



Primary Care and Prevention: Changes Under Federal Reform

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OVERVIEW

A substantial portion of the health reform package is dedicated to improving the primary care system. Numerous provisions in the legislation attempt to create a renewed focus on primary care and prevention, while investing in infrastructure, training, and delivery in order to meet the anticipated increase in utilization.

As is the case nationwide, California is facing a shortage of primary care providers. In 2008, there were 3.3 million Californians living in Health Professional Shortage Areas.¹ Though there is not a specified ideal ratio, the Council on Graduate Medical Education recently recommended that no less than half of all physicians should be identified as primary care.² While primary care providers currently comprise 36% of the U.S. physician workforce,³ that number is quickly dwindling as only two percent of U.S. medical students entered primary care in 2009.⁴ Primary care providers experience comparatively lower reimbursement rates resulting in about half the salaries/incomes of specialists. Incentives based on quantity of care rather than quality in addition to administrative overhead result in overwork and burnout.⁵ Medical students, especially those with large student loans, are deterred from entering primary care for many of these reasons. An estimated 16,500 additional practitioners are required to meet the needs of the 65 million Americans living in communities that cannot easily access a primary care provider.⁶ The AAMC projects a nationwide shortage of up to 150,000 PCPs over the next 15 years.⁷

The Patient Protection and Affordable Care Act (HR 3590) aims to bolster primary care in a number of ways. The promotion and expansion of medical homes, community clinics and accountable care organizations will improve the coordination of care, thereby allowing primary care physicians to better manage patients' conditions. Increased training opportunities and grant programs will expand the non-physician workforce, easing the workloads from increased utilization. Boosting reimbursement rates, improving other financial incentives, and creating additional residency spots will encourage more medical students to enter primary care. In addition, the legislation invests millions of dollars in prevention, wellness, and community-based programs aimed at lowering chronic

¹ The Henry J. Kaiser Family Foundation. (2008). California: Health professional shortage areas. Accessed from: <http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=156&rqn=6>

² Steinwald B. (2008) Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services, GAO Testimony Before the HELP Committee, Feb 12, 2008. Accessed from: <http://docs.google.com/viewer?a=v&q=cache:ZsFzt4mY7HMJ:www.gao.gov/new.items/d08472t.pdf+primary+care+physician+ratio+ideal&hl=en&gl=us&pid=bl&srcid=ADGEEShpFmCT21XMWvyEP0eYRUmrLaxVRdCA1rVCpj4deEz7TY2bfizPuSAAdlxzdKZ7xEv08SyuwOPNhWJM93qNEzssyEB8MbtNwVBCTUFPDJeFdbhrRRfLZF3CuGsCIADbTKnAvax&sig=AHlEtBQ455si23srQlwVo4zqEYCYtGLbFw>

³ University of California - San Francisco. (2007). US Low In Primary Care Physician Visits, According To Comparison Study. Accessed from: <http://www.sciencedaily.com/releases/2007/06/070614090041.htm>

⁴ The Henry J. Kaiser Family Foundation (2008). California: Nonfederal primary care physicians as a percent of total physicians. Accessed from: <http://www.statehealthfacts.org/profileind.jsp?ind=432&cat=8&rqn=6>

⁵ Woo B. (2006). Primary care – The best job in medicine? *The New England Journal of Medicine*. 355(9), 864-866.

⁶ Democratic Policy Committee. (2010). Investing in our nation's health care workforce. Accessed from: http://dpc.senate.gov/dpccdoc-sen_health_care_bill.cfm

⁷ Sataline S. & Wang S. (2010). Medical schools can't keep up. *The Wall Street Journal*. Accessed from: http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html?mod=WSJ_hpp_MIDDLENexttoWhatsNewsSecond

disease rates, improving health outcomes, and creating a national focus on lifestyle and public health.

