threat is now chronic disease instead of communicable disease, and the funding for preventive services that public health has traditionally provided is shifting to the health care sector and primary care settings.²⁴² In terms of resources and public health priorities, provision of direct service appears to be a less strategic use of discretionary public health dollars which are desperately needed to build up capacity in the areas of informatics, planning, communications, cross-sector convening, and policy and systems change work.²⁴²

Experts and leaders have consistently urged health departments to at least consider this question and explore billing for services as in the Georgia Health Policy Center's Leading for Health System Change pilot tool, which offers several scenarios for health departments to consider.²⁵⁹



Some, such as the Trust for America's Health, have called explicitly for public health departments to pay for direct service only when they cannot be paid for by an insurer, given the scarcity of public health dollars.³ TFAH's Executive Director Jeff Levi wrote in a blog for Huffington Post, "public health departments should reassess their role in the direct provision of medical services (including the option of becoming an FQHC), to ensure they do not use their public health budgets to pay for services that could be billed to insurers or paid for through health center dollars."

As stated in the Institute of Medicine (IOM) report *For the Public's Health: Investing in a Healthier Future*, "in large measure, health departments must be freed to focus more on the delivery of population-based services." The IOM notes that there are exceptions, such as specialized services with a population health component or delivered in a community setting; an example of the former being tuberculosis control and the latter being nurse home visiting or CHW activities. Even in these areas, health departments should prioritize a strategic population, health-focused role in monitoring population health data and assuring access to quality care over the provision of direct services, since others can provide the direct services but no one else has the role and expertise to ensure the former.²⁴¹

That being said, the Massachusetts experience has shown that there is continued need, even after near universal coverage, for wraparound and critical services for continued uninsured underinsured residents. It will take several years for residents to enroll in the insurance available to them, and even then, low-income residents will drop off of their coverage; many will have plans for which deductibles and co-pays are a barrier, even with ACA protections, and a subset of the population will remain uninsured by choice or because they are ineligible for any options.²⁶⁰

The essential tasks for MCDPH will be, through population health analysis of public health and provider data and discussions with health plans and health care providers, 1) to determine what services have continued priority critical need for the county; 2) to decide, in light of potentially shifting strategic priorities for the health department, what the health department role should be; and, 3) to establish systems and contracts in order to bill insurers for eligible services.

While this report will not recommend specific services to continue to provide or specific services to eliminate, it will offer considerations for how to adapt the provision of any continued services in a health reform environment. By exploring the Massachusetts experience in several key programs, including recommendations from Massachusetts public health professionals to you as their colleagues, MCDPH will have more tools to make these decisions and adapt before the ground completely changes underneath you.

The Massachusetts Example. For some health departments, funding reductions may compel a binary yes or no decision to whether to continue direct services. Yet for other health departments, the reality is likely to be more complex and occur in stages. *Leading Through Health System Change* offers three approaches. After the ACA, health departments might 1) continue to provide direct services, but seek reimbursement; 2) assume a lead role in assuring access to clinical preventive services without being the primary provider; and, 3) leverage public health practice to guide the development of patient centered medical homes.²⁵⁹

Massachusetts adopted a hybrid approach, scaling back or eliminating operating grants to external clinics while focusing more on billing, epidemiologic and assurance roles. Their focus for the future of preventive and clinical services is on assuring access to preventive services, integrating into primary care for specific disease, data monitoring, training and quality assurance, while requiring contracted providers to bill and supporting billing efforts. While MDPH efforts may not be explicitly linked to Massachusetts' Patient Centered Medical Home Initiative, the work of public health supplementing and integrating into primary care is a valuable laboratory for PCMHs, and could demonstrate some of the value-added wraparound and epidemiological services health departments can offer the health care system.

Massachusetts' changes were compelled by major state budget funding cuts which were caused by a combination of the recession and increased state budget pressure due to increased spending on health insurance for low-income residents.



Former MDPH Commissioner John Auerbach highlighted the importance of planning the concrete details of billing as soon as possible rather than waiting and resisting change. He also noted how difficult the change can be for program directors to shift to reducing discretionary funds and having services rely increasingly on billing.²⁶¹

After health reform, MDPH began to phase out and change many traditional roles. In order to promote the medical home as the center of care and strategically target reduced discretionary funds, MDPH scaled back funds to STD clinics, protecting unique public health services while ending operational grants. Four clinics closed and four remained open, funded either through billing and/or other public funding services (HIV/Hepatitis C funding). MDPH also shifted away from paying for newly covered services, such as billing insurers for Early Intervention autism specialty services, for which a recent law in Massachusetts mandates coverage. MDPH also got smarter about communications, ending their role as “pamphlet producers” and using social media instead.²⁶²

MDPH found that these changes have not had an adverse effect on health outcomes. In fact, increased health coverage combined with strategic public health services have improved health outcomes in most of these areas. Since health reform, Massachusetts has experienced a dramatic reduction of new HIV infections and a reduction of viral load among those already infected. The working theory is that this is the result of increased insurance coverage combined with focused public health efforts.²⁶³ Tuberculosis rates have continued to decline, with most of the new cases in newly arrived immigrants. Non-HIV STD incidence has remained parallel to national trends.²⁶⁴ Increased screening resulted in an increase in reported cases of chlamydia, and there has been a spike in syphilis among Men who have Sex with Men (MSM), mostly diagnosed in private care settings.²⁶⁵

There were — and still are — many challenges, and change has come slowly and bumpily. Negotiations with health plans and hospitals took time and often required the Commissioner’s direct involvement to move forward. Staff and providers that embraced the traditional public health model of providing free

services understandably didn’t want clients to be billed by insurers and resisted change. There was a huge learning curve for MDPH key staff about billing and working with insurers, and the uneven nature of electronic health information infrastructure and electronic billing IT created major barriers. In fact, a top recommendation by the Nurse Manager for the Tuberculosis Prevention and Control Program is for the state and county to create an electronic billing system.^{261,266,267}

Communicable Disease

In Massachusetts, most public health infectious or communicable disease programs are on a trajectory to integrate into primary care, and all have adopted or are in the planning stages (HIV/AIDS) of requiring providers to bill for services. The Director of the MDPH Bureau of Infectious Disease, which combines HIV/AIDS and Communicable Disease Control, described a range of core and cross-cutting issues facing the bureau as a result of health reform, including:

- “the ability and appropriateness of health departments continuing to finance and manage a range of public health clinical interventions;
- [increasing] capacity of clinical providers to participate in infectious disease public health interventions;
- proper role of state health workers in infectious disease management;
- maximizing emergent data collection opportunities;
- sharing in the resource base derived from expanded health insurance coverage; and,
- mechanisms for maximizing limited discretionary public health grant funding.”²⁶⁸

STD Services

Under budget pressures, the state scaled back funding for STD clinic operations, ending their operational grants, and is now supporting the rapid integration of STD care into primary care, with a strong ongoing reliance on safety net providers.



The state still provides free laboratory services, though those funds are expected to be eliminated soon because of anticipated federal cuts (and they are part of the preventive services required to be covered under the ACA). This direction made sense because physicians have stronger training around STDs than some of the other communicable diseases, like TB, and the goal is for sexual health to be part of primary care.

Some challenges remain, as there has been a loss of dedicated, confidential space and lack of STD diagnostic and treatment skill in other sites, as well as less access to a wider range of needed medications. The MDPH role has focused on addressing these gaps and challenges, as well as maintaining critical epidemiological contact tracing services, which are unreimbursed. The health department arranged to use tuberculosis clinics to purchase, store, and dispense bicillin for syphilis treatment, and MDPH transported bicillin to clinical sites. Preserving priority treatment access as needed in eight clinical sites was leveraged through HIV funding for integrated HIV/STD/viral hepatitis screening system. MDPH also leveraged the CDC-funded HIV/STD Prevention Training Center to strengthen the skill, confidence and capacity of primary and specialty care providers to address STDs.²⁶⁸

HIV/AIDS

MDPH Office of HIV/AIDS is in the process of planning how to establish billing for services among contracted providers in order to free state public health resources for monitoring, training, support for co-pays and wraparound services, population health education and other activities as needed. The Director of the MDPH Office of HIV/AIDS offered primary lessons learned post-health reform as:

- “Coverage does not equal access;
- Benefits of reform are not uniform;
- Medical providers may not have capacities to address eligible patients’ needs;

- Some public costs cannot be shifted in a health reform environment (offsetting premium/co-pay costs for low-income HIV-positive for drug access, viral hepatitis patients need access and navigation, care coordination not covered by insurance);
- Training needs for clinical providers may be significant as specialized “public health” functions are pushed into primary care settings; and,
- Establish baseline and future data needs and variables to track impacts.”²⁶⁹

TB Services

The MDPH Tuberculosis (TB) Program began billing for services in advance of health reform, when it became increasingly expensive to provide services and hospitals were losing so much money on clinics that they were in danger of dropping them.

Clinics’ biggest concern was how to protect patients from being billed and thus potentially threatening their continuity of care and treatment. After two years of unsuccessfully encouraging contracted clinic providers to bill for services, the MDPH Commissioner convened the providers and told them the state could no longer fully fund them and in order to survive, they will need to bill third parties for their services.

- One insight from the TB program is the need to re-assess from a population health point of view what MDPH reimburses TB clinics for in terms of their services to uninsured and underinsured clients as an analogue of what providers are getting reimbursed for by health plans. The clinic services director identified the need to better capture reimbursement for partial co-pays, since the rate is set lower than current co-pays borne by clients. She is considering the best way for MDPH to spend dollars such as reimbursing clinics for services like CHWs and nursing case management. For rate-based contracts with providers, health departments should consider bundling broader needed population health services into the rate just as public health should be advocating for other payers to do.



Looking forward, the TB Division has a new initiative to explore if they can successfully integrate screening and treatment of TB infection into a person's medical home, piloting with some CHCs. MDPH is providing training but not funding; the programs will be financed through billing insurers. Regional TB nurses will support these sites and the program is also looking for new physicians for the existing dedicated clinics. It is unlikely that they will sustain as many dedicated clinics, but may focus on a handful of Centers of Excellence that will see people with active TB, and then MDPH funding can reimburse providers for a wider range of services to support this population.

Immunization

In Massachusetts, the Adult Immunization Program identified the need for Local Health Departments (LHDs) to begin billing for vaccine services. As this was a major culture and operating change, LHDs needed significant support in doing this. With funds from the PPHF, the state health department set up an Interservice Agreement with the Massachusetts Medicaid program, MassHealth. LHDs have gone through the process to become MassHealth and Medicare providers, and the state contracted with a public consulting agency, the University of Massachusetts Medicine's Commonwealth Institute, to train public providers and handle billing and payment.

The Director of the MDPH Adult Immunization Program explained that while health plans were at first resistant to contracting with local health department providers for flu vaccine, when they learned about the low rates of adult vaccination and that primary care providers aren't routinely vaccinating, they recognized that public health was a key part of the solution. Public health and LHDs have a unique role being close to the community, and having relationships with local community-based organizations and other local partners. Providers wanted assurance that primary care providers would get information back about their patients' vaccinations. That is why the establishment of a statewide vaccine registry was critical.

