Initial Recommendations on Federal Health Care Reform Impacts

Governor's Advisory Group

Preliminary Working Draft

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Executive Summary

Pending federal health care reform legislation will create challenges but could also be a tremendous opportunity for Washington State to significantly improve our health care system, reduce the number of uninsured citizens, and help reduce the rate of future cost increases. This is especially true since the proposed legislation requires the states to implement most of the reforms. Acknowledging the need to begin preparations now, more than a dozen industry leaders have collaborated in preparing these initial draft recommendations to the Governor on how to best implement reform in our state.

Major Recommendations (not yet in priority order)

- Prepare now to quickly analyze the financial implications of final federal legislation
- Maximize the federal share in all matching fund programs (especially Medicaid)
- Learn from our prior experiences to help ensure insurance reforms work as intended
- Prevent further erosion in state care/coverage programs over the next three years
- Encourage development of delivery innovations such as accountable care organizations
- Fully integrate prevention/wellness expertise and strategies into all reform efforts
- Refocus existing health work force training programs on strategic priority areas
- Encourage scope of practice expansions that maximize the use of existing resources
- Apply any initial new federal funding to create a change management infrastructure
- Devote the resources needed for effective communications to engage the public

Introduction

Implementing federal health care reform in Washington State will confront us with major administrative, fiscal, and political challenges. All states will shoulder substantial new responsibilities – including overseeing the new insurance exchange and insurance market reforms – but each state will have unique challenges. As currently envisioned, federal health care reform will be phased in over a long period. This means there will be ample opportunity for backlash and political/policy revisions. Reform could take years and will play out in the context of considerable uncertainty, misaligned incentives, conflicting interests, and differing political perspectives. Despite the extended roll-out period, however, it is essential that the state begin planning immediately and there is a need for urgent action to begin initiating effective change management policies. Successful implementation of federal health care reform at the state level will not happen using ad hoc work groups and fragmented accountability.

The purpose of this paper is to briefly highlight major policy issues and concerns related to successfully implementing federal health care reform in Washington State. Six broad topics are addressed, based on what we know now about the reforms:

- Financing reform implementation
- Effects of insurance reforms
- Bridge strategies
- Delivery system and payment reforms
- Wellness and prevention
- Work force and capacity

The paper concludes with a set of recommendations on change management and the need for effective communication to engage the public in supporting the changes ahead.

Topic 1 – Financing Reform Implementation

Major Recommendations

- Prepare now to quickly analyze the financial implications of final federal legislation
- Maximize the federal share in all matching fund programs (especially Medicaid)

Other Recommendations

- Use existing state program funding to help initiate reform implementation
- Work with other states to assure federal solutions come with adequate funding

Financing health care reform is a major concern for all states. Under any scenario of federal health care reform currently being discussed, the added costs of reform will be financed through some combination of: 1) reduced federal spending in public programs (especially Medicare), 2) increased state obligations, and 3) new federal revenues.

- ***Reduced federal spending*** will be most apparent in the Medicare program. These Medicare "savings" strategies could have a significant and lasting negative impact on our regional healthcare infrastructure if they accentuate rather than remediate existing inter-state disparities in Medicare payment rates and increase cost shifting.
- ***Increased state obligations*** include eligibility expansions of the Medicaid program to cover many currently uninsured adults. An enhanced federal match rate for new enrollees may cover the added costs, but possibly only for the first few years. The Senate bill provides enhanced FMAP for new populations at 100 percent through 2016, dropping to 32.3 percent beginning in 2019 and thereafter. The House bill would pay 100 percent of costs for the new populations in 2013 and 2014, and then drop to a 91 percent match rate for 2015 and beyond.
- ***New federal revenues sources*** may take the form of new or increased taxes on drugs, devices, or insurers, and/or new revenues from taxes on non-healthcare sources, such as increased taxes on higher income individuals.

Most of the current financing attention is focused on covering short-term reform costs. Longer range savings are expected to be derived from the numerous pilots and initiatives aimed at promoting more efficient delivery of health services and reducing fragmentation of the system. The way federal reform is financed will have a lasting impact on our state economy in general and specifically on the type of health care system we have once the reforms are fully implemented. We need to assure that expansion of insurance coverage actually results in more persons getting the care they need, and that the opportunity to modernize our delivery system is not swamped by overly burdensome federal regulations. Further, we need to assure that expansions are adequately resourced, and that new federal health care reform requirements will not force the state to cut funding for other important priorities of state government.

The specific details of how federal reform will be financed are not yet known, given the differences remaining in the House and Senate bills now under consideration. We can frame our innovation opportunities, however, by assuring we understand the impact that these potential financing methods will have in our local market.

- Medicare payment changes – The state must take every opportunity available to maximize federal resources while driving better value and accountability across our state. If reduced Medicare payments fail to cover the costs of service provision, we must find ways to reduce or minimize further cost shifting while also keeping medical practices, hospitals and other service providers financially viable.