It is important to understand the provisions and appropriations in the legislation in terms of the unique 'California context.' While our state boasts high health rankings in obesity and smoking status, we rank below average in a number of other categories. Our state and county public health systems are poised to act as a foundation to build upon, as is our safety net system and some of our health plans. We also have made promising strides in HIT development and expansion, though there is still much work to be done. Moving into the new world of health reform, these California variables must be elucidated and understood in order to steer federal funding to the highest needs, maximize reform's effectiveness, and exemplify California public health as an innovator and laboratory of success.

I. UTILIZATION AND ACCESS

The expansion in insurance coverage through federal subsidies and Medicaid will certainly lead to an increase in primary care utilization for the uninsured and underinsured. Eliminating cost sharing for preventive services in Medicare Part B insurance, private insurance, and the Exchange will also increase utilization of effective preventive services. Standardization of payor's administrative processes will ideally allow physicians to spend more time with their patients rather than paperwork.

Community clinics are a lynchpin in health reform, for they already provide a substantial amount of primary care to those who will benefit the most from the coverage expansion; we found that California's 850 free and community clinics delivered care to 3.7 million people in 2006. Almost 46% of total clinic visits were from uninsured patients, with an additional 35% of visits from Medi-Cal.⁸ As much of their care to the uninsured and low-income populations is currently reimbursed at low rates if at all, clinics stand to gain an unprecedented amount of revenue. In 2006 we calculated almost \$1.7B in total clinic revenue. Following full implementation of reform's coverage expansion we expect at least \$17B *annually* in new federal dollars for care to California's low-income and uninsured populations.

The necessity for clinics to become reform-ready cannot be understated, and even the smallest sites have much to gain; a Community Health Center (CHC) fund will be established to invest in CHC infrastructure, appropriating \$11B for CHCs between 2011 and 2015. All plans in the Exchange are required to include CHC's in their network and will also be required to pay FQHCs at a rate no less than their PPS Medicaid rate. It will be important for primary care physicians and clinics to evolve and become part of plans and networks that are effective at

⁸ ITUP Report: 2006 Overview of the Uninsured. Accessed at: <http://itup.org/Reports/Statewide/California%20Overview%202006.pdf>

coordinating care in order to meet higher utilization rates and take advantage of the new revenue streams. With the alternative being isolation and crowd-out, this will require an entirely new perspective; collaborative relationships with specialists and hospitals through Accountable Care Organizations (ACOs), playing a central role for managed care organizations and provider networks, widespread adoption of health information technology, and acting as the focal point of managing chronic conditions.

Primary health services in underserved areas will also expand through school-based health, as the legislation will grant \$50M a year from 2010 through 2013 to establish school-based health clinics (SBHC), which will provide comprehensive primary and preventive care (including mental and physical health) to medically underserved children and their families during school hours.

II. PHYSICIAN INCENTIVES

Coverage expansion facilitates but does not guarantee access. It will be crucial for California to bolster its primary health care delivery system. Currently, California ranks 21st in availability of primary care physicians (118 PCPs per 100,000, 121 nationally).⁹ As medical school debt continues to rise, the lower-paying primary care profession becomes less and less attractive to future doctors. Providing incentives for individuals to practice primary care will increase numbers of primary care physicians.

Reimbursement Rates

A central feature of the legislation is a concerted effort to improve desirability and sustainability of the primary care workforce through increased reimbursement rates. Beginning in 2011, primary care physicians in Medicare will receive a 10% bonus payment for services rendered. In 2013, Medicaid payment rates to primary care physicians will increase to 100% of Medicare. California physicians face some of the lowest Medicaid rates in the nation (4th lowest)¹⁰, and many physicians are actively dropping patients due to low reimbursements. The increase is fully federally funded for two years, so these provisions will undoubtedly improve the dwindling structure, in terms of both providers' financial stability and patients' access without further straining the state budget.

The modifications to Medicare payment formulas are also specifically geared towards improving primary care compensation, a boon to California PCPs.