Another major challenge for LHDs was the need to bill. This was a big learning process, and the program director had to repeatedly deliver the message that "This is the future. If you want to still be here 5 years from now, you are going to have to figure out how to bill for services you provide."²⁷⁰

The Massachusetts program is in the process of expanding from health plans reimbursement of public health providers for flu vaccine to reimbursing for all adult U.S. Preventive Services Task Force A and B recommended vaccines. The MDPH Adult Immunization Program was able to identify funds to hire a part-time health professional who had previously been on staff at the Massachusetts Association of Health Plans. This has helped open the door to necessary meetings at the plans to discuss what is being reimbursed.

For children's vaccinations, advocates and the health department have successfully passed budget language allowing the assessment of health insurers for the cost of childhood vaccines and allow assessment for registry maintenance. This immunization assessment was increased to help fund the Prevention and Cost Control Trust Fund.

Breast and Cervical Cancer Early Detection

The National Breast and Cervical Cancer Early Detection Program NBCCED is another program facing concerns about its future under the ACA, as first-dollar preventive services will include mammograms and cervical cancer screening for an expanded group of insured women. This is in tension with authorization language that requires 60% of program funds to be spent on screening and referral and only 40% on other activities.

The ACA did not directly change the BCCED Program; eligible women will still be able to receive screenings through BCCED or, if they qualify, for AHCCS comprehensive treatment. However, the directive in authorizing language limits the program's ability to account for the increase in insurance coverage for women, including for breast and cervical cancer screening. Local challenges will shift to focusing on population health strategies to promote screening and reach out to an increasingly hard-to-reach population that remains uninsured.



In Massachusetts' experience, the on-the-ground needs in an environment with many more women insured do not adequately match what the funding currently allows.

The CDC is also considering how to make changes to the program in the context of health reform while sustaining the current dollars. If federal authorization for the program changes, it will support continued efforts to assure access to breast and cervical cancer screening and treatment for vulnerable women in the context of the ACA. By spring 2014, the United States Congress will have either reauthorized the program or reallocated the dollars to some other purpose, such as insurance coverage.²⁷¹

CDC has been funding demonstration sites to combine different risk factors into the coordinated chronic disease approach. In one example, the CDC funded Massachusetts and two other states (Arizona was part of this effort for a while) to combine cardiovascular screening and behavioral interventions with the breast and cervical cancer screening, through the WISE Woman initiative. Intended to reduce fragmentation and duplication, this effort has run into the challenge of finding specialists, such as OB/GYN doctors, who are unfamiliar with whole-person centered and primary care such as checking blood pressure and weight.²⁷¹

One recommendation is for CDC to shift funds towards states, like Arizona, that are expected to retain a higher percentage of uninsured women. Another recommendation is to increase the income eligibility.²⁷² And if authorization language changes, the CDC may shift away from the 60% dollars required for direct screening and referral and instead allow more flexibility for states to focus on educating and assuring that all women get timely screenings and treatment. This population health approach shifts resources to increasing rates of screening for women who have barriers to access, acknowledging that many women will still be un- and underinsured. NBCCEDP does currently cover "planning and implementation" of activities to enhance screening rates and assure timely initiation of treatment.

The social ecological model embraced by the NBCCEDP can serve as a framework for future directions for Arizona's program, in particular the Organizational, Community, and Policy levels. For example, AZ could use NBCCEDP funds to assure screenings by promoting clinical best practices, such as automatic provider reminders for screenings and provider performance feedback loops and organizational practices such as paid time off for screening, and policies.²⁷³

The Massachusetts Women's Health Network, a program of the MDPH, had to evolve after health reform was implemented in the state, to focus more on care coordination than on screening and treatment. While the CDC worked as much as possible to be flexible with Massachusetts, unfortunately, the effort to align the program within the national authorizing language's limits was ultimately unsuccessful, and the Massachusetts Women's Health Network is no longer a NBCCEDP.

Some of the ways in which the Women's Health Network attempted to adapt to an expanded health coverage environment included focusing more on assuring timely and comprehensive treatment, coordination of care, and addressing medical and social needs that have an impact on disease progression and health outcomes. Through contracts with CHCs, WHN focused more on providing patient navigators, case management, risk reduction education, and lifestyle intervention to promote overall health and well-being. However, despite the redesign, Massachusetts budget makers have not been convinced that the Women's Health Network is needed, and the state portion of the funding has been cut significantly. The program was on the chopping block for complete elimination for a while, and advocates faced the misunderstanding by state budget makers that the care coordination model of the new NHP/MHP was already being accomplished by the health care system and that women's breast and cervical cancer screening needs were addressed. In fact, medical homes and care coordination are not yet routine in Massachusetts, and the WHN/MHP is a valuable laboratory for developing these approaches.



Likewise, the legislature did not understand why the continued Medicaid program was important when there were now private, subsidized coverage options for women with incomes between 100% (childless) 138% (caregivers) FPL and 250% FPL. However, given that there is an enhanced federal match for women in Medicaid through the Breast and Cervical Cancer Treatment Program and no federal match for women in the subsidized private insurance plans, it is in everybody's interest to maintain the Medicaid program.

The Massachusetts program experience offers several other points of guidance. They needed more personnel per client to provide case management for their insurance support needs. It is a big change for women to go from being uninsured with free services to becoming insured, with all kinds of administrative requirements and changes. Without this support, women will lose their insurance but be ineligible for WHN services.

The WHN found that staff was suddenly spending much more time helping women identify the right health insurance plan and enroll, rather than helping to schedule mammograms. In addition, there was a great amount of "churning," as women's income levels and situations changed and they gained and lost eligibility for different plans. This required significant staff support as well to attempt to maximize continuity of care. All of this led to screening numbers declining significantly, with concomitant pressure from the CDC that the same level of funding was not needed. The CDC understood the importance of this work and was as flexible as possible, but ultimately, Massachusetts found the structural issue of the program design not intended for insured women to be too big a barrier. Arizona should be prepared for the extensive time required to train staff and keep them up-to-date on identifying and enrolling clients in insurance as well as for the challenge of this structural barrier.²⁷¹ If Arizona has a significant number of women who remain uninsured, it may be less acute a challenge than it was for Massachusetts, where the uninsured rate plummeted.

Another unexpected consequence of MA health reform that may hold true in Arizona is that low-income working families that were previously uninsured bought insurance as a result of the new requirements and often purchased more affordable high-deductible plans. These families couldn't qualify for the program but also couldn't afford mammograms out-of-pocket. In Massachusetts, the state legislated that insurance plans had to set a maximum deduction per family, which the ACA establishes as well. The ACA will not allow deductibles for Grade A and B preventive services, which includes appropriate breast and cervical cancer screening; but it won't cover people on grandfathered plans not subject to the total deductible cap. This points to a continued need for screening services for people who remain on grandfathered high deductible plans.

The advice from the former director of the MWHN to Arizona is to make a transition plan. It will take several years for most currently uninsured women to become insured, and in the interim, they will have intensive needs for education and support to navigate the insurance system. And there will continue to be a need for targeted and population efforts to support timely screening, diagnosis and treatment.²⁷¹

Overall, the experience of MDPH direct service programs points to the need to:

- plan for scenarios of billing, losing funding, and not providing services directly;
- dedicate time and resources to train staff in direct service (and all) programs in understanding the new insurance plans, eligibility, and enrollment processes;
- dedicate significant staff time to helping clients understand, enroll in, use, and stay on insurance;
- establish robust electronic medical record systems;
- dedicate time to helping direct service staff learn to bill for services; and,
- set up systems and relationships necessary to bill for direct services.

Approaches to Becoming a Provider: Billing

There is a spectrum of approaches health departments can take to begin billing insurers and supporting subcontractors (whether local health departments or clinics) to bill for services they are used to providing free or for a modest fee. Many of these could occur in combination. The National Association of County and City Health Officers (NACCHO) has a Toolkit with more than 150 resources from across the country, including billing manuals, workforce training, health information technology information, and glossaries/FAQ.²⁷⁴

Central Coordination. Health departments will need to designate central staff and ideally an office to coordinate and support the establishment of billing and relationships with health plans across departments. In addition, there should be central support for an electronic billing platform. This office could also support the education and training of staff to understand the change to billing as well as understand the mechanics of the change.

FQHC. Health departments may be eligible to become *Public Agency Community Health Centers* and qualify for Section 330 funding if they meet a range of requirements, including a consumer-directed board, providing case management services and a continuum of services to patients, either directly or through formally established arrangements.²⁷⁵ There are many advantages to becoming a Public Health Center, including eligibility for federal grants to support the costs of uncompensated care, enhanced reimbursement for Medicaid, reimbursement from Medicare, and CHIP beneficiaries as well as to participate in the 340B Drug Pricing Program.²⁷⁵

NACCHO has produced an issue brief on *Developing Quality Applications for Community Health Center Funding*. Health departments could also apply with a co-applicant, such as a FQHC, to meet all the requirements. Because MCDPH already has a Homeless Clinic FQHC, this would be something to build off of, since that entity already has met the requirements.¹⁷⁴

Referral Arrangement. A health department can develop a referral arrangement with a health center or other provider. In this arrangement, both organizations retain their own scope of service and agree to use the other as the referral site for specific services. If this is to allow the health department's FQHC application to become a Public Health Center, the organizations need a formal arrangement.

Contracting to provide specific services. Health departments have specialized services to offer, such as community health workers, nurse home visiting, outreach and enrollment, and CDSM. These services will likely be in demand by providers, such as hospitals or community health centers, which may contract with MCDPH via a purchase of service agreement. The provider would reimburse the health department for services and bill third party payers directly.

Becoming a network provider/Essential Provider. It provides the best access for clients if the health department is to become an in-network provider for as many health plans as possible so that there are no deductibles and co-pays and patients can be reimbursed for whatever billable services are provided, instead of just a contracted activity.

An efficient mechanism to assure that health plans establish contracts with health departments is to deem health departments "essential community providers (ECPs)." The ACA requires that certified plans sold through the Marketplace/Exchange include in their network "essential community providers", where available, that serve predominantly low-income, medically underserved individuals." In some states, such as Minnesota, the state health department has a role in accepting applications and determining ESPs.²⁷⁶

Other than STD and TB clinics, health departments per se are not among the already specified ESPs, but there is still the possibility and opportunity to be included in that list. The Secretary of HHS will provide more guidance on the ESP provisions of the ACA, and thus there is still a window to educate federal policy makers about why health departments are indeed ESPs.



Without ESP status, it is more challenging, but still recommended, to go through the process of becoming an in-network provider.

Contracting with an intermediary administrator.

MDPH contracted with an intermediary, the University of Massachusetts Commonwealth Medicine's Center for Healthcare Financing, to set up contracts with and bill private insurers for adult flu and pneumococcal vaccine clinics. The program continues to develop, growing from 80 approved providers in 2009 to 166 in 2011–2012, generating an average of \$6,000 per provider annually. They offer training to local public health providers, helping them to understand the insurance information and billing process as well as taking responsibility for electronic billing of the insurers for vaccine purchase and administration and electronic payment of providers. Appendix 5 shows a slide from the training presentation by Commonwealth Medicine to providers with guidance for how to shift to properly collecting and submitting clients' insurance information.²⁷⁷ The Commonwealth Medicine Center for Healthcare Financing takes a fee of 10 % of claims received to provide this service.

Administrative Medicaid. CMS has established mechanisms for eligible entities to claim a portion of costs necessary for the administration of the state Medicaid plan, including:

- Medicaid eligibility determinations;
- Medicaid outreach;
- Prior authorization for Medicaid services;
- EPSDT administration;
- Third party liability activities; and,
- Utilization review.

