



MOVING THE FIELD FORWARD

POLICY, ADVOCACY AND EDUCATION TOOLKIT

HEALTH CARE REFORM AND PARITY

2011 - 2012

TABLE OF CONTENTS

1. HEALTH CARE REFORM IMPLEMENTATION

- [10 Priorities for Health Reform Implementation](#)
- [Health Reform Priority Recommendations and Provisions in the ACA](#)
- [Kaiser Family Foundation Health Reform Source](#)
- [Preventive Services Covered by Private Health Plans under the Affordable Care Act](#)
- [The Perils of Health Insurance Sold Across State Lines](#) (NEW)
- [New site lets consumers monitor health insurance rate hikes](#) (NEW)
- [The Bottom Line: How the Affordable Care Act Helps America's Families](#) (NEW)
- [What Other States Can Learn from Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System](#) (NEW)
- [Maximizing Systems for a Change](#) (NEW)
- [Ten Ways to Make Health Coverage Enrollment and Renewal Easy](#) (NEW)

2. PARITY

- [Parity Toolkit](#)
- [Illinois Parity Law, House bill 1530](#)
- [Oregon's Mental Health Parity Law Improves Coverage at Minimal Cost](#) (NEW)
- [Beyond Parity: Mental Health and Substance Use Disorder Care under Payment and Delivery System Reform in Massachusetts](#) (NEW)
- [Mental Health Parity and Addiction Equity Act of 2008: Frequently Asked Questions](#) (NEW)

3. ESSENTIAL HEALTH BENEFITS

- [Comments to the IOM Essential Benefits Panel](#)
- [National Health Council White Paper on Essential Benefits](#)
- [Description of a Good and Modern Addictions and Mental Health Service System](#)
- [Coalition for Whole Health Recommendations for Essential Health Benefits Framework](#)
- [Actuarial analysis of a Model Insurance Policy](#)
- [IOM Says U.S. Should Weigh Cost in Deciding Essential Health Benefits](#) (NEW)
- [National Academy for State Health Policy Webinar: Looking into the Crystal Ball: Preparing for the Essential Health Benefits](#) (NEW)
- [CMS Essential Health Benefits Bulletin](#) (NEW)

4. MEDICAID EXPANSION

- [Defending Medicaid in Hard Times: A Guide for State Advocates](#)
- [Mental Health Financing in the United States: A Primer](#)
- [Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness](#)
- [Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles](#)
- [Ensuring Access to Care in Medicaid under Health Reform: Executive Summary \(NEW\)](#)
- [Medicaid HMOs can deliver good health care – But Some Fall Short \(NEW\)](#)
- [Oregon Is Pushing Coordinated Care Organizations To Save Medicaid \(NEW\)](#)
- [A Look at Medicaid Spending, Coverage and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012 \(NEW\)](#)
- [More states limiting Medicaid hospital stays \(NEW\)](#)
- [California Gets OK For Large Cuts To Medi-Cal \(NEW\)](#)
- [Shaping Medicaid Managed Care Expansions to Better Serve Consumers \(NEW\)](#)

5. IN THE STATES (NEW CHAPTER)

- [Louisiana to Overhaul and Expand Mental Health and Addiction Services](#)
- [Nebraska Struggling With Rural Mental Health Services](#)
- [A Framework for Tracking the Impacts of the Affordable Care Act in California](#)
- [Building Partnerships: State Officials and Advocates Working on Health Reform](#)
- [Two Universities to Launch Recovery Programs \(NEW\)](#)
- [Oregon's Mental Health Parity Law Improves Coverage at Minimal Cost \(NEW\)](#)
- [Oregon Is Pushing Coordinated Care Organizations To Save Medicaid \(NEW\)](#)
- [What Other States Can Learn from Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System \(NEW\)](#)
- [New CA Law On Telehealth May Mean Better Care, Easy Access \(NEW\)](#)
- [California Gets OK For Large Cuts To Medi-Cal \(NEW\)](#)
- [Florida Health Centers to Receive Extra Funding \(NEW\)](#)
- [Minnesota Health Care Rivals' Partnership Improves Patient Satisfaction, Lowers Costs \(NEW\)](#)
- [In West Virginia, health overhaul may trim costs for state prison \(NEW\)](#)
- [State of Indiana takes on health rules \(NEW\)](#)
- [Ohio Insurance costs rise faster for families \(NEW\)](#)
- [Maryland Citizens' Health Initiative officials present a road map to state leaders \(NEW\)](#)
- [Building Medical Homes: Lessons from Eight States with Emerging Programs \(NEW\)](#)

6. INTEGRATION OF SUD SERVICES WITH PRIMARY CARE

- [Evolving Models of Behavioral Health Integration in Primary Care](#)
- [A Unique Opportunity to Integrate Behavioral Health Into the Person-Centered Medical Home](#)
- [Delivering Substance Use Care Within Health Reform: Opportunities and Challenges to Integrated Care](#)
- [Collaborative Care in Primary Care and Behavioral Health: Are We at the Tipping Point?](#)
- [Key Considerations in Designing the Medicaid Health Home State Plan Amendment](#)

7. HEALTH CARE DELIVERY *(NEW CHAPTER)*

- [Preventing Chronic Disease: The New Public Health](#)
- [Uses of Express Lane Strategies to Promote Participation in Coverage](#)
- [Managing Costs and Improving Care: Team-based Care of the Chronically Ill](#)
- [Community health centers hit hard by Washington deficit cuts *\(NEW\)*](#)
- [CMS Announces Comprehensive Primary Care Initiative *\(NEW\)*](#)
- [Blue Cross and Blue Shield Association Unveils Action Plan To Improve Quality Rein In Rising Costs *\(NEW\)*](#)
- [Minnesota Health Care Rivals' Partnership Improves Patient Satisfaction, Lowers Costs *\(NEW\)*](#)
- [New Teen Alcohol Risk Screening Guide *\(NEW\)*](#)
- [Obama Administration announces as much as \\$1 billion in grants as part of the Health Care Innovation Challenge *\(NEW\)*](#)
- [Building Medical Homes: Lessons from Eight States with Emerging Programs *\(NEW\)*](#)

8. HEALTH INFORMATION TECHNOLOGY AND MEASUREMENT

- [Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today](#)
- [A Framework for Tracking the Impacts of the Affordable Care Act in California](#)
- [Federal Government Has Put Billions into Promoting Electronic Health Record Use: How Is It Going?](#)
- [Strengthening Medicaid with Health Information Technology: Are Providers & States Up to the Challenge?](#)
- [New CA Law On Telehealth May Mean Better Care, Easy Access *\(NEW\)*](#)
- [SAMHSA awards up to \\$25 million to expand use of health information technology *\(NEW\)*](#)

9. HEALTH INSURANCE EXCHANGES

- [State Legislation on Insurance Exchanges](#)
- [Establishing Health Insurance Exchanges: An Update on State Efforts](#)
- [Thirteen States and DC allotted \\$185 million to build insurance exchanges](#)
- [Wellmark of Iowa Undecided On Insurance Exchange](#)