The substantial increase in insurance coverage will lead to a reduction in uncompensated care, allowing physicians to be properly compensated for the

⁹ United Health Foundation. (2009). America's health rankings. Accessed from: <http://www.americashealthrankings.org/statecompare/2009/zUS/CA.aspx>

¹⁰ Kaiser Family Foundation, (2009) statehealthfacts.org. Accessed from: <http://www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4>

care they provide. Some estimate the average physician uncompensated care for uninsured patients is about 2% of office expenses.

Graduate Medical Education

A number of provisions are aimed at bolstering primary care through medical education. A new policy allows unused residency training slots to be redistributed to other sites for the purpose of primary care training. Another provision greatly expands funding for primary care residency programs through Teaching Health Center grants, and includes supplementary primary care training methods as qualifying 'residency time'. Increasing the availability of residency slots will ease the path for future primary care physicians, for medical schools currently limit admission slots because of the residency slot 'bottleneck'.

III. BOLSTERING THE PRIMARY CARE WORKFORCE

The primary care workforce is scheduled to get stronger to meet increased demand. The increase in newly insured Americans, the provision that select preventive services be offered with no copay, and the enrollment of high-risk individuals into managed care will place an even larger demand on the primary care workforce.

In order to better identify, assess, and address national health care workforce needs, a National Workforce Commission will be created. The existing national workforce analysis entity will be broken into multiple regional entities to monitor local primary care workforces and coordinate data with the Commission.

Building Capacity

Investing in new and innovative ways to increase numbers of skilled workers in the field will help to address workforce shortage. The legislation explores methods to boost numbers of skilled primary care workers both in general and in underserved areas. In addition, competitive grants will encourage states and local governments to create their own innovative plans to develop the health care workforce, such as establishing new health career paths.

Entering the health care workforce requires substantial training and is therefore a large time commitment and financial investment. With primary care providers earning about half the salary of specialists, medical students are deterred from entering primary care residencies.¹¹ Easing the burden of applying for and repaying loans can encourage students to become primary care providers. For example, primary care student loans will have less rigid qualifications, shorter payback periods, and more forgiving non-compliance provisions. And, a loan repayment program will be established for pediatric subspecialists.

¹¹ Woo B. (2006). Primary care – The best job in medicine? *The New England Journal of Medicine*. 355(9), 864-866.

Certain areas experience more drastic physician shortages than others. These include rural, low-income, and tribal regions. California ranks first in total number of primary and dental care HPSAs (554 and 302, respectively, compared to 6,156 and 4,181 nationally) and second in total number of mental health HPSAs (268 compared to 3,233 nationally).¹² The legislation includes a variety of ways to increase the non-physician and physician health care workforces in these communities. These include:

- Providing loan repayment to public health students and workers who work at least three years at federal, state, local, or tribal public health agencies (scholarships will also be awarded to mid-career professionals to receive additional training).
- Creating a loan repayment program for providers of children's mental/behavioral health in Health Professional Shortage Areas (HPSAs) and medically underserved areas.
- Providing loans for allied health professionals at agencies that provide health care to patients in HPSAs and/or medically underserved areas.
- Offering up to \$600,000 per year to medical schools who recruit medical students to practice in underserved rural areas..
- Increasing funding for the National Health Service Corps, which provides loan repayment to primary care medical, dental and mental health clinicians who serve two years in an HPSA, providing \$1.5B through 2015, and allows teaching to count as clinical practice for up to 50% of service .¹³

Underserved or vulnerable populations often utilize nurse-managed health clinics (NMHCs). NMHCs are primary care practices managed by advanced nurses that provide care to these populations. NMHCs provide primary care with an emphasis on health promotion and disease prevention.¹⁴ They return high patient satisfaction with quality of care and practice in a manner that, if operating at capacity, have the potential to greatly contain costs.¹⁵ The legislation awards \$50 million in 2010 to support operation of these clinics.