There is precedent for health departments to bill for Administrative Medicaid, but it must be through an arrangement with the state Medicaid agency and necessitates completing a time study of relevant employee activity to determine what percentage of their time might be billed.²⁷⁸

Section 17. Education, Assurance and Advocacy

Policy and Advocacy Work

Public health leaders in Arizona will have many priorities for advocacy at the state and federal level. Questions for this report focused on how the ACA might increase the need for advocacy for safety net providers, continued funding for preventive services, and expansion of benefits. These important considerations are addressed below. However, as stated elsewhere in this report, public health leaders should prioritize advocating for policy that promotes primary and community prevention and for the public health infrastructure that will allow public health departments to have the capacity to play a critical role in the new health landscape. While others will advocate for safety net providers, no one else will advocate for the safety net providers of total population health. Likewise, no one will focus on primary, community-based prevention which has the greatest power to improve health.

Health departments have the broadest view of *total* population health — defined by geopolitical boundaries, not a version of population health that is limited to those individuals in a health care system's catchment area or health plan enrollees. Health departments have the long view of what conditions will promote health, equity and quality of life from pre-conception through death. Thus health departments have the vision and tools to make the most enduring and effective change in health outcomes with the right resources and allies.

Health payers will naturally gravitate towards prevention and wellness interventions that are most within their control, such as fitness, nutrition, and chronic disease management programs. These are important, but inadequate. It is up to public health leaders to draw attention back to the upstream causes of preventable and inequitable illness and injury. Public health must strategically frame the solution to better health outcomes, quality, and lower cost as primary prevention, which is the jurisdiction of public health. And public health must win allies that understand that underinvesting in public health hurts their bottom line as payers and employers.

Indeed, health care payers and providers are the most logical source for increased investment in primary prevention, as they will benefit most financially from it.

The recommendation report will more fully explore strategies for funding primary prevention, some of which were mentioned in earlier sections. Here, we:

- Assemble a clear, concise, and strategic message about the role of public health in health reform. Make the case for public health and primary prevention in terms of ROI, reduced medical costs, and economic benefit, not just health outcomes and moral rightness;
- Arrive at the table of relevant meetings regarding economic development, health care financing, and other areas, such as planning. Continue to make the case as a valuable partner in these realms;
- Develop plans for how to increase primary prevention awareness and funding with allies such as foundations, faith-based communities, employers, and health care leaders and health access advocates who may understand that if care is too costly, it will not be affordable or available;
- Look for “moving vehicles” such as economic development bills to which to attach new public health funding plans. Such new funding should be structured in a way not to supplant existing public health funding; and,
- Make the case that there is still a need for public funding for some priority traditional public health preventive services for Arizona’s continued uninsured, at least during a transition period.

An overarching question remains what the safety net, including public health, looks like and how is it financed. The ACA and related phenomena, such as reduced state and federal funding for health department clinical services, are changing and will continue to change the safety net as it is currently constructed. In particular, what will the network of services be for undocumented immigrants and those legally present but waiting for the five-year eligibility period? These questions point to important

roles for Arizona health departments and are also a worthy subject for exploration and planning by a group of invested stakeholders, as we suggest below. There will continue to be a critical role for public health, with partners, to assure access to preventive and other services.

17A. POLICY WORK TO ASSURE CONTINUED STRONG HEALTH CARE SAFETY NET

Safety net providers face considerable uncertainty with the changes in the face of ACA implementation, along with pressures over the past several years from increased demand for services by uninsured patients. The ACA provides an opportunity for many safety net providers, as it will enable them to bill Medicaid for services for newly insured patients who were previously uninsured. However, uncertainty about the potential impact of the changes in Disproportionate Share Hospital (DSH) funding and other reimbursement and demand for services pose a number of financial concerns for safety net providers.

Increased Medicaid and Medicare Rates for Safety Net Hospitals

The Commonwealth Fund Commission on a High Performance Health System proposed several policies for sustaining the financial viability of safety net hospitals while encouraging them to provide high quality, coordinated, and cost-effective care.²⁷⁹

In states where Medicaid hospital rates are below the cost of efficiently delivered care, states can increase Medicaid rates for hospitals with the highest share of Medicaid patients and lowest share of privately insured, if they meet quality targets. The Commission recognizes that states are unlikely to increase Medicaid rates broadly due to current economic conditions. However by directing these increases to hospitals with large Medicaid shares, they can ensure that services remain available for vulnerable populations. This methodology incorporates value-based purchasing, by tying rate increases to performance measures. Quality measures can be structured around issues of most importance, such as creating incentives for care to be provided in the most appropriate setting.²⁷⁹

Prevent Readmission to Safety Net Hospitals to Avoid New ACA Readmission Penalties

Under the ACA Hospital Readmissions Reduction Program (HRRP), CMS will impose financial penalties for Inpatient Prospective Payment System Hospitals that have higher rates of readmissions within 30 days of discharge and for three conditions, compared to the national average. Safety net hospitals are approximately 30% more likely to have 30 day hospital readmission rates that are above the national average, suggesting that that the reduced payments under the HRRP will disproportionately affect them.²⁸⁰

Safety net patients are more likely to be readmitted because of complicating factors; they have higher rates of chronic health problems, disability, mental illness, and substance abuse compared to the general population. They have complex personal and social needs that adversely affect their health, including homelessness, and unsafe housing, and lack of social support systems.²⁸⁰ Serving a higher proportion of patients with these characteristics may make it more difficult for safety net hospitals to improve their readmission rates compared to other hospitals that serve a lower percentage of patients with complex needs. Some providers have suggested that CMS modify this measure and its penalties for safety net providers, due to the specific challenges of the populations that they treat.²⁸¹ Another approach is to focus efforts to prevent readmission.

Adopting bundled payment models can help create incentives for care coordination and quality improvement that will lead to reduced readmission. There has been some work by the CMS Innovation Center to fund development in this area, such as the Bundled Payments for Care Improvement Initiative, the Medicaid Global Payment System Demonstration Project, and the Medicaid Bundled Payments Demonstration.²⁸⁰ The CMS Innovation Center is a testing ground for new models, and this work may lead to innovations that support safety net providers over the long term.

Partnership with Health Department on Hot Spot Analysis and Population Health Plans. As discussed earlier, Health departments can conduct “hot spot” analyses of communities with high readmission rates to safety net hospitals and partner with hospitals to focus interventions in these communities.

Quality Improvement Collaborations. Efforts for safety net providers to learn and implement quality improvement strategies and interventions may help reduce the rates of readmission, including discharge planning, the care transitions model and follow-up care. One way to provide support to safety net providers is through establishing learning collaboratives. For example, the National Association of Public Hospitals and Health Systems works with quality improvement expert organizations to provide its safety net member hospitals with access to a collaborative network of professionals and learning activities.²⁸⁰

Target Remaining Disproportionate Share Funding to Safety Net Hospitals.

Beginning in FY2014, the amount of DSH funding will decrease significantly, since fewer people are expected to receive uncompensated care due to insurance expansion in other parts of the ACA. DSH payments will be reduced by \$14.1 billion during 2014 to 2019.⁷⁷ The new methodology for how DSH funding will be distributed has not yet been finalized. Some providers have suggested that rather than cutting DSH funding based on the assumption that safety net providers will receive increased funding through Medicaid that will balance the decrease in DSH funds, reductions in DSH should occur after the decline in uninsured care can be measured.²⁸¹

Another policy approach suggests that states target remaining DSH payments to support hospitals that provide the greatest amount of uncompensated care. To do this, DSH funds could be linked specifically to services provided to uninsured patients. Safety net hospitals would “bill” a state’s DSH pool for services rendered to uninsured patients and receive reimbursement valued at some fraction of the Medicaid rate.²⁷⁹

Help Safety Net Hospitals Participate in ACOs

Access to Capital and Technology. Safety net providers are well equipped in some ways to participate in collaborative delivery models, such as ACOs and PCMHs, as established primary care providers, often using a medical home approach.



However, many safety net providers might not be equipped for these arrangements because their lack of access to capital, including technology, and limited resources for implementing new strategies.²⁸¹ Many are already stretched to their limits and have little time for planning or ability to raise additional funds or increase their revenues from private payers, making them unable to invest in the staff or infrastructure needed to evolve. Access to capital is important.

One policy approach is to support safety-net hospitals' access to the capital to implement large-scale delivery system reform.²⁷⁹ A possible source of funding for safety net hospitals include Medicaid waivers under Section 1115 of the Social Security Act. These waivers enable federal and state governments to target financial support for high-priority capital projects and system restructuring at safety-net hospitals. The Commonwealth Fund Commission on the subject of a High Performance Health System recommends that states consider using waiver funding to support essential investments at safety-net hospitals, especially those that support the development of ACAs at these facilities. Another more limited source of funding is through the CMMI Challenge Grant²⁷⁹ which recently released another RFP.

Require ACOs to include safety net providers. To ensure that safety net providers have the opportunity to participate in ACOs, one policy approach is to set regulations that require or support inclusion of safety net providers in ACOs. Federal regulations and state and local rules regarding ACO development, operation, and inclusion of safety net providers could support the ability of ACOs to participate.²⁸¹ For instance, in California, where oversight of ACO development is handled by the state's Division of Managed Health Care, policy recommendations have been proposed that examine capitalization requirements and medical liability rules, to make sure that they do not create barriers that prevent safety net providers from participating.²⁸²

Coordination with Other Safety Net Providers. Another factor that may contribute to safety net providers' ability to participate in ACO and other new models of care is their level of integration with other health care providers. Providers that have affiliations with health plans, and that are actively using health technology, may have advantages in participating in ACOs.²⁸¹

Some safety net providers have been working together to integrate their services, enabling them to provide more coordinated care, practice more efficiently as a system, and potentially make them more able to enter new arrangements like ACOs. For instance, the Healthy San Francisco program links 29 clinics and five hospitals. These facilities share an eligibility and medical record system, and are thus able to share information on patients seeking care. The system has helped patients identify primary care providers and has helped improve the referral process. It also allows the city to monitor use of the safety net.²⁸¹ While this is not a policy change per se, it is one way that safety net providers can adapt. State agencies are in a unique position where they can be a neutral convener to broker arrangement that enable safety net providers with other stakeholders, such as health plans, other health centers and hospitals, without violating anti-trust rules.¹

Creating/Restoring Arizona Funding to Cover Continued Services to Uninsured

Until 2011, Arizona had two programs that provided services to vulnerable uninsured populations. The first was the Catastrophic Coverage, or "spend down" program which provided temporary AHCCCS coverage for people who did not qualify for Medicaid but had serious health problems and high medical costs. The second was through funding provided from state tobacco funds to CHCs to provide primary care services to uninsured people. The funding for both of these programs were eliminated in 2011, as part of the state's efforts to address state budget problems.⁹⁸

In addition, some uninsured Arizona residents with preexisting conditions have participated in the federal Preexisting Condition Insurance Program (PCIP), which will be eliminated in 2014, as other ACA provisions are expected to cover the needs of these individuals. Arizona's Safety Net Care Pool, in which local dollars are matched by federal dollars to help cover uncompensated care costs, will be eliminated in 2014. The City of Phoenix and local hospitals are working on establishing a similar funding arrangement for Phoenix hospitals, subject to CMS approval.⁹⁸ The effectiveness of the local model as a solution is therefore not yet known.