10. WORKFORCE

11. THIRD PARTY PAYERS

12. POLITICAL AND POLICY STRATEGIES

- [Medicaid, the Budget, and Deficit Reduction: The Threat Continues](#)
- [11th Circuit Rules that Americans Can't Be Forced to Buy Insurance](#)
- [Republican Governors Announce Proposals To Overhaul Medicaid](#)
- [Community health centers hit hard by Washington deficit cuts](#) (NEW)
- [Senate Appropriations Committee Approves FY 2012 Labor HHS Bill](#) (NEW)

13. MOBILIZING AND ORGANIZING THE GRASSROOTS

- [Building Partnerships: State Officials and Advocates Working on Health Reform](#)

14. MODEL LEGISLATION

- [Illinois Parity Law, House Bill 1530](#)

15. FUND RAISING

16. BEST PRACTICES

- [Illinois Parity Law, House Bill 1530](#)

CHAPTER ONE

HEALTH CARE REFORM IMPLEMENTATION

- [10 Priorities for Health Reform Implementation](#) Soon after the passage of Health Reform legislation, the [National Academy for State Health Policy](#) (NASHP) identified 10 aspects of federal health reform that states must get right if they are to be successful in implementation. States that adopt a coordinated, strategic approach to implementing federal health reform will find that the new law contains many provisions that support significant improvements in their health care systems. Simultaneously, states will face significant challenges implementing the new law—due to the many tasks they must complete, and due to extremely constrained financial and staff resources. The 10 areas are: *(May 2010)*
 1. [Be Strategic with Insurance Exchange](#)
 2. [Regulate the Commercial Health Insurance Market Effectively](#)
 3. [Simplify and Integrate Eligibility Systems](#)
 4. [Expand Provider and Health System Capacity](#)
 5. [Attend to Benefit Design](#)
 6. [Focus on the Dually Eligible](#)
 7. [Use Your Data](#)
 8. [Pursue Population Health Goals](#)
 9. [Engage the Public in Policy Development and Implementation](#)
 10. [Demand Quality and Efficiency from the Health Care System](#)
- This issue brief from [NASADAD](#) focuses on [health reform priority recommendations and provisions in the ACA](#) that directly and indirectly impact the substance use disorder community. It highlights and explains what federal and state policymakers, state associations, providers, consumers and other stakeholders need to pay attention to as the implementation of health reform continues to march on. *(February 2011)*
- The Kaiser Family Foundation launched an online gateway providing easy access to new and comprehensive resources on the health reform law. Recognizing the transition from the debate about passage to the realities of implementing a law, the [Health Reform Source](#) has many new features that provide explanations of the basics of the law, in-depth analysis of policy issues in implementation, and quick and easy access to relevant data, studies and developments. *(May 2011)*
- [Preventive Services Covered by Private Health Plans under the Affordable Care Act](#)

A new Kaiser Family Foundation fact sheet outlines new private insurer prevention requirements created by the ACA and discusses their possible impact. Private health plans – other than “grandfathered plans” (in existence prior to March 23, 2010) – must provide coverage for these preventive services without charging copayments, deductibles, or co-insurance to patients. These rules apply so long as the preventive service is performed by an in-network provider, is not billed separately from the office visit, and is the main reason for the office visit. Among the no-cost-sharing services are screening for depression, alcohol screening and counseling for anyone age 11 and older, counseling for drug and tobacco use and other common health concerns.

Insurers must provide coverage for evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the [United States Preventive Services Task Force](#) (USPSTF), an independent panel of clinicians and scientists that includes behavioral health specialists.

The majority of the preventive care requirements for non-grandfathered plans went into effect on September 23, 2010. The fact sheet examines which types of preventive services must be offered to individuals in general and which preventive services must be offered to special populations such as children, youth and women. *(September 2011)*

(NEW)

- [The Perils of Health Insurance Sold Across State Lines](#)
This [Families USA](#) issue brief explains the hidden dangers in legislation—being pushed at the state and the federal level—that lets out-of-state insurers evade state regulation. Instead of being licensed and regulated in each state where they do business, insurers could be licensed and regulated in just one state but still sell insurance in other states. Proponents say that this would give consumers more “choice”, allowing them to buy policies that cost less. But these cheaper policies often have surprising holes in the coverage they offer. Policy makers need to consider the consequences. Will consumers really get the protection they need when they buy insurance across state lines from a company that is not regulated by their state? *(July 2011)*

(NEW)

- [New site lets consumers monitor health insurance rate hikes](#) Health consumers across the country can now click their state on a [federal Web page](#) to see if a health insurer has raised its rates, as well as the company's reason for doing so. That information was mostly unavailable before as only a few states include rate raises on their websites. Now, however, all insurance companies must file that information with HHS because of last year's Affordable Care Act. *(October 2011)*

(NEW)

- [The Bottom Line: How the Affordable Care Act Helps America's Families](#) This Families USA report measures the net bottom line impact of the Affordable Care Act on family budgets using a sophisticated economic model. Built on publicly available data the report looks simultaneously at all the major provisions of the Affordable Care Act, measuring their impact on families in 2019. The analysis uses 2019 in order to capture the effects of the Affordable Care Act when it is fully implemented. Providing a five-year window (2014-2019) for implementation allows for both full enrollment in programs that expand coverage and the effects of initiatives that are designed to slow the growth in health care costs. The reports key findings are that both lower- and middle-income families will be financial winners, and both uninsured and insured families will come out ahead. *(October 2011)*

(NEW)

- [What Other States Can Learn from Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System](#) Vermont is the first state to enact single-payer health care legislation, successfully navigating the competing interests of businesses, providers, and the public while overcoming legal constraints and limited state budget resources. The May 2011 law, expected to become operational in 2015, creates a public-private, single-payer system financed through payroll taxes and offering a generous standard benefit package. According to this Commonwealth Fund-supported analysis in *Health Affairs*, Vermont's single-payer health care law will produce annual savings of 25.3 % compared with current spending, cut employer and household spending by \$200 million, create 3,800 jobs, and boost the state's overall economic output by \$100 million. *(July 2011)*

(NEW)

- [Maximizing Systems for a Change](#) *(Joint Project of SAAS and AHP Healthcare Solutions)*
This report explores the powerful catalysts shaping healthcare services and demanding new business models, access mechanisms, quality practices, and financing paradigms. Many of these catalysts have a “multiplier” or compounding effect. One example would be how the 2008 Mental Health Parity and Addiction Equity Act of 2008 is being magnified by the Affordable Care Act.

The report discusses why and how a *systems change* approach is necessary to help SUD providers understand and adapt to changes taking place in the most beneficial ways possible. The report proposes an actual scope of work that all States can consider and conduct with limited external support and facilitation. Having framed the current environment, the report offers a series of global recommendations for action at the State level that are based on what is taking place nationally. We believe it's in every stakeholder's best interest to act now and to be thorough in this process. Making hasty changes or waiting too long to act will likely have negative and potentially dire unintended long-term consequences. *(October 2011)*

(NEW)

- [Ten Ways to Make Health Coverage Enrollment and Renewal Easy](#) When enrollment for expanded coverage starts in 2013, how will the process work for consumers? Will it be like comparison shopping at “Orbitz.com” (with an integrated process to find out whether you qualify for a discount), or will it be like completing an annual income tax return. Ensuring that Americans get enrolled will also take concerted public education campaigns to let people know that coverage and financial aid are available to them and that signing up for coverage is easy. This [Enroll America](#) issue brief presents key elements of an easy enrollment process that can guide enrollment policy decisions in any state.
(August 2011)

CHAPTER TWO

PARITY

- The Parity Implementation Coalition provides a comprehensive [Parity Toolkit](#) to aid individuals in and seeking recovery from addiction and mental illness. It is also useful for their families, providers and advocates to help them understand their new rights and benefits under the parity law. The toolkit is a resource in how to better communicate with plans, how to prepare and document information should disputes arise with a health plan over coverage or reimbursement and better understand your basic appeals rights and procedures. Because each plan has its own appeals policies and procedures, participants must become informed about the appeal process in their own plan.

