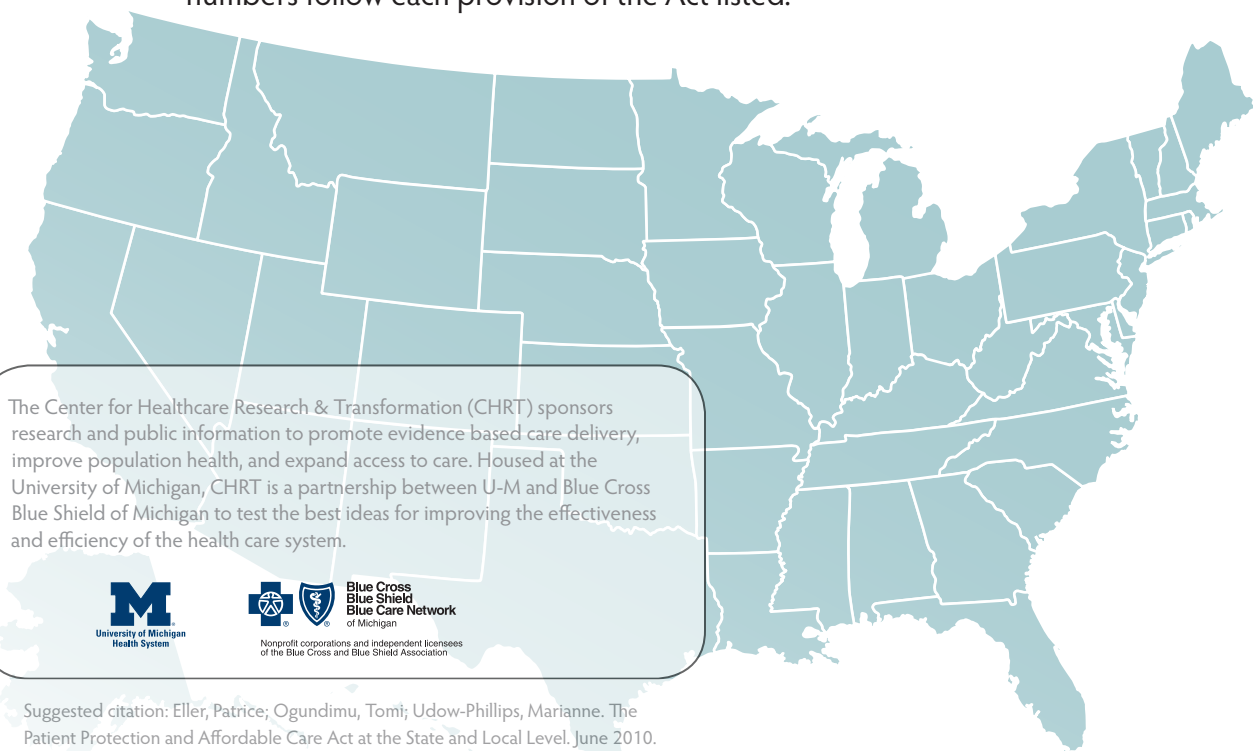


# The Patient Protection and Affordable Care Act at the State and Local Level



**W**hile health care reform has its foundation and framework at the federal level, many key elements will be carried out at the state and local level. Considerable attention has been focused on insurance reforms that will substantially alter the picture of coverage in the country, but the Act also includes other provisions that will affect the way care is delivered in every hospital and doctor's office in the country: everything from the way providers are paid and practitioners are educated to how quality is measured. Policy-makers, providers of care, individuals, foundations, and others interested in having an impact on the implementation of health reform will have many opportunities to do so at the state and local level.

Changes to health insurance coverage have been the subject of most reports on the Patient Protection and Affordable Care Act (P.L. 111-148). Rather than addressing changes that apply to private sector health insurance, this policy brief summarizes some of the most salient state requirements and state and local opportunities with regard to coverage and health care delivery. Section numbers follow each provision of the Act listed.



The Center for Healthcare Research & Transformation (CHRT) sponsors research and public information to promote evidence based care delivery, improve population health, and expand access to care. Housed at the University of Michigan, CHRT is a partnership between U-M and Blue Cross Blue Shield of Michigan to test the best ideas for improving the effectiveness and efficiency of the health care system.



