# SUGGESTIONS FOR MOVING FORWARD WITH HEALTH REFORM IN WASHINGTON STATE

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Background

This paper was prepared for the Community Health Network of Washington during the spring of 2012. It is based upon a survey of health care reform initiatives currently underway in Washington and nine other states recommended to the author as leaders in implementing health care reform. The states include California, Connecticut, Illinois, Iowa, Massachusetts, Minnesota, Oregon, Vermont, and Wisconsin.

Due to limits of time and resources, the review was conducted through internet research, and variations in the amount and quality of information provided on-line presented a challenge. Nevertheless, the survey revealed findings that are worthy of consideration as Washington implements the provisions of the Affordable Care Act (ACA). The paper is organized in three sections: Section One provides a brief overview of the major trends that emerged from reviewing the reform initiatives in the nine states; Section Two provides a direct comparison of the major ideas driving reform in those states with the key concepts in the legislation that created Apple Health for Kids; and Section Three provides specific suggestions for moving forward with reform here in Washington. Notes on the key features of reform in each state can be found as appendices.

Section One: General Findings

1. **The states that appear to be making the most progress toward reform have benefited from the work of grassroots organizations pushing for change, enlightened leadership from elected officials and administrators, and the organizational infrastructure required to deliver on the promise of reform.**

   Citizen coalitions backing reform have been active for many years in most of the states that are leading reform. In Oregon, Vermont, Connecticut, Massachusetts and Illinois, these coalitions have spent years engaging diverse segments of the population in conversation about the problems with the present system and potential solutions, and they have provided a framework for civic activism in support of reform, often through sophisticated use of internet tools. Here in Washington, the Health Coalition for Children and Youth (HCCY) helped to design solid reforms and successfully defended them through difficult times, although to date HCCY has focused only on children's health. Like the grassroots coalitions in several other states, HCCY has had strong support from many of Washington's elected officials, who have worked closely with the Coalition to create and defend Apple Health for Kids. Other coalitions, such as "Friends of the Basic Health Plan" and "Healthy Washington" have also been effective advocates, working

closely with legislators to preserve the basic framework of Washington's pioneering Basic Health Plan when the program was threatened with elimination to help balance the State's budget.

Although Washington's coalitions are similar to those in the states that are in the forefront of reform, some of those other coalitions appear to have strengths Washington's coalitions have not yet developed:

- A coherent vision of health care reform that extends beyond Children's Health;
- Support from the state government administrators charged with implementing reform;
- Consistent and transparent communications between government officials, stakeholders and the general public.

**2. The survey indicated that most of the leading states are actively engaging citizens in the design and implementation of health care reform.**

Most of the states surveyed have citizen boards appointed by public officials to guide the development of public coverage programs. These boards are usually separate from those established to run the health exchanges, although it is not clear why they could not also assume that role. The citizen health boards vary in size and composition, from nine members in Oregon to more than 24 in Connecticut. They are generally comprised of a mix of civic leaders, health care providers, business and labor representatives, health care activists, and, in some cases, representatives of faith communities. Their purpose is to represent the public interest and ensure the state's programs are well-designed and effectively operated.

Although Washington now has a functioning Exchange Board and informal advisory groups for various aspects of its health programs, there is no citizen board that has oversight of the development of Washington's health reforms to ensure the programs that are created are coherent, efficient, cost effective, and fully transparent to the public.

**3. The most promising reform efforts are predicated on achieving a "Triple Aim": improving health, expanding access to health care, and controlling costs.**

This description of the goals of reform was virtually identical in Oregon, Minnesota and Connecticut. The description is significant for several reasons. For more than three decades, the debate about health care reform has been polarized between advocates of expanding access for the uninsured and those focused on controlling costs. The Triple Aim reframes the goals of reform to include both these priorities as equally important, and adds a third and even more fundamental goal: *actually improving the health of the population*. This new way of framing the goals creates the basis for a new social contract in which "everyone is covered, everyone pays their fair share, and services are designed to improve the health of every member." [1] Under the

[1] (footnote to be added)

banner of the "Triple Aim," these states appear to be building a durable base of popular support for fundamental changes in the way health care is organized and financed.

4. **The states surveyed had each been pursuing health care reform in their own way prior to the passage of the Affordable Care Act, and their plans to implement the ACA generally build upon the foundations of the programs they had already established.**

   The fundamental goal of the Affordable Care Act is to expand health care coverage so all people (or nearly all) are covered. Massachusetts achieved near-universal coverage through an individual mandate adopted in 2006. Other leading states were working toward that goal incrementally before the passage of the federal law. In many cases, these efforts focused on expanding health coverage for children. However, states such as Illinois, Wisconsin, Vermont and Washington also had established state programs aimed at covering low-income adults who are not eligible for Medicaid. The states used different methods: Some created discreet programs, like Washington's Basic health Plan or Vermont's Catamount Care; others (like Illinois and Wisconsin) chose to expand their children's programs to cover parents or other individuals under the same brand. Prior to the passage of the ACA, Wisconsin and Connecticut appear to have been working toward universal care financed through payroll taxes.[2]

   Assuming the Supreme Court allows the implementation of the ACA to go forward, states will have significantly more federal funding with which to pursue the goal of universal coverage. A critical choice facing the states is whether to use those resources in a patchwork of discreet programs or to create more seamless systems of coverage across a broader spectrum of the population. Some states are clearly embracing the opportunity to use ACA resources to transform their entire systems. Vermont is planning to use the opportunity to establish a single-payer system[3], while Oregon is working to reform the delivery of care through the Oregon Health Plan, with the goal of creating a "public option" that will ultimately be attractive to government employees and others who will be seeking care through the Exchange.[4] The choice facing Washington is whether it will implement health care reform in a patchwork fashion, or re-imagine its programs to create a new whole that is greater than the sum of its parts.