As health care costs have increased, public and private health plans have imposed stricter cost containment techniques on health benefits. Many plans have subjected addiction and mental health benefits, often called “behavioral health” benefits, to an even stricter form of cost containment, often in the form of higher co-pays and deductibles, shorter day and visit limits, pre-approval or “prior-authorization” for these services and other forms of “medically managing” these benefits that are more stringent than how other medical benefits are managed.

- In the 2011 legislation session, [Illinois HB 1530](#) overwhelmingly passed in both chambers and is now waiting for the Governor’s signature which is expected shortly. This bill
 - Requires mental health insurance parity that matches the federal requirements under the Wellstone-Domenici Parity Act.
 - Adds substance use treatment to the list of parity required health insurance benefits to existing state law.
 - Gives the Department of Insurance the power to more aggressively enforce federal standards.
 - Extends the parity requirement to employers with just two or more employees, going beyond Wellstone-Domenici.
 - Includes a medical necessity determination for substance use disorders using criteria established by the American Society of Addiction Medicine. (*August 18, 2011* Public Act . [97-0437](#))

(NEW)

- [Oregon’s Mental Health Parity Law Improves Coverage at Minimal Cost](#)
Oregon’s “Mental Health Parity and Addiction Equity Act of 2008”, which prohibits commercial health plans from imposing limits on mental health and substance abuse services that are not also imposed on medical-surgical services, has improved insurance coverage without substantial cost increases, according to [a study](#) published in the American Journal of Psychiatry. The act also restricts the use of managed care tools that apply to behavioral health benefits in ways that differ from how they apply to medical-surgical benefits. (*September 2011*)

(NEW)

- [Beyond Parity: Mental Health and Substance Use Disorder Care under Payment and Delivery System Reform in Massachusetts](#) Like most other states, Massachusetts is grappling with implementing major health care changes with passage of the ACA of 2010 and the Wellstone Domenici Mental Health Parity and Addiction Equity Act of 2008. The purpose of this [Johns Hopkins School of Public Health](#) report is to examine how these two laws and policy initiatives will impact care for individuals and families with MH and SUD. It describes the policy context and offers recommendations for initiating a community conversation about how these major policy changes might be implemented with the goal of improving mental health and addiction care in Massachusetts. (*October 2011*)

(NEW)

- [Mental Health Parity and Addiction Equity Act of 2008: Frequently Asked Questions](#)
This one page fact sheet from the CMS Center for Consumer Information and Insurance Oversight is the latest in a series of Frequently Asked Questions on the implementation of the MHPAEA.

CHAPTER THREE

ESSENTIAL HEALTH BENEFITS

- [Comments to the IOM Essential Benefits' Panel](#)
The Coalition for Whole Health, co-chaired by the [Legal Action Center](#), is a broad coalition of national organizations representing the mental health and addiction prevention, treatment and recovery communities. Last December, the Coalition drafted and presented comments to a panel of Institute of Medicine experts looking into an essential benefit package. Some of the issues addressed by the comments include the definition of medical necessity, criteria and methods currently used by insurers to determine coverage and how to best take into account the needs of diverse segments of the population, including persons with disabilities. *(December 2010)*
- [National Health Council White Paper on Essential Benefits](#)
This paper considers the approach the Secretary of HHS may take in defining the federal essential health benefits package. The paper: provides a background on insurance mandates; describes the essential health benefits package created in ACA; explores the potential challenges in defining “essential”; considers the Medicare program and the Blue Cross Blue Shield Standard Option available to federal employees as potential frameworks for the federal standard; and evaluates benefits mandated at the state level, including those established under Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program for children. *(September 2010)*
- [Description of a Good and Modern Addictions and Mental Health Service System](#)
This SAMHSA document describes the basic services required for a delivery system of mental health and addiction services that offers a continuum of effective treatment and support services spanning healthcare, employment, housing and educational sectors, where integration of primary care and behavioral health is an essential component.

The document is designed to foster discussion among the Department of Health and Human Service Operating Divisions and other federal agencies on how best to integrate mental and substance use disorders into the health reform implementation agenda. This document can provide clarity to federal agencies that regulate or purchase services for individuals with mental and substance use disorders; offer guidance to agencies that are presently making decisions about expanding services to these populations; and assist in planning possible changes to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Services Block Grant. *(April 2011)*
- The Coalition for Whole Health has [developed recommendations](#) to fully include mental health and substance use disorders within the Essential Health Benefits framework of the Affordable Care Act. This paper details the mental health and substance use disorder benefits that the Coalition believes must be included by the Essential Health Benefits package covered by “new” small employer and individual plans, qualified health plans operating in state Exchanges, and Medicaid expansion plans. [Over 150 national, state, and local organizations have endorsed](#) the Coalition’s Essential Health Benefits recommendations. To sign on to the Coalition’s recommendations, please email [Sherie Boyd](#). *(August 2011)*
- [Essential Health Benefits Package – the Next Big Thing](#)
An [actuarial analysis of a model insurance policy](#) under the health care law estimated annual premiums of \$5,000 for an individual and \$12,500 for a family. Its actuarial value would be near the “platinum” level established in the law – one of the most generous plans. The analysis released by Avalere Health and the [National Health Council](#), an advocate for the chronically ill, estimated premiums and out-of-pocket charges for a model plan similar to what BC/BS offers to federal employees. Annual out-of-pocket spending for people with chronic illnesses often can run into the thousands. People with chronic conditions and limited incomes and resources may have a tough time affording insurance even with government subsidies. *(August 2011)*

(NEW)

- [IOM Says U.S. Should Weigh Cost in Deciding Essential Health Benefits: In a new report](#), the [Institute of Medicine](#) tells the HHS Secretary how to define the minimum benefits. That is a huge decision that could affect 68 million people, individuals, families and businesses that obtain coverage through new state-based insurance exchanges. One of the key recommendations is to explicitly consider cost as a factor in deciding what health benefits must be provided by insurance plans. The IOM panel said the cost of any new benefits should be “offset by savings” elsewhere in the health care system and in defining “essential health benefits,” the government should try to guarantee that the average premium would not exceed benchmarks to be set by HHS. *(October 2011)*

(NEW)

- [National Academy for State Health Policy Webinar: Looking into the Crystal Ball: Preparing for the Essential Health Benefits](#): In this webinar, expert presenters will help states identify how to get started on benefit design, provide insights on how what HHS’ guidance on the essential health benefits package might look like. Discussion topics will include:
 - * Aligning Medicaid, CHIP, and state basic health plan benefits with benefits in plans available through the exchange
 - * Anticipating essential health benefits package implications for exchanges, Medicaid, the commercial insurance market, and existing state benefit mandates
 - * Analyzing opportunities for state flexibility regarding the essential benefits*(December 2011)*