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POLICY BRIEF

# State Responsibilities in Health Reform

Many of the key elements of health care reform are envisioned to be delivered at the state level. As such, states are charged with establishing some key mechanisms for implementation. For those states that choose not to put those components in place, the Secretary of the U.S. Department of Health and Human Services (HHS) will set up alternative mechanisms, often working through local non-profit organizations.

## State Requirements

### In 2010, the state must:

- Establish a consumer assistance/health insurance ombudsman program to respond to consumer complaints. (§1002)\*
- Put in place a process to review “unreasonable” insurance premium increases. (§1003)
- Within 90 days of enactment (i.e., by June 23), establish a temporary high risk pool to cover those who were previously excluded from coverage as a result of pre-existing conditions until 2014. (§1101)
- By July 1, establish a mechanism so all residents can identify affordable health insurance options in the state. (§1103)
- Maintain at least existing levels of coverage in Medicaid and CHIP through 2019. (§2001)
- Upon enactment, provide direct payments to freestanding birthing centers. (§2301)
- Within six months of enactment, conduct a needs assessment related to maternal, infant and early childhood home visitation services. (§2951)
- Cover tobacco cessation services for Medicaid covered pregnant women. (§4107)

### By 2014, the state must:

- Establish American Health Benefit Exchanges and a Small Business Health Options Program (SHOP) to offer Qualified Health Plans (QHPs) to provide specified health benefits coverage to individuals and small businesses. Establishment grants are provided to the states in 2011 to begin development of the Exchange. (§1311)
- Contract with one or more reinsurance entities to replace the temporary high risk pool. (§1341)
- Establish secure, electronic transfer of information between Medicaid, CHIP and the Exchanges. (§1413)
- Expand Medicaid coverage to all those up to 133 percent of poverty (states have the option to expand Medicaid coverage starting in 2010. If phased in, they must start with the most needy). (§2001)
- Report on federally promulgated quality and health measures for the Medicaid program. (§2701)
- Collect a wide range of data in order to better measure and address health disparities. (§4302)\*

The Patient Protection and Affordable Care Act provides considerable funding to states, both for the implementation of these requirements and the expansion of coverage. For example, from 2014-2016, the federal government will provide 100 percent of funding for the expanded population that is covered under Medicaid. Subsequently, federal funding is phased down to some degree until it reaches 90 percent in 2020. In addition, in 2013 and 2014, primary care practitioners in Medicaid will be paid at 100 percent of Medicare rates for primary care services, fully funded by the federal government. Finally, grants of various sizes go to states with the intent of enabling them to comply with the administrative requirements of the Act.

\*Funding is not appropriated.

## State Demonstration or State Level Program Options

In addition to the requirements established in P.L. 111-148, states have a number of options to participate in demonstration projects, principally related to the Medicaid eligible population or to the population covered in the health benefit exchanges. For many of these projects, funds have been authorized but not yet appropriated, so some initiatives contemplated in the Act may not come to fruition in the end. Some of the most notable options described in the Act include:

### In 2010:

- Extension of the Money Follows the Person Demonstration project. (§2403)
- Funding to expand aging and disability resources. (§2405)
- A Medicaid global payment approach to capitate safety net hospitals in up to five states from 2010-2012. (§2705)\*
- Grants for maternal and infant early childhood home visitation programs, 2010-2014 (grants may go to non-profits if by 2012 states have not applied). (§2951)
- Grants for “personal responsibility education programs” to reduce teen pregnancy and births, 2010-2014 (local organizations may submit a grant if states do not). (§2953)
- Funding for abstinence education, 2010-2014. (§2954)
- Additional grants for outreach and educational activities to State Health Insurance Programs, Area Agencies on Aging, and Aging Disability Resource Centers. (§3306)
- Grants to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. (§3505)\*
- Grants to states for improving immunization coverage for children, adolescents, and adults through the use of evidence-based interventions as recommended by the Community Preventive Services Task Force. (§4204)\*
- Grants for state partnerships to plan and lead workforce development strategies, including planning grants and grants to support data collection and workforce analysis. (§5102 and §5103)\*
- A three year demonstration program for ten state-based non-profit public/private partnerships that provide access to comprehensive and affordable health services to the uninsured. (§10504)\*

\*Funding is not appropriated.