- Increased state obligations – The state must draw down as many federal resources as possible, again while driving better value and accountability across our state. Reducing the numbers of uninsured by enrolling them in a greatly expanded Medicaid program - without improving Medicaid payment levels - would be a serious problem, potentially leading to severe access problems and massive cost shifting.
- The current Senate bill adds a new tax of $6.7 billion on insurers that will be placed on only the fully-insured business of these companies, effective January 1, 2010. This is estimated to add about $150 million a year in new taxes for state insurers, which could then be used to help offset the added costs of Medicaid expansion. These new taxes will increase premiums and may push more firms into self-funding their health benefits, however, likely reducing the number of firms subject to the tax. There is also a much smaller tax ($40 million) on third party administrators.
- A "Cadillac" tax of 40 percent is proposed on plans that cost over $8,000 for individuals and $21,000 for families. If this provision passes, companies impacted may respond by reducing benefits so that costs are below the tax threshold.

The goal of reducing the uninsured will be achieved mainly by greatly expanding Medicaid, beginning in 2013 or 2014. Earlier implementation of targeted programs (such as a re-insurance pool for early retirees aged 55-64) is also under consideration. Current estimates are that the expansion of Medicaid to low-income adults without children could add as much as $1 billion a year to the costs of Washington's Medicaid program. The threshold limit for defining "low income" adults is still under debate.

The state needs to begin preparing <u>now</u> for the in-depth analyses that must be quickly completed once the final bill financing provisions are known. The types of analyses that are needed include:

- Model the number and demographics of insured and uninsured populations in Washington for the most likely implementation scenarios.
- Assess changes to Medicare Advantage payment levels, hospital payments, physician payments, Disproportionate Share Hospital payments, and other service payments.
- Model the cost shifting impacts of Medicare, Medicaid, and other federal payment changes, and to the extent possible assess the impacts on markets (e.g., willingness of physicians or hospitals to treat Medicare patients if payment levels are decreased).
- Model Medicaid caseload and budgetary projections based on current, enhanced, and reduced provider payment scenarios, plus model state payment impacts for uncompensated care and for undocumented residents.
- Assess shifts in accountability for dual eligible Medicare/Medicaid populations.
- Assess how the federal match may shift over time for long term care, one of the biggest areas of state expenditures.
- Conduct economic analysis of various new taxes and assessments, including modeling how fully insured/self funded employer health benefits costs may be affected, and the subsequent impact on how people get their coverage.

The Governor has a long track-record of innovative leadership on health care reform issues, dating back to before the groundbreaking work of the Blue Ribbon Commission. This leadership needs to continue as we move into the implementation of federal health care reform, beginning by assigning clear responsibility for conducting the above analyses, which must be completed as soon as is feasible after the passage of the bills.

This analytic responsibility could be given to a single agency, or possibly, to an inter-agency "SWAT" team working under the direction of an oversight agency such as OFM.

There are obvious limitations on what the state can do about the financing implications of federal health care reform. It seems unlikely, however, that Washington will be unique in facing these challenges, and we need to work with our delegation in Congress and the National Governor's Association to ensure federal financing is adequate.

Topic 2 – Effects of Insurance Reforms

Major Recommendation

- Learn from our prior experiences to help ensure insurance reforms work as intended

Other Recommendations

- Keep the timing in sync on implementing insurance reforms and coverage expansions
- Facilitate insurance reforms and expanded coverage to reduce number of uninsured
- Determine how the high risk pool mechanisms can be used in the new environment
- Enforce the individual mandate to preserve underlying insurance principles

A major focus of federal health care reform will be to correct problems in the individual and small group health insurance markets, standardizing insurance practices and consumer protections across all states. Small groups are defined as 1-100 employees, although states may have the option to decrease this to 50 employees. Washington State has been a leader in individual insurance reforms over the past fifteen years, and the expected impacts of federal insurance reforms may therefore be less dramatic when applied in our state. The major components of federal insurance reform need to be understood in terms of how they will impact our current practices.

- ***Pre-existing condition exclusions*** will be eliminated in 2010. Washington insurers now use a state-approved health screen to deny coverage and refer a fixed percentage of patients with pre-existing conditions to the high-risk pool. State law also allows a nine month pre-existing condition exclusion for individual coverage. Both the health screen and the exclusion will be eliminated under federal reform.
- There will be ***guaranteed renewability*** of health insurance policies. This is already required in Washington in the small group market, although neither current state laws nor proposed federal reforms set limits on how high the premiums can go for renewals. Guaranteed renewability may therefore prove unaffordable for some.
- ***Annual and life-time limit maximums*** will be eliminated. Currently, annual and life-time maximum benefit limits are common in Washington, frequently at $250,000 or $500,000 annually and set at $1 million or $2 million for a life-time maximum.
- ***High Risk Pools*** are included in proposed legislation, although they would be phased out by 2013. Washington already has a high risk pool, although its function in a world without pre-existing condition exclusions will need to be re-examined.
- There will be an ***Individual Mandate*** for all residents to have basic health insurance. There is currently no such requirement in Washington. The requirements for being insured under the mandate in federal reform impose a $750 penalty in the House bill; or 2½ percent of income penalty in the Senate bill. If enforcement is not done jointly by federal and state governments, then enforcement in Washington State may be problematic, as we have no state income tax. If the requirement is weak, there may be a financial incentive not to purchase insurance

until it is needed, and instead simply pay the penalty each year. Particularly for younger, healthier, lower-income people, enforcing the mandate may be a challenge.