(NEW)

- [Essential Health Benefits Bulletin](#) This bulletin from the CMS [Center for Consumer Information and Insurance Oversight](#) provides information and solicits comments on the regulatory approach that HHS plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value is not addressed. Guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage will be released in the near future. Future guidance will be issued on essential health benefit implementation in the Medicaid program. Public input is welcome on this intended approach. Send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov *(December 2011)*

CHAPTER FOUR

MEDICAID EXPANSION

- [Defending Medicaid in Hard Times: A Guide for State Advocates](#)
Community Catalyst reports that 46 states faced budget shortfalls in fiscal year 2011. Because of Medicaid's prominence in state budgets (17% of spending), the program becomes a popular target for cuts. Thirty-eight states and the District of Columbia cut Medicaid in fiscal year 2011 by reducing eligibility, benefits or provider payments and increasing patient co-payments. The outlook is equally grim for fiscal year 2012. To prevent harm from these types of Medicaid cuts and to preserve the Medicaid program for its 2014 expansion, defenders must persuade policymakers that:
 - [Cutting eligibility, benefits or rates, or creating barriers to enrollment are bad ideas.](#)
 - [Better alternatives to Medicaid cuts](#)

This [Community Catalyst](#) guide distills lessons from Medicaid defense work in a number of states and provides tools to fight cuts and introduce the most promising alternatives. *(November 2010)*

- The Kaiser Family Foundation's Commission on Medicaid and the Uninsured explores key aspects of mental health care financing and access. [Mental Health Financing in the United States: A Primer](#) provides an overview of behavioral health care, reviews the sources of financing for such care, assesses the interaction between different payers and highlights recent policy debates in mental health. It also discusses the role of Medicaid, currently the largest source of financing for behavioral health services in the nation, covering a quarter of all expenditures. *(April 2011)*
- This issue brief from the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, [Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness under the Affordable Care Act](#), examines the salient issues raised in a recent roundtable discussion of national and state experts to discuss Medicaid policy options available under health reform to help meet the needs of adults with mental illness. *(April 2011)*
- The [Kaiser Commission on Medicaid and the Uninsured](#) recently released a report on dual eligibles, [Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS](#). In July 2011, CMS released a "State Medicaid Director" letter containing preliminary guidance on opportunities to align Medicare and Medicaid financing, testing both capitated and fee-for-service integration models. The capitated model would receive a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports. The proposed designs will describe how states would "structure, implement and evaluate an intervention aimed at improving the quality, coordination and cost-effectiveness of care" for duals, with implementation targeted for 2012.

This policy brief summarizes significant characteristics of the preliminary proposals including the type of entity to deliver benefits, target population and enrollment, benefits package, financing, beneficiary protections, stakeholder involvement and proposed timeframe. The 15 states are -California - Colorado -Connecticut -Massachusetts -Michigan -Minnesota -New York -North Carolina -Oklahoma - Oregon -South Carolina -Tennessee -Vermont -Washington -Wisconsin. *(August 2011)*

(NEW)

- The [Kaiser Commission on Medicaid and the Uninsured](#) convened a roundtable meeting on December 14, 2010 with a group of federal and state officials and experts to identify key access to care issues. [Ensuring Access to Care in Medicaid under Health Reform: Executive Summary](#) summarizes those issues and points out that access to mental health care is critical as millions of low-income adults, many with MH and SUD treatment needs become Medicaid eligible. The high prevalence of mental health conditions and substance use disorders in the Medicaid population sharpens concerns about system capacity, the lack of coordination between physical and mental health services and the need to reduce fragmentation at both the federal and state levels between Medicaid and mental health agencies. Models that integrate behavioral health with physical health, co-location of mental health and primary care and payment mechanisms that foster integration are all important directions for improving access to mental health care in Medicaid. *(May 2011)*

(NEW)

- [Medicaid HMOs can deliver good health care—But Some Fall Short](#) How well does Medicaid managed care provide care? As part of the Robert Wood Johnson Foundation's "Care About Your Care" campaign, Consumer Reports is publishing [National Committee for Quality Assurance \(NCQA\) rankings](#) of Medicaid HMO plans. The Medicaid rankings include results from 99 Medicaid HMO plans in 30 states and the District of Columbia. (October 2011)

(NEW)

- [Oregon Is Pushing Coordinated Care Organizations To Save Medicaid](#) Oregon Gov. John Kitzhaber wants to prove his state can contain soaring Medicaid costs without reducing services to recipients or slashing fees to doctors and hospitals. He then wants to apply this same strategy to saving Medicare. His state plan is to shift Oregon's Medicaid recipients into "[coordinated care organizations](#)," (CCOs) that would oversee patients' physical, mental and dental health. A group of 40 stakeholders from 15 Oregon counties representing mental, physical and oral health form the [\(CCO\) Criteria Work Group](#) that will make recommendations to be given to the Legislature next February. (October 2011)

(NEW)

- [A Look at Medicaid Spending, Coverage and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012](#) This Kaiser Family Foundation's Commission on Medicaid and the Uninsured report finds that Medicaid officials in virtually every state are enacting a variety of cost cutting measures as states' spending for Medicaid is projected to increase 28.7 percent in fiscal year 2012 to make up for the loss of federal stimulus money. The end of federal stimulus spending is going to mean nothing but pain for state Medicaid programs in fiscal 2012. State Medicaid spending is projected to grow by an average of 29 percent in the budget year that began July 1, the biggest increase in its history. To counter the cost surge in Medicaid, which typically accounts for a quarter of state budgets, nearly every state is either reducing benefits, cutting fees to doctors and hospitals, or doing both. (October 2011)

(NEW)

- [More states limiting Medicaid hospital stays](#) In the latest sign of how desperate they are to control rising Medicaid costs, a small but growing number of states are sharply limiting hospital coverage — to as few as 10 days a year. Advocates for the poor and hospital executives say the moves will restrict patients' access to care force hospitals to absorb more costs and lead to higher charges for privately insured patients. States defend the actions as a way to balance budgets hammered by the economic downturn and the end of billions of dollars in federal stimulus funding this summer — funds that had helped prop up Medicaid, the state-federal health insurance program for the poor. Arizona plans to limit adult Medicaid recipients [to 25 days of hospital coverage a year](#), starting as soon as the end of October. Hawaii is going even further. In April 2012, it plans to cut Medicaid coverage to [10 days a year](#) -- the fewest of any state.