5. **The survey revealed that the leading states believe that expanding access and improving health care delivery hold the key to controlling costs.**

   The advocates of the Oregon Health Plan provide a cogent description of the history of cost-control efforts in that state (and others such as Washington):

[2] (footnote to be added)
[3] (footnote to be added)
[4] (footnote to be added)

*"Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven unsuccessful in reducing the actual cost of care and can squelch investments in health improvement that lead to lower future costs. In the creation of Coordinated Care Organizations (CCOs), HB 3650 lays the foundation for a fourth pathway: Rather than spending less on an inefficient system, change the system for better efficiency, value and health outcomes."*[5]

Most states surveyed see providing health coverage to those that have not had it as the first step in making the health system more efficient because it removes the perverse incentives that drive uninsured people to delay care and/or use emergency rooms, which are the most expensive ways to address their needs. Expanding coverage creates the potential to care for these individuals in more appropriate and less expensive settings, reducing the burden of uncompensated care on safety net providers and the shifting of those costs to other residents.

The evidence from Massachusetts, where the individual mandate has raised the percentage of residents who are covered above 98%, shows that expanding coverage is, in fact, very helpful in controlling costs; but it is not the only step that must be taken. As the peoples of Massachusetts were debating the 2006 reforms, an economist at the Massachusetts Institute of Technology predicted that the costs of expanding coverage to the uninsured could be fully covered by the savings that would be realized in the state's uncompensated care pooling fund, which was expending $1 billion annually to compensate safety net hospitals for the costs of caring for the uninsured. Once the reforms were in place, expenditures from the pooling fund did decline significantly, but the savings were only enough to cover about half the costs of the expansion in coverage. As this report is being drafted, Governor Patrick and both houses of the Massachusetts legislature are working on bills to impose additional controls on health care costs.

Other leading states seem to have learned from Massachusetts and are implementing additional measures to control costs, which they also expect to improve health outcomes. These measures generally fall into the following categories:

a. <u>Coordinating care through medical homes/Coordinated Care Organizations</u>

   The states have different approaches to implementing this concept. Some, like Minnesota and California, are focusing first on developing medical homes for specific populations, such as homeless adults or children with special needs that have high costs and the greatest potential for both savings and improvement in health outcomes. Others, like Oregon, see "patient-centered medical homes" at the heart of "Coordinated

[5] (footnote to be added)

Care Organizations" that will transform health care delivery for the entire population served by the Oregon Health Plan.

b. Improving health information technology

Nearly all of the leading states are helping providers convert to electronic medical records. They see this strategy as a way to improve the coordination of care and gather the data needed to improve care over time.

c. Streamlining eligibility criteria and administrative systems

A Harvard University study in 2003 estimated that the costs of the paperwork involved in the United States health care system in 1999 amounted to $1,059 per year per person. By contrast, the costs of paperwork in the Canadian health care system were estimated to be just $307 per capita. If the costs of paperwork in America's health system were reduced to match Canada's, our nation could save more than $200 billion each year.[6]

In 2011, a study published in the journal Health Affairs reported that the average doctor in the United States spent $61,000 per year more on administrative services related to health insurance than the average physician in Canada. Much of the cost is generated by the complexity and competing incentives inherent in our current system of private health insurance, but the administrative costs in public programs such as Medicaid and SCHIP are also worthy of attention. Washington State has made important strides in streamlining eligibility requirements and other administrative procedures as part of Apple Health for Kids, and those improvements have expanded enrollment, reduced churning, and improved satisfaction levels among parents of the children enrolled. A study by the University of Wisconsin showed that similar results were achieved by streamlining the administrative systems for the BadgerCare Program.[7]

The importance of streamlining administrative processes cannot be overstated. It is one major way to improve provider and patient satisfaction, increase participation, and most importantly, reduce costs. The savings that are realized through streamlining can be used to provide more adequate reimbursement rates for providers and make investments to improve health services. Redesigning administrative systems to be less complex will also make the health care system easier to navigate for those who are newly eligible for coverage and public subsidies.

d. Using the state's purchasing power to help transform the health care delivery system and contain costs

[6] (footnote to be added)
[7] (footnote to be added)

Several of the states surveyed are working to aggregate the various population groups that participate in public coverage programs to create a risk pool that is sufficiently large and diverse to improve the state's bargaining position, share risk more widely, and lower costs. Oregon, Connecticut and Vermont are working on long-range plans to include state employees and certain other groups within the same public risk pool as those in Medicaid, and Vermont is preparing to implement a single-payer system in which most people in the state could participate in the same risk pool.

e. Integrating public health strategies as part of clinical practice

It is clear that the public health movement is having a significant impact on how the states are planning to target the interventions of the health care delivery systems under reform. Many of the leading states are considering changes in reimbursement methods to encourage providers to focus more attention on preventative measures such as smoking cessation and weight control, and the effective management of chronic diseases such as hypertension and diabetes. States such as Connecticut are integrating public health at the highest level of their state governments by including public health officials as members of the health policy boards (or "cabinets") that are implementing health care reform.

## Section Two: A comparison of the major ideas driving reform in other leading states to the key concepts in the legislation that created Washington's Apple Health for Kids

The legislation that created Apple Health incorporated six fundamental ideas:[8]

a. Universal Coverage : The "Cover All Kids" legislation was written to ensure every child living in the state has access to health insurance their families can afford.

b. One Program: The legislation called for blending public funding streams such as Medicaid, the State Children's Health Insurance Program and other sources to create a single, coherent program for all children.

c. Uniform Benefits: The legislation provided all kids with access to the same benefits (essentially the Medicaid benefit package) regardless of their family's income. Families with incomes above 200% contribute a share of the cost on a sliding scale, and families with incomes above 300% were to have the right to "buy in" to the plan by paying the full cost.

d. "Medical Home": Once enrolled, the legislation envisioned that all kids should be connected to a "medical home" to ensure they actually received needed care.

[8] (footnote to be added)

e. A New Brand: The legislature wanted the program to have its own brand, free from the stigma of "welfare."

f. Provider Rates based upon performance: The legislation (and subsequent budget actions) increased provider rates, and linked future increases to performance. The legislation called for standards of performance to be based on the delivery of services that have been proven to improve health.

It is important to note that several of these concepts have not been fully implemented, and Apple Health for Kids has not yet reached its true potential. Yet, since its inception, the percentage of the state's children and youth with health coverage has increased significantly, churning among coverage programs has diminished, support among the public and in the legislature has grown, and the state has been able to secure tens of millions of dollars in performance bonuses from the federal government as a result of the program's success.