- There is likely to be a requirement for a ***minimum benefit package***. There is a five year grandfathering provision for keeping existing plan designs, but enrollees in grandfathered plans will not be eligible for federal subsidies.
- A ***"public option"*** may be created for people to purchase health insurance, competing with the private insurance market. It is not clear whether this provision will be in the final federal legislation. If it is, the state may have the responsibility (or, at least, the option) to create the public option health plan for Washington.
- An ***Exchange*** for purchasing individual health benefits may be required, and if so this may be how low-income subsidies are administered. We do not have specifics yet about how the proposed Exchange requirements will work and so cannot make specific recommendations. Washington State will need to be ready to quickly design options for the structure of its exchange and the populations to be covered, especially since the exchange will likely be needed to support our bridge options.

In general, the health insurance rating reforms outlined above will not go into effect until 2013, giving the state several years to prepare for them. Implementation must be timed properly to assure that the underlying principles of insurance are maintained. The market could be destabilized by inconsistent timing; for example, liberalizing coverage terms before implementing the individual mandate requiring coverage.

There are several opportunities for the state to continue leadership innovations:

- Basic Health and the state High Risk Pool are long-standing examples of state leadership and innovation in dealing with the challenges of health insurance. With careful planning, these programs may be adapted and continued as state programs to help low-income residents maintain coverage through the transition period.
- A connector program, similar in concept to the federal Exchange proposals, is already under development here and could be launched early (before 2013) to provide information and enrollment opportunities to Washington residents.
- It may be possible to adopt some aspects of market reform earlier, and others later, given the state's long-standing leadership role in insurance reform, state efforts initiated under the Blue Ribbon Commission, and our unique regulatory environment. For example, transitioning Basic Health into the state's public health insurance option as quickly as possible might enable the state to seek federal implementation funds for this program well before 2013, and thereby avoid having to make further draconian cuts to Basic Health enrollment due to budget problems.

To jump-start preparations for implementing insurance reform, the state should engage major carriers, providers, concerned citizens, self-funded employers, and third party administrators in discussions about how to successfully implement insurance reform and minimize some of the potential points of friction. The state needs to have a single point of accountability for implementing insurance reform, and the Office of the Insurance Commissioner (OIC) is the logical convener of these discussions. By having an established structure in place early, with all major stakeholders agreeing on the sequencing of reforms, the state may even be able to influence the order and pace of new federal regulations. Early wins could include mapping coverage transition requirements, from individual market to Basic Health to Medicaid, to help citizens maintain coverage. A state-sponsored web site - similar to that used in Massachusetts - could also make a major difference in citizen acceptance of the insurance reforms.

Finally, in considering insurance reforms, it is important to note that the exclusion of non-citizens from federal reform and federal programs will still leave many people in Washington uninsured and dependent on overstressed ER and community safety net resources. Focused efforts must be made to ensure the continuation of safety net providers' capacity to treat those excluded from the benefits of health insurance reform.

Topic 3 – Bridge Strategies

Major Recommendation

- Prevent further erosion of state care/coverage programs over the next three years

Other Recommendations

- The revived Health Insurance Partnership can help cover low income persons
- The high risk pool might become a vehicle to temporarily fund threatened programs
- Seek flexibility in using newly available federal funding to help bridge the gap
- Coordinate efforts to apply bridge funding strategically, rather than by program
- Use short-term pilots to test ideas and refine approaches during the gap period

Washington, like many other states, is faced with continuing, severe budget shortfalls. Most of the federal coverage expansions, however, are not scheduled to start until 2013 or later. The current state budget shortfalls put at risk existing innovative programs and state coverage expansions that could and should serve as important bridging programs to federal expansions, and which may also serve as effective and efficient ongoing programs as part of future federal/state reform strategies. It is important to prevent further erosion of care and coverage during the three year gap period prior to the full implementation of federal reforms.

In the absence of significant federal help during the gap, how can we best promote a responsible and effective transition to the new healthcare model envisioned by the pending federal proposals? The implications, opportunities, and challenges for our state in successfully bridging the gap include the following:

- All state public programs that are discretionary are under immediate threat. This includes Basic Health, GA/U, and non-mandatory children's health expansions. Even if these programs can be maintained at current (2009) levels, provider payment levels may continue to decline relative to actual costs due to payment freezes.
- All "optional" benefits for mandatory public programs are also under immediate threat. These include a wide range of specific Medicaid and SCHIP benefits.
- Increasingly inadequate payments will negatively affect the continued viability of safety net providers, which serve high numbers of individuals who will remain uninsured until the federal reforms are implemented (and in some cases afterwards as well).
- New federal taxes and assessments on health plans may be immediately loaded onto existing premiums, making insurance coverage less affordable in the short term, particularly before federal subsidies for low income individuals become available.