Education and Training

Working to increase the numbers of primary care professionals is only effective if training spots are available. Therefore, the legislation aims to increase and expand training opportunities for the future workforce. This includes investing in schools, faculty, and fellowship and training programs. Starting in 2010, \$125M will be designated to develop and operate training programs for family medicine, general internal medicine, general pediatrics and physician assistantship. This includes providing financial assistance to trainees and faculty and gives priority to programs that have "team-based" approaches to health care (such as utilizing

¹² Trust for America's Health. (2010). California state data. Accessed from: <http://healthyamericans.org/states/?stateid=CA>

¹³ U.S. Department of Health & Human Services, National Health Service Corps. (2010) Loan repayment. Accessed from: <http://nhsc.hrsa.gov/loanrepayment/>

¹⁴ Coddington J. & Sands L. (2008). Cost of health care and quality outcomes of patients at nurse-managed clinics. *Nursing Economics*. 26(2), 74-84.

¹⁵ Coddington & Sandis, 2008

the patient centered medical home). Amounts designated between 2011 and 2014 will be determined as needed.

Nurses are a critical component of primary care. California ranks first in terms of nursing shortage, with a 47,600 nurse deficit (compared to 405,800 nationally).¹⁶ Nursing shortages and issues with retention have been long-term problems in the U.S. The short supply of educational programs and challenges facing nurses are a few of the reasons it is difficult to recruit and retain nurses.¹⁷ The bill offers grants to strengthen nursing education and improve retention in order to expand facilities and invest in increasing job satisfaction by:

- Offering loan repayment to nursing faculty who serve at least four out of six years at an accredited facility (incentivizes more nurses to return to academia to train future professionals).
- Allowing recent family nurse graduates may participate in a 12-month primary care training program at Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics (three year grants of up to \$600,000/year per facility for at least three practitioners).
- Appropriating \$338M to existing nursing workforce development programs, such as advanced education, workforce diversity, faculty loan programs, geriatric education, Service Corps, and education, practice and retention grants.¹⁸

Comprehensive approaches to health care are critical – many factors must be taken into account when treating a patient such as language, culture, and education. In addition, it is important to understand disease trends in communities in order to best treat populations. Public health training and professionals are critical to improving quality and outcomes in health.

- Grants will be awarded to states, public health departments, clinics, hospitals, FQHCs and other non-profits to utilize community health workers.
- Community health workers will offer translation services, counseling, culturally relevant health education, and some primary care services to patients.
- Public health epidemiology workforce shortages will be addressed in state and local health departments.
- The Surgeon General will establish a U.S. Public Health Sciences Track, which will train medical professionals in emergency preparedness, team-based care, public health, and epidemiology.
- Students who serve as Commission Corp officers will receive one year of tuition remission for every two years served.

¹⁶ Trust for America's Health. (2010). California state data. Accessed from: <http://healthyamericans.org/states/?stateid=CA>

¹⁷ AYA Healthcare. (2010). Nursing shortage. Accessed from: <http://www.ayatravelnursingjobs.com/nursingshortage/causes/>

¹⁸ American Nursing Association. (2010). Funding for nursing workforce development. Accessed from: <http://www.nursingworld.org/EspeciallyForYou/Educators/NursingWorkforceDevelopment.aspx>

Grants will also be awarded for education and training in primary care related fields. These include:

- Long-term care support; general, pediatric and public health dentistry
- Alternative dental health (for those serving in rural, tribal and underserved communities)
- Geriatric care (24 grants of \$150,000 each)
- Mental and behavioral health (\$8M for social work, \$12M for graduate psychology, \$10M for child and adolescent mental health, and \$5M for paraprofessional child and adolescent work).

The legislation also expands existing programs to further develop cultural competency in prevention and public health and capacity for working with disabled individuals.