The key concepts that provide the framework for Apple Health are found to varying degrees in the broader health reform initiatives underway in other leading states:

a. Universal Coverage

Expanding health care coverage to all (or nearly all) residents of the United States is the central purpose of the Affordable Care Act. The ACA envisions reaching this goal through an amalgam of employer-based coverage, public programs, and subsidies for individuals to purchase coverage in the private market through health "exchanges." The complexity created by this patchwork approach to coverage is a major challenge to those charged with implementing the ACA in each of the states surveyed. For example, in the majority of those states, there does not appear to be a clear connection between the health insurance exchanges and other aspects of their strategies to increase coverage. Several states appear to be struggling to weave together the various elements of the ACA with their own programs to create a coherent system. Absent that coherence, there is a danger that the resulting patchwork of coverage programs will be so complicated that it will be difficult for the newly eligible populations to navigate, and both burdensome and costly for the states to administer.

b. One Program

The success of Apple Health for Kids in combining multiple funding streams in a single, coherent program provides an important model. Surprisingly, only a few other states have managed to implement that model to date, although several were moving in that direction as the ACA was passed by Congress.The challenge is to find a way to combine the various ingredients contained in the ACA with the state's existing programs to create a seamless approach to coverage for the full spectrum of the eligible population. Apple Health for Kids comes close to achieving that goal for children and pregnant women by

using Medicaid, SCHIP, and state general funds for children who are not eligible for federal programs, along with the premium contributions from families with incomes between 200% and 300% of the federal poverty level (FPL). The "buy-in" provisions contained in the legislation were intended to make the program available to children in families with incomes above 300% of FPL who are willing to pay the full cost, effectively creating a "public option" for children's health coverage.

If Washington State were to decide to apply this same approach to the adult population, the ACA will provide many of the necessary ingredients when it takes full effect in 2014:

- Medicaid will provide coverage for citizens and legal immigrants up to 133% of FPL.
- The Federal Basic Health Option could provide coverage for those making between 133% and 200% of FPL; and
- The exchange could make affordable options available to those with incomes above 200%.

c. Uniform Benefits

There can be no question that the myriad benefit packages available in the private insurance market allows consumers to make choices between the breadth of coverage and the cost of the benefit package. It is also clear that the differences in benefits, and in required co-pays and deductibles, add substantial confusion for consumers and substantial administrative costs for the health care system.[9] It may also be the case that the array of benefit packages that are available complicates the task of providing the most effective health services for patients, since some services that have been proven to be effective may not be covered, while others with less evidence of benefit, are. It is interesting to note that in Illinois the problem of inadequate coverage was judged to be so severe that the state's public programs are being used as a backstop to cover the costs of services the state believes to be valuable that some private insurance plans do not cover.[10]

In Washington State, the benefit package for the state's Basic Health Plan has been less comprehensive than Medicaid. If the state were to move toward a seamless system of coverage for the full spectrum of its residents, it will need to resolve these differences with a uniform benefits package that incorporates the best evidence-based practices.

[9] (footnote to be added)
[10] (footnote to be added)

d. Medical Homes

Nearly all of the states surveyed have incorporated the concept of linking families and individuals to a "medical home" as part of their plans for health reform. The states seem to have different interpretations of what constitutes a medical home, and there are major differences in the roles they intend to assign to medical homes during the early stages of reform. Minnesota and California have secured Medicaid waivers to test the use of medical homes to manage the care of special needs (and high cost) populations, such as homeless adults with multiple health problems (Minnesota) and children with special needs (California). The Minnesota experiment is interesting because it combines medical care, behavioral health services and some social services in a single capitation rate. California's program tests the performance of four different types of medical homes ranging from primary care clinics to specialty care centers.

Oregon has by far the most ambitious plan, with "patient-centered medical care homes" serving as the nucleus of the "Coordinated Care Organizations" (CCOs) that are the cornerstone of their plan to transform the health care delivery system. The CCOs are local networks of providers, governed by community boards, that integrate medical, dental, and behavioral health care services for members of the Oregon Health Plan. Each CCO will operate within a "global budget" that blends all (or nearly all) public funding streams to provide care for its members. A detailed implementation plan for this system was submitted to the federal government in January 2012,[11] and on May 4th the federal government reached an agreement that could provide Oregon with up to$1.9 billion to implement the plan during the next five years, assuming the State meets certain benchmarks. Eventually, Governor Kitzhaber wants to expand the Oregon Health Plan to cover state workers and be available to the general public.[12]

e. A New Brand

Each state surveyed has chosen a new brand other than "Medicaid" for the program(s) it has created to expand health coverage. Here are some examples:

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|---|---|
| Connecticut | SustiCare |
| Illinois | All Kids, Family Care |
| Iowa | Hawk-i Health |
| Oregon | Oregon Health Plan |
| Vermont | Green Mountain Care, Catamount Health |
| Wisconsin | BadgerCare, BadgerCare Plus |
| Washington | Apple Health for Kids, Washington Basic Health Plan |

[11] (footnote to be added)
[12] (footnote to be added)

These brands seem to have given the programs a fresh identity that does not carry the stigma that, rightly or wrongly, many people associate with Medicaid. As Washington expands coverage through the ACA, it will be important to consider the name that will be used to market the program.

f. Fair Provider Rates Based Upon Performance

Providing payment rates that are adequate to support a high quality network of providers in all areas of the state has been a serious challenge in every state surveyed. As the leaders of the Oregon Health Plan have stated, when budgets are tight, legislators have historically employed three strategies to cut costs. They have: 1) reduced eligibility; 2) reduced the range of services covered; and 3) reduced provider rates. All of these strategies have proven to be counterproductive in terms of improving health outcomes.

When the legislature created Apple Health, it also increased provider rates and introduced the concept of predicating future rate increases on performance. The measures of performance were to be based on the extent to which practices that have been proven to improve health were incorporated in the care of patients (for example, the percentage of patients in the practice who are up to date on their immunizations). However, in the face of budget pressures created by the recession, the legislature again reduced provider rates, and work on the new concept of reimbursement was suspended.