Despite these challenges of the next three years, there are several opportunities for the state to build on innovative programs or new opportunities to help bridge the gap:

- The recently revived Health Insurance Partnership (HIP) is giving the state valuable "ramp-up" experience with health insurance exchange concepts and may also be a vehicle to assist small businesses in sponsoring health insurance for employees in a sheltered manner until the federal reforms apply.
- The state's high risk pool population will disappear over time, because pre-existing condition exclusions and the health screen will be eliminated. The "self-taxing" mechanism used to fund the high risk pool, however, may allow the state to work cooperatively with health insurers to temporarily fund important program continuations during the bridge period. To increase equity, adding self-funded employers as sponsors of the high risk pool can be considered if ERISA rules can be overcome. Permanent funding using this mechanism would not work, but the pool might be an important source of funding for bridge programs. Both the House and Senate bills include immediate (2010) additional funding for state high risk pools.
- The Senate bill provides regular FMAP for phasing-in the new Medicaid population beginning on enactment of the bill. The state could model how best to leverage existing Basic Health state funds with federal match, by determining an eligibility level for refinancing Basic Health that makes use of these new federal funds.
- The new federal Public Investment Fund includes additional funding for the National Health Service Corps to place primary care providers in health professional shortage areas and tribal areas – this will help bridge the gap in current primary care work force shortage areas and prepare for the influx of persons seeking care. It may be possible for medical providers to access these funds in 2011, helping bridge the gap.
- There may also be flexibility in using other federal dollars, leveraging any short term federal assistance – federal stimulus funding (ARRA) extensions, additional funds to community health centers over the next five years, primary care reimbursement adjustments, expanded disproportionate share funding, etc. – to help essential programs continue during the gap. Taking a coordinated approach to this issue is essential to enable flexibility in using the federal funds in strategic ways.

Preparations are already underway at the individual, programmatic level to patch together gap strategies that continue essential programs for the next two biennia. There does appear to be a need for a higher-level, strategic planning process that considers all these program needs together. This can occur in a coordinated, priority-setting manner that takes into account how these programs will be impacted (and in some cases replaced) by federal health care reform changes. Having this broader, and longer-range, perspective should help identify cross-program efficiencies and synergies that a flexible bridging strategy could achieve.

There are several major limitations on what the state can do about bridging the gap to sustain current programs until federal health care reform applies. These include the obvious financial limitations of a weak economy and the related State-budget shortfall, the limitations imposed by current and new federal requirements, and the lack of short term state revenues to fill gaps. A final challenge that must be kept in mind is that Washington is a large and complex state, and it will be important to respect urban versus rural realities in delivery system capabilities. Some bridge strategies that work well in urban areas cannot be exported to remote or rural areas simply because the delivery system there is too fragile to survive rapid programmatic changes. Bridge strategies must be carefully evaluated to ensure there are no unintended consequences.

Topic 4– Delivery System and Payment Reforms

Major Recommendation

- Encourage development of delivery innovations such as accountable care organizations

Other Recommendations

- Use existing state programs to pilot test promising delivery and payment changes
- Focus efforts on urban areas large enough to support strong infrastructure needs
- Support existing state efforts already underway in delivery and payment reform
- Changing payment incentives alone may not bring about needed cultural changes
- Medical homes are one example of innovative delivery system and payment changes

Ensuring that services provided to patients are timely, appropriate, and effective is central to improving outcomes and reducing cost increases. Reforming the delivery system and payment methods for health services are essential to reducing the rate of future cost increases. The proposed federal legislation includes many payment cuts to reduce federal spending, primarily in the Medicare program, but so far appears to lack a comprehensive and coordinated approach to controlling costs system-wide. The state therefore has an opportunity to take a leadership role in encouraging these needed improvements in the delivery of care and payment methods.

Most current federal payment levels and methodologies penalize cost effective states and cost effective practices. Payment incentives and quality goals are rarely aligned, and the current system often encourages excess care. These problems contribute to far too many unjustified variations in care. The federal government, through its Medicare payment levels and methodologies, both influences commercial payment methodologies and shifts costs to other purchasers. Several new ideas on changes in delivery systems and payment methods to promote value are being proposed, but most lack field testing.

Paying for value could significantly help control future costs, with the underlying goal of getting the patient the right care at the right time. Payment and delivery system reform requires encouraging new payment methods and the creation of delivery systems in which risk can be placed appropriately. The relatively new concept of "accountable care organizations" has been proposed as one way to improve care coordination and enable providers to handle new payment approaches. Full and partial capitation arrangements can be explored, as well as testing payments for episodes of care (for certain conditions). Primary care capitation and other bundled, fee-for-service payments can be linked to the concept of medical homes, as explained on the next page as an in-depth example.

If federal legislation does not include comprehensive, incentive-changing payment reforms (such as accountable care organizations, non-payment for excess hospital readmissions, multi-service sector payment bundling, administrative simplification, and other forms of payment for value), Washington State should advance these concepts through its health purchasing programs, ideally, in concert with private market initiatives. If the final version of federal health care reform allows the states to create their own public option, consider using existing programs as learning labs: expanding Basic Health or the Uniform Medical Plan (ideally a more managed version of it) are options to consider. This would allow testing new payment methods, such as paying for episodes of care and penalizing for avoidable hospital re-admissions. The large state purchasing programs, especially working in conjunction with private sector purchasers, have the potential to transform how health care is delivered and paid for. This should

initially occur on the basis of pilot projects, some of which are already underway in the private sector. The state will need to evaluate whether it is best to use administrative rule making or legislative action to initiate or expand these innovative programs.