IV. SUPPORTING THE EXISTING WORKFORCE

A number of existing programs have already been working to bolster the primary care workforce. Many of these programs will be sustained, while others will be given extra funding to expand their efforts and increase their reach. In order to promote a more holistic health education for existing primary care providers, a Primary Care Extension Program will be established to educate primary care providers about preventive medicine, health promotion, chronic disease management, evidence-based medicine, and mental health (six-year grants to establish programs with \$120 million annually for 2011-2012 and determined as needed thereafter).

Minority students and students from low socioeconomic backgrounds are more likely to practice primary care.¹⁹ Therefore, a priority has been given to increasing workforce diversity in order to bolster the primary care workforce:

- The Centers of Excellence program, administered by the National Center on Minority Health and Health Disparities, increases workforce diversity by overseeing recruitment, training, and academic support for minorities interested in careers in health. The bill will give the Centers \$50M, which is 150% of its 2005 allocation.
- Faculty committed to training diverse health care professionals will receive an increased loan repayment from \$20,000 to \$30,000 annually (\$5M for 2010 through 2014).
- Nursing diversity grants will be expanded to include associate degrees and bridge or degree completion programs.
- \$60M will be provided for educational assistance for individuals from a disadvantaged background in 2010, and also determined as needed thereafter.

¹⁹ Lakhan S. (2003). Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*. 3(6):PubMed

- Scholarships for disadvantaged medical students committed to working as primary care providers in underserved areas will increase from \$37M to \$51M in 2010, and determined as needed thereafter.
- \$5M will be appropriated annually from 2010-2014 to enhance education and support activities for primary care in underserved communities.

V. QUALITY AND CARE COORDINATION

The law makes a substantial effort to shift health care delivery from a fee-for-service, quantity-based structure towards a system based on quality and health outcomes, particularly in the public Medicare and Medicaid programs. The CMS Innovation Center will initiate pilots to test patient-centered payment models in Medicare, Medicaid, and SHCIP. The new non-profit Patient-Centered Outcomes Research Institute coupled with a national quality improvement strategy will identify gaps in quality measures, fund measure development, and develop priorities to improve primary care delivery.

Additional payment bundling and salary-based reimbursement demonstration projects will be initiated in both Medicare and Medicaid, which will include post-acute primary care services. Though program-wide provider guidelines will take some time to develop, proactive PCPs should be able to take advantage of the financial incentives linked to evidence-based and coordinated care in the legislation's pilots. Primary care physicians will also be able to supply significant input during the development process.

Promoting Care Coordination

Primary care physicians in California will be able to participate in the new value-based Medicare Shared Savings Program in Accountable Care Organizations (ACOs), where groups of providers will receive bonus payments based on the savings realized from better-coordinated and evidence-based care (see Cost-Containment for more information on ACOs). Potential ACOs may have to meet additional quality standards to be eligible for the payments, including the use of health information technology (EHRs, e-prescribing, etc.) in primary care settings. Utilizing the financial momentum and incentives created through ARRA, primary care physicians should continue to implement widespread use of HIT.

The Independence at Home demonstration program will provide \$5 million annually in financial incentives for home-based primary care teams in Medicare. The program is intended for high-need beneficiaries; teams that are successful in reducing preventable hospitalizations and readmissions, increasing efficiency, and improving outcomes and satisfaction will be able to share in the savings.

The Community-based Collaborative Care Program will provide grants to develop provider networks in low-income and underserved areas. Primary care physicians that participate in these networks aimed at improving care integration

will be able benefit financially and in improved delivery. New grants will also be available to physicians who co-locate primary and specialty care in community-based mental health settings.

Improving Quality

New quality initiatives may increase the administrative burden on some primary care physicians, particularly with provider certification processes, transparency provisions and required data reporting.

Primary care physicians will be able to improve delivery to dual eligibles through the new Federal Coordinated Health Care Office. The Office will assist in the integration of federal and state benefits in order to improve access, allowing physicians to better manage needed care for this population.