Other states that are perceived to be leaders in reform have faced similar problems. In Massachusetts, rate increases promised as part of the state health care reforms of 2006 were never delivered. Other states have not been able to contemplate rate increases at all in the context of massive budget deficits. Nevertheless, several of the states surveyed are moving to implement the basic concept that was envisioned in the Apple Health Legislation. Vermont described this as "shifting from 'volume-based' reimbursement to 'value-based' reimbursement."

Once again, Oregon appears to be in the vanguard when it comes to actually implementing this concept. The implementation plan the state submitted to the federal government contains a fairly detailed description of how the concept will be implemented. It lays out five principles, along with specific examples of how the concept could be used, but gives the Coordinated Care Organizations considerable flexibility in designing the reimbursement arrangements they will use.

## Section Three: A Proposal for implementing the Affordable Care Act in Washington State

This vision for health care reform is derived from a survey of states that are in the vanguard of implementing health care reform, and from Washington State's own history of innovation in health care. It is based upon the following principles:

1. Washington's health policies and programs should be designed to achieve the "Triple Aim":

    - Expand access to health care services to all residents of the state;
    - Control the costs of care
    - Improve the health of the people of Washington.

2. The State should actively engage the public in planning its approach to reform and be fully transparent in its decision-making.

3. Our state's plan for reform should build upon the success of Apple Health for Kids and the Washington Basic Health Plan.

4. Every family and individual should have an opportunity to choose a "medical home" that has the capacity to coordinate a comprehensive spectrum of health care services.

5. Administration of the State's health care programs must be streamlined to reduce the costs of paperwork .

6. Public health, medical and dental services, behavioral health, school health and related services should be coordinated at the community level to create coherent local health systems that are focused on improving health in the way that will be most effective in that community.

7. Payment mechanisms should shift from "volume-based reimbursement" to "value based reimbursement" that is focused on the goal of improving health and provides fair compensation to all members of the health care team.

8. Our state's approach to reform must address disparities in health through the provision of services that reduce linguistic, economic and social barriers to care and honor the value of culture in promoting health.

In keeping with these principles, we suggest that Washington State implement the Affordable Care Act through the creation of **a single coherent health program** to serve the full spectrum of those who will benefit from the expansions in public coverage made possible through the provisions of the ACA, as well as those who are currently enrolled in State programs such as Apple Health for Kids, Medicaid, and the Basic Health Plan. We suggest the program be named **"Apple Health for Washington"** to take advantage of the name recognition and public support the state has earned through the success of Apple Health for Kids.

Apple Health for Washington would have these characteristics:

1. **Coverage opportunities for the full-spectrum of the population**. Like Apple Health for Kids, the program would be designed to cover all eligible individuals in a seamless program with a single brand. The various federal funding streams intended to cover different population groups

should be accounted for appropriately behind the scenes, as they currently are with Apple Health for Kids, but the public should perceive Apple Health as a seamless program that is easy to understand and to use. Members of Apple Health should not be faced with the prospect of losing their coverage when there are minor changes in their circumstances.

2. **A single benefit package.** The benefit package for all members of Apple Health for Washington should be the same, just as it is for Apple Health for Kids. To the extent that legal requirements or cost concerns militate against uniform benefits, we urge that those concerns be subjected to tough scrutiny, because the administrative costs associated with managing variations in benefit packages are substantial, and the benefits of having a relatively comprehensive package of benefits are significant. The State should seek federal waivers if necessary to achieve this goal.

3. **A simple sliding scale**. Apple Health for Kids currently provides care free of charge for children in families with incomes up to 200% of the federal poverty level. Families with incomes between 200-300% pay premiums for each child according to a sliding scale, with a cap on premiums for large families. The "Cover All Kids" law also included a provision that would enable families with incomes above 300% to "buy-in" to the program by paying the full cost of the program, but the State has yet to implement that provision of the law. Since the federal government has been more generous with children's coverage than for adults (and the ACA continues that preference), the sliding scale for adults participating in Apple Health will be different than for children, but it need not be much more complex. Under the provisions of the ACA, those with incomes under 133% of the federal poverty level will be covered by Medicaid funds, so their care in Apple Health for Washington would be free. Those with incomes between 133% and 200% will become eligible for federal subsidies, which presumably will be based upon a sliding scale. Therefore, the premiums for Apple Health coverage for adults who are eligible for subsidies would simply reflect the State's full cost for the coverage, less the federal subsidy. Those with incomes above 200% of FPL should be afforded the right to participate in Apple Health for Washington by "buying in" at full cost through the Exchange. This will enlarge the risk pool, and enable individuals and small businesses to take advantage of the State's purchasing power.

4. **Connections to medical homes**. Apple Health for Washington can only achieve the "triple aim" if each member has a "medical home" where a team of health care providers feels a direct responsibility for coordinating all aspects of that member's health care. Each medical home should be an integral part of a complete network of providers that has the capacity to provide the full spectrum of services. Apple Health should be designed to strengthen the "medical home" concept by retooling reimbursement systems to provide greater flexibility to tailor services to the patient's needs. One strategy to achieve this objective would be to provide a "global budget" for patient care that combines funding streams that have heretofore been segregated in separate categorical programs. (For example, if the State were to combine funding streams for medical and dental care, behavioral health, substance abuse treatment, and categorical programs such as WIC, family planning, and other essential services, it should be possible to provide medical home providers with the resources and flexibility to do a better job of meeting the varied needs of their patients within a fixed budget.

5. **Coordinated Care Organizations**. In most cases, medical homes will not be sufficiently large to act as stand-alone providers of all specialty services that may be required by their patients, or to assume financial risk for the costs of caring for their patients. These needs can only be met

through the development and maintenance of Coordinated Care Organizations (CCOs) that create coherent systems of primary care, specialty care and hospital services and share financial risk among providers. CCOs can be organized by existing health insurance plans, or by new co-operative agreements among providers who are willing to share risk. To qualify to participate in Apple Health, prospective CCOs should:

- Offer a network of providers with the capability to provide a full range of services to the population it proposes to serve.
- Have a track record of success in caring for members of State health programs in a manner that has produced member satisfaction and high quality care.
- Invite broad participation by health care providers, patients, and community representatives in governing the CCO and designing the services it provides.
- Have a demonstrated commitment to reducing health disparities among communities.
- Have sufficient financial strength to assume risk for the population it proposes to serve.
- Have a commitment to containing costs through evidence based practice.
- Have strong ties to other community services, such as housing, employment, social services and schools to enable the organization to tap those resources for the benefit of those it serves.