Both efforts are pending federal approval, which state officials consider likely because several other states already restrict hospital coverage, among them Alabama (16 days), Arkansas (24 days), Florida (45 days), and Mississippi (30 days). Last year, Massachusetts started a 20-day per stay limit. (October 2011)

(NEW)

- [California Gets OK For Large Cuts To Medi-Cal](#) The Obama administration will allow California to cut hundreds of millions of dollars from Medi-Cal, a move doctors and experts say will make it harder for the poor to get medical treatment. California plans to reduce rates by 10 percent to many providers, including physicians, dentists, clinics, pharmacies and most nursing homes. (October 2011)

(NEW)

- [Shaping Medicaid Managed Care Expansions to Better Serve Consumers](#) Half of all Americans covered by Medicaid are in managed care plans run by companies paid a per member fee to provide most medical services. State governments are increasingly mandating this approach for seniors in long-term care and for people with disabilities, rather than serving them through traditional fee-for-service. In many states, these changes are motivated by efforts to control growth in Medicaid costs. At its best, Medicaid managed care provides opportunities for improved coordination, quality and efficiency of services. But it comes with risks for consumers, such as restricted access to needed care, requiring vigilance and advocacy from consumer groups and providers. The principles outlined in this Community Catalyst policy brief can help guide consumer advocates as they work for managed care that best serves seniors and people with disabilities. *(October 2011)*

NEW CHAPTER FIVE

IN THE STATES

- [Louisiana to overhaul and expand mental health and addiction services](#)
Louisiana's state health agency taps Magellan to streamline and coordinate services among multiple providers with a goal to improve health outcomes for the state's Medicaid and uninsured populations. The new program is set to launch March 1, 2012. *(September 2011)*
- [Nebraska Struggling With Rural Mental Health Services](#)
The state Medicaid director testified before a legislative panel that Nebraska is still struggling to provide rural, community-based mental health and substance abuse services to children. The state will have to rely more on such providers as it tries to come into compliance with federal rules for mental health and substance abuse treatment. At stake are millions in federal matching dollars given to Nebraska to administer the services. *(August 2011)*
- [A Framework for Tracking the Impacts of the Affordable Care Act in California](#) The goal of this State Health Access Data Assistance Center's project was to recommend how California (and the California HealthCare Foundation) can measure and monitor the impacts of health care reform in three areas: health insurance coverage, affordability and comprehensiveness of health insurance coverage and access to health care services. The study also addresses the best data source for each measure, gaps in existing data and issues for data presentation. It identified a total of 51 measures that California can use to monitor the impacts of health care reform over time: 19 related to insurance coverage, 15 related to affordability and comprehensiveness of coverage, and 17 related to access to care. *(June 2011)*
- [Building Partnerships: State Officials and Advocates Working on Health Reform](#) In March 2011, state officials and consumer advocates from nine southern states came together to discuss health reform implementation and ways to work together. The meeting was convened by the [National Academy for State Health Policy](#) (NASHP) in collaboration with Community Catalyst, and funded by the Public Welfare Foundation. This paper highlights themes from this meeting, such as lessons learned in building stronger or more effective relationships between these groups and ways to work together as health care reform implementation proceeds at the state level. *(June 2011)*

(NEW)

- [Two Universities to Launch Recovery Programs](#): The University of Michigan (UM) and the Pennsylvania State University (Penn State) announced plans to launch drug and alcohol recovery programs this summer. UM's Collegiate Recovery Program is slated to launch using \$10,000 in university health services funds, providing self-help recovery courses and alcohol- and drug-free activities. Penn State has dedicated space and staff for its recovery program. In related news this summer, 20 colleges formed the Association for Recovery in Higher Education to promote the spread of similar programs. *(August 2011)*

(NEW)

- [Oregon's Mental Health Parity Law Improves Coverage at Minimal Cost](#)
Oregon's "Mental Health Parity and Addiction Equity Act of 2008", which prohibits commercial health plans from imposing limits on mental health and substance abuse services that are not also imposed on medical-surgical services, has improved insurance coverage without substantial cost increases, according to [a study](#) published in the American Journal of Psychiatry. The act also restricts the use of managed care tools that apply to behavioral health benefits in ways that differ from how they apply to medical-surgical benefits. *(September 2011)*

(NEW)

- [Oregon Is Pushing Coordinated Care Organizations To Save Medicaid](#) Oregon Gov. John Kitzhaber wants to prove his state can contain soaring Medicaid costs without reducing services to recipients or slashing fees to doctors and hospitals. He then wants to apply this same strategy to saving Medicare. His state plan is to shift Oregon's Medicaid recipients into "[coordinated care organizations](#)," (CCOs) that would oversee patients' physical, mental and dental health. A group of 40 stakeholders from 15 Oregon counties representing mental, physical and oral health form the [\(CCO\) Criteria Work Group](#) that will make recommendations to be given to the Legislature next February. (October 2011)

(NEW)

- [What Other States Can Learn from Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System](#) Vermont is the first state to enact single-payer health care legislation, navigating the competing interests of businesses, providers, and the public while overcoming legal constraints and limited state budget resources. The May 2011 law, expected to become operational in 2015, creates a public-private, single-payer system financed through payroll taxes and offering a generous standard benefit package. According to this Commonwealth Fund-supported analysis in *Health Affairs*, Vermont's single-payer health care law will produce annual savings of 25.3 percent compared with current spending, cut employer and household spending by \$200 million, create 3,800 jobs, and boost the state's overall economic output by \$100 million. (July 2011)

(NEW)

- [New CA Law On Telehealth May Mean Better Care, Easy Access](#) The new California law ([AB 415](#)) that takes effect January 1, 2012, is designed to streamline the practice of telehealth in a number of ways and will improve patient care significantly in rural areas. For instance, the law addresses an existing requirement that physicians and other health care providers have dual credentialing, meaning they need to be credentialed at the facility where they work and the telehealth facility where the patient is being treated remotely. The current system requires health care providers to explain exactly why they need to use telehealth before they can use it. (October 2011)

(NEW)

- [California Gets OK For Large Cuts To Medi-Cal](#) The Obama administration will allow California to cut hundreds of millions of dollars from Medi-Cal, a move doctors and experts say will make it harder for the poor to get medical treatment. California plans to reduce rates by 10 percent to many providers, including physicians, dentists, clinics, pharmacies and most nursing homes. (October 2011)

(NEW)

- [Florida Health Centers to Receive Extra Funding](#) CMS officials have announced that as part of the Advanced Primary Care Practice demonstration project, nineteen of Florida's community health centers will receive a boost in federal dollars over three years to speed up Medicare patients' access to primary care. The hope is that quick appointments will keep patients from resorting to hospital emergency rooms, thus save money while improving the quality of care. Florida's participating clinics -- among 500 participating centers nationwide sharing \$42 million over three years -- will use the money to extend their hours, hire extra workers or improve technology. (October 2011)

(NEW)

- [Health Care Rivals' Partnership Improves Patient Satisfaction, Lowers Costs](#) In Minnesota, a partnership between two rivals offers a glimpse of the future under a cornerstone of the federal health care overhaul. HealthPartners and Allina Hospitals and Clinics together tested strategies to improve care and reduce health costs for some 27,000 patients. The partnership calls the effort a "learning lab" for the Accountable Care Organization envisioned under the federal health care law. They say they've proven that such an organization can lower costs while improving quality. The systems say they've proven that such an organization can lower costs while improving quality. After a year, their collaboration saved about \$6 million, which was enough to bring the growth rate of health care costs down from 8 percent to just 3 percent. Patient satisfaction scores improved as well. (October 2011)

(NEW)

- [West Virginia Health overhaul may trim costs for state prisons](#) The State Division of Corrections could save up to \$2 million a year in inmate medical care costs when new federal health care laws take effect in 2014. Provisions in the Patient Protection and Affordable Care Act that passed last year overhaul eligibility requirements for Medicaid to include individuals who make less than 133 percent of the federal poverty level, regardless of whether they have children. While this expansion means states eventually will have to spend significantly more to fund their portion of the Medicaid program, part of the rule change may trim costs in state corrections programs. *(October 2011)*

(NEW)