Massachusetts has a similar program in place called the Health Safety Net program, which subsidizes uncompensated care for low-income, uninsured people seeking care at CHCs. This program remained intact after the state implemented health reform to address the portion of the population that remains uninsured or underinsured.¹¹⁴ The Health Safety Net is funded by a combination of hospital assessments, payer surcharges and government payments. This fund provided crucial support to two large safety net hospitals that were struggling financially post health reform,⁹⁸ demonstrating the need for bolstered support of safety net providers, even after insurance expansion.

Reinsurance. A review of the literature did not identify any models for reinsurance programs or funding fees for safety net hospitals. Much of the ACA-related focus concerning safety net providers emphasizes ensuring their ability to participate in the new models of care that will allow them to treat people who are newly covered by Medicaid or other payers.

Health Department Partnership on CHNAs. The ACA/IRS requirements that nonprofit hospitals complete CHNAs every three years could require significant time and resources for safety net providers. As discussed in the section on Planning and Informatics, local health departments have value added to offer to this process by coordinating multiple health assessments and could contract with safety net hospitals to efficiently coordinate this effort and integrate it with the health department CHAs and CHIPs.

Convening a Safety Net Services Working Group. In addition, the MCDPH may want to consider convening a group focused on safety net services post-ACA. This could grow out of the MCDPH plan for a health care gap analysis in the CHIP and embrace a broader mission to assure sustained safety net services for the uninsured and underinsured vulnerable populations. Such a group should include health department safety net services in its consideration. Assuring access to preventive services could be an expanded focus for this group or a separate group.

An important issue for FQHCs and other safety net providers, potentially including MCDPH, is ensuring that FQHCs are considered essential community providers in order to ensure their participation in qualified health plans (QHPs) which will enable them to attract newly enrolled Medicaid patients in their mix. Some states have raised concerns about state level rules related to this. Some states may delegate the enforcement of these standards to departments of insurance, so there is a need to educate staff at these agencies about the role the safety net has historically played in serving Medicaid enrollees and the uninsured. State departments of insurance could consider updating network adequacy standards for QHPs in ways that incentivize contracting with safety net providers.¹

Because of the penalty for hospital readmissions, it will be important for safety net hospitals to look for potential partnerships with organizations that can support patients post-discharge. Health departments can partner to provide home visiting and other wraparound services designed to prevent readmissions.

One area of opportunity is exploring funding that is available for FQHC look-alikes to gain FQHC status which would give them access to more federal dollars. Data also shows that Arizona has a lower percentage of patients served by CHCs than neighboring states.¹²⁶ It would be important to explore opportunities to place new CHCs in geographically underserved areas. The need for additional CHCs has been documented, for example by a 2006 report from the U.S. General Accounting Office that indicated that 39% of medically underserved areas in Arizona lacked a CHC.¹²⁶

In addition, because of the anticipated substantial changes in demand and supply in AZ, there is potentially a need for a state or county agency to monitor financial information and utilization of safety net providers and other providers in order to better identify problems, cost drivers, and plan to address problems. In Massachusetts, this role that has been handled by one state agency, the Massachusetts Center for Health Information and Analysis, formerly the Division of Health Care Finance and Policy enabling it to monitor trends effectively.¹²⁶



There are also opportunities to strengthen loan repayment programs which may create incentives for practicing in underserved areas. To support CHC's abilities to hire physicians and other clinical staff, Massachusetts developed a loan repayment program, funded by private funds and state funds and supported by the Massachusetts Leagues of Community Health Centers.¹¹⁴ MCDPH could convene Maricopa safety net and other providers to identify opportunities to offer recruitment and retention incentives for primary care clinicians, particularly those who treat the most vulnerable populations.

17B. ASSURANCE OF PREVENTIVE SERVICES

Preventive Services in Massachusetts after Health Insurance Expansion

No current analyses explore whether there was an increase in preventive service cost in Massachusetts after health reform. By looking at other data on costs and screenings, HRiA can infer that there was an increase in use of preventive services which did not appear to result in a net increase of costs to the health care system. In fact, there may have savings, though this has not been fully analyzed.

Massachusetts residents are getting more care, including more primary care. After reform, fewer Massachusetts residents have unmet health care needs and more residents report a usual source of care, a doctor and dental visit in the past year.⁸ Between Fall 2006 and Fall 2009, there was a significant increase in residents reporting a preventive care visit, rising from 71% of respondents to 78%.²⁸³ And while levels of women over 40 receiving mammograms and men receiving prostate exams has remained stable, the rate of adult vaccination and sigmoidoscopy and colonoscopy has increased after health reform.²⁸⁴ According to the Director of Adult Immunization for Massachusetts, the improved adult vaccination rate is perhaps more a result of intensified provider education and intensive public health efforts that grew out of H1N1 preparation and funding as it was a result of health reform.²⁸⁵

While these are signs of increased preventive services, health care costs in Massachusetts have not grown faster since health reform. However, people are spending a bigger percentage of their paycheck on health care now. The recession and stagnant wages combined with health reform and health care cost control efforts has led to an increase in deductibles and other benefit reductions even as on the surface, premium growth has slowed.²⁵⁴ At the same time, because of protections and increased subsidized insurance for low-income individuals, fewer people have significant (greater than 5 or 10% of household budget) health care expenses.⁸

Though analyses of emergency department use in Massachusetts vary, one analysis of Massachusetts hospitals (2004–2008) showed a decline in *preventable* emergency department use, particularly among low-income populations, as well as a decrease in preventable hospital admissions originating from emergency departments, as well as of length of stay. The decrease in emergency department based hospitalization after reform pointed to increased use of some preventive services outside the hospital. For example, there were fewer emergency department based hospital admissions for adult asthma and lower limb amputation after reform, suggesting these people may have received better asthma and diabetes management with their primary care provider.²⁸⁶

According to this same analysis, reform did not lead to overall greater costs for the Massachusetts hospitals. However, because this study did not capture non hospital preventive costs, it is likely that physician practices had an increase in cost for preventive services. This hasn't been analyzed specifically, but more recent analysis does show that the biggest health care cost growth area in Massachusetts is in physician visits.²⁸⁷

At the same time, barriers to preventive and primary care remain in Massachusetts, pointing to challenges likely to be faced in Arizona. One-in-five non elderly adults reported challenges in finding a physician who would see them. Just over half of adult diabetics reported receiving recommended preventive services. Massachusetts still shows significant avoidable hospitalizations and emergency department use, representing approximately a billion dollars in avoidable spending.⁸



Under the ACA, health plans must provide coverage for Essential Health Benefits (EHB) which encompass: ambulatory patient services; emergency services; hospitalization; laboratory services; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative and habilitate services and devices; preventive and wellness services and chronic disease management; and, pediatric oral and vision care. Approximately 1.3 million Arizona residents, roughly half of whom were previously uninsured, will gain the ability to receive preventive services through primary care with no co-pays or deductibles through the Medicaid benchmark plan or plans purchased through the Marketplace.

This does not immediately change access to preventive service for people on grandfathered health plans which do not have to comply with ACA's preventive care mandate. While the number of people on grandfathered plans will decline annually, it is likely that in 2014, up to 614,400 AZ adult employees may not receive comparable preventive services or EHB coverage through their grandfathered health plan, which are not required to provide first-dollar preventive services coverage. However, most of those plans will eventually end their grandfather status, and few, if any people will remain in grandfathered plans. In addition, an estimated 10% of Arizonans will remain uninsured after the ACA because they are not eligible or elect not to enroll in programs.

There will be a continued need for population health strategies to assure access to preventive services for both the newly insured with preventive services benefits as well as for those who are uninsured or underinsured. One study showed that fewer than 50% of adults aged 50 years or older were currently on select recommended screenings and vaccinations, regardless of plan type.^{288,289} The Agency for Health Research and Quality (AHRQ)'s 2010 Healthcare Disparities Report noted significant disparities in use of preventive services by race, ethnicity, geography and other factors.²⁹⁰ A 2011 poll by the Kaiser Family Foundation revealed that many of the uninsured were unaware of improved access to preventive services under the ACA. Only 29% were aware that the ACA eliminates co-pays and deductibles for certain preventive services.²⁹¹

As prevention is essential to achieve the Triple Aim of improving the quality of health care, improving the health of populations, and reducing per capita costs of health care, the public health field will need to ensure that people know about their benefits, and have access to and utilize preventive care. The ACA included measures in Section 4004 to promote awareness of preventive services, including authorizing an education and outreach campaign regarding preventive benefits, but this campaign has not yet been funded. The burden remains predominantly on state and local education efforts and partnerships with health plans and providers to assure the provision of quality preventive services. Education and advocacy efforts will determine whether needed safety net preventive services funding for health departments and other sites continues as well.

Convening a task force on preventive services.

Mobilize partners from both traditional and non-traditional health sectors including community-based organizations, businesses, healthcare providers, insurers, and other governmental agencies who have a stake in a healthier population to develop a plan to assure people know about their benefits and access preventive services. Include Marketplace and Marketplace Navigator stakeholders; Navigator health promotion efforts can include highlighting preventive services.

Include focus on preventive services by community health teams (CHTs). It is important to engage multi-disciplinary teams in communicating the value and importance of prevention. MCDPH should have a role in any CHT effort and could take a role in the promotion, training and certification of CHTs that would include a focus on preventive services.²⁸⁸

Leverage Health Information Technology (HIT) with providers. MCDPH can partner with safety net and other providers on quality initiatives to incorporate preventive screening questions into electronic medical records to ensure that all individuals are regularly and uniformly asked about preventive services by clinicians. This should be part of a Health Information Exchange that shares information with the health department in order to collect data on preventive services utilization and will be important to document whether there is a return on investment in covering such services relative to health and financial outcomes.



The capacity to share information between clinicians and public health on infectious diseases, immunizations, patient education, and wellness opportunities available in the community will not only enhance primary care quality, but will also enhance the public health department's disease surveillance and health promotion functions.

Promotion of prevention through communications. MCDPH can take a lead role in the promotion and communication around available preventive services to the public, policy makers, etc. Traditional and social media campaigns can reach a variety of audiences to educate them about the importance of investing and participating in preventive services.

Familiarizing health plans with services that public health offers. An important public health role is to reinforce with payers the magnitude of the impact of obesity and smoking on the population's health, and reiterating the need for primary prevention and preventive clinical services. Chronic conditions, many of which are related to obesity, lack of physical activity and tobacco use, are among the biggest drivers of health care costs,³ and are of high concern to payers. Public health can provide payers with an understanding of the work that public health has done to measure the impact of these conditions on communities and the interventions that have been found to be effective. Payers have tended to address these conditions on an episodic level, but ACOs and other health delivery system redesign shifts the perspective to population health, which may be a newer lens for payers.

In some cases, payers may have had limited opportunity to learn about the services that public health departments offer. Providing an overview of services related to health promotion, management of chronic conditions, health literacy, outreach to vulnerable populations, along with other functions such as health assessment and surveillance, would be a practical starting place.

Helping Connect Providers with Covered Wellness Services. Payers have traditionally focused on reimbursing services provided in health care settings. A growing body of evidence affirms that community

based prevention programs and supports need to be made available if individuals are to meaningfully improve their health status. Wellness services such as CDSM programs are covered under the preventive services requirement of the ACA. Examples of community based prevention programs ripe for reimbursement include diabetes prevention initiatives that help promote physical activity, good nutrition and smoking cessation, as well as CDSMPs.