6. **Pay for performance**. The payment structures for Apple Health should be designed to reward performance, and the measures of performance should reflect the latest evidence to guide clinical practice toward the improvement of health status. Ideally, this would change the reimbursement system from rewarding "quantity" to rewarding "quality." The system we envision would combine a transition to "global budgeting" with performance bonuses for CCOs and medical homes that achieve goals such as: improvement in immunization rates; clinical management of hypertension and diabetes; and/or reductions in inappropriate use of emergency rooms.

7. **Community participation in governance.** The development and future operations of Apple Health for Washington should be guided by a citizen Board appointed by the Governor and Legislature that is comprised of citizens with expertise in health care delivery, public health, economics, and other disciplines that are essential to the quality of the program. The appointees to the Board should have a demonstrated commitment to achieving the "triple aim" and an understanding of the factors which have resulted in the health disparities among communities within our state. The current members of the Exchange Board represent a cross-section of the State's population, and provide an example of the type of Board that needs to be assembled to guide the development of Apple Health.

8. **Administrative leadership and clarity.** Apple Health for Washington will need the type of inspired leadership that is apparent in Oregon and several of the other leading states. Washington's elected officials have provided that kind of leadership in creating and defending Apple Health for Kids. That leadership in policy-making must now be matched by creative administration and management. The Board of Apple Health must name a director who believes in the vision and has the necessary skills to implement all of its provisions. The Board must also work with the State Insurance Commissioner, Department of Health, and Department of Social and Health Services to clarify how each of those agencies will contribute to the success of Apple Health for Washington.

# APPENDICES

## WHAT CAN WE LEARN FROM CALIFORNIA?

(www.healthcare.ca.gov)

Citizen Energy and Organizational Infrastructure

n/a

Strategies to Improve Access and Health Outcomes

- California secured a Medicaid Waiver in November 2010 to implement a 5-year, $10 billion "Bridge to Reform."
- The "Bridge" has 4 components:
    1. Expands coverage to more uninsured adults
        a. "Newly eligibles" 19-64 years with incomes up to 133% of FPL.
        b. Adults with incomes between 134-200% of FPL who will be eligible for subsidies through the "exchange" in 2014
    2. Supports safety net hospitals' uncompensated care costs. (Note: California has an existing "Safety Net Care Pool Fund").
    3. Improves care coordination for Vulnerable Populations
        a. Mandatory enrollment of seniors and persons with disabilities in managed care
        b. Tests four models of care for children with special health care needs.
            i. Primary care case management
            ii. Accountable care organizations
            iii. Specialty health care plan
            iv. Medicaid Managed Care Health Plan
    4. Promotes Public Hospital Delivery System Transformation
        a. Infrastructure development (technology and human resources)
        b. Innovation and redesign (e.g., medical homes)
        c. Population-focused improvements for the 5-10 highest burden conditions based on cost

d. Urgent improvement in care – dissemination of best practices for California public hospitals.

- California has “Healthy Families” program (SCHIP) for low-income kids not eligible for Medicaid. Open only to US citizens and qualified immigrants – has premiums and co-pays.

# WHAT CAN WE LEARN FROM CONNECTICUT?

(www.healthreform.ct.gov/ohri/)

Citizen Energy and Organizational Infrastructure

- The Universal Health Care Foundation of Connecticut has been a catalyst for reform. Since 2003 it has been headed up by a former legislator.
- State has an "Office of health Reform and Innovation" in Lt. Governor's Office charged with coordination agencies of state government including Medicaid and the Exchange.
- Health Care Cabinet, chaired by the Lieutenant Governor, includes:
  - 2 health care industry reps
  - 1 community health center rep
  - 1 insurance producer
  - 1 member at large (appointed by the Governor)
  - 1 dentist
  - 1 labor rep
  - 1 Registered Nurse
  - 1 consumer advocate
  - 1 primary care physician
  - 1 health information tech expert (appointed by legislative leaders)
  - 1 home health rep
  - 1 small business rep
  - 1 hospital rep
  - 1 faith community rep
  - 1 member at large (appointed by SustiNet Health Partnership)
  - 1 health care advocate
  - Commissioner of Public Health
  - Comptroller
  - Special advisor to the Governor on health care reform
  - Commission of Social Services
  - Secretary of Policy and Management (ex-officio voting members)
  - Commissioner of Mental Health and Addiction Services
  - Commissioner of Children and Families
  - Commissioner of Developmental Services
  - Commissioner of Insurance
  - Non-profit Liaison to the Governor
- The Health Insurance Exchange is a quasi-public entity governed by a 14-member board chaired by the Lt. Governor with some overlap in membership with the Cabinet.

Strategies to Improve Access and Health Outcomes

- State is focused on the "Triple Aim" – promoting health, improving access and reducing costs.
- The advocates convened the SustiNet Health Partnership, which secured passage in 2009 of a law designed to create a public health coverage plan emphasizing preventive care and management of chronic illnesses.
- SustiNet was designed to create a large insurance pool by combining state employees, retirees and people covered by state assistance programs. It would be open to members of the public without adequate health coverage, and employers, starting with small businesses, non-profits, and municipalities.
- The Board of SustiNet appointed working groups to focus on:
    - Medical homes
    - Clinical care and safety guidelines
    - Preventive care and improved outcomes
    - Health care workforce issues
- The SustiNet Plan has had broad public support including the Connecticut Association of Realtors and "small businesses for healthcare reform," as well as the faith community.
- Since passage of the ACA, the SustiNet Board appears to have shifted its focus to implementing the federal reforms in a manner that is consistent with the original vision for SustiNet.