- [State of Indiana takes on health rules](#) Indiana wants to exempt some of the state's health insurers from having to spend a minimum portion of customers' premiums on medical services — instead of on profits and administrative costs such as marketing and salaries. If the federal government approves the state's request to waive that new rule included in the 2010 health care law, some Hoosiers won't get the refunds required from insurers who spend less than 80 cents of every \$1 collected in premiums on medical care. If the rule were in place last year, Hoosiers who bought plans on their own would have received almost \$24 million in rebates, according to estimates the state included in its waiver application. The Obama Administration estimates that as many as 9 million Americans could be eligible for rebates worth a combined \$1.4 billion next year. *(October 2011)*

(NEW)

- [Ohio Insurance costs rise faster for families](#) As health-insurance costs continue to rise, employers are passing on a bigger share of those increases to their workers, especially those who choose family policies. The cost of family health policies in Ohio has increased by 82 percent over the past decade. During that time, workers' share of the policies has jumped 142 percent, according to an analysis of federal health data by Ohio researchers. The cost and workers' share of policies for single employees increased by 68 percent over 10 years. Experts say employers are doing this to limit their risk of covering spouses and children who might have health problems. *(October 2011)*

(NEW)

- The [Maryland Citizens' Health Initiative](#) officials have presented a road map to state leaders at the Maryland Health Exchange Board, whose members are working to implement the national health care reform law. The proposal was supported by documents prepared by the Johns Hopkins Bloomberg School of Public Health, the Center for Medical Technology Policy, and America's Agenda. [The extensive proposal can be viewed here.](#) *(November 2011)*

(NEW)

- [Building Medical Homes: Lessons from Eight States with Emerging Programs](#) Many states are strategically engaging public and private payers in the design of medical home programs as a means of achieving better health outcomes, increasing patient satisfaction, and lowering health care costs. Eight states profiled in this Commonwealth Fund/ NASHP report – Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—are at different stages in the development and implementation of a medical home, using different strategies to encourage primary care providers to adopt the model, including developing state medical home qualification standards instead of national standards. Their experiences demonstrate that states can play a critical role in convening stakeholders, helping practices improve performance, and addressing antitrust concerns that arise when multiple payers come together to create a medical home program. *(December 2011)*

CHAPTER SIX

INTEGRATION OF SUD SERVICES AND PRIMARY CARE

- [Evolving Models of Behavioral Health Integration in Primary Care](#)
The U.S. mental health system fails to reach and/or adequately treat the millions of Americans suffering from mental illness and substance abuse. This [Milbank Memorial Fund](#) report offers an approach to meeting these unmet needs: the integration of primary care and behavioral health care. The report summarizes the available evidence and states' experiences around integration as a means for delivering quality, effective physical and mental health care. For those interested in integrating care, it provides eight models that represent qualitatively different ways of integrating/coordinating care across a continuum—from minimal collaboration to partial integration to full integration—according to stakeholder needs, resources, and practice patterns.

The Fund commissioned this report to provide policymakers with a primer on integrated care that includes both a description of the various models along the continuum and a useful planning guide for those seeking to successfully implement an integrated care model in their jurisdiction. *(May 2010)*
- [A Unique Opportunity to Integrate Behavioral Health Into the Person-Centered Medical Home](#)
The Patient Protection & Affordable Care Act (PPACA) established a new medical home pilot program which allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness and substance use disorders, into medical homes beginning in 2011. Health homes will be composed of a team of health professionals that will provide a comprehensive set of medical services, including care coordination. This National Council for Community Behavioral Health fact sheet explains what this means for states, emphasizes the importance of insuring the careful consideration necessary to assure access for and engagement of persons living with behavioral health conditions, and provides examples of patient centered medical homes initiatives.
- [Delivering Substance Use Care Within Health Reform: Opportunities and Challenges to Integrated Care](#) This power point presentation reviews CMS guidance for establishing health homes, presents the AECOM service delivery system as a model for a behavioral health home with a substance use focus and presents guiding principles for states in developing the standards for health homes targeting substance users. *(May 2011)*
- [Collaborative Care in Primary Care and Behavioral Health: Are We at the Tipping Point?](#)
This power point presentation addresses major issues in creating collaborative systems of care in primary care and behavioral health settings. Among the issues the presentation examines are: why integration matters for the treatment of behavioral health patients, what are the key ingredients of collaborative care, does integrated care mean the same as collaborative care and whether the formation of health homes and accountable care organizations equate to arriving at the promised land. Also examined are the concepts of quality outcomes and measurement tools *(May 2011)*
- [Key Considerations in Designing the Medicaid Health Home State Plan Amendment](#)
This power point presentation examines key discussion points as policymakers and policy analysts think through their state's interest to use health homes in coordinating care for individuals with chronic conditions. The discussion points include a definition of health homes, expectations of CMS, outcome measures, reimbursement, planning and implementation considerations as well as some proposed approaches. *(May 2011)*

NEW CHAPTER SEVEN

HEALTH CARE DELIVERY

- [Preventing Chronic Disease: The New Public Health](#) A number of provisions in the health reform law are aimed directly at improving population health by addressing conditions where Americans live, learn, work, and play – at their schools, worksites, restaurants and more.

How can prevention and public health be leveraged to improve health and reduce health care costs, particularly within Medicare, Medicaid, and CHIP? What are the threats to the “new public health” in light of budget constraints on the federal, state and local levels? How does the Patient Protection and Affordable Care Act (ACA) relate to public health and prevention activities? How are the resources in the \$15 billion Public Health and Prevention Fund, set up under the ACA, being deployed? How might budget cuts affect public health programs and population health? This [Alliance for Health Reform](#) briefing addresses these questions and others. *(July 2011)*

- [Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage](#) Under the ACA, millions of uninsured adults and children will gain eligibility for health coverage through new health insurance Exchanges beginning in 2014. The law calls upon states to develop simple and streamlined processes for establishing, verifying and updating eligibility for Medicaid, CHIP and federal subsidies. This Kaiser Family Foundation issue brief examines how states can employ “express lane” principles in designing systems to help identify individuals who may be eligible for Medicaid, CHIP or premium subsidies. *(July 2011)*
- [Managing Costs and Improving Care: Team-based Care of the Chronically Ill](#) It may be possible to improve the quality of care for the chronically ill while altering the trajectory of spending for their care. Savings have been shown in some private and public sector approaches using teams that span multiple sites of care, reduce fragmentation and improve health outcomes. The ACA establishes new pilots and innovations that could change the way we deliver and pay for care to the chronically ill. The [Alliance for Health Reform](#) and the [Commonwealth Fund](#) co-sponsored this briefing to discuss partnerships among Medicare, Medicaid, private plans and providers to develop new approaches and achieve public health goals. Could these programs address the different needs of populations in institutional care versus community-based care? How do these new models differ from former approaches? What infrastructure and training enhancements are needed? What have we learned from states that have tried Medicaid case management for the chronically ill? *(August 2011)*

(NEW)

- [Community health centers hit hard by Washington deficit cuts](#) The funding cut was a result of a federal budget compromise in March to keep the government running. That agreement reduced federal spending by nearly \$80 billion, including a \$600 million trim in funding for ongoing operations at existing health centers. Advocates were left frustrated that they would not be able to serve the growing numbers of uninsured and poor people or be ready for an influx of patients under the Affordable Care Act. *(October 2011)*