## In 2011:

- Community First Choice Option to provide home and community based attendant services for those under 150 percent of poverty and other incentives and options to shift Medicaid beneficiaries out of nursing homes and into home and community based options (HCBS). (§2401, §2402 and §10202)
- A demonstration project for “health homes” for Medicaid recipients with chronic disease. (§2703)
- A demonstration project for mental health care in private institutions to stabilize emergency medical conditions (2011-2015). (§2707)
- Grants to test evidence-based approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and determine scalable solutions. (§4108)
- Planning and program grants to state level Primary Care Extension Program “hubs” which must include state level entities, at least one health professions school and health care associations, to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. (§5405)\*
- Five year demonstration grants to evaluate alternatives to current civil tort litigation. (§10607)\*

## In 2012:

- A demonstration project in up to eight states to evaluate bundled Medicaid payments reflecting episodes of hospital care, 2012-2016. (§2704)
- A demonstration project for pediatric accountable care organizations, 2012-2016. (§2706)\*

## After 2012

- Starting July 1, 2014, 10 state wellness demonstration projects in the individual market. (§1201)
- Optional co-op, member owned health plan (must be a new health plan). Loans/grants must be provided by 2013. (§1322)
- Optional basic health program providing essential health benefits for those 133-200 percent of poverty as an alternative to the Exchange for this population (but, must have equivalent coverage, at least). (§1331)
- Starting in 2017, 5 year waivers to the Exchange are permitted (alternatives must be equivalent). (§1332)
- Starting in 2016, development of interstate compacts for one or more Qualified Health Plans. (§1333)
- Incentive payment to states that add preventive services recommended by the U.S. Preventive Services Task Force for eligible Medicaid adults and with no cost sharing for these services. (§4106)

\*Funding is not appropriated.

# Provider/Community Delivery System Options

At the local community level, health reform includes many options for health care providers and others to test new ideas for health care quality and efficiency improvements, expanding public health, and delivering care to special populations. P.L. 111-148 includes both infrastructure supports and direct funding/grants for research in a breadth of areas. As with the state optional projects, many of the projects included in health reform have funds authorized but not yet appropriated, and many require matching funds. Therefore, the full scope of what can actually be implemented will depend on the level of support that occurs in the appropriation process and at the community level. Community and provider-level components of health reform include demonstration projects, research, and training/workforce development.

## Demonstration Projects

The health reform act includes opportunities for numerous demonstration projects. Most significantly, P.L. 111-148 §3021 establishes the Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to reduce cost and improve quality. The CMI will generate many more ideas; providers and others will have the chance to participate in testing these ideas. More than \$10 billion is appropriated for this work from 2010-2019, and projects could begin as early as 2011. Specific demonstration projects in the Act include:

### In 2010:

- Extension of the existing Medicare gainsharing demonstration program (through September 2011) to evaluate if incentives based on net savings improve the quality and efficiency of care. (§3027)
- Extension of the existing Rural Community Hospital demonstration to include additional eligible states for five more years. (§3123)
- Extends and allows additional counties and physicians to participate in an existing demonstration that permits eligible rural entities to test new models for care delivery. (§3126)
- Grants to demonstrate the effectiveness of dental disease management activities. (§4102)\*
- Childhood obesity demonstration project established under the Children's Health Insurance Program, with a wide range of eligible entities and a goal to develop an effective, community based model to reduce childhood obesity. (§4306)

### In 2011:

- Funding to hospitals and community entities for evidence-based care transition services for Medicare beneficiaries at high risk of readmission. (§3026)
- Demonstration programs to provide patient navigator services, conduct outreach to health disparity populations, and coordinate health services, referrals, and information on clinical trials. (§3510)\*
- A nursing home demonstration project for IT enhancement, best practices implementation, and culture change. (§6114)\*

### In 2012:

- Medicare shared savings program with accountable care organizations. (§3022)
- A demonstration program for chronically ill Medicare beneficiaries, using home based teams. (§3024)

### In 2013:

- Medicare pilot program on payment bundling. (§3023)

### Timing Not Specified:

- A demonstration program to allow patients eligible for hospice care to also receive all other Medicare covered services during the same period of time. (§3140)

\*Funding is not appropriated.

## Research and Innovation Grants

The Act includes considerable funding for research to be carried out by academic and other provider organizations. Most notable is funding for the Patient Centered Outcomes Research Institute (PCORI, Sec 6301). The PCORI is funded to do comparative effectiveness research with a focus on both care management and clinical research. Funding for the PCORI is expected to grow from \$10 million in 2010 to \$500 million by 2013.