The establishment of a Shared Decision-Making Resource Center will facilitate collaboration between patients and primary care providers. Grant-funded programs will allow providers to develop, implement, and assess efforts aimed at promoting informed patient preferences in creating a medical plan. Standardized “Patient Decision Aides” will allow for a better working relationship between provider and patient in order to tailor an effective delivery plan.

Health Information Technology

Widespread adoption of electronic health records, telemedicine, and other health IT will need to complement many of the new regulations regarding physician reporting, quality measures, and care coordination. Slowly but surely, California is fostering this growth. A survey released by the California Health Care Foundation found that the state is leading the way in personal health record (PHR) adoption with a 15% usage rate, compared to 7% nationally.²⁰ The University of California recently announced a \$27 million contract with AT&T to develop the California Telehealth Network, and Cal eConnect was designated to oversee the state’s health information exchange from the \$100 million in ARRA health care funds. The well-known dedication by Kaiser Permanente is also helping to promote adoption statewide.²¹

VI. PREVENTION AND WELLNESS

While investing in the improvement of the physician workforce is one important aspect of improving the nation’s health, a comprehensive approach is necessary in both health education and disease prevention. Health promotion is a multifaceted concept in itself – it involves attention to individuals’ behaviors *and* environments. Effective health education may arm individuals with the knowledge

²⁰ California Health Care Foundation, (2010). Consumers and health information technology: A national survey. Accessed from: <http://www.chcf.org/topics/view.cfm?itemid=134205>

²¹ Dougherty A. (2009) ITUP Update on HIT in California. Accessed from: <http://itup.org/Reports/Solutions/HIT%20Update.pdf>

they need to make healthy choices, but policies must be put in place in order to alter environments in a manner by which those choices can be made. To improve prevention and wellness, the bill addresses contributors to chronic diseases and explores ways to reduce those rates by promoting healthy lifestyles through education and policy changes.

Health Rankings^{22,23,24}

California appears to have a head start in terms of lifestyle and health promotion, as we rank 2nd in smoking prevalence (14% of the population, 18.3% nationally) and 9th in obesity (24% of population, 26.6% nationally). We also fare slightly better in the percent of adults who exercise moderately or vigorously (50.2%, 49.2% nationally), and in access to healthy food retailers (83.5% of census tracts, 72% nationally). While public health efforts have indeed promoted healthier behavior, the state ranks poorly in childhood immunizations (28th at 81%, 78% nationally), infectious disease cases (ranked 43rd) and air pollution (ranked 47th). Mental health continues to be a problem, with nearly 40% of adults reporting poor health (33% nationally).

California has a sub-par rates for diabetes (rank 30th at 8.5%, 8.2% nationally), pneumococcal vaccination for 65+ (rank 49th at 60.1%, 67.2% nationally), and advanced-stage breast cancer diagnosis (93.7 per 100,000, 89.4 nationally). Our cancer treatment methods are significantly higher given our lower death rate (162.3 per 100,000, 180.7 nationally), and our prenatal care rate (77.5%, 69.4% nationally) ranks 9th in the nation. Insurance coverage is inherently linked to health care access, and as California ranks 44th in coverage (18.4% uninsured, 15.3% nationally) there are clearly significant barriers to overcome.