# WHAT CAN WE LEARN FROM ILLINOIS?

Citizen Energy and Organizational Infrastructure

- "Campaign for Better Health Care" is statewide coalition working for reform (www.cbhconline.org)
- The organization has created a sophisticated website that provides information on most aspects of reform. It also provides tools for taking action to advocate for reform.
- The coalition includes a "Faith Caucus" with its own vision statement about the morality of reform.
- The coalition's Board is comprised of progressive health care groups, academics, faith community, labor, disabled citizens.
- The coalition is funded by foundations, including the Robert Wood Johnson Foundation.
- ACA implementation is guided by the Illinois Health Care Reform Implementation Panel.
- IllinoisHealthMatters.org is an active blog on reform

Strategies to Improve Access and Health Outcomes

- Illinois "All Kids" program currently provides coverage for 1.6 million children. It features on-line application and premium payment, covers kids regardless of immigration status; sliding scale for kids up to 300% of FPL; provides back-up insurance coverage for kids who have insurance parent's employer.
- "Family Care" offers coverage to parents of children enrolled in All Kids (www.familycareillinois.com) up to 200% of FPL with premiums on a sliding scale. Family Care Rebates provide subsidies for employer-provided coverage.
- Health.Illinois.gov provides an online portal that enables citizens to determine what coverage they qualify for.
- The State has created a Health Information Exchange Authority to create secure exchange of health information among providers.

Strategies to Control Costs

- Illinois is facing severe cuts in its Medicaid program ($2.7 billion over one year (IllinoisHealthMatters.blogspot.cm)
- Advocates are proposing "expanding coordinated care" as a way to save dollars instead of making the cuts proposed.

# WHAT CAN WE LEARN FROM IOWA?

(www.idph.state.ia.us)(www.hawk-i.org)

Citizen Energy and Organizational Infrastructure

- Program is guided by a citizen board appointed by the Governor. Agendas and minutes ore on-line.

Strategies to Improve Access and Health Outcomes

- Iowa's health programs for children were ranked first in the US in 2011.
- State's hawk-i program provides health coverage for children in working families with no family paying more than $40 per month. The program is separate from Medicaid.
- A grassroots outreach network covers the entire state.
- All school districts are required to report the names of parents of children who are eligible for free and reduced lunch via excel spreadsheets.

Strategies to Control Costs

n/a

# WHAT CAN WE LEARN FROM MASSACHUSETTS?

(www.en.wikipedia.org; http://macommonwealthcare.com)

Citizen Energy and Organizational Infrastructure

- Reforms were advanced by a citizen coalition called Affordable Care Today (ACT) that collected 75,000 signatures for a ballot proposal.
- A 2006 law created an independent public authority (Commonwealth Health Insurance Connector Authority).
- Statute also established "Health Care Quality and Cost Council" and a "Disparities Council"
- Massachusetts Health Care Reform Coalition has been formed to support implementation. Its membership resembles Washington's Health Coalition for Children and Youth, but also includes Business Groups like the Boston Chamber of Commerce.

Strategies to Improve Access and Health Outcomes

- Passage of the federal Emergency Medical Treatment and Active Labor Act required hospitals to treat emergency treatment without regard to ability to pay.
- Costs of uncompensated care led to creation of a $1 billion Uncompensated Care Pool from insurance plans, and providers.
- 2006 law established an individual mandate to obtain state regulated level of health insurance coverage and provides free health care coverage for residents earning less than 150% of federal poverty level (FPL).
- Original bill had a fee for employers that do not provide coverage (like Vermont). Romney vetoed that provision as well as dental care and coverage for some immigrants, but the legislature overrode his eight vetoes.
- Tax penalties for residents who fail to enroll are pegged to 50% of costs of lowest cost plan.
- Legislation has provisions for employer "fair share contributions" and "free-rider surcharges."
- Coverage for low-income folks not eligible for Medicaid (MassHealth) is provided by Commonwealth Care. Folks up to 150% have no premiums; 150-300" based on sliding scale. There are no deductibles.
- Coverage is provided through four non-profit plans and one out-of-state for-profit plan.
- The number of uninsured dropped from 6% in 2006 to 2% of the state's population in 2010.
- Massachusetts is nearing universal coverage (above 98%) but rising costs continue to be a challenge.

Strategies to Control Costs

- MIT professor predicted the reform law costs would be covered by the "free care pool funds"
- Study following enactment did not show enough decline in emergency room utilization and costs to fully cover costs of reform. Five hundred million dollars per year must come from other sources.
- Expenditures from the Health Safety Net Pooling Fund dropped 38-40% as more people were insured, but still exceeded available funds by $38 million.
- Enrollment in Commonwealth Care has exceeded projections by more than 50% and this increase, combined with continuing increases in the costs of health care services, has required additional funding.
- Since passing reform, Massachusetts has gone from 1st to 9th in the cost of health insurance premiums for the average family.
- The reform statute provided for provider rate increases but that has not happened.
- 2012 amendments expected to introduce price controls. Governor Patrick and both houses of the legislature have proposed bills aimed at holding the cost of health care below the growth in the Gross State Product.

# WHAT CAN WE LEARN FROM MINNESOTA?

(www.mn.gov/health-reform/)

Citizen Energy and Organizational Infrastructure

- Community meetings sponsored by Mayo Clinic, foundations, etc., laid the groundwork for reforms
- Governor's Executive Order established Task Force on Health Care Reform (see appendix for composition)

Strategies to Improve Access and Health Outcomes

- Reforms are based on the Triple Aim: "better care, lower costs, better health."
- State reforms were passed in 2008. The state is now seeking to integrate state reforms with the provisions of the Affordable Care Act.
- The state places a heavy focus on public health measures.
- Accountable Care Organization (ACO) demonstration project in Hennepin County (Hennepin Health) is aimed at integrating medical care, behavioral health, social services and other county services such as food supports under a single capitation rate.
- "Hennepin Health" operates in four counties and is governed by a board with four county commissioners, 2 Health Plan board members, and MDs.
- "Hennepin Health" is aimed at 10,000 adults without children with incomes under 75% FPL who qualify for Medical assistance (sounds like Disability lifeline).

Strategies for Controlling Costs

- "Hennepin Health" is intended to reduce costs through better care management of a population with multiple needs, who are frequent users of health and social services.