While the use of community based services may have been most often targeted to Medicaid populations, these will be important for private insurers as well, since many of them will be gaining members through the insurance exchange. Such an example includes coverage of group wellness programs through a community based organization, such as a YMCA or a community center, which might include exercise and wellness classes and coaching on lifestyle changes.³ Use of community based providers may become more common in ACOs, in which providers have more flexibility to determine which services to cover at the local level. Payers can also consider opportunities to directly contract with these types of programs, which could be relevant for all populations, either at risk for or managing chronic conditions.

Public health has a history of working with community based providers and may be more familiar with their programs and services. Because of this, public health may be able to provide guidance to payers about evidence-based programs as they explore opportunities to utilize these programs.

Monitoring Health Plan Use of Patient Incentives.

As more providers participate in ACOs that include incentives for meeting quality targets, there is some movement to develop insurance benefits that incentivize patients toward choices that help meet these targets.

For example, Arizona's Banner Health is negotiating with large employers for accountable care contracts to start next year, and health system officials are seeking changes to benefit designs that will "drive and incentivize positive behavior," said Dr. Tricia Nguyen, Chief Medical Officer of Banner Health Network.¹⁴¹ Banner's plans indicate an interest in creating incentives for patients to choose "high value services".¹⁴¹



Employer health plan incentives to encourage weight loss, smoking cessation, and preventive care have grown more widespread as one strategy within their control to attempt to influence behaviors associated with chronic disease. Cash, gift cards, or reduced health insurance premiums are increasingly awarded to workers who complete health evaluations, reduce a major health risk, such as smoking, or work with coaches to prevent complications from ailments such as congestive heart failure.¹⁴¹ Similar incentives are being used in Medicaid plans, described in another section of this report.

As discussed in Section 12, the evidence is mixed on the consequences of disincentive policies, and health departments should become familiar with the evidence base around these programs and monitor for negative effects. Furthermore, they inefficiently direct resources toward changing individual behavior as opposed to partnering with public health to invest in more effective population health strategies that change the environment in which people live and make choices. Health departments can offer their expertise to health plans to partner on these more efficient interventions.

17C. EDUCATION AND OUTREACH: HELPING RESIDENTS FIND, ENROLL IN, AND REMAIN ON HEALTH INSURANCE AND USE CARE APPROPRIATELY

Effective outreach efforts and strategies designed to enroll and retain insurance participants in subsidized public and private insurance options are critical to successfully accomplish the goal of increased coverage for low-income residents.¹²

The ACA created the role of Exchange/Marketplace Navigators and authorized funding for Navigators, organizations and/or individuals that will assist individuals in enrolling in health insurance through the Marketplace. As noted earlier, CMS released an RFP for Navigator entities, due June 7, 2013. CMS defined the role of Navigators to:

- stay up-to-date on health insurance plans, eligibility and enrollment information;

- provide public education about the Exchange;
- give independent, unbiased information about all plans;
- help people select a qualified health plan;
- refer people to the appropriate offices to file a grievance; and,
- provide culturally and linguistically appropriate materials and information.²⁹²

MCDPH is advised to work with partners applying for this grant to define a paid Navigator role for at least some MCDPH program/s. MCPHD staff have indicated an interest in having personnel in their clinics and programs, which have direct patient contact, receive Insurance Exchange Navigator training. Programs operated by MCDPH that are particularly relevant include Health Care for the Homeless, Healthy Start, WIC, immunization and screening programs, Nurse Family Partnership, and school-based programs such as Oral Health clinics. The Health Care for the Homeless program offers a promising opportunity for Navigator and 'post enrollment' patient navigation funding. MCPHD clinic staff located in FQHCs may be eligible for HRSA's supplemental \$150 million dollar outreach and enrollment funding for qualified health centers and for other initiatives as navigation needs change.

Based on both Massachusetts and Boston health departments' experiences, certain staff will play a major role in educating and potentially enrolling uninsured individuals in health insurance, and it will be important to identify resources to support this work and enhance this capacity.

The Massachusetts experience is useful in considering the needs of the health department for training and planning as well as for more fully considering the Navigator role. The CMS Navigator definition does not capture all of the potential important roles of a Navigator as explored by the Blue Cross Blue Shield of Massachusetts Foundation in a report on *Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Coverage*.



This report, which is part of the Foundation’s Health Reform Toolkit Series, documents the ingredients of the success in Massachusetts and points for additional areas for Arizona to consider in Navigator and population health strategies to maximize enrollment in newly available coverage. The key ingredients in Massachusetts’ success in accomplishing health coverage for 98.1% of the population included the need to:

- build an education, outreach, and enrollment infrastructure;
- use diverse channels to reach the uninsured;
- provide “comprehensive technical assistance to organizations providing outreach and enrollment;
- employ targeted enrollment strategies. The role of navigators and outreach and enrollment providing organizations should include:
 - » sustained support to the newly-insured to remain on insurance;
 - » support to the newly-insured to change their use of care from episodic, ED-based to preventive and primary care-based; and,
 - » guidance in promoting wellness and preventing/ managing chronic disease.²⁹³

Targeted Enrollment Strategies and Enrollment Maintenance

To encourage Maricopa County’s eligible, uninsured populations to enroll in health insurance through the ACA, targeted community based outreach and enrollment assistance is critical. This assistance should address barriers that these populations have faced historically, including: difficulty completing the application; confusion about eligibility; language and literacy challenges; fears about immigration enforcement for families with mixed immigration status; and, cultural barriers.¹⁴ Education and outreach strategies should convey the benefits of insurance to a population that is accustomed to not having it. Messages should also communicate that enrolling in insurance is simple and affordable.

Outreach and enrollment campaigns should be targeted toward specific groups of individuals with high rates of uninsurance and poor health outcomes, including Hispanics, legally present immigrants, individuals with low-English proficiency, low-income individuals, LGBT populations and prison populations. They should also be targeted towards younger adults and males, who also are projected to have lower rates of insurance enrollment.²⁹⁴

Public health has experience in these kinds of targeted outreach strategies, as well as having direct contact with many uninsured and low-income residents through health department programs. The state and county health department can provide valuable expertise in helping to develop outreach strategies broadly for the state and county as well as internally, through MCDPH programs and constituents.

In order to facilitate enrollment, under the ACA, states will be required to provide a simplified enrollment process for Medicaid and Marketplace coverage that enables individuals to apply through multiple avenues, including online.¹⁴ In Massachusetts, a central “Virtual Gateway” Internet portal was linked to the state’s electronic enrollment system. The state provided regular training to health and human service agencies to learn how to use the Gateway in their own sites to enroll clients. In Arizona, it will be key to assure appropriate web access and training for a range of agencies in order that as broad as possible a group of official and unofficial navigators can help enroll individuals where they are.

In addition to educating on the value of insurance and supporting enrollment, it will be important to educate uninsured residents about the requirement to have insurance as well as about redetermination. In Massachusetts, outreach and enrollment workers found that newly insured did not understand the annual redetermination notices they received from insurance plans, and often ignored them, resulting in being dropped from coverage. The state added a responsibility to outreach and enrollment grantees that they must help clients stay enrolled and support them in the redetermination process.



Evolution of Navigator Role to Appropriate Use of Care and Wellness

As the attention in Massachusetts shifted from expanded coverage alone to systemic changes in order to reduce health care costs and improve health outcomes, this was reflected in a further shift of state requirements for outreach and enrollment grantees. Once insured, it is also important to address challenges in accessing care, such as language, literacy, and cultural barriers and fears and confusion related to navigating the health care system. By the fourth year, the focus on grants was not just on enrollment and redetermination, but also on helping enrollees establish a relationship with a primary care provider and linking to preventive and wellness education.²⁹³

A value that MCDPH could add to collective navigator/outreach and enrollment efforts is to develop training and protocol for navigators to promote appropriate use of care and wellness skills education and help assure that other navigators are incorporating these components into their work with uninsured and newly-insured residents. This is likely to be an area where MCDPH has expertise that other groups do not, and these elements will be critical to cost-savings and population goals for the health system. CHWs are a promising workforce to carry out these duties.

Health Department and Partner Organization Capacity

The Massachusetts experience was that almost all health and human service organizations, whether funded to perform outreach and enrollment activities or not, had a steep learning curve and the need to dedicate time and resources to internal learning as well as educating clients. MCDPH will, by necessity, play some kind of role in educating staff and clients about eligibility for new plans and benefits for low-income residents. Convening these community organizations early in the process in order to help them understand the law and how to communicate its relevant provisions to their clients, as well as provide them with technical assistance in preparing their agencies for communicating the changes to clients, could be very valuable. It will be important to plan for it and also maximize and leverage funding.

MCDPH should look at hiring new staff and/or identifying and training current staff to help clients and train other staff to help clients navigate AHCCCS, the Marketplace, staying insured, and the health care system. In addition, MCDPH can play a lead role in educating partners, through the cloud structure and working groups, about major requirements of reform, gaps and strategies to help the uninsured become insured and utilize new benefits and services.

The Mayor's Health Line in Boston, a BPHC referral line that provides connection to a range of services, including health insurance, was in existence previous to health reform, but with health reform it took an expanded role. Grants allowed the expansion of staff and intensive training in the requirements of and plans available through health care reform. Health Line staff were trained in the use of the Virtual Gateway and could directly enroll clients in insurance electronically over the phone. This program also played a role internally in the health department as experts who stayed abreast of health care reform developments and educated other health department staff. As the focus in Massachusetts shifted to reducing health care costs through strategies such as connecting people to primary care and improving the appropriate use of care, the Health Line developed a Primary Care Connection component, described earlier in this report. Through this service, Health Line staffers help callers identify primary care providers who are taking new patients and even schedule a first appointment.

Given the high numbers of uninsured in Maricopa County who will be newly-eligible for insurance, MCDPH should coordinate with other navigator organizations to identify gaps and make a plan for the best role for MCDPH. MCDPH could build capacity, through a CHW program or a call center, perhaps targeted to particular populations that would complement other services, such as a bilingual program, or focusing on helping clients identify a primary care provider and get a first appointment, if another hot line provides adequate services to help people identify coverage.



Paying for Navigators/Expanded Outreach and Enrollment Capacity

In Massachusetts, the Blue Cross Blue Shield MA Foundation (BCBSMA) provided grants for health insurance education and outreach work prior to health reform that continued through reform. Just prior to reform, the state authorized half a million dollars in grants to community based organizations across the state to ramp up outreach and enrollment activities and to provide ongoing training and support to grantees through the Massachusetts Health Care Training Forum.²⁹³

These Massachusetts funds are analogous to federal funding for navigators, although they were more comprehensive. Unfortunately, after approximately six years, the grant program ended as a result of state budget cuts. The BCBSMA Foundation continued to fund outreach and enrollment work, and organizations absorbed what they could, but much capacity was lost. MCDPH can begin conversations with local foundations about what role they can play in assisting with successful AZ health reform now, so that they can begin planning for beneficial roles similar to the BCBSMA Foundation.

Ideally the state and foundations will consider how to best supplement federal funding and take the long view on a broad range of services that navigators can fulfill. Beyond that, the health department and other health and human service organizations that will need to expand capacity can look to maximizing Administrative Medicaid billing for services to enroll clients in Medicaid and also to making the case in conversations with the CDC and other funders of preventive services, like immunization and TB, that a significantly increasing amount of time will be needed to train staff and then for staff to provide one-on-one support to clients to explain health insurance and help them identify options for enrollment.