Any pilots are best tested in urban areas, which have the population size to support the delivery system infrastructure needed to become accountable care organizations. A single payment model will not fit all areas. Accountable care organizations require sufficient population concentrations to support the needed infrastructure. Rural system needs differ from urban needs, and totally eliminating traditional payment is impractical in geographic areas where ensuring the delivery system's survival is critical. These same considerations also apply to urban area safety net providers (community health centers).

Expanding the concept of primary care medical homes is one promising way of restructuring medical care delivery to meet these goals. Medical homes are discussed here as an example of the type of innovative payment reform that also improves outcomes. The medical home is team-based primary care which includes enhanced access and proactive, planned visits with the care team, based on evidence-based medicine and clinical support tools, in order to track patients and their needed care, support patient self-management of chronic conditions, and coordinate care across the continuum. The intention is to enhance prevention and screening, manage chronic conditions optimally, coordinate resources, and reduce emergency room use and hospital admissions for conditions which should have been cared for in doctor's offices.

Expanding the use of medical homes is best understood as part of reforming the broader system and illustrates the changes that must be made in the management of care and payment reform for hospitals, physicians, and others. To make the system most efficient, all providers must be given aligned financial incentives for improving patient outcomes and decreasing unnecessary costs. This can be achieved in integrated delivery systems such as accountable care organizations, as discussed above. Medical homes are one effective way to compensate and incent primary care teams to be financially accountable for improving outcomes and reducing the rate of increase in health care costs. These approaches require providers to meet higher performance standards to receive augmented payment. This will be a value added process that gives higher payments to primary care only if explicit improved outcomes and financial savings targets are met.

The state is fortunate to have a number of major initiatives underway to transition primary care into a medical home structure. The Department of Health has been sponsoring a collaborative of over thirty clinics which are preparing for medical home practice transformation. The two major state health care purchasing programs (Medicaid and PEBB) are currently co-sponsoring a pilot project with the Puget Sound Health Alliance that aligns the payment methods of the major payers and purchasers with the medical home concept. In addition, several other activities are underway – large clinics such as the Everett Clinic are restructuring care delivery, the Boeing Company has piloted a project to aggressively manage high-risk populations, and community health centers, Swedish Medical Center and others are experimenting with different primary care models that promote use of medical homes. Washington can become a leader in this innovation, but to be successful in controlling costs and ensuring that all people in the state have access to this improved care, a sustained and expanded effort is needed. The state, through its purchasing policies, can greatly expand use of medical homes as an effective model for improved and cost-effective care delivery. Building on our current efforts, we should be able to implement medical homes in multiple communities throughout the state in the next five years.

Topic 5 – Wellness and Prevention

Major Recommendation

- Fully integrate prevention/wellness expertise and strategies into all reform efforts

Other Recommendations

- Take advantage of the expertise of locally-based leaders in global health improvement
- Assure continuing insurance coverage for evidence based, clinical preventive services
- Assure adequate resources and work force for community preventive services

Clinical and community prevention strategies must be a fundamental component of health care reform implementation in Washington State. It is well recognized that:

- Investing in prevention improves the overall health and quality of life of Washingtonians, strengthens the productivity of our work force, enhances our ability to compete nationally and globally, and has a measurable financial pay off;
- Prevention and wellness are highly likely to be a significant and highly integrated element of national health care reform legislation. Appropriation marks for new, dedicated funding for wellness and prevention in the current House and Senate versions of the legislation are at $30B and $15B, respectively;
- Effective prevention is usually at the top of the list of the values people want from their health care. Of no surprise, an increased emphasis and investment in prevention and wellness rank very high in recent polls regarding the features most important to the public in health care reform.

Yet, despite the importance of prevention, history demonstrates that with respect to both attention and financing, prevention usually takes a back seat to other health care priorities. The single most important action Washington can take relative to implementing prevention and wellness in health care reform is to change this historical paradigm. The new paradigm must be to:

- Prioritize prevention and wellness strategies and integrate prevention and wellness expertise in the overall implementation of health care reform.

Prevention and wellness are often divided into two qualitatively different components – clinical prevention services and community-based prevention services. Both are critical, and their integration with the overall health care reform effort is vital.

Clinical Prevention Services

Prevention services provided to patients as part of the routine delivery of their medical care are called clinical prevention services. Examples include mammography, immunizations, PAP tests, and tobacco cessation assistance. Washington currently does not do well delivering preventive services, ranking 35th among states overall, and 46th for childhood immunization coverage. Early, urgent Clinical Prevention Service issues that Washington State health care reform implementation must tackle include:

- Assuring continuing coverage for evidence based, clinical preventive services (like maternity support services) during the upcoming “bridge period”, and plan for universal coverage and elimination of co-pays for preventive services beginning in 2013, including adopting national prioritization strategies for the delivery of clinical prevention services;

- Assisting in the development and standardization of reminder/recall/registry systems and electronic health records to enable improved delivery and tracking of prevention service delivery across practices and provider groups;
- Supporting routine measurement and public reporting of health care systems' performance in delivering clinical prevention services (as is currently undertaken by the Puget Sound Health Alliance);
- Evaluating and implementing additional promising cost-effective strategies to boost clinical preventive services coverage, particularly in poor and minority populations.