County and State Public Health Programs

The estimated General Fund expenditures for health services in California this year (2009-2010) is about \$16B, which accounts for about 19% of the state's General Fund spending.²⁵ Of this General Fund money, \$192M is allocated to the Department of Public Health (DPH). DPH receives an additional \$1.9B from the federal government and \$1.4B from special funds and reimbursements²⁶. DPH oversees a variety of programs aimed at a broad range of health issues.²⁷ With funding from the health care reform legislation, these programs are given numerous opportunities to obtain additional federal support for their community-based public health programs. This is especially critical as California faces a

²² Kaiser Family Foundation, (2009) statehealthfacts.org, Accessed from: <http://www.statehealthfacts.org/comparecat.jsp?cat=2&rgn=6&rgn=1>

²³ United Health Foundation. (2009). America's health rankings. Accessed from: <http://www.americashealthrankings.org/statecompare/2009/zUS/CA.aspx>

²⁴ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. (2008). California: Preventive care quality measures and metrics compared to all states. Accessed from: http://statesnapshots.ahrq.gov/snaps08/meter_metrics.jsp?menuId=8&state=CA&level=1®ion=0&compGroup=N

²⁵ The Legislative Analyst's Office. (2010). The 2010-2011 Budget: Health and social services budget primer. Accessed from: http://www.lao.ca.gov/analysis/2010/health/hss_primer_0310.aspx

²⁶ Schwarzenegger A, Belshe K, & Horton M. (2010). Governor's budget highlights, Fiscal Year 2010-11. *California Department of Public Health*.

²⁷ The Legislative Analyst's Office, 2010

\$20B budget shortfall and critical public health programs are at risk of being cut or eliminated all together.

Promoting National Health

Federal oversight of national health and wellness is a key element to the health promotion and disease prevention strategy. The law creates new entities and gives existing ones additional responsibilities in order to create, monitor, support, and evaluate programs aimed at improving health and lowering rates of chronic diseases. These entities will convene field experts to create national recommendations based on practices related to prevention and develop outreach strategies to disseminate information to the general public. In addition, a Prevention and Public Health Fund (\$500M in 2010 phased up to \$2B in 2015 and each year thereafter) will be established as a national investment to create prevention programs and curb the costs of health care.

Within the first year of the bill's signing, a national strategy for improving the nation's health will be created. The establishment of tangible goals allows for quantitative, annual evaluations of the nation's progress in public health efforts. A National Prevention, Health Promotion and Public Health Council, chaired by the Surgeon General, will convene representatives from relevant Federal agencies to establish this national prevention and health promotion strategy with detailed goals and objectives for improving U.S. health through federally funded programs. The purpose of the Council will be to oversee Federal coordination of national health and wellness and provide recommendations regarding identified policy changes aimed at addressing imperative health prevention and promotion issues.

Clinical preventive services for issues such as cancer screenings, tobacco cessation, heart disease, and physical activity often vary widely from one provider to the next. Two individuals seeking services for an identical issue might receive two completely different treatments. In order to ensure that individuals are being given the best possible care, national best practice standards will be scientifically established. Clinical practices determined by experts to produce the best health outcomes will be provided in a "Guide to Clinical Preventive Services." Experts for the U.S. Preventive Services Task Force and the Community Preventive Service Task Force will recommend the most effective clinical approaches to preventive issues.

An important aspect of any newly established service or opportunity is communicating it to the public so that it is properly utilized. Many new opportunities for disease prevention and health promotion will become available. A nationwide outreach and education campaign will inform the general public of what is offered. The Secretary of the Department of Health and Human Services (DHHS) will create a campaign (\$500M) using timely, evidence-based behavioral research to promote the use of preventive services, encourage healthy behaviors and explain options for use of Federal and Exchange prevention services. The

plan will be designed to address screening, lifestyle and the five leading causes of life-threatening diseases. It will include web-based tools for individuals to receive individualized recommendations based on their disease risks.

More attention will be given to standardizing best practices related to prevention. The Director of the Centers for Disease Control (CDC) will work with the Secretary to research best practices. The CDC will develop strategic methods to effectively disseminate these evidence-based interventions strategies to clinics and communities, so that they are well informed of the desired prevention practices for their patients and populations.