(NEW)

- [CMS Announces Comprehensive Primary Care Initiative](#) The Comprehensive Primary Care (CPC) initiative is a new CMS-led, multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care Without a significant enough investment across multiple payers, independent health plans– covering only their own members and offering support only for their segment of the total practice population– cannot provide enough resources to transform entire primary care practices and make expanded services available to all patients served by those practices. The CPC initiative offers a way to break through this historical impasse by inviting payers to join with Medicare in investing in primary care in 5-7 selected localities across the country. Two models will be tested simultaneously: a service delivery model and a payment model. *(October 2011)*

(NEW)

- [Blue Cross and Blue Shield Association Unveils Action Plan To Improve Quality Rein In Rising Costs](#) The BCBSA released a comprehensive, interconnected action plan that fundamentally transforms the healthcare system, moving it away from a fee-for-service model to a patient-centered model. The action plan, [Building Tomorrow's Healthcare System: The Pathway to High-Quality, Affordable Care in America](#), provides specific recommendations to improve healthcare quality and tackle rising costs and is based on the experience of BCBSA's 39 Plans in all 50 states and federal territories, in every market and every zip code. An independent economic analysis of the recommendations shows that more than \$300 billion in federal savings will be realized over the next 10 years. (October 2011)

(NEW)

- [Health Care Rivals' Partnership Improves Patient Satisfaction, Lowers Costs](#) In Minnesota, a partnership between two rivals offers a glimpse of the future under a cornerstone of the federal health care overhaul. HealthPartners and Allina Hospitals and Clinics together tested strategies to improve care and reduce health costs for some 27,000 patients. The partnership calls the effort a "learning lab" for the Accountable Care Organization envisioned under the federal health care law. They say they've proven that such an organization can lower costs while improving quality. After a year, their collaboration saved about \$6 million, which was enough to bring the growth rate of health care costs down from 8 percent to just 3 percent. Patient satisfaction scores improved as well. (October 2011)

(NEW)

- [New Teen Alcohol Risk Screening Guide](#) The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has just released a guide for health care professionals to help identify children and teenagers age 9 to 18 who are at risk for alcohol-related problems, provide brief counseling, and refer them to treatment resources. The evidence-based guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide* includes a two-question risk assessment as well as links to resources for motivational interviewing. NIAAA developed the guide and supporting pocket guide in collaboration with the American Academy of Pediatrics. (October 2011)

(NEW)

- The Obama Administration announced as much as \$1 billion in grants as part of the [Health Care Innovation Challenge](#) designed to improve not only public health and create health care jobs. Proposals are encouraged to focus on high cost/high-risk groups including populations with multiple chronic diseases and/or MH or SUD, poor health status, multiple medical conditions, or high cost individuals. [These grants](#) will be awarded in March 2012 to applicants who implement the most compelling new ideas to deliver better health, improved care and lower costs to Medicare, Medicaid and CHIP enrollees, particularly those with the highest health care needs. (November 2011)

(NEW)

- SAMHSA has announced [\\$15 million in grants](#) to support and promote better primary care and behavioral health services for individuals with mental and substance use disorders. These grants are funded by the [ACA's Prevention and Public Health Fund](#) to improve health status by improving the coordination of healthcare services delivered in publicly funded community-based behavioral health settings, including community mental health centers and public health departments. (October 2011)

(NEW)

- [Building Medical Homes: Lessons from Eight States with Emerging Programs](#) Many states are strategically engaging public and private payers in the design of medical home programs as a means of achieving better health outcomes, increasing patient satisfaction, and lowering health care costs. Eight states profiled in this Commonwealth Fund/ NASHP report – Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—are using different strategies to encourage primary care providers to adopt the model, including developing state medical home qualification standards instead of national standards. Their experiences demonstrate that states can play a critical role in convening stakeholders, helping practices improve performance, and addressing antitrust concerns that arise when multiple payers come together to create a medical home program. (December 2011)

CHAPTER EIGHT

HEALTH INFORMATION TECHNOLOGY AND MEASUREMENT

- [Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today](#)
The ACA's transformative vision for eligibility and enrollment in publicly subsidized health coverage is an enrollment superhighway that is streamlined, modern, seamless, integrated, easy for consumers to use, and connects Medicaid, CHIP and Exchange coverage. This vision contrasts sharply with most states' welfare-era, paper-based systems that rely on complex eligibility rules and outdated technologies. This [National Academy for State Health Policy](#) paper frames ACA's vision and discusses gaps between 2014 and today and opportunities to close these gaps in four key areas: 1) Consumer Experience; 2) Eligibility and Enrollment Policy; 3) Technology and Systems Infrastructure; and 4) Governance and Administration. *(March 2011)*
- [A Framework for Tracking the Impacts of the Affordable Care Act in California](#) The goal of this State Health Access Data Assistance Center's project was to recommend how California (and the California HealthCare Foundation) can measure and monitor the impacts of health care reform in three areas: health insurance coverage, affordability and comprehensiveness of health insurance coverage and access to health care services. The study also addresses the best data source for each measure, gaps in existing data and issues for data presentation. It identified a total of 51 measures that California can use to monitor the impacts of health care reform over time: 19 related to insurance coverage, 15 related to affordability and comprehensiveness of coverage, and 17 related to access to care. *(June 2011)*
- [The Federal Government Has Put Billions into Promoting Electronic Health Record Use: How Is It Going?](#) This [Commonwealth Fund](#) article reports that despite the huge government investment to incentivize hospitals and providers to adopt electronic health records (EHR) systems, the progress made to that end has been slow and obstacles remain. The article also highlights the rewards for adopting EHR, field support available through Regional Extension Centers, workforce training and related issues. *(June/July 2011)*
- [Strengthening Medicaid with Health Information Technology: Are Providers & States Up to the Challenge?](#) Under the American Recovery and Reinvestment Act of 2009, providers can receive Medicare and Medicaid payment incentives when they adopt electronic health records and demonstrate their "meaningful use." Additionally, the ACA requires states to establish a website for Medicaid beneficiaries to electronically enroll and renew coverage. Yet many challenges remain for health information technology to help Medicaid operate more effectively.

The [Alliance for Health Reform](#) sponsored this briefing to discuss HIT's impact on Medicaid's care delivery and administration. Some of the questions that were addressed: How are states preparing to integrate their HIT systems with the exchanges? What role are state Medicaid agencies playing? How can Medicaid health plans and providers use HIT to provide better care delivery, improve outcomes and reduce costs? What have HIT initiatives such as the Beacon Communities learned about deploying HIT resources? How does meaningful use strike the right balance between encouraging progress and achievability? *(August 2011)*

CHAPTER SEVEN

HEALTH INSURANCE EXCHANGES

- [State Legislation on Insurance Exchanges](#) - This [Center on Budget Policies and Priorities](#) report provides a summary of proposed or enacted state exchange legislation introduced in the 2011 legislative sessions, focusing on governance and conflict of interest provisions. *(July 2011)*
- This [Kaiser Family Foundation](#) issue brief, [Establishing Health Insurance Exchanges: An Update on State Efforts](#) examines states' progress in creating health insurance exchanges. As most states' 2011 legislative sessions have concluded this brief examines the trends in states' initiatives to establish or study exchanges.