# WHAT CAN WE LEARN FROM OREGON?

(www.oregon.gov/OHA/)

Citizen Energy and Organizational Infrastructure

- Reform is led by Governor Kitzhaber with strong support from staff and Oregon Health Authority (OHA) and bipartisan support in the legislature.
- The Oregon Health Authority (OHA) has strong, innovative leader and policy is guided by a citizen board.
- Reforms are focused primarily on developing the Oregon Health Plan which covers the Medicaid population and other low-income group

Strategies to Improve Access and Health Outcomes

- Oregon's reforms focus on the "Triple Aim": Improve health, improve health care, lower costs
- The cornerstone of reform is the Coordinated Care Organization (CCO)
  - Comprised of local networks of providers
  - Focused on "patient-centered health care homes"
  - Governed by those at financial risk, providers, local patient/citizen reps
- CCOs are intended to integrate services including medical, behavioral, and dental care.
- Global budgets for CCOs include all (or nearly all) public funding streams
- The reform plan encourages conversion from "pay for quantity" to "pay for quality" – performance-based provider payments.
- The CCOs will emphasize chronic condition management (obesity, smoking, behavioral health, etc.) and reduction of disparities among ethnic groups.
- The plan envisions increased use of community health workers, peer counselors and patient navigators.
- A detailed implementation plan was published on January 24, 2012.
- Feds announced award of $1.9 billion for implementation on May 4, 2012
- Governor wants to expand Oregon Health Plan over time to cover state workers and the public.

Strategies to Control Costs

- Theory at work in Oregon: Streamlining the system and cutting the paperwork are the keys to:
  - Public comprehension
  - Political support
  - Organizational coherence
  - Cost savings
  - Better outcomes
- Implications for Washington:
  - 2007/2008 Apple Health Legislation contains many of the same ideas.
  - It's conceivable Washington's "Heath Care Homes" could become "Coordinated Care Organizations"

- Washington seems way behind in global budgeting.
- Appears Washington may be moving in the opposite direction with recent RFP for Apple Health contracts.
- Leadership and governance structures must be strengthened.
- More transparency will be needed.

# WHAT CAN WE LEARN FROM VERMONT?

(www.hcr.vermont.gov)

Citizen Energy and Organizational Infrastructure

- Vermont is a small state where progressive politicians (such as former Governor Howard Dean) have led civic conversations that have created bipartisan support for health reform.
- Vision of reforms for entire system not just Medicaid and those using the Exchange
- Vermont's reforms are based on the principle that "everyone is covered, and everybody pays." Individuals and families pay on a sliding scale based on income. Employers pay a heath care contribution based upon the number of uninsured employees. $365/year increased annually to match increase in Catamount premium growth (small number of employees exempted, number of exempt employees declines in phases)

Strategies to Improve Access and Health Outcomes

- Vermont is using the Exchange to transition to a single payer system like a "public utility" called Green Mountain Care
- Vermont currently has a "family of plans" to address various needs accessible through "Green Mountain Care" website.
  - Long-term care (Medicaid)
  - Pharmacy assistance (4 programs)
  - Employer-sponsored insurance (Premium Assistance)
  - Catamount Health (similar to BHP) for those 18 and above
  - Vermont Health Access Plan (similar to Catamount)
  - Dr. Dynasaur (similar to Apple Health for pregnant women and children under 18)
  - Medicaid
- Vermont received a Medicaid Waiver in 2005 to de-categorize most Medicaid programs to reduce number of uninsured. The State converted the State Medicaid Office into Public Managed Care Organization. The waiver allows federal dollars to be invested in Catamount health and employer care subsidies for families (households) below 200% FPL. State funds are used to support households between 200-300%.
- Vermont's roadmap to implement Green Mountain Care is described in "An act relating to a universal and unified health system" VT LEG 270379.1 The 141-page bill deals with every aspect of the transformation in general terms:
  - It uses the Exchange as a critical element of the transformation
  - It vests the development of GMC with a five-member Board appointed by the Governor and confirmed by the Senate
  - It fixes responsibility for the various aspects of the transformation and management of GMC with specific agencies
  - It envisions the inclusion of Medicare

- It contains provisions that address workforce issues, including shortages of primary care providers and specialists, and the re-training of employees who are displaced from their jobs by administrative simplification.

Strategies to Control Costs

- Eliminate (reduce) cost shift
- Promote wellness and prevention
- Improve chronic care
- Improve health information technology
- Provide transparent price and quality information
- Streamline administration
- Revenue sources:
  - Employer contributions
  - Tobacco taxes
  - Medicaid
  - Federal demonstration dollars
- Shift reimbursement from “volume-based” to “value-based.”

# WHAT CAN WE LEARN FROM WISCONSIN?

(www.dhs.wisconsin.gov)

Citizen Energy and Organizational Infrastructure

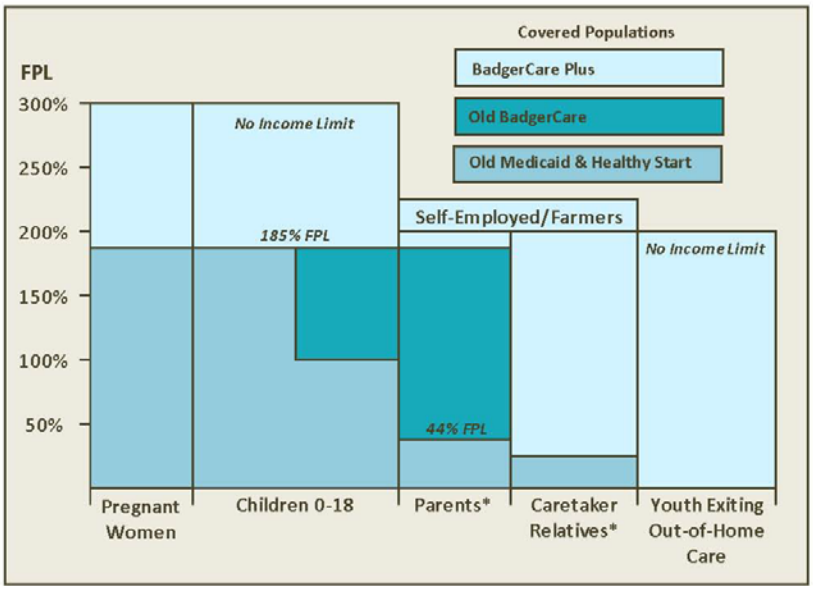
- Wisconsin began in 1999 to experiment with strategies to unify and streamline public coverage programs and extend coverage beyond children and pregnant women. (This began under a moderate Republican Governor.)
- The combined program was initially branded as "Badger Care," and has since been expanded as "Badger Care Plus."