### In 2010, grants are also included for:

- Post-partum depression research, screening, and treatment, 2010-2012. (§2952)\*
- Extension of the existing Flex Grant program (through 2012), which helps states to implement initiatives to strengthen rural health care infrastructure. (§3129)\*
- Local entities, through the Center for Quality Improvement and Patient Safety at AHRQ, to improve safety, focus on health care acquired infections, improve ICU care and reduce readmissions, 2010-2014. (§3501)\*
- Implementing and supporting medication management services to improve the quality of care and reduce treatment costs among patients with chronic disease. (§3503)\*
- Four pilot programs to design, implement, and evaluate innovative regional emergency care and trauma systems, 2010-2014. (§3504)\*
- Prevention, wellness, and public health activities. (§4002)
- Development and operation \* of school-based health centers. (§4101)
- Activities that promote individual and community health and prevent the incidence of chronic disease. (§4201)\*
- Five-year pilot programs to improve the health status of 55-64 year olds. (§4202)\*
- Nurse managed health care clinics, 2010-2014. (§5208)\*
- Establishment and operation\* of new federally qualified health centers. (§5601 & §10503)
- Community mental health centers to coordinate and integrate services through co-location of primary care and specialty care. (§5604)\*
- The Cures Acceleration Network, to support innovation and research for high need cures (\$500 million authorization, no appropriation). (§10409)\*
- Research on prevention of and new screening tests for breast cancer in young women, 2010-2014. (§10413)\*
- A national diabetes prevention program, 2010-2014. (Title V Amendment)\*

### In 2011:

- An IOM conference and research on pain management. (§4305)\*
- A grant program to assist eligible small businesses to provide new comprehensive workplace wellness programs. (§10408)\*
- \$100 million authorization (no appropriation) for up to 20 centers of excellence in depression in first year, up to 30 by 2016, 2011-2015. (§10410)\*

### Timing Not Specified:

- A program to provide grants for the development of community health teams to support developing medical homes. (§3502)
- Research in public health services and systems including best practices relating to prevention, translation of interventions from academic settings to communities and identifying effective strategies for delivering public health services in real world settings. (§4301)\*

\*Funding is not appropriated.

## Training and Work Force Development

Finally, there are many components of health reform focused on strengthening the work force and training. While there is considerable funding described in these provisions, most of the work force development funding is not yet appropriated. Notable work force provisions in the Act are in the following areas:

### In 2010:

- Education of medical students in patient safety and quality improvement. (§3508)\*
- Education and training program for pain management and treatment. (§4305)\*
- Expansions of primary care training programs. (§5301)\*
- Development of dental training programs. (§5303)\*
- Training of alternative dental health care providers to provide services in rural and other underserved communities. (§5304)\*
- Career ladder grants for practitioners to become degree prepared nurses. (§5309)\*
- Initiatives that support the use of community health workers to promote positive healthy behaviors and outcomes in medically underserved areas. (§5313)\*
- Area health education centers (AHEC) to establish or enhance community based workforce programs in underserved areas. (§5403)\*
- Establishment or expansion of primary care residency programs in community based, ambulatory patient care centers. (§5508)\*
- Expansion or establishment of programs to increase the number of practitioners located in underserved, rural communities. (Title V Amendment)\*

### In 2011:

- Up to 24 geriatric education centers to train faculty and practitioners. (§5305)\*
- Training programs for nurse practitioners to practice in federally qualified health centers and nurse managed health centers. (§5316)\*
- Training for graduate medical education in preventive medicine or public health specialties. (Title V Amendment)\*

## Conclusion

As should be evident from this policy brief, P.L. 111-148 provides tremendous opportunities at the state and local level and includes a scope that goes well beyond an impact on health care coverage alone. Those most interested in influencing the future of health reform would be well served to identify the state and local options of most interest to them, become involved in shaping their implementation and design, and work to assure federal, state, and local funding for those options.

\*Funding is not appropriated.



**Center for Healthcare Research & Transformation**

2929 Plymouth Road, Suite 245 • Ann Arbor, MI 48105-3206

Phone: 734-998-7555 • [chrt-info@umich.edu](mailto:chrt-info@umich.edu) • [www.chrt.org](http://www.chrt.org)