Community Based Prevention

Prevention services provided outside of the health care system to people and communities are called community-based prevention services. Examples include anti-tobacco television advertisements, water fluoridation, restaurant inspections, and construction of biking and walking paths. Effective community-based preventive services have the potential to have more overall impact on health than medical care or clinical preventive services and are among the most cost-effective of all strategies to improve the health of people and communities. Early, urgent Community-based Prevention Service issues that Washington State health care reform implementation must tackle include:

- Identifying and enabling implementation of the proven community-based prevention services, including those most effective in reducing health disparities. In particular, we have a significant opportunity to innovate using global health tools and methods given our combination of diverse communities and locally-based, global health leaders with in-depth field and research expertise.
- Developing and applying community health indicators that measure the effectiveness of efforts to prevent obesity, tobacco use, and injuries and efforts to increase physical activity and improved nutrition, among others.
- Developing a community health policy agenda and designing and evaluating additional innovative, promising strategies to improve community health, including proven global health strategies.
- Assuring adequate resources and work force for the necessary community preventive services foundation, implemented as an integrated part of health care reform in Washington.

Topic 6 – Work Force and Capacity Recommendations

Major Recommendations

- Refocus existing health work force training programs on strategic priority areas
- Encourage scope of practice expansions that maximize the use of existing resources

Other Recommendations

- Target scholarships and loan forgiveness programs on work force shortage areas
- Invest now in expanding data system capabilities for measuring the health work force
- Continue support for developing an integrated health information infrastructure
- Incorporate the recent recommendations from the Work Force Diversity Committee

Washington already has huge challenges in recruiting and retaining essential health professionals. These problems will worsen as the population grows and ages, as the cost and complexity of health care increases, and as more people have access to health services through health care reform. In particular, national declines in U.S. physicians entering primary care fields will adversely impact access to these critical services. This is particularly true for family medicine and general internal medicine (the foundation of rural and inner city health care) as well as for general surgery (the cornerstone of rural hospital procedural care). There is also considerable unmet need for preventive dental care in the state, and the supply of dentists (relative to the growing population) is projected to decline in the next decade. The situation will be compounded by worsening shortages of advanced practice nurses (APNs), physician assistants (PAs) in primary care, registered nurses (RNs), medical assistants (MAs), and home care aides (HCAs). The current health work force will be reduced by retirement of "baby boomer" providers at the same time as the demand for more health care increases. Rural counties and less-affluent portions of the state will be hit hardest by work force shortages.

Once enacted, federal health care reform is expected to expand health insurance coverage to millions of currently uninsured Americans. Yet expanded coverage alone will not produce expanded access to care, since our health care work force is already in short supply in many locations and specialties. A central challenge in implementing health care reform will be to address work force and access constraints before they undermine the entire health care reform effort. Addressing work force and access issues also entails support for safety net providers to manage demand, implementation of payment rates and methods that do not create disincentives for access, and keeping hospitals that serve the lion's share of the uninsured and underinsured viable. Four linked strategies are needed to increase the essential health care work force:

1. ***Refocus existing health work force training programs on strategic priority areas.*** Increasing class sizes in state-supported schools is a real challenge given the state budget situation. Recognizing these constraints, education expansion efforts should focus on shortage areas, especially in primary care (including general and pediatric dentists), geriatrics and general surgery. Admission policies and financial aid should favor students likely to choose needed careers, such as in community health centers and rural primary care. This effort also includes expanding our training capacity – especially a problem in nursing education where faculty shortages have long blocked our ability to increase nursing school enrollment – through use of new training methods (distance learning, simulators, credit for prior clinical experiences, and other innovative programs).

2. ***Support post-graduate medical education*** programs in ambulatory settings and expand training slots in the most needed areas, including primary care (family medicine, general internal medicine and pediatrics), general surgery, and psychiatry. The state can re-focus its medical education priorities to help cover the costs of expanding training in these critical areas. The state should financially support training programs in these areas and reimburse time spent by resident physicians in community-based settings. This strategy can also be applied to dentistry residencies, which are an important source of preventive care for underserved populations. The state should work with federal legislators to remove caps on GME education for primary care and other residency programs of strategic need.

3. ***Target scholarships and loan repayment programs*** on students entering rural practice in primary care medicine and dentistry. Providers who receive scholarships

and loan repayments with requirements for service in rural areas are more likely to remain in rural areas and more likely to practice in community health centers. Expanding these programs for providers working in underserved locations would help steer the new providers into the highest need locations and practice categories.

4. ***Scope of practice expansions and payment reform to support new models of care.*** State health purchasing programs could implement demonstration projects in payment reform that emphasize primary care, surgery and psychiatry as well as underserved and rural practice. New approaches of payment for primary care (e.g. care coordination fees) and integrated medical groups (e.g. new forms of partial or whole capitation) should continue to be developed, tested, and implemented. Other options include strategic development of mid-level practitioners who can expand work force capacity and increase access (e.g., dental therapists). Greater emphasis on coordinating care across providers and hospitals, such as rural-urban referral networks, is also needed to ensure that the available work force is used most efficiently. In some cases, legislation will be needed to promote expansion of these scope of practice changes and new care models to various categories of providers.

Other innovative options include attracting and retaining U.S. trained-providers from outside Washington through programs such as loan repayment, scholarships with in-state service requirements, and attracting international medical graduates to the state. Diversity in the health care work force is also essential to meet the needs of a changing society. The Work Force Diversity Committee of the Governor's Interagency Council on Health Disparities has recently produced a set of specific recommendations on this topic.