Legislatures in 13 states passed laws to establish exchanges. In Utah and Massachusetts additional legislation may be required to comply with ACA's specifications. Other states enacted legislation that allowed the state to continue investigating whether or how to establish an exchange. North Dakota and Virginia both passed laws stating their intent to create an exchange and delegated responsibility for planning to the state insurance and health and human services agencies. Mississippi and Wyoming decided to study the feasibility of creating an exchange. By January 2013, the HHS will evaluate states to identify those that have not made sufficient progress toward establishing a "fully operational" state-based exchange. *(July 2011)*

- On August 12th, the [Obama Administration](#) allotted [\\$185 million](#) to 13 states and the District of Columbia to help build new insurance exchanges. It also [issued rules](#) on how the new marketplaces will enroll individuals, provide subsidies and interact with state Medicaid programs. As the next big step to help states establish the exchanges, [the guidelines](#) stipulate that states need to provide a "one-stop shop" system to determine eligibility for insurance and tax credits. The proposed rules highlight the expectation of a smooth connection between state-run exchanges and federal systems to make sure they connect and share information.

Last year, HHS awarded \$1 million planning grants to 49 states and the District of Columbia, although some states gave the money back. States awarded exchange grants Friday are Maryland, Connecticut, Missouri, Mississippi, California, Illinois, Kentucky, Minnesota, Nevada, New York, North Carolina, Oregon and West Virginia. Indiana, Rhode Island and Washington received exchange grants in May. *(August 2011)*

- [Wellmark of Iowa Undecided On Insurance Exchange](#)
Iowa's dominant health insurer is considering staying out of the state's planned insurance exchange, which could hamstring the initiative. Insurance exchanges are expected to be a key part of the national health reform program. Wellmark Blue Cross/Blue Shield provides three-quarters of policies to Iowa individual consumers and small businesses. *(August 2011)*

CHAPTER EIGHT

WORKFORCE

CHAPTER NINE

THIRD PARTY PAYERS

CHAPTER TEN

POLITICAL AND POLICY STRATEGIES

- [Medicaid, the Budget, and Deficit Reduction: The Threat Continues](#) This [Families USA](#) paper provides an analysis of the provisions of the recently signed-into-law Budget Control Act of 2011 and its potential impact on Medicaid, Medicare and other entitlements. The deficit reduction legislation includes nearly \$1 trillion in spending cuts over the next decade, including cuts to vital programs.

Although Medicaid was spared in those initial cuts the program is still at risk. The new law establishes a “super committee” of 6 Democrats and 6 Republicans, whose charge is to come up with a specific plan by the end of November—policy and funding changes that would reduce the deficit by another \$1.5 trillion over the next 10 years. To reduce the deficit the committee can consider cutting or restructuring Medicaid, Medicare or Social Security, as well as raising revenue. If the committee can't decide on a plan approved by Congress and signed by the President, automatic spending cuts ensue. *(August 2011)*

- 11th Circuit Rules that Americans Can't Be Forced to Buy Insurance
In mid-August, the [11th Circuit Court of Appeals](#) in Atlanta ruled that the federal government cannot force individuals to purchase health insurance under President Obama's landmark health care overhaul.

The federal court ruling against a key provision of the health care reform law makes it almost certain the Supreme Court will decide the law's constitutionality in the 2012 term. The court has two very strong reasons to take the case now. First, there are two circuit courts that have ruled in opposite directions on the constitutionality of the law's individual mandate. And second, because the Obama administration lost in the latest ruling, it is going to be the one filing the appeal. The Supreme Court rarely turns down such requests from the federal government. As court action continues, some policy experts expect that [efforts to find an alternative to the individual mandate](#) will intensify. *(August 2011)*

- [Republican Governors Announce Proposals To Overhaul Medicaid](#)
The nation's Republican governors released a detailed list of policies in late August that would give them greater control over their Medicaid programs by limiting spending and allowing them to design programs without federal interference. The 31 recommendations include longtime Republican priorities such as repealing the health care reform law's "maintenance of effort" requirement that forbids states from cutting their Medicaid rolls. *(August 2011)*

(NEW)

- [Community health centers hit hard by Washington deficit cuts](#) The funding cut was a result of a federal budget compromise in March to keep the government running. That agreement reduced federal spending by nearly \$80 billion, including a \$600 million trim in funding for ongoing operations at existing health centers. Advocates were left frustrated that they would not be able to serve the growing numbers of uninsured and poor people or be ready for an influx of patients under the Affordable Care Act. *(October 2011)*

(NEW)

- [Senate Appropriations Committee Approves FY 2012 Labor HHS Bill](#) The Senate Appropriations Committee approved their FY 2012 Labor, Health and Human Services, and Education Appropriations bill by a 16 to 14 party-line vote. Under the funding bill, most SAMHSA programs would receive funding level to FY 2011. In this extremely challenging funding environment, it is encouraging that the Senate appropriators crafted a bill that would avoid major cuts to drug and alcohol programming. However, final decisions about the FY 2012 funding levels have yet to be made and discussions in Congress continue to focus on the possibility of very significant cuts to discretionary funding in 2012 and beyond. Our advocacy for the strongest possible funding remains critically important and we have a long way to go.

CHAPTER ELEVEN

MOBILIZING AND ORGANIZING THE GRASSROOTS

- [Building Partnerships: State Officials and Advocates Working on Health Reform](#) In March 2011, state officials and consumer advocates from nine southern states came together to discuss health reform implementation and ways to work together. The meeting was convened by the [National Academy for State Health Policy](#) (NASHP) in collaboration with Community Catalyst, and funded by the Public Welfare Foundation. This paper highlights themes from this meeting, such as lessons learned in building stronger or more effective relationships between these groups and ways to work together as health care reform implementation proceeds at the state level. (*June 2011*)

CHAPTER TWELVE

MODEL LEGISLATION

- In the 2011 legislation session, [Illinois HB 1530](#) overwhelmingly passed in both chambers and is now waiting for the Governor's signature which is expected shortly. This bill
 - Requires mental health insurance parity that matches the federal requirements under the Wellstone-Domenici Parity Act.
 - Adds substance use treatment to the list of parity required health insurance benefits to existing state law.
 - Gives the state, through the Department of Insurance, the power to more aggressively enforce federal standards.
 - Extends the parity requirement to employers with just two or more employees, going beyond Wellstone-Domenici.
 - Includes a medical necessity determination for substance use disorders using criteria established by the American Society of Addiction Medicine. (*August 18, 2011*, Public Act . . [97-0437](#))

CHAPTER THIRTEEN

FUND RAISING

CHAPTER FOURTEEN

BEST PRACTICES

- In the 2011 legislation session, [Illinois HB 1530](#) overwhelmingly passed in both chambers and is now waiting for the Governor's signature which is expected shortly. This bill
 - Requires mental health insurance parity that matches the federal requirements under the Wellstone-Domenici Parity Act.
 - Adds substance use treatment to the list of parity required health insurance benefits to existing state law.
 - Gives the state, through the Department of Insurance, the power to more aggressively enforce federal standards.
 - Extends the parity requirement to employers with just two or more employees, going beyond Wellstone-Domenici.
 - Includes a medical necessity determination for substance use disorders using criteria established by the American Society of Addiction Medicine. (*August 18, 2011*, Public Act . . [97-0437](#))