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Appendix 1: Comparison of AZ Benchmark Plan to Federal PPO Basic Plan

	Federal PPO Basic Plan Coverage?	AZ State EPO Plan Coverage?	Limitations to AZ State Employee EPO Coverage
Hospitalization			
Hospital services	Yes	Yes	
Hospital room and board	Yes	Yes	
Inpatient physician/surgeon services	Yes	Yes	
Long term acute care	Yes	Yes	
Skilled nursing facility*	No	Yes	90 day limit per member per plan year
Hospice care	Yes	Yes	Covered when diagnosed by a participating provider as having a terminal illness with a prognosis of six months or less to live.
Assistant surgeon	Yes	Yes	
Anesthetist	Yes	Yes	
Transplant	Yes	Yes	No coverage if member is an organ donor for a recipient other than a member enrolled under this plan. Travel & lodging expenses are limited to \$10,000 per transplant. Travel and lodging are not covered if the member is a donor.
Emergency Services			
Emergency room (not followed by admission)	Yes	Yes	
Ambulance services	Yes	Yes	
Ambulatory Patient Services			
Urgent care	Yes	Yes	
Office visit	Yes	Yes	
Office visit (Specialist)	Yes	Yes	
Home health care	Yes	Yes	42 visits per member per plan year.

	Federal PPO Basic Plan Coverage?	AZ State EPO Plan Coverage?	Limitations to AZ State Employee EPO Coverage
Ambulatory Patient Services (Continued)			
Outpatient surgery	Yes	Yes	
Bariatric surgery	Yes	Yes	
Pediatric medical	Yes	Yes	
Chiropractic	Yes	Yes	Limited to 20 visits per member per plan year subject to being medically appropriate.
Podiatry**	Yes	No	
TMJ	Yes ¹	Yes ²	
Reconstructive	Yes	Yes	
Cosmetic surgery	No ³	No ⁴	
Second opinion	Yes	Yes	
Christian Science Practitioners**	Yes	No	
Christian Science Facilities	Yes	Yes	
Maternity and Newborn Care			
Maternity and newborn care	Yes	Yes	
Birthing centers	Yes	Yes	
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment			
Benchmark plan option offered at parity ⁵	Yes	Yes	
Mental Health inpatient	Yes	Yes	
Psychiatric assessment/stabilization/treatment in an inpatient hospital setting	Yes	Yes	
Psychiatric assessment/stabilization/treatment in an emergency room setting	Yes	Yes	
Residential treatment services*	No	Yes	Maximum of 90 days and limited to two treatments per plan year for chemical and alcohol dependency.



	Federal PPO Basic Plan Coverage?	AZ State EPO Plan Coverage?	Limitations to AZ State Employee EPO Coverage
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment (Continued)			
Partial Hospitalization/ Day Treatment services	Yes	Yes	
Crisis assessment/ stabilization in the community	No	No	
Mental Health outpatient	Yes	Yes	
Psychiatric services	Yes	Yes	
Psychological & Neuropsychological testing services	Yes	Yes	
Respite services	No	No	
Peer/recovery support services	No	No	
Electroconvulsive therapy (ECT)	Yes	Yes	
Substance abuse inpatient/ outpatient coverage	Yes	Yes	Maximum of 90 days and limited to two treatments per plan year for chemical and alcohol dependency.
Substance abuse inpatient/ outpatient coverage	Yes	Yes	In-patient detoxification coverage is limited to two treatments per year and a lifetime maximum of five.
Methadone/Buprenorphine coverage	Yes	Yes	Rx limitations on Buprenorphine.
Behavioral health treatment	Yes	Yes	
Behavioral health counseling/ therapy services	Yes	Yes	
Pharmacotherapy (medication management)	Yes	Yes	
ABA therapy for autism*	No	Yes	
Developmental testing**	Yes	Yes	

	Federal PPO Basic Plan Coverage?	AZ State EPO Plan Coverage?	Limitations to AZ State Employee EPO Coverage
Prescription Drug			
Generic (Retail)	Yes	Yes	
Generic (Mail Order)*	Yes	Yes	
Formulary brand (Retail)	Yes	Yes	
Formulary brand (Mail Order)*	Yes	Yes	
Non-formulary brand (Retail)	Yes	Yes	
Non-formulary brand (Mail Order)*	No	Yes	
Specialty (Retail)	Yes	Yes	
Specialty (Mail Order)*	No	Yes	
Rehabilitative and Habilitative Services and Devices			
Physical therapy	Yes	Yes	60PT/ST/OT combined per year.
Speech therapy	Yes	No	60PT/ST/OT combined per year.
Occupational therapy	Yes	Yes	60PT/ST/OT combined per year.
Hearing aids	Yes	Yes	1 hearing aid per ear/ per plan year.
Durable medical equipment	Yes	Yes	
Orthopedic**	Yes	No	
Prostheses	Yes	Yes ⁶	
Acupuncture**	Yes	No	
Laboratory Services			
Outpatient laboratory services	Yes	Yes	
Outpatient x-ray services	Yes	Yes	
Complex imaging services	Yes	Yes	



	Federal PPO Basic Plan Coverage?	AZ State EPO Plan Coverage?	Limitations to AZ State Employee EPO Coverage
Preventive and Wellness Services and Chronic Disease Management			
Adult physical exam	Yes	Yes	1 visit per member per plan year.
Adult male screening	Yes	Yes	1 visit per member per plan year.
Adult female screening	Yes	Yes	1 visit per member per plan year.
Well baby	Yes	Yes	
Well child (immunizations)	Yes	Yes	
Family planning office visit	Yes	Yes	
Family planning services	Yes	Yes	Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the plan.
Hearing exam*	No	Yes	One per member per plan year.
Oxygen	Yes	Yes	
Smoking cessation	Yes	Yes	
Pediatric Services, Including Oral and Vision Care			
Pediatric dental	No ^{7,8}	No ⁹	
Pediatric vision	No	No	

*AZ State Employee Plan covers, Federal Employee Plan does not

**Federal Employee Plan covers, AZ State Employee Plan does not

Footnotes:

¹ Orthodontic care for treatment of TMJ excluded.

² Limited to an accident, a trauma, a congenital defect, a developmental defect or a pathology.

³ Covers congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease or surgery.

⁴ Covers medically necessary reconstructive surgery or corrects a congenital defect.

⁵ Though a plan may have a “No” here, it is still compliant with current law which includes an exemption for small groups with 50 or fewer employees.

⁶ Coverage only following a mastectomy.

⁷ Covers restorative services to repair accidental injury.

⁸ Provides for diagnostic and preventative services.

⁹ Covers services for accidental dental injury. Orthognathic treatment/surgery, dental and orthodontic services as deemed medically necessary.

Source: Adapted from: Mercer; “Essential Health Benefits: Arizona Department of Insurance” 2012



Appendix 2: MA State Quality Advisory Committee Recommended Indicators

COMMUNITY HEALTH CENTERS (CHC)

Priority Areas	NQF#	Measure	Data Source(s)	Structure, Process or Outcome Measure			Recommendation Level (S/M)
				Data Already Reported	Mandated		
COMMUNITY & POPULATION HEALTH CHRONIC DISEASE MANAGEMENT	21	(HEDIS) Annual monitoring for patients on persistent medications	MHQP website/Claims & clinical records	P	X	X	S
	577	(HEDIS) Use of spirometry testing in assessment of chronic obstructive pulmonary disease (COPD)	MHQP website/Claims & clinical records	P	X	X	S
		(HEDIS) Cholesterol management for patients with cardiovascular conditions	MHQP website/Claims & clinical records	O	X	X	S
	18	(HEDIS) Controlling high blood pressure	Claims & clinical records	O		X	S
	731	(HEDIS) Comprehensive adult diabetes care	Claims & clinical records	PO		X	S
	36	(HEDIS) Use of appropriate medications for people with asthma	MHQP website/Claims & clinical records	P	X	X	S
	54	(HEDIS) Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	Claims & clinical records	P		X	M
	53	(HEDIS) Osteoporosis management in women who had fracture	Claims & clinical records	P		X	M
	549	(HEDIS) Pharmacotherapy of chronic obstructive pulmonary disease (COPD) exacerbation	Claims & clinical records	P		X	M
	1799	(HEDIS) Medication Management for People with Asthma	Claims & clinical records	P		X	M
	9	(HEDIS) Children with Chronic Conditions	Claims & clinical records	P		X	M
	283	Adult asthma admission rate (PQI 15)	HDD & provider linking	O	X		S
	275	Chronic obstructive pulmonary disease admission rate (PQI 5)	Claims & clinical records	O	X		S
	277	Congestive Heart Failure Admission Rate (PQI 8)	HDD & provider linking	O	X		S
	272	PQI 01: Diabetes Short-Term Complications Admission Rate	HDD & provider linking	O	X		S
		Annual Percentage of Pediatric Asthma Patients with One or More Asthma-Related Emergency Room Visit	HDD & provider linking	O			M



COMMUNITY HEALTH CENTERS (CHC)

Priority Areas	NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure				
			Data Already Reported	Mandated	Recommendation Level (S/M)		
COMMUNITY & POPULATION HEALTH	PEDIATRIC	69 (HEDIS) Appropriate treatment for children with upper respiratory infection	MHQP website/Claims & clinical records	P	X	X	S
		1516 (HEDIS) Well-child visits in the third, fourth, fifth and sixth years of life	MHQP website/Claims & clinical records	P	X	X	S
		2 (HEDIS) Appropriate testing of children with pharyngitis	Claims & clinical records	P		X	S
		108 (HEDIS) Follow-up care for children prescribed ADHD medication	MHQP website/Claims & clinical records	P	X	X	S
		(HEDIS) Adolescent well-care visits	MHQP website/Claims & clinical records	P	X	X	S
		1407 (HEDIS) Childhood immunization status	Claims & clinical records	O		X	M
		1506 (HEDIS) Immunizations for adolescents	Claims & clinical records	O		X	M
		(HEDIS) Lead screening in children	Claims & clinical records	P		X	M
		(HEDIS) Weight assessment and counseling for nutrition and physical activity for children/adolescents	Claims & clinical records	P		X	S
		(HEDIS) Children's and adolescents' access to primary care practitioners		P		X	M
	1959 (HEDIS) Human Papillomavirus Vaccine for Female Adolescents	Claims & clinical records	O		X	M	
	MATERNAL & NEONATAL CARE	1391 (HEDIS) Frequency of ongoing prenatal care	Claims & clinical records	P		X	M
		1517 (HEDIS) Prenatal and postpartum care	Claims & clinical records	P		X	X
		1392 (HEDIS) Well-child visits in the first 15 months of life	MHQP website/Claims & clinical records	P	X	X	M
278 Rate of live birth weighing less than 2,500 grams (PQI 09)		HDD or DPH reporting	O	X	X	M	



COMMUNITY HEALTH CENTERS (CHC)