Strategies to Improve Access and Health Outcomes

- In 2008 and 2009, Democrats sought to pass the "Healthy Wisconsin" plan to extend the Badger Care Plus program as a "public option" that would "provide every resident with the same affordable, high-quality, comprehensive coverage that state legislators receive." Financing was to be accomplished through payroll taxes. (www.familiesusa.org/assets/pdfs/healthy-wisconsin.pdf)
- These initiatives are described in greater detail below:

The state of Wisconsin proposed a multi-phase path toward its goal of providing access to coverage for 98% of Wisconsin residents. The first phase—the focus of this brief—expands coverage for children and caretaker adults. The second phase, implemented in June 2009, extends a Core Benefit plan opportunity for low-income childless adults. Figure 1 illustrates the income eligibility expansions implemented in Phase I.

**Figure 1. BadgerCare Plus Population: Phase I**




*Parents/Caretakers must pay monthly premiums on a sliding scale starting at 150% FPL.

Program simplification is the bedrock of the BadgerCare Plus program. Wisconsin, like other states, previously had a complicated patchwork of eligibility rules and laws that had become expensive to administer and difficult to navigate. This complexity often discouraged qualified families from applying for or enrolling in Medicaid and other public health benefit programs. Those enrolled in BadgerCare, Medicaid, or Healthy Start faced onerous requirements for reporting, verification, and re-certification of income, employment, insurance access, and citizenship status. These requirements, along with variations in the criteria governing eligibility for each program, appeared to result in unnecessary exiting and churning. (1)

The new BadgerCare Plus program is branded as a single program with two insurance products: the Standard Plan, for enrollees < 200% FPL., and the Benchmark Plan for enrollees >200% FPL. Program eligibility rules pertaining to the calculation of income, income disregards, and insurance access are consistent for all applicants and are notably simpler. Application, reporting, and verification processes have also been streamlined.

## HEALTHY WISCONSIN IN BRIEF

Healthy Wisconsin builds on Governor Doyle's BadgerCare Plus plan, an expansion of both Medicaid and BadgerCare that is also included in the Biennial Budget Bill. If Healthy Wisconsin is enacted, it will provide every resident with the same affordable, high-quality, comprehensive coverage that state legislators receive. Care will be provided through either a statewide fee-for-service plan or through a "Health Care Network" that contracts with a new governing body—the Healthy Wisconsin Board.

The Healthy Wisconsin plan will ensure that both employers and employees pay their fair share for quality health care. Employees would pay no more than 4 percent of their wages subject to Social Security tax (an average of $140 a month), and employers would pay between 9 and 12 percent of employees' Social Security wages (an average of $370 a month per employee) to finance the program.

To protect consumers and employers, Healthy Wisconsin will implement new regulations in the health care market. For example, participating health care networks will be required to spend at least 92 percent of the revenue they receive on direct medical care (as opposed to administrative costs) and on measures to improve quality and contain costs. Healthy Wisconsin would also prohibit these networks from denying enrollment or coverage for participants based on age, sex, race, health status, employment status, and a number of other factors. These rules will make the system fair for all people in Wisconsin.

- Progress toward Wisconsin's health care reform goals has been stalled by the Scott Walker administration, which is opposed to the ACA and has implemented deep cuts in the state budget, including enrollment caps on Badger Care Plus.

# WHAT CAN WE LEARN FROM APPLE HEALTH?

Citizen Energy and Organizational Infrastructure

1. Apple Health is supported by a broad coalition of supporters, led by an "honest broker" - the Children's Alliance.
2. The Coalition was able to defend universal coverage and the benefit package and most aspects of affordability, but was less successful in preserving adequate provider rates.
3. The struggle to provide adequate provides rates constitutes a serious threat to the Coalition, and ultimately, to the integrity of Apple Health.
4. The program needs, but has not had, a leader within the state bureaucracy who shares the vision contained in the legislation that established Apple Health.
    - The integrity of Apple Health as a single, coherent program is not evident in the organizational structure of the bureaucracy or the public information it disseminates, e.g., web site quickly links to DSHS and HCA.
    - The Health Care Authority has opened Apple Health to for-profit national insurance plans in a manner that threatens to undermine local systems.
    - The current HCA leadership has not always been transparent with plans, providers, and the public.

Strategies to Improve Access and Health Outcomes

1. Apple Health was designed to be a single, coherent health program for children that is available to all income levels and has its own brand. The design:
    - Streamlines outreach, marketing, eligibility determinations, etc.
    - Reduces churning, increases retention
    - More kids get care
    - Reduces administrative costs
2. Apple Health has a single, relatively comprehensive benefit package (Medicaid).
3. The success of the program suggests there is great value in a simple value proposition → all kids get care; it's an investment in the future.
    - Emphasis on prevention, primary care as cost effective alternative
    - Link to educational achievement
4. The original legislation contained "buy-in" provisions for families above 300% of FPL, but those provisions have yet to be implemented.
5. The concept of linking children to "health care homes" was embraced by elected officials, but not fully realized.
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6. Apple Health has unrealized potential:
    - Re-alignment of the delivery system
    - Integration with public health
        - Maternal and child health

        - Immunizations
        - Health screenings
    - Home visits Impact measurement
        - Health status
        - Cost containment, etc.
    - Support for educational achievement
    - Support for family success
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<u>Strategies for Containing Costs</u>

1. Streamlining the system and cutting the paperwork are the keys to:
    - Public comprehension
    - Political support
    - Organizational coherence
    - Cost savings
    - Better outcomes
2. The recent decision to accept proposals from private, for-profit, out-of-state health plans appears to move in the opposite direction.