The state should also invest in the collection and analysis of data examining current and future work force supply/health care demand relationships. The Senate bill establishes a national health care work force commission and establishes regional centers for health work force analysis. The House bill establishes an Advisory Committee on Health Work Force Evaluation and Assessment. The state needs a similar entity to coordinate data collection and analyses to effectively interact with the new federal work force efforts. These activities should begin immediately in order to be in place for significant work force capacity pressures as reform is implemented. Enhanced data collection and analysis capability will be essential for forecasting and responding proactively to shortfalls in provider capacity. Since the state is responsible for most health professionals training programs and also sets scope of practice requirements, there are few limitations (other than financial constraints) on what the state can do to address the challenges identified in this section. This is one arena where the state can take a strong leadership role to the extent funds become available.

One final capacity issue involves continued support and expansion of health information technology, which has the potential to greatly improve the functionality and efficiency of the current health care system in all areas by allowing innovative changes due to an improved information infrastructure. The state already has taken an active leadership role in this expansion, and this support must be continued and strengthened, not relegated to a lower priority due to the new challenges of successfully implementing federal health care reform at the state level. Maintaining a continued priority for health information technology investment, integration, and innovation will help the overall Washington health system improve in all areas. Supporting efforts by providers to make meaningful use of these new technologies is also essential. This can be done by continuing grants and aid to small practices to upgrade their capabilities.

Next Steps

The immediate next steps for state leadership to adopt in addressing federal health care reform are to initiate effective change management strategies to prepare for the coming transition and to devote sufficient resources to educate the public about reform.

Implement Effective Change Management

Major Recommendation

- Apply any initial new federal funding to create a change management infrastructure

Successful implementation of federal health care reform at the state level will not happen using ad hoc work groups and fragmented accountability. Washington State needs to take a strong leadership role in managing these changes. The following recommendations provide a framework for undertaking this challenging work:

1) Define what successful implementation of federal health care reform will look like.

2) Maximize the chances for success, both short and long term, by:
   a) assuring we have the collective support of and a sense of shared responsibility among all the important stakeholder groups; and
   b) assuring implementation does not become overly politicized.

3) Clearly identify the cross-functional/cross-jurisdictional issues and gaps created by health care reform or that currently exist, both within the state and between the state and federal governments.

4) To achieve these objectives, identify the ***structures and processes*** needed by state agencies and the private sector to effectively orchestrate reform implementation:
   a) Assure we can learn as we go and allow for implementation flexibility;
   b) Think systematically and across traditional agency lines to incorporate innovative and patient-centered approaches that achieve high quality and value;
   c) Assign explicit accountability for identifying and addressing short term and long term issues;
   d) Determine the appropriate roles of the legislature, the Governor and her administration, the insurance commissioner, and the private sector (payers, purchasers, providers, unions, and the public);
   e) Identify those responsible for coordinating within and among these entities; and
   f) Establish clear lines of accountability within the state and to and from the federal government.

5) There is a clear need for centralized support of large scale change management. How can we assure this centralized support operates effectively and has an appropriate level of transparency and stakeholder / public engagement?

6) Assure that delivery system improvements are coordinated with the insurance reforms. Avoid implementing insurance reforms (e.g., guaranteed issue) while delaying delivery system enhancements (e.g., provider payment reforms).

Communications to Engage the Public

Major Recommendation

- Devote the resources needed for effective communications to engage the public

The prospect of sweeping health care reform is both exciting and anxiety-inducing. A window of opportunity now exists to establish realistic expectations for the public on what will be happening. It is essential public education and communication be adequately resourced at the state level. Effectively communicating the intent of and reasons for health care reform, and the context in which it will occur, are very important to help prepare the public for these changes. The recent release of the mammography guidelines without preparing consumers and providers is an example of what can happen when there is insufficient attention paid to having an effective communication strategy.

Engaging the public in understanding and implementing delivery system and payment reforms is the best way to prepare the public to understand these important changes. Tremendous interest in health care reform has developed among much of the public. The challenge for the state and the health care community is to mobilize this interest to make sure citizens understand delivery system and payment reform are essential to creating a sustainable health care system. In these efforts, it is very important to use the public's language, not bureaucratic or industry jargon.

The Governor will be an important spokesperson to the public on the changes underway and a champion for an improved health system. Emphasizing the importance of the reforms and assigning clear lines of accountability for implementing these reforms, the Governor will play a critical role in guiding successful implementation in this state. Health plans, hospitals, doctors, employers, unions and consumer groups should all be engaged in an organized communications strategy that reassures Washington residents about the changes taking place. Finally, the state can also play an important role as a convener of stakeholders within the industry to set expectations and influence their behaviors. This is a time for confident leadership and careful planning.