Priority Areas		NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure	Data Already Reported	Mandated	Recommendation Level (S/M)
COMMUNITY & POPULATION HEALTH	PREVENTIVE HEALTH	31 (HEDIS) Breast cancer screening	MHQP website/Claims & clinical records	P	X	X	S
		34 (HEDIS) Colorectal cancer screening	MHQP website/Claims & clinical records	P	X	X	S
		32 (HEDIS) Cervical cancer screening	MHQP website/Claims & clinical records	P	X	X	S
		1395 (HEDIS) Chlamydia screening in women	MHQP website/Claims & clinical records	P	X	X	S
		(HEDIS) Adult BMI Assessment	Claims & clinical records	P		X	M
		(HEDIS) Adults' access to preventive/ambulatory health services	Claims & clinical records	P		X	M
		40 (HEDIS) Flu shots for older adults	Claims & clinical records	O		X	M
		43 (HEDIS) Pneumonia vaccination status for older adults	Claims & clinical records	O		X	M
		37 (HEDIS) Osteoporosis Testing in Older Women	Claims & clinical records	P		X	M
		39 (HEDIS) Flu Shots for Adults Ages 50-64	Claims & clinical records	O		X	M
		1388 (HEDIS) Annual dental visit	Claims & clinical records	P		X	M
BEHAVIORIAL HEALTH	SUBSTANCE ABUSE	4 (HEDIS) Initiation and engagement of alcohol and other drug dependence treatment	Claims & clinical records	P		X	S
		27 (HEDIS) Medical Assistance With Smoking and Tobacco Use Cessation	Claims & clinical records	P		X	M
		28 Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Claims & clinical records (CPT codes)	P			M
		Unhealthy Alcohol Use: Screening & Brief Counseling	Claims & clinical records (CPT codes)	P			M



COMMUNITY HEALTH CENTERS (CHC)

Priority Areas		NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure	Data Already Reported	Mandated	Recommendation Level (S/M)
BEHAVIORAL HEALTH MENTAL HEALTH & DEVELOPMENT	105	(HEDIS) Antidepressant medication management (doctor follow-up).	MHQP website/Claims & clinical records	P	X	X	S
	576	(HEDIS) Follow-up after hospitalization for mental illness	Claims & clinical records	P	X	X	S
	1879	Adherence to Antipsychotics for Individuals with Schizophrenia	Claims & clinical records (CPT codes)	O	X	X	S
	418	Screening for Clinical Depression	Claims & clinical records (CPT codes)	P	X	X	S
CARE COORDINATION CARE TRANSITIONS	554	(HEDIS) Medication reconciliation post-discharge	Claims & clinical records	P		X	M
	1768	(HEDIS/NCQA) Plan All-Cause Readmission	Claims with provider link	O		X	M
		Ambulatory Care Experiences Survey (ACES) – MHQP Ambulatory Patient Experiences of Care Survey (for Adults and for Children)	Survey	PO	X	X	M
OTHER	58	(HEDIS) Avoidance of antibiotic treatment in adults with acute bronchitis	Claims & clinical records	P		X	S
	52	(HEDIS) Use of imaging studies for low back pain	Claims & clinical records	P		X	S
	22	(HEDIS) Use of high-risk medications in the elderly	Claims & clinical records	P		X	M
	553	(HEDIS) Care for older adults	Claims & clinical records	PO		X	M
	71	(HEDIS) Persistence of beta-blocker treatment after a heart attack	Claims & clinical records	PO		X	M
		(HEDIS) Glaucoma screening in older adults	Claims & clinical records	P		X	M
	35	(HEDIS) Fall Risk Management	Claims & clinical records	P		X	M
	30	(HEDIS) Management of Urinary Incontinence in Older Adults	Claims & clinical records	O		X	M
	29	(HEDIS) Physical Activity in Older Adults	Claims & clinical records	P		X	M
		(HEDIS) Aspirin Use and Discussion	Claims & clinical records	P		X	M
		(HEDIS) Potentially harmful drug-disease interactions in the elderly	Claims & clinical records	P		X	M



HOSPITALS

Priority Areas		NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure	Data Already Reported	Mandated	Recommendation Level (S/M)		
COMMUNITY & POPULATION HEALTH	CHRONIC DISEASE MANAGEMENT	136	HF-1: Discharge instructions – hospital	CMS/Hospital Compare	PO	X	X	S	
		135	HF-2: Evaluation of left ventricular systolic (LVS) function – hospital	CMS/Hospital Compare	PO	X	X	M	
		162	HF-3: angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for leftventricular systolic dysfunction (LVSD) – hospital	CMS/Hospital Compare	PO	X	X	M	
		143	CAC-1: Use of relievers for inpatient asthma	Claims	P			S	
		144	CAC-2: Use of systemic corticosteroids for inpatient asthma	Claims	P			S	
	MATERNAL & NEONATAL CARE	474	PSI 17: Birth Trauma – Injury to Neonate	HDD	O	X		S	
			Rate of Babies Electively Delivered Before Full-Term	Leapfrog	P	X		S	
			PSI 19: Obstetric Trauma – Vaginal Delivery without Instrument	HDD	P	X		M	
	BEHAVIORAL HEALTH	MENTAL HEALTH & DEVELOPMENT	552	HBIPS-4: Patients discharged on multiple antipsychotic medications	Claims & clinical records (CPT codes)	P			M



HOSPITALS

Priority Areas		NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure	Data Already Reported	Mandated	Recommendation Level (S/M)	
CARE COORDINATION	CARE TRANSITIONS	338	CAC-3: Home Management Plan of Care Document Given to Patient/Caregiver	MHQP website/Claims & clinical records	P	X	X	S
		1789	Yale/CMS Hospital-Wide All-Cause Readmission Measure	MHQP website/Claims & clinical records	O	X	X	S
			CCM-3: Timely transmission of transition record	MHQP website/Claims & clinical records	P	X	X	S
	COORDINATION & COMMUNICATION	166/228	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	Survey	PO	X	X	S
			Computerized physician order entry standards	Leapfrog	SP	X		M
		1641	Hospice and Palliative Care — Treatment Preferences	Clinical records	P			M
OTHER		164	AMI-7a: Fibrinolytic therapy received within 30 minutes of hospital arrival — hospital	CMS/Hospital Compare	P	X	X	S
		163	AMI-8a: Primary percutaneous coronary intervention (PCI) received within 90 minutes of hospital arrival — hospital	CMS/Hospital Compare	P	X	X	S
		639	AMI-10: Statin Prescribed at Discharge	CMS/Hospital Compare	P	X	X	S
		300	SCIP-Inf-4: Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose	CMS/Hospital Compare	O	X	X	S
		453	SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero	CMS/Hospital Compare	P	X	X	S
		284	SCIP-Card-2: Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who received a Beta-Blocker During the Perioperative Period	CMS/Hospital Compare	P	X	X	S
		92	AMI-1: Aspirin at arrival — hospital	CMS/Hospital Compare	P	X	X	M
		142	AMI-2: Aspirin prescribed at discharge — hospital	CMS/Hospital Compare	P	X	X	M



HOSPITALS

Priority Areas	NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure				
			Data Already Reported	Mandated	Recommendation Level (S/M)		
OTHER	160	AMI-5: Beta-blocker prescribed at discharge — hospital	CMS/Hospital Compare	P	X	X	M
	148	PN-3b: Blood cultures performed in the emergency department prior to initial antibiotic received in hospital — hospital	CMS/Hospital Compare	P	X	X	M
	147	PN-6: Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients — hospital	CMS/Hospital Compare	P	X	X	M
	527	SCIP-Inf-1a: Prophylactic antibiotic received within one hour prior to surgical incision — overall rate — hospital	CMS/Hospital Compare	P	X	X	M
	528	SCIP-Inf-2a: Prophylactic antibiotic selection for surgical patients — overall rate — hospital	CMS/Hospital Compare	P	X	X	M
	529	SCIP-Inf-3a: Prophylactic antibiotics discontinued within 24 hours after surgery end time — overall rate — hospital	CMS/Hospital Compare	P	X	X	M
	301	SCIP-Inf-6: Surgery patients with appropriate hair removal — hospital	CMS/Hospital Compare	P	X	X	M
	452	SCIP-Inf-10: Surgery Patients with Perioperative Temperature Management	CMS/Hospital Compare	O	X	X	M
	217	SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis ordered	CMS/Hospital Compare	P	X	X	M
	218	SCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	CMS/Hospital Compare	P	X	X	M
		PSI 03: Pressure Ulcer Rate	HDD	O	X		S
	346	PSI 06: Iatrogenic Pneumothorax Rate	HDD	O	X		S
		PSI 07: Central Venous Catheter-Related Blood Stream Infections Rate	HDD	O	X		S
	533	PSI 11: Postoperative Respiratory Failure Rate	HDD	O	X		S
	450	PSI 12: post-operative PE/DVT	HDD	O	X		S
	345	PSI 15: Accidental Puncture or Laceration Rate	HDD	O	X		S
		PSI 08: Postoperative Hip Fracture Rate	HDD	O	X		S



SKILLED NURSING FACILITIES (SNF)

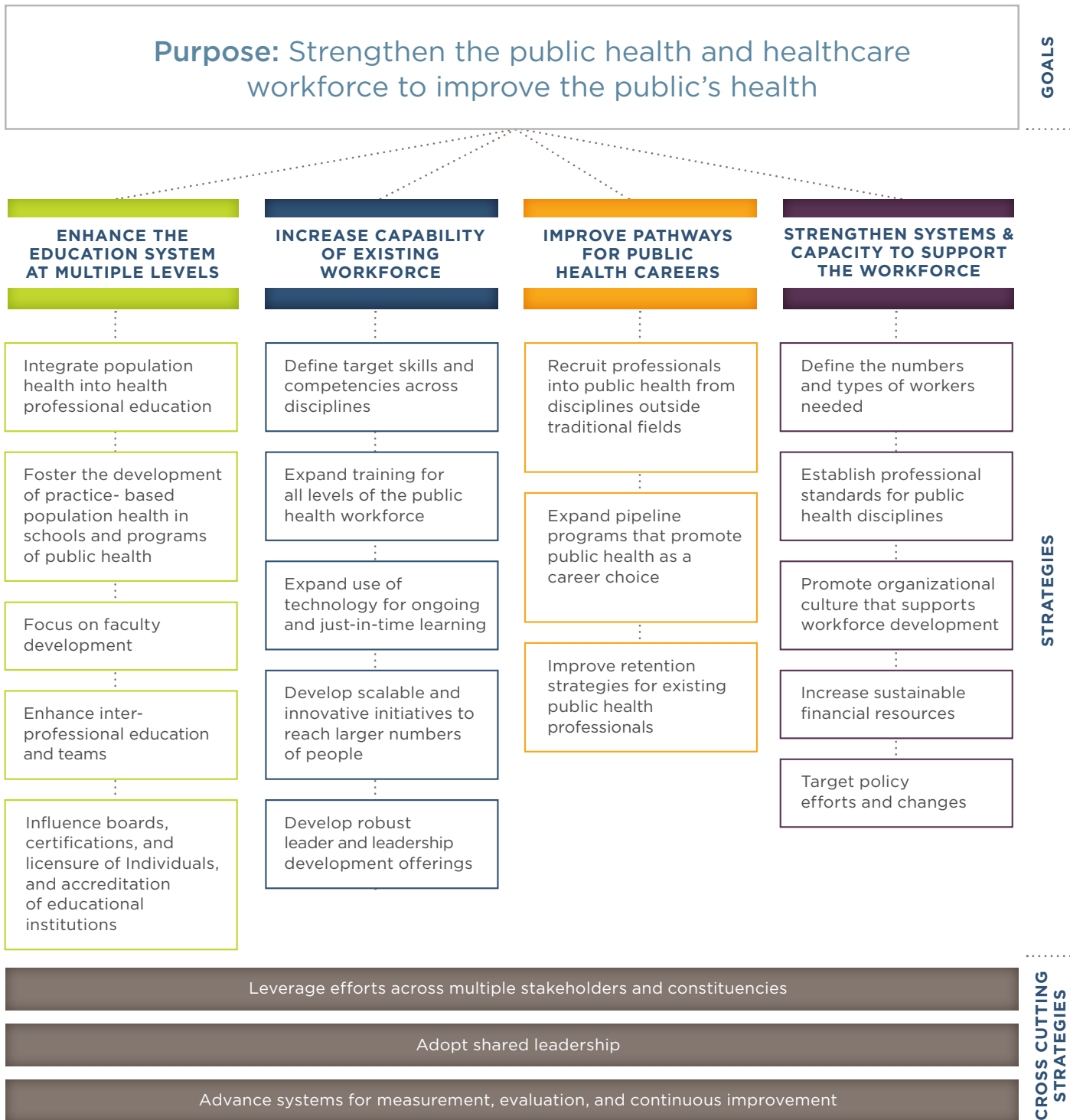
Priority Areas	NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure			Recommendation Level (S/M)	
			Data Already Reported	Mandated			
OTHER	678	Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	CMS	O	X	X	S
	679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	CMS	O	X	X	S
	676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	CMS	O	X	X	S
	677	Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	CMS	O	X	X	S