With 60.7% of the 16+ population currently employed²⁸, the workplace is pinpointed as a venue through which we can promote healthy behaviors to a large portion of the population. The law provides \$200M for small businesses that initiate new workplace wellness programs, and employers can now reduce employee share of premiums by as much as 30% for participation in health promotion/disease prevention programs. The CDC will study and evaluate employer-based wellness practices to promote health in the workplace. They will create a comprehensive educational campaign for employers, which will explain the many benefits of a healthy workplace, such as reduced employee absenteeism and increased work productivity.

Health disparities are prevalent throughout the U.S., and especially in California and Los Angeles. Minorities face unique barriers to health as a result of income, language, and access issues. The bill will establish a Federal health program to monitor health trends among minorities in order to understand these trends and address them accordingly. A program at the CDC will be created to provide grants to states and local governments aimed at surveying and responding to disease outbreaks.

All existing Federal health and wellness programs and initiatives will be reviewed by the Secretary of DHHS to ensure that they are meeting their goals.

Public Programs

To encourage wellness among Federal health program beneficiaries, the bill aims to improve access to preventive services and establish new ways to promote healthy behaviors. Medicare beneficiaries will no longer have coinsurance requirements for most preventive services (100% of the costs of these services will be covered by Medicare) and will be able to take advantage of annual wellness visits with no co-pays or deductibles. These wellness visits will allow Medicare-eligible individuals to create personalized prevention plans with their doctors, which will include screening recommendations, strategies to address identified disease risk factors, and general healthy lifestyle education.

²⁸ U.S. Census Bureau. (2008). Employment status data set: 2006-2008 American community survey 3-year estimates. Accessed from: http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_S2301&-ds_name=ACS_2008_3YR_G00

Incentives are available to states to expand preventive services to their Medicaid beneficiaries. State Medicaid programs will receive an additional one percent Federal Matching Assistance Percentage (FMAP) should they choose to provide clinical preventive services recommended by the U.S. Preventive Services Task force and immunizations recommended by the Advisory Committee on Immunization Practices without requiring co-pays or deductibles. Grants will be awarded to States who provide incentives for Medicaid beneficiaries to participate in healthy lifestyle promoting programs and who demonstrate success in helping individuals lose weight, quit smoking, prevent diabetes, lower cholesterol, and lower blood pressure. States will be required to provide full coverage for comprehensive tobacco cessation services for pregnant women, which includes pharmaceuticals and therapy.

The bill appropriates \$25M for a demonstration project aimed at reducing childhood obesity from 2010 to 2014 through the Children's Health Insurance Program (CHIP).

Community Health

Some of the responsibility for improving wellness and controlling costs will be given to communities, states, and employers. An estimated 23-69% in cost savings will result from state purchases of adult vaccines through CDC compared to the private sector. In addition, grants will be provided to pilot programs using evidence-based interventions to improve immunization coverage and thereby reduce the risk of preventable outbreaks.

On a local level, grants will be awarded to communities who carry out programs to reduce chronic diseases that are a result of obesity, tobacco use and mental illness (20% designated to rural areas). And, high-risk patients who use community health centers will be given individual wellness plans in order to reduce preventable conditions and thus lower avoidable utilization of the centers.

In order to encourage healthy eating and curb rising obesity rates, restaurants with more than 20 locations will be required to disclose nutrition information (including calories, fat, saturated fat, cholesterol, sodium, carbohydrates, sugars, dietary fiber and protein) to customers upon request.

And, in order to promote breast-feeding and remove avoidable barriers, businesses with more than 50 employees will be required to provide break time and a breast-feeding location for nursing mothers.

The legislation promotes individual responsibility through financial incentives for healthy behaviors. Smoking cessation will be promoted through higher health insurance premiums for individuals who smoke. Smokers will pay a 50% higher monthly premium than non-smokers.

Additional Resources

Insure the Uninsured Project (2010). The Patient Protection and Affordable Care Act: Section-by-section guide. Access from:

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Dougherty, A. (2010). Implementation timeline for health reform, 2010-2011. *Insure the Uninsured Project*. Accessed from:

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