Appendix A – Governor's Advisory Group Participants

Overall Advisory Group Coordinator

Mary McWilliams – Executive Director, Puget Sound Health Alliance

Work Group 1 – Financing, Insurance Reforms, and Bridge Strategies

Pam MacEwan – Executive Vice President, Public Affairs, Group Health - ***Group Coordinator***

Steve Hill – Administrator, Washington State Health Care Authority

Mary Looker – Chief Executive Officer, Washington Association of Community and Migrant Health Centers

Jack McRae – Senior Vice President, Premera Blue Cross of Washington

Karen Merrikin – Executive Director, Public Policy, Group Health Cooperative

Work Group 2 – Other Important Implementation Issues

Margaret Stanley – Retired Health Insurance Expert – ***Group Coordinator***

Bob Crittenden, MD – Chief, Family Medicine Service, Harborview Medical Center

Tom Curry – Executive Director/CEO, Washington State Medical Association

David Fleming, MD – Director and Health Officer, Public Health - Seattle & King County

Peter McGough, MD – Chief Medical Officer, UW Medicine Neighborhood Clinics

Randy Revelle – Senior Vice President, Washington State Hospital Association

David Rolf – President, SEIU Healthcare 775NW

Dorothy Teeter – Chief of Health Operations, Public Health - Seattle & King County

Appendix B – Links to Additional Background Materials

- **A State Policymakers' Guide to Federal Health Reform - Part I: Anticipating How Federal Health Reform Will Affect State Roles**
  November 2009
  Many critical aspects of federal health care reform will be implemented by the states. Through program design, regulations, policies and practices, state decisions and actions already play a profound role in shaping the American health care system. Both the House and Senate reform proposals would dramatically change the federal structure within which state health policy operates. Part I of this State Policymakers' Guide provides a high-level view of existing state roles in the health care system and how federal reform will affect those roles.
  Download the file: Policymakers Guide Part 1

- **State Policymakers' Priorities for Improving the Health System**
  November 2009
  This State Health Policy Briefing presents the issues identified by NASHP's state leadership as their most significant priorities for improving their health systems. As Academy members discussed their priorities, a set of broader themes emerged. These larger policy goals are: Connect People to Needed Services; Promote Coordination and Integration in the Health System; Improve Care for Populations with Complex Needs; Orient the Health System toward Results; Increase Health System Efficiencies. This briefing also provides a more detailed list of states' priorities presented in four major categories of state health policy: Coverage and Access; Health Systems Improvement; Special Services and Populations; and Long Term and Chronic Care.
  Download the file: Policymakers' Priorities

- **Supporting State Policymakers' Implementation of Federal Health Reform**
  November 2009
  States will have enormous short-term and long-term needs for assistance as they grapple with federal health care reform legislation. Significant federal and private resources to support state-level implementation will be necessary. Implementation support must be defined and coordinated quickly. Technical assistance must be provided in a manner that corresponds with state needs. State officials should be involved in the design of technical assistance so that it is most effective given varied state circumstances, needs, and capacities. Technical assistance should inspire innovation among leaders even as it helps all states meet minimum standards of performance.
  Download the file: Supporting Implementation of Federal Reform

- **http://healthyamericans.org/reports/prevention08/**
  July 2008
  Prevention for a Healthier America - Investments in Disease Prevention Yield Significant Savings, Stronger Communities. In this study, TFAH finds that a small strategic investment in disease prevention could result in significant savings in U.S. health care costs. The report includes potential annual savings and return on investment figures for every state in America and Washington, D.C.

- **Crisis in Rural Primary Care (Policy Brief)**
  Date: 04 / 2009
  Topics: Physicians, Work force
  Primary care provides initial and ongoing care for the majority of patient health care needs. Primary care providers are the backbone of rural health care, yet primary care in rural locations is in crisis. The number of students choosing primary care careers has declined precipitously. Low compensation, rising malpractice premiums, professional isolation, limited time off, and scarcity of jobs for spouses discourage the recruitment and retention of rural primary care providers.

- **Threats to the Future Supply of Rural Registered Nurses (Policy Brief)**
  Date: 04 / 2009
  Topics: Nurses, Work force
  Shortages of registered nurses (RNs) in rural areas of the United States may grow even greater in coming years as the "baby boom" generation retires and as RNs commute to larger towns and urban areas for work.

- **Crisis in Rural Dentistry (Policy Brief)**
  Date: 04 / 2009
  Topics: Dental health, Work force
  Rural populations have fewer dentists, lower dental care utilization, and higher rates of dental caries and permanent tooth loss than urban populations. Reports from the Surgeon General and the Institute of Medicine call for more dentists in rural locations. Federal and state programs have focused on expanding rural dentist supply to increase dental access and improve oral health, but efforts may need to intensify to meet the needs of rural communities.

- **Crisis in Rural General Surgery (Policy Brief)**
  Date: 04 / 2009
  Topic: Work force
  The dramatic decline in the number of rural general surgeons in the U.S. since the early 1980s has precipitated a crisis in rural general surgery. General surgeons are vital members of the rural health care system, performing emergency operations, underpinning the trauma care system, backing up primary care providers, reducing drive time for rural residents, and contributing to the financial viability of small hospitals.

  http://www.latimes.com/business/la-fi-mandates16-2009nov16,0,3600032,full.story
  November 16, 2009 – Los Angeles Times
  Federal healthcare bills could jeopardize states' consumer protection laws. Opening the door for insurers to sell policies across state lines could allow health plans to avoid tougher requirements in places like California.

  http://www.politico.com/news/stories/1109/29555.html
  November 2009
  POLITICO's list of the biggest land mines in the recently passed House bill.