HOME HEALTH CARE

Priority Areas	NQF# Measure	Data Source(s)	Structure, Process or Outcome Measure			Recommendation Level (S/M)
			Data Already Reported	Mandated		
CARE COORDINATION CARE TRANSITIONS	171	OASIS: Acute care hospitalization (risk-adjusted)	CMS	O	X	S
	173	OASIS: Emergent care (risk adjusted)	CMS	O	X	S
	526	OASIS: Timely Initiation of Care	CMS	P	X	S



Appendix 3: The National Public Health Workforce Strategy Roadmap 2012



Appendix 4: Public Health Workforce Provisions Summary and Funding Status¹

HEALTH WORKFORCE TRAINING

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Public Health Workforce Training	Public Health Workforce Loan Repayment Program (Section 5204)	Creates a new program that provides up to \$35,000 in loan repayment for public health professionals who work for a minimum of three years at a federal, state, local, or tribal public health agency.	FY10: \$195 m FY11-14: SSAN	
	Mid-Career Training Grants (Section 5206)	Creates a new grants program to support scholarships for mid-career public health and allied health professionals working in public health agencies for advanced education.	FY10: \$60 m FY11-14: SSAN	
	Preventive Medicine and Public Health Training Grants (Section 10501(m)(1))	Expands the existing preventive medicine residency program at HRSA to support training to preventive medicine physicians at schools of public health, medicine, hospitals, and state, local, or tribal health departments. The law also expands the Public Health Training Center program at HRSA to support continuing education in core competencies for current public health workers.	FY11: \$43 m FY12-14: SSAN	FY10: Prev Med Res: \$9 m from PPHF; 27 Public Health Training Centers: \$16.8 m (\$15 m from PPHF) FY11: \$29.6 m (\$20 m from PPHF) FY12 PBR: \$25.1 m (\$15 m from PPHF)
	Fellowship Training in Public Health (Section 5314)	Expands the existing health fellowships program to train public health professionals in epidemiology, laboratory science, and informatics, the Epidemic Intelligence Service (EIS), and other training programs that meet public health science workforce needs.	FY10-13: \$39.5 m (\$24.5 m for EIS, \$5 m for each of the other programs)	FY10: \$8 m FY11: \$20 m from PPHF FY12 PBR: \$25 m from PPHF
	U.S. Public Health Sciences Track (Section 5315)	Creates a new public health sciences track at selected schools of medicine, dentistry, nursing, public health, behavioral and mental health, physician assistance, and pharmacy to train health professionals in team-based service, public health, epidemiology, and emergency preparedness and response.	FY10 and onwards: SSAN from Public Health and Social Services Emergency Fund	

HEALTH WORKFORCE TRAINING (CONTINUED)

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Clinical Health Care Provider Training	Public Health National Health Service Corps (Sections 5207, 5508(b), 10501(n), 10503)	Expands the existing National Health Service Corps program, which provides scholarships and loan repayments to primary, dental, and mental and behavioral health care providers who practice in medically underserved areas for a minimum of two years. The law also increased the loan repayment amount from \$35,000 to \$50,000, allowed for part-time service, and allowed for teaching to be counted toward recipients' service requirement.	FY10: \$320 m disc FY11: \$290 m mand/\$414 m FY12: \$295 m mand/\$535 m FY13: \$300 m mand/\$691 m FY14: \$305m mand/\$893 m FY15: \$310 m mand/\$1,154 m	FY10: \$141 m (discretionary) FY11: \$290 m (mandatory); + \$141m (discretionary) FY12: \$295 m (mandatory); PBR: \$124 m (discretionary)
	Title VII Health Professions (Sections 5301, 5303, 5307, 5401, 5402, 5403)	Expands the Title VII programs that support training in primary care, dentistry, physician's assistants, and mental and behavioral health providers (Sections 5301 and 5303) and enhances the Title VII workforce diversity provisions, including Centers of Excellence (Section 5401), Area Health Education Centers (AHECs) (Section 5403), and loan repayment and scholarship initiatives (Section 5402), and improves a program to train providers in cultural competency, prevention, public health, and working with individuals with disabilities (Section 5307).	FY10: \$390 m total	FY10: \$241 m discretionary total for all Title VII Health Professions + \$200 m from PPHF for primary care training FY11: \$241 m FY12 PBR: \$404 m
	Title VIII Nursing Education Programs (Sections 5202, 5208, 5308, 5309, 5310, 5311, 5404 10501(e))	Expands the Title VIII programs that support training and diversity in nursing, including student loan programs (Section 5202), grants and scholarships for undergraduate and graduate nursing education and retention (Sections 5308, 5309), loan repayment for nurse faculty (Section 5310, 5311), a new nurse- managed health clinic program (Section 5208), and a new demonstration program for family nurse practitioner training (Section 10501(e)), and grants to help minority individuals complete associate or advanced degrees in nursing (Section 5404).	\$338 m total	FY10: \$244 m discretionary total for all Title VIII programs + \$30 m from PPHF for nursing education FY11: \$244 m



HEALTH WORKFORCE TRAINING (CONTINUED)

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Clinical Health Care Provider Training	Primary Care Extension Program (Section 5405)	Creates a new program, modeled from the Agricultural Cooperative Extension Service, to provide support and information about preventive medicine, health promotion, chronic disease management, evidence-based therapies, and other health care-related issues to practicing primary care providers.	FY11-12: \$120 m FY13-14: SSAN	FY12 PBR: \$313 m

PUBLIC HEALTH INFRASTRUCTURE

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Public Health Infrastructure	Elimination of Cap on Commissioned Corps (Section 5209)	Eliminates the previous cap of 2,800 for active Regular members of Commissioned Corps members in the U.S. Public Health Service.		
	Establishing a Ready Reserve Corps (Section 5210)	Transfers all of the current members of the U.S. Public Health Service Corps to the Regular Commissioned Corps, and creates a new Ready Reserve Corps consisting of personnel who can assist Regular Corps members in times of emergencies.	FY10-14: \$17.5 m	
	Epidemiology and Laboratory Capacity Grants (Section 4304)	Expands the National All-Hazards Preparedness for Public Health Emergencies program by adding a grant program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.	FY10-13: \$190 m	FY10: \$20 m from PPHF FY11: \$40 m from PPHF FY12 PBR: \$40 m from the PPHF
	Grants to Promote the Community Health Workforce (Section 5313, 10501(c))	Creates a new program for the CDC to award grants to states, local health departments, health clinics, hospitals, or community health centers promote positive health behaviors in underserved communities through the use of community health workers.	FY10-14: SSAN	



PUBLIC HEALTH INFRASTRUCTURE (CONTINUED)

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Public Health Infrastructure	Grants for the construction and operation of School-Based Health Centers (Section 4101)	Creates new grant programs to fund construction and operations of School-Based Health Centers.	Construction: FY10-13: \$50 m mandatory each year Operation: SSAN	FY11: \$50 m FY12 PBR: \$50 m

NEW PUBLIC HEALTH PROGRAMMING

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
New Public Health Programming	Maternal, Infant, and Early Childhood Home Visiting Program (Section 2951)	Creates a new grant program to support states, tribes, and certain nonprofit agencies in funding early childhood home visiting programs, focused on reducing infant and maternal mortality by enhancing prenatal, maternal, and newborn health; child health and development, parenting skills, school readiness, and family economic self-sufficiency.	All mandatory: FY10: \$100 m FY11: \$250 m FY12: \$350 m FY13: \$400 m FY14: \$400 m	\$88 m in mandatory funding released in July 2010
	Community Transformation Grants (Section 4201)	Creates a new program modeled on the Communities Putting Prevention to Work (CPPW) program included in the American Recovery and Reinvestment Act (ARRA) that provides support for evidence-based, community-based activities to promote health and prevent chronic diseases, such as smoking cessation or prevention programs, or enhanced access to nutrition or physical activity.	FY10-14: SSAN	FY11: \$145 m from PPHF (\$100m in grants released May 2011) FY12 PBR: \$221 m from PPHF

HEALTH CARE WORKFORCE ANALYSIS

Category	Provisions	Summary	FY10-FY14 ACA Authorization & Appropriations ¹	FY10-FY14 Funding Status, FY12 President's Budget Request ²
Health Care Workforce Analysis	National Health Care Workforce Commission (Sections 5101, 10501(a))	Creates an independent, 15-member Commission tasked to review health care workforce supply and demand, and make recommendations on national priorities and policies regarding the recruitment, retention, and training of the health care workforce.	SSAN	FY12 PBR: \$3 m
	National Center for Workforce Analysis (Section 5103)	Codifies and expands the existing National Center for Health Care Workforce Analysis at HRSA and establishes State and Regional Centers for Health Workforce Analysis to research and identify workforce gaps and needs. The Center oversees the State Health Care Workforce Development Grants.	FY10-14: \$7.5 m for National Center, \$4.5 m for State and Regional Centers	FY10: \$2.8 m FY11: \$2.8 m FY12 PBR: \$20 m FY10: \$5.75 m from PPHF
	State Health Care Workforce Grants (Section 5102)	Establishes a new competitive grants program to fund workforce planning, development, and implementation activities.	FY10: \$158 m, SSAN for subsequent years	FY12 PBR: \$51 m

¹ Funding is discretionary unless otherwise indicated. m=million, SSAN=such sums as necessary, PPHF=Prevention and Public Health Fund. For more information about the Prevention and Public Health Fund, visit: <http://www.healthcare.gov/news/factsheets/prevention02092011b.html>.

² FY12 PBR= President's Budget Request for Fiscal Year 2012. Note that the President's Budget Request does not guarantee those funds will be appropriated, as final appropriations are made by Congress. For more information about the President's 2012 budget proposal regarding the health workforce, visit: <http://www.hhs.gov/about/hhsbudget.html>.



Appendix 5: Example: How to Prepare for Billing

PREPARING FOR YOUR FLU CLINIC:



