HOT TOPIC: Health Care

EXERCISING THEIR PRIVATE OPTIONS

Telemedicine Connects Care to Communities
Seeking Relief in the Weed
New AHA Chair: Compassion Is More Efficient

“... it’s stupid to hurt your own people because you’re mad at them (the federal government) when hurting your own people doesn’t change them.”
Arkansas Gov. Mike Beebe

PLUS: How You Can Be a Healthier Policymaker
West Virginia Gov. Earl Ray Tomblin, CSG president, and Tennessee Senate Majority Leader Mark Norris, CSG chair, have selected State Pathways to Prosperity as the leaders’ initiative for 2014. Throughout the year, CSG will present resources to address issues that can block success. Those issues will be the focus of four subcommittees of the CSG Workforce Development and Education Task Force, which will move the initiative forward.

WWW.CSG.ORG/STATEPATHWAYSTOPROSPERITY
Florida lawmakers passed legislation allowing use of a strain of medical marijuana that helps alleviate seizures in children in the Sunshine State. But, as sponsor Matt Gaetz put it, "Not all medical marijuana is created equal."
12 MEDICAID PRIVATE OPTION
Several states—including Iowa and Pennsylvania—followed Arkansas’ lead in seeking a waiver to use federal dollars targeting Medicaid expansion to help people buy private insurance.

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The initial enrollment period for coverage under the Patient Protection and Affordable Care Act has ended with more than 7 million people gaining access. But that doesn’t mean the controversy is over.

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Improving health care in rural areas remains a challenge, but Oklahoma is using a federal grant to grow an extension network to help physicians help themselves.

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The use of electronic telecommunications technology to diagnose or treat a patient in need of care, service or monitoring—telemedicine, or telehealth—is becoming even more important as the physician shortage grows.

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Families with children suffering from uncontrollable seizures made headway in several states to get access to an oil created from a strain of marijuana that has shown to be effective in children in other states.

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I can’t remember a time as a kid that I didn’t look forward to visiting my Grandma Nellie. She had a way of making everyday life an adventure for me. She always had a garden and, as a result, there were lots of good things cooking and baking in her kitchen. She grew up working the ranches of the Kansas Flint Hills, where she learned to cook for the farmhands using a wood-burning stove. I asked her once how she knew when the stove had reached the right temperature. She told me she just opened the door, shoved her arm in and if it felt right, it was hot enough. I thought that advice should have been followed by the disclaimer: “Trained professional, do not attempt this at home.”

A meal at her house was a treat. Fresh sliced tomatoes in season, chicken fried in an iron skillet, corn on the cob, thick slices of watermelon and strawberries or peaches with sweet cream for dessert. The bounty of her table remains a wonderful memory.

Today, my daughter Nell attends a middle school that has, in part, a land-based curriculum. She and her classmates raise fish, chickens, herbs, fruit and honey. She even oversees an aquaponics project in which herbs and fish are raised in a closed symbiotic ecosystem. This provides her with an opportunity to learn math, science and nutrition up close and hands on. It works. Nell understands her health is directly tied to what she consumes as food. She knows where food comes from and she understands how animals, insects, flowers, water and crops all share a destiny with her. She is also keenly aware that supermarkets and many restaurants offer food choices that can contribute to her good health.

Today there is a profound change happening in what Americans want to eat. A new focus on healthy food and a growing interest in where food comes from is one of the most powerful current trends in our nation. Business is responding to this food revolution and offering more choices for consumers. Most cities and towns now have farm to table, urban gardening and farmers’ markets as emerging elements of their food culture.

If one understands that the health of our nation is inextricably linked to what we as a nation eat, we can’t help but begin to wonder how public policy can help advance improved health. The prevalence of sugar and sodium in many prepared food offerings has been shown to contribute to adverse health outcomes. The cost of bad food choices to states is high as obesity, high blood pressure and diabetes continue to fuel significant increases in public health care spending.

Personal responsibility is undeniably a key aspect of achieving better health, but the convenience and low cost of unhealthy choices often makes it harder for consumers to make good choices. Food industry leaders are proactively responding to the food revolution and thereby demonstrating how free markets constructively respond to changing consumer preferences.

A new food culture is growing throughout our nation as people increasingly choose heaping helpings of healthier fare. This trend is one we predict will continue as communities and states revolutionize the way in which we connect what we eat to our health. My grandma would say that’s something worth harvesting for the future.
People are more concerned where their food is coming from, what practices are going into creating the food, and whether it’s organic.”

—Catherine de Ronde, agricultural economist for the Massachusetts Department of Agricultural Resources, citing data from the USDA’s Census of Agriculture, in an April Boston Globe article about a legislative attempt to rejuvenate the University of Massachusetts’ agriculture extension site in Waltham.

You should be able to walk into a grocery store, pick an item off the shelf & tell whether it’s good for your family.”

—Tweet from first lady Michelle Obama in February after the U.S. Food and Drug Administration announced plans to update the Nutrition Facts label for packaged foods.

We need more supermarkets, more fresh foods, better foods in the area instead of processed foods where many children have to subsist on now.”

—Tennessee Rep. Craig Fitzhugh, after the Tennessee Obesity Task Force walked from Legislative Plaza to a market on Church Street in Nashville, according to WKRN-TV. Supporters hoped to draw lawmakers’ attention to food deserts in the city.

I think most would argue that denying residents of my state $112 a month in nutrition assistance is morally wrong.”

—Connecticut Gov. Dannel Malloy, in a March letter to U.S. House Speaker John Boehner, after Boehner called some states cheaters and frauds for thwarting congressional efforts to reduce food stamp payments, according to The New York Times.

IT IS NOT A DRIVE-THRU MCDONALD’S BY ANY MEANS. WE STILL EXPERIENCE DIFFICULTIES.”

—Maryland Gov. Martin O’Malley, discussing the continuing problems with the state’s health insurance website in March, according to WBAL radio. Even with the problems, however, O’Malley said the number of people who have signed up for insurance exceeded the state’s goals.

People are dying, this is not a political issue, this is about life and death.”

—Kendra Miller, a Minnesota woman with severe Crohn’s Disease, discussing her support for legalizing medical marijuana in Minnesota, according to an article on KARE-TV in Minneapolis.
WOMEN IN BUSINESS
Massachusetts Gov. Deval Patrick’s administration announced plans to fund at least a dozen yearlong fellowships that will place women in state managerial roles in an effort to increase mentorship opportunities for aspiring women executives, The Boston Globe reported in March. In addition to placing fellows in state managerial roles at full salary for a one-year period, the program also will offer seminars on a range of management issues. Officials hope to select and place fellowship recipients by September.

HUNTING RIGHTS
Landowners in Vermont will have more options to restrict hunting on their property under new regulations being implemented by the state’s Department of Fish and Wildlife. According to the Burlington Free Press, the Vermont Constitution provides the right “to hunt and fowl” on unenclosed properties. Under previous regulations, property owners had the choice to either allow or prohibit hunters from using their land, but the new regulations will give landowners the option of allowing hunting by permission only.

E-CIGARETTES
Electronic cigarettes, or e-cigarettes, are not currently regulated in Connecticut, but Gov. Dannel Malloy hopes to change that, according to The Hartford Courant. Under Senate Bill 24, the sale of e-cigarettes to anyone under 18 would be prohibited. If passed, violators could face fines of $200 for the first offense and up to $500 for subsequent offenses.

FOOD STAMPS
Data from the Delaware Department of Health and Social Services show the number of the state’s residents receiving food stamps nearly tripled between 2003 and 2013 as the population grew only 14 percent, The News Journal of northern Delaware reported in March. Rates varied by county, with all Delaware counties experiencing an increase of at least 97 percent, and one county’s food stamp usage growing by 325 percent. Overall, the state’s food stamp enrollment grew by 196 percent from 2003 to 2013. National rates of food stamp recipients increased by 124 percent during that same timeframe.

INMATE EDUCATION
New York Gov. Andrew Cuomo hopes to revive a program to provide inmates with access to college classes in an effort to reduce recidivism rates, according to National Public Radio. Inmate education programs were eliminated nationally with the passage of a 1994 crime bill, but advocates argue providing educational opportunities to inmates could save money in the long run by reducing recidivism rates. Cuomo says he intends to fund a pilot program in 10 prisons across the state.

MAINE COMMISSION APPROVES FIRST VIRTUAL CHARTER SCHOOL
The Maine Charter School Commission in March approved the creation of Maine Connections Academy, what could be the state’s first virtual charter school. According to the Maine Public Broadcasting Network, the school could open as early as September 2014, but must first meet a series conditions set by the commission. Those conditions include limitations on enrollment and a requirement to operate independently from its parent for-profit company, Connections Education. The school also must agree to hire a third-party evaluator to assess its ongoing relationship with its parent company.

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Following the vote, Carol Weston, a board member at Maine Connections, appeared supportive of the conditions.

“A virtual school in Maine is brand new,” she said. “I think that those requirements are there to make sure that the kids in Maine succeed.”

The commission had twice denied previous applications for virtual charter schools in the state. The commission denied another virtual charter school application after it approved the one for Maine Connections Academy.

“Look across the whole country and there’s success, there’s failure,” Jana LaPoint, the commission’s chair, told reporters after the decision. “We’re trying to find that ground that says that we have something that’s good. And that we can oversee it.”

Meanwhile, Gov. Paul LePage, a supporter of virtual charter schools, vetoed a bill passed by the Maine legislature that would have placed a moratorium on all virtual charter programs until 2015, according to the Bangor Daily News. The Maine Senate sustained the veto 23-12.
OIL SPILL
Shipping traffic through the Houston Ship Channel was temporarily stalled in March when a barge collided with a ship in the Galveston Bay, The New York Times reported. The collision caused 1,000 barrels of oil to leak into the bay and left nearly 100 ships briefly stranded on both sides of the channel.

GUN RIGHTS
The Georgia Legislature in March approved a bill to expand gun rights in the state, The Atlanta Journal-Constitution reported. Religious leaders now have an “opt in” option to allow guns in houses of worship. The law also permits the use of silencers for hunting.

VOTER ID
Virginia election officials are preparing to educate the public about the state’s new voter ID law, The Roanoke Times reported in March. Voters will receive a flier about the changes as they exit the polls during the May and June primaries. Those who don’t have acceptable forms of identification can receive a new voter ID, which will be available in July.

PORT OF SAVANNAH
To the surprise of Georgia lawmakers, President Obama’s most recent budget proposal did not include construction funding for the $652 million expansion of the Port of Savannah. Vice President Joe Biden pledged last year the Savannah project will be completed. The new White House budget, however, seeks just $1.52 million for the project. Despite the shortfall, Gov. Nathan Deal plans to start deepening the shipping channel.

UNUSUAL LAWSUIT
In what some are calling a first-of-its-kind lawsuit, BlueCross BlueShield of Tennessee has filed a lawsuit against TriStar Southern Hills Medical Center on behalf of one of its policyholders, The Tennessean reported in April. BlueCross is suing the medical center, which is outside of its provider network, saying the $44,000 one BlueCross policyholder was charged after being treated for a stroke is too much for anybody to pay.

FUNDING INCREASE ALLOWS TEXAS SCHOOLS TO KEEP STAFF, RAISE SALARIES
Two years after cutting $5.4 billion from the state’s education budget, the Texas legislature restored $3.9 billion to the education fund, the Houston Chronicle reported in March.
That means Texas public school districts are in a position of having to compete for prospective teachers. The increased funding is allowing districts to increase teachers’ salaries. Teacher career fairs in Houston—some of which took an attendance hit during the 2011 budget cuts—have waiting lists for prospective teachers. Some small Houston-area school districts are offering starting salaries of $50,000.
The raises are necessary to compete, some school districts believe. The Aldine Independent School District was one of the first to hit the $50,000 starting salary mark. Aldine Superintendent Wanda Bamberg said the district’s need for bilingual teachers is pushing those wages even higher. Bilingual teachers in the district will receive a $4,500 stipend, making their starting salary $54,500.
The minimum mandated Texas teacher salary of $27,320 is mostly relevant to teachers in rural areas with lower costs of living. Independent school districts in urban areas, such as Houston, are not just in competition with each other in terms of salary now, but they also are in competition with private industry, which can offer better paying opportunities.
But prospective teachers also identify other factors, such as school reputation and adaptability to new teachers, as ranking high on their prospective employer wish list, proving that, although money does count, it is not the only key to winning qualified applicants.
CHILD SUPPORT PAYMENTS
The Wisconsin Department of Children and Families says nearly 4,000 people with debit accounts connected to their child support payments were affected by last year’s Target security data breach, though in only a very few cases was fraud detected. According to WKOW News, the company that manages the state’s debit MasterCards is working to resolve the issue and provide new cards to those affected. Nationally, the data breach impacted credit and debit accounts in late 2013.

INMATE RECIDIVISM
Former inmates in Ohio are returning to prison less frequently than ever before, according to new statistics released by the Ohio Department of Rehabilitation and Correction. The recidivism rate among former Ohio inmates in 2010 was 27.1 percent, down from the previous record low rate of 28.7 percent, according to The Columbus Dispatch. Nationally, recidivism rates among former prison inmates range from 40 to 44 percent.

SCHOOL FINANCES
Illinois school districts are struggling as a result of decreased state aid, higher operational costs and the slow pace of the economic recovery. According to the Chicago Tribune, 121 of the state’s school districts received low or dismal ratings in the state’s annual financial report card for schools, more than twice the number of districts in the lowest two categories two years ago. Estimates indicate that 62 percent of the state’s districts are now deficit spending in the current operational budget.

ONLINE LOTTERY
New online instant scratch-off ticket sales by the Minnesota Lottery have raised the ire of state legislators, The Associated Press reported in March. A bipartisan group of leaders in the Minnesota House and Senate chambers, upset that state lottery officials developed the online games without legislative approval, are seeking a one-sentence amendment to state law that would shut down the new lottery portal. Minnesota is the first state to launch online scratch-off lottery tickets, though other states are considering or already offer Internet gambling and lottery ticket sales.

ROAD REPAIR
Michigan drivers will get some relief following a long, tough winter and its impact on the state’s roads. The Michigan legislature has approved $215 million to improve the state’s roads, the Detroit Free Press reported in March. Of the total allocation, $100 million will go toward road repair, while the remaining $115 million will fund pet road projects.

INDIANA BECOMES FIRST STATE TO OPT OUT OF COMMON CORE
Indiana Gov. Mike Pence has signed a bill making the state the first in the nation to opt out of the common core education standards. According to The Indianapolis Star, Pence expects Indiana, in its response to the now controversial curriculum guidelines, will serve as a model for other states.

“I believe when we reach the end of this process, there are going to be many other states around the country that will take a hard look at the way Indiana has taken a step back, designed our own standards, and done it in a way where we drew on educators, we drew on citizens and parents, and developed standards that meet the needs of our people,” said Pence.

The new law, which removes common core education standards in total from the state, does not prohibit the state from adopting parts of common core into new standards being developed by the Indiana Board of Education.

Indiana was among early adopters of the common core in 2010. To date, 45 states have adopted the standards, though states such as Oklahoma are considering measures to halt the standards.

The National Governors Association and the Council of Chief State School Officers developed the standards to serve as curriculum guidelines to provide students with the math and English skills needed in each grade to prepare them for postsecondary schooling or entry into the workforce.
JOB GROWTH
Nevada’s economy is showing signs of improvement. Though the state still ranks second in the nation for its unemployment rate of 8.7 percent, research by Arizona State University indicates Nevada was among the top 10 states in 2013 for nonagricultural job growth, Stateline.org reported. The national job growth rate in 2013 was up 1.7 percent from 2012, with 2.26 million jobs added to the economy. Nevada ranked sixth in the nation in 2013 for its job growth rate, up from 19th in 2012.

GEOTHERMAL REVENUES
Hawaii Attorney General David Louie issued a formal ruling in March declaring all royalties generated from geothermal resource development on Hawaiian home lands must benefit Native Hawaiians, the Honolulu Star Advertiser reported. The opinion also concluded the state’s Department of Hawaiian Home Lands is the only state agency authorized to manage geothermal resources in the state.

FRACKING
The Wyoming Supreme Court reversed a lower court ruling over exemptions for oil and gas companies to disclose chemicals used in hydraulic fracturing, or fracking. At issue in the case was a challenge to decisions made by the Wyoming Oil and Gas Commission, which granted more than 100 exemptions, Wyoming Public Media reported, giving companies the right to keep chemicals secret. A 2011 district court ruling deferred to the commission’s determination of what constitutes a trade secret.

MARIJUANA TAXES
Colorado collected slightly more than $2 million in taxes from recreational marijuana sales in January, The Denver Post reported. Based on total tax revenues generated in January, officials estimate $14 million in recreational marijuana sales across the state, mostly in the Denver area. If sales continue at the same rate, sales and tax revenues for recreational marijuana would fall below initial forecasts.

CALIFORNIA PROGRAM AIMS TO REDUCE TOXINS IN CONSUMER PRODUCTS
A new program in California aims to reduce the toxins found in children’s sleeping products and home and building supplies sold in the state, the Contra Costa Coastal Times reported. The Safer Consumer Products program, the first of its kind in the nation, will require manufacturers to eliminate chemicals known to cause cancer and other illnesses in the production of goods.

Kathleen Curtis, national coordinator for the Alliance for Toxic-Free Fire Safety, expressed her enthusiasm for the program.

“I can’t even tell you what a big deal this is,” she said. “It’s a super smart strategic move by the state of California.”

State officials have announced an initial list of priority chemicals they hope to reduce or eliminate from consumer goods sold in the state, including children’s bedding, spray foam used as building insulation, and paint strippers, removers and surface cleaners.

Among the list of chemicals to be eliminated from consumer products is TDCPP, a flame retardant used in infant and toddler bedding. TDCPP, also known as Tris, has been linked to the development of cancer in rats.

State regulators expect to announce a second, longer list of targeted chemicals and products in October.

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JUVENILE COURT RECORDS
Washington state legislators have reached a compromise on a bill that would allow the majority of juvenile court records to remain sealed, The Seattle Times reported. The bill requires courts to hold sealing hearings when a juvenile turns 18 or upon completion of his or her sentence, and requires juvenile records be automatically sealed under certain conditions.

Under current law, residents can petition to seal juvenile records. Gov. Jay Inslee is expected to sign the bill.

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Texas AHEC is operating in the new state of Texas where the state's health care system is being challenged to make changes that will achieve the Institute for Healthcare Improvement’s ambitious “Triple Aim Initiative” of better health, better care and lower costs. Area health education centers, or AHECs, based in widely diverse communities across the United States, respond to this challenge with services and programs that directly address the changing health care environment. The National AHEC Organization, the membership association of AHECs, and its network of AHEC programs and centers are nimble and effective, successfully recruiting, retaining and educating today’s and tomorrow’s health professions workforce.

Texas AHECs, with more than 40 years experience in building the country’s health care workforce, are arguably the nation’s best coordinated and distributed tool to reach rural, frontier and inner-city health providers. Linking local communities to health professions education, AHECs help ensure all Americans have access to health professionals and quality care.

Each AHEC develops, with an intensely local flavor, community-based health care workforce training with an emphasis on primary care, community-based training, teaching, recruiting and supporting a health professions workforce in underserved areas. Each AHEC works to foster a diverse health professions workforce that reflects the nation’s population as a means of preparing health professionals to expand practice and develop collaborative team models of care. What makes each AHEC unique is it’s responsiveness and provision of services that address key needs of the changing health care landscape in each community.

AHECs are instrumental in integrating public health and primary care, placing medical students in community-based primary care settings, coordinating clinical placements of nurses and health professions students in rural and underserved areas, increasing access to health care and insurance for those that need it most, increasing skills in team-based care and better care coordination through interprofessional education initiatives and focusing on health professions training that improves patient safety and clinical outcomes.

AHECs also have an excellent and long-lasting track record of recruiting, mentoring and training health professions students from underrepresented minority, rural and disadvantaged populations, and, by no coincidence, the people who work in AHECs are as diverse as the people they work with. AHECs are a critical link between communities and a high-quality health care workforce for the future.

Given the crucial link AHECs have forged with their local communities and the role AHECs play in workforce development, it is vitally important state policymakers understand that a key and enduring strength of the National AHEC Organization and the AHEC network is their ability to creatively adapt national initiatives to help address local and regional health care issues, which ultimately impacts community health while providing a robust return on public investment.

The National AHEC Organization and the network of AHECs are critically aware, instinctively adaptable and creatively implementing programs and services that are helping hundreds of rural, frontier and urban underserved communities adapt to the changing health care environment. This strength is a valuable reminder of how well AHECs respond to the health education needs of health professionals, students and community members and how critically important it is to support AHECs at the local level.
The Affordable Care Act brought many changes to health care in the United States. After the U.S. Supreme Court ruled that states could choose to expand Medicaid, 24 states chose not to do so. Some states, however, are looking at the private option, which would use expansion money to help the same Medicaid-eligible population buy private health insurance. Arkansas was the first state to use such a plan, and Gov. Mike Beebe discusses the reasoning behind that decision. Dr. Jonathan B. Perlin, chief medical officer for Hospital Corporation of America and chair-elect of the American Hospital Association, believes coverage for all is imperative for better health, better care and lower costs. The federal health care law includes funding for states to improve health care in rural areas, and some states are looking at telemedicine as one way to narrow that coverage gap.
As the question of whether to expand Medicaid has been hotly debated in several states during the past year, one expert says it appears as if history is repeating itself.

“It will take time,” said Vernon K. Smith, principal at Health Management Associates, an independent national health care research and consulting firm. Smith also tracks trends in Medicaid for the Kaiser Family Foundation. “It will not be any different than what it was when Medicaid was originally adopted by the U.S. Congress in 1965.”

In fact, the number of states that had adopted Medicaid in 1966, a year after the program was approved—26—is the same number that adopted expansion after a year, Smith said.

While two dozen states may be holding out on traditional Medicaid expansion because of political or philosophical reasons, some state policymakers are forging a new path with expansion programs the likes of which have never been seen before.

**How We Got Here**

Smith points out that Medicaid has always focused on specific population groups—children and the adults who care for them, people with disabilities...
The Affordable Care Act was designed to change that. The law told states to expand Medicaid to those who traditionally hadn’t been covered, childless adults ages 18-64 who met certain income limits. The federal government is covering 100 percent of the costs of Medicaid expansion until 2016, gradually reducing it to 90 percent in 2020.

But a June 2012 ruling by the U.S. Supreme Court threw Medicaid expansion up in the air. “The Supreme Court kind of turned the Medicaid expansion into a choice for states,” said Matt Salo, executive director of the National Association of Medicaid Directors. “States were essentially given the choice of do it or don’t. The way that played out was pretty clear. About half of the states said, ‘Yes, we’ll do it,’ and half of the states said, ‘no thanks.’”

States that expanded Medicaid could take the federal money, while those that didn’t left money on the table. Arkansas came up with a third option—the private option—and it is proving to be a popular idea among some states.

Arkansas’ Private Option
Arkansas Surgeon General Dr. Joe Thompson—who also is director of the Arkansas Center for Health Improvement, a nonprofit health policy center dedicated to improving the health of the state’s residents—said health care in the state was in crisis mode before the Affordable Care Act.

“We had the lowest (Medicaid) eligibility levels of any state in the nation,” he said. “To be on our program, you had to be a parent and to make less than 17 percent of the federal poverty level and have less than $2,000 in assets.”

The program covered no childless adults. “We also had, I think, a growing kind of loss of private health insurance,” Thompson said. “It was really putting our health care, public and private sector, into a fairly dramatic crisis.”

Thompson said 25 percent of the state’s 19- to 64-year-olds were uninsured. In some counties, that rate was as high as 40 percent. “Obviously, that puts the hospitals at risk,” he said. “It makes it to be a place where doctors don’t want to locate. It was a fundamental cause of a lot of the problems we were experiencing.

“We had huge needs. We were kind of at a tipping point. We had started some efforts to stabilize (the health care market), but the uninsured issue was a real cancer, if you will, that we had to address or our system was going to potentially collapse.”

Thompson said an expansion of the traditional Medicaid program was not going to fly in Arkansas. Legislators were concerned about expanding state government and low-income residents losing eligibility for federal tax credits that could be used to buy private health insurance.

The answer, Thompson said, came in an option states were given when Medicaid was created in 1965—premium assistance. If an employer’s private insurance plan was deemed to be more cost effective and the benefits just as good as those offered by Medicaid, the state could use the federal money to buy into private plans. But because employers’ insurance plans varied so widely, it was too time consuming for states to evaluate thousands of insurance plans and almost nobody ever used premium assistance, he said.

The Affordable Care Act, however, standardized what must be covered by insurance plans, opening the door for what has come to be called the private option. Arkansas became the first state to receive a waiver from the federal government to enact the private option.

“It essentially, it’s not fee-for-service and it’s not Medicaid managed care,” he said. “It’s actually us using Medicaid dollars through premium assistance to buy private insurance on the new marketplace exchanges.

“I think it solved some of the political issues for us locally because we now were buying private health insurance and not growing state government. We were solving the issue of our uninsured. We were going to be able to offer our providers commercial payment rates as opposed to the discounted Medicaid payment rates. I think from a solution perspective, we had a lot of benefits and not very many negatives.”

Thompson said policymakers estimate 220,000 to 230,000 residents may be eligible for the private option. By mid-March, almost 97,000 people had signed up.

Iowa and Premiums
Iowa, the second state to receive a waiver for Medicaid expansion, modeled its program after the Arkansas private option, but expanded the idea to include premiums. The Iowa Health and Wellness Plan charges

“I THINK THE SIGNIFICANCE OF THE ARKANSAS APPROACH IS THAT IT OPENS A DOOR FOR OTHER STATES, REGARDLESS OF THE POLITICAL MAKEUP OF THEIR LEGISLATURE AND GOVERNOR’S OFFICE, TO CONSIDER A WAY TO TAKE ADVANTAGE OF THIS OPPORTUNITY PROVIDED BY THE (AFFORDABLE CARE ACT).”

—VERNON K. SMITH, PRINCIPAL AT HEALTH MANAGEMENT ASSOCIATES
premiums—$5 monthly for those 50 to 100 percent of the federal poverty level, $10 for those above 100 percent of the poverty line—for residents enrolled in the Medicaid expansion. Premiums will be waived for the first year of eligibility and a wellness program can reduce premiums in following years. Plan members also can claim financial hardship and have the premium waived.

“Beginning this year, members who engage in prescribed healthy behaviors during the first year will have their premiums waived in the second year,” said Amy Lorentzen McCoy, public information officer for Iowa’s Department of Human Services. “The program uses a primary care case management program, giving members a primary care provider to coordinate all health care needs.”

Salo said states are walking a very fine line when they try to get waivers that include premiums for Medicaid patients. Iowa’s financial hardship exemption helped its waiver.

“It’s very tricky,” Salo said. “The administration does not take very kindly to placing health care out of the reach of people who can’t afford it. ... What they agreed on is sort of a half a loaf, where Iowa is allowed to...
Pennsylvania’s Work Requirements

Pennsylvania is seeking federal approval for its Medicaid waiver, which includes a private option, premiums for all Medicaid recipients above 100 percent of the federal poverty line and reduced premiums for those completing a wellness program.

The unique piece in the Keystone State’s original waiver application was the requirement for the majority of Medicaid recipients who work fewer than 20 hours a week to take part in a job-training program to qualify for coverage.

“I think based on some of the conversations that we’ve had with (the Centers for Medicare and Medicaid Services), they clearly indicated that they have a very strong policy position about tying employment to Medicaid eligibility,” said Leesa Allen, executive Medicaid director for the Pennsylvania Department of Public Welfare.

In March, Gov. Tom Corbett submitted a revised waiver including a voluntary, one-year pilot project. Those working 30 hours or more per week would receive an automatic premium or copayment reduction of 40 percent. Those working 20–29 hours would receive a reduction of 25 percent, and those working fewer than 20 hours per week would be asked to participate in monthly job training or employment activities. Medicaid recipients who successfully complete the training or activities would receive a 15 percent reduction in premiums and copayments.

“I think Gov. Corbett has been very clear that we want to encourage folks to participate in job training and employment opportunities,” Allen said.

Smith of Health Management Associates said he’s unsure how the CMS will respond to Pennsylvania’s proposal. The agency, he said, has shown an interest in working with states to achieve other public policy goals or requirements as they are increasing insurance coverage.

“CMS is probably more constrained in what it can actually approve than what most states would like,” he said. “But within the constraints of CMS, they have demonstrated that they are interested in working with states in going as far as they possibly can.”

The Future of Private Option

Smith said the private option has been crucial in getting states reluctant to participate in the Affordable Care Act engaged in extending health insurance coverage.

“I think the significance of the Arkansas approach is that it opens a door for other states, regardless of the political makeup of their legislature and governor’s office, to consider a way to take advantage of this opportunity provided by the ACA,” Smith said. “It will be in play.”

But those plays may not be easy, even in Arkansas.

Earlier this year, the legislature had a bruising battle to reauthorize funding for the private option. Funding bills require a three-fourths approval in the Arkansas legislature. While the senate approved the funding legislation by a 27-8 vote, the house had four failed votes before finally passing it by a narrow 76-24 margin.

“It was a bruising fight,” Thompson said.

“My greatest fear is — that line is, nobody knows. … I think really looking at that and continuing to work with CMS and press them on some of those key policy issues is really critical for states.”

But, Salo cautions, administration officials have been on record saying only a limited number of waivers would be approved. Where that line is, nobody knows.

“At the end of the day, the core question is what does it take for the administration to be able to declare success,” Salo said. “Does success mean for them getting as many people covered as quickly as possible by whatever means necessary, or does success mean for them holding out as long as possible to get as many people covered through the traditional Medicaid program as possible. Those are two pretty different guiding philosophies. I don’t know which is theirs right now. … That, to me, is the key.”
How does the private option work in Arkansas?
“Taking the same federal money that would otherwise be available for Medicaid expansion, utilizing basically the same eligibility pool—we couldn’t change the eligibility pool at all—and instead of going on traditional Medicaid, we’re purchasing private health insurance with those funds so the individuals who are covered are covered by private health insurance rather than traditional Medicaid, even though it’s the same population.”

What are some advantages to this?
“In Arkansas—as many states do—we have a premium tax on health care policies. So this creates a flow of money through additional health care policies that will help offset the state’s responsibility going forward, for the state’s share. ... Another advantage is you really do affect that churning problem. One of the problems that was pointed out with the Medicaid expansion is if somebody gravitated between 138 or 139 or 137 percent of poverty, you’d have this churning where they’d be knocked off a certain thing and would have to go to a different kind of thing and the confusion and the costs and all that. You really do attack that problem this way, because you don’t have to necessarily change policies, you just go to a different way of subsidized insurance rather than the straight Medicaid.”

How does the cost compare to the cost of traditional Medicaid and what the cost for expansion would have been for the state?
“We think they’ll be relatively comparable. We’ve done some preliminary analysis. That’s one of the things the feds wanted to ensure … that we were in a parameter of it not being overly expensive this way vis-a-vis traditional Medicaid, so the costs are relatively comparable.”

What were some challenges you faced in getting this approved and funded?
“Arkansas is unique and the issue for us is unique because of a constitutional requirement on a supermajority on appropriations. We didn’t have another debate about whether to continue the private option. That’s a 51 percent vote. … We’ve got way more than sufficient majorities on both sides of the aisle to ensure there’s never going to be a problem there. The issue is appropriations bills, according to an antiquated constitution, require a three-fourths—that’s 75 percent—majority vote. The issue is how in the heck do you get … 75 percent on any issue that has any degree of controversy?”
So how did you get three-fourths?

"Pragmatism. It’s what (former President Bill) Clinton calls arithmetic, too. You have a coalition of Democrats and traditional business Republicans who can add and subtract. The opposition is the ideological tea party opposition. Those people that voted against it just couldn’t get over the idea that they hate Obamacare and Obama and the federal government and this whole thing so much, that they couldn’t overcome that hatred with looking at the ramifications of arithmetic, but that’s just obviously less than 25 percent."

Do you see challenges down the road for maintaining funding?

“I think there will always be those challenges, but there are a number of things that obviate for continuation and makes it easier going forward than it was going backward. It’s working, first of all. There are over 115,000 people that are now in the private option. … We were able to reduce some actual general revenue we were sending either to hospitals or to various health care providers for uncompensated care. Total uncompensated care obviously doesn’t go away overnight, so we didn’t take all the money away from them. But we were able to conservatively reduce dollars for those entities that we were paying out in uncompensated care because now they were no longer going to have that because some of that population is going to now be covered. As a result of all that, we anticipated a $90 million savings and the legislature wanted to give that savings back to the people.”

What would be the impact of not continuing the private option?

“Part of how all this stuff is being paid for is under the federal health care act, the Affordable Care Act. Medicare payments to hospitals are reduced … and states can’t do anything about this. Our hospitals are going to pay for this and, theoretically, they are going to get some money from Medicaid patients that they were having to treat free before—that uncompensated care population. Theoretically, that offsets their reduction in their Medicare payments. If (states) don’t take the expansion, their hospitals are paying for this and getting nothing in return. None of this is free lunch. It all costs money, so your state taxpayers are paying it in the form of their federal taxes. Your hospitals are paying it in the form of reduction in Medicare reimbursements. And if you don’t take it, what you’re saying is, ‘We want to pay for New York and California and Oregon and Washington, but we don’t care about our own people, we don’t care about our own hospitals, we don’t care about our own taxpayers.’”

What plans do you have to ensure the program remains viable?

“Just tell the truth. Just tell the truth. And show the facts. The facts speak for themselves. Rational thought and objective analysis should be enough for anybody that’s willing to look at the facts. Doesn’t need to be any smoke and mirrors. Doesn’t need to be any tricks or games or political threats. It’s just the facts, the objective criteria and objective facts and common sense. Anybody that’s going to use common sense is going to be able to see it.”

So basically let the program speak for itself?

“Absolutely! If we don’t do it, we don’t change Obamacare. We just leave our people, our hospitals, our taxpayers, our businessmen, … we just leave them out. If we don’t do it, and any state doesn’t do (it), it hasn’t changed anything in Washington, D.C., except to hurt their own businesses, their own hospitals, their own people. … I’m not trying to convince anybody to be for Obamacare. That’s not the issue. What we’re seeing is all these Republican governors, friends of mine, colleagues of mine, Republican governors, Republican legislators across the country that can’t stand Obamacare … that run against it, that don’t want it, that would repeal it tomorrow. They’re doing what we did because it’s logical, because it’s common sense, because it’s stupid to hurt your own people because you’re mad at them (the federal government) when hurting your own people doesn’t change them.”

What will you measure to see if it is a success?

“We’ll look at the costs and see that they’re in the parameters of what we thought. … We’ve already seen, for example, in one month compared to the same month a year ago, a significant percentage decrease in uncompensated care. There are a lot of objective measures that you can use. You’ve already seen the advantage of the people getting their money back. How big of a success is that? They’ve already got the tax relief. That’s something that’s measurable that’s real easy to see.”
The first enrollment period for health care insurance under the Patient Protection and Affordable Care Act has ended. The Obama administration announced in April that more than 7 million people had enrolled on state and federal health care exchanges.

Here are some updates on what’s going on in the states with regard to health care reform.

by Debra Miller

**UPDATE ON THE AFFORDABLE CARE ACT**

Kansas is the latest state to advance a bill to join a proposed interstate compact that, after Congressional approval, would exempt states from the requirements of the Affordable Care Act. Eight states have adopted the compact and Kansas is one of 12 more considering it, according to the Health Care Compact website.

The Kansas House in March approved the bill and sent it to the Senate. Sen. Mary Pilcher-Cook, chair of the Senate Public Health and Welfare Committee, told the KHI News Service it was too late to take up the bill in her committee, but she said she hoped Senate leadership would find a way to consider the bill.

The eight states adopting the compact so far...
Consumers dread having to compare health insurance policies and research shows they aren’t very good at it. They barely have better than chance alone at identifying the lower cost plan, according to Consumer’s Checkbook, a nonprofit organization that has a 35-year history preparing plan comparisons for federal employees to use during their open enrollment period.

The Affordable Care Act charges the health insurance exchanges to “assist consumers in making easy health insurance choices.” As most employers do, the exchanges list plans in order of premium price, from low to high. While they provide consumers information to compare premiums, out-of-pocket maximums, deductibles and copayments, “consumers often choose a plan in much less time than they spend on a new car purchase,” according to Robert Krughoff, founder and president of Consumer’s Checkbook.

He said his organization has a better idea and they put up, free of charge to Illinois, a parallel website to the exchange to help consumers compare their likely health costs for the year. The organization is working on similar sites for Massachusetts and Colorado.

Estimates for each plan offered on the Illinois site include premiums and all other out-of-pocket expenses based on family size, ages of family members, self-reported health status and other characteristics, such as expected major health procedures or events. A second estimated annual expense is provided for a bad year, with higher than average health expenses, and the chances of having a bad year. The estimates can show the lowest premiums don’t necessarily mean the lowest out-of-pocket costs.

The Illinois website also provides consumers access to provider lists to see whether their preferred doctors are in the plan’s network. In addition, the website provides in-depth plan quality information and the ability to personalize the quality information to factors important to the consumer.

The Illinois website was created without support from the state or federal governments as a way to show policymakers the types of information that could be provided to consumers. The website helps consumers choose the best-priced policy for themselves and then sends them back to the official federal marketplace to enroll in the selected policy.

The website was introduced in February to more than 200 Illinois health navigators, people hired to assist consumers to sign up for subsidized health insurance plans through the exchange. Local media also have promoted the site.

Joel Ario, former director of the federal Cabinet for Health and Human Services’ Office of Health Insurance Exchanges and a former insurance commissioner in two states, predicted tools will be developed that go even further. “I’d bet on Amazon and Google to create the tools rather than a state exchange,” he told The Associated Press.
CONNECTICUT TO MARKET EXCHANGE EXPERTISE

By all reports, Connecticut’s health exchange—Access Health CT—has been a success. Now the state has designs on setting up a consulting business to help other states.

“We have something that is working and we want to share it,” Lt. Gov. Nancy Wyman told The New York Times. Wyman serves as the chair of the board of directors for the exchange.

Plans are underway to license the Connecticut technology, selling an ‘exchange in a box,’ according to Kevin Counihan, executive director of the exchange. The Hartford Courant reports Maryland is considering shutting down its exchange and using Connecticut’s for the next open enrollment period. The Courant also reported Connecticut is looking for $11 million from the federal government to perfect its model and spread it to other states.

Federal enrollment data released in March showed only four states with larger numbers of sign-ups for marketplace health insurance plans than Connecticut, but those states—California, Colorado, New York and Washington—are all considerably larger. Even before the last month of open enrollment, 57,465 individuals in Connecticut had selected a marketplace health insurance plan, compared to a goal of 33,000.

Only 15 states are running their own health insurance exchanges and, like Maryland, some of them have encountered significant problems. States can reconsider their earlier decision to forego a state exchange and apply for federal funds and designation in 2014.

NEARLY 5 MILLION MISSING OUT ON HEALTH COVERAGE

As debates over expanding Medicaid eligibility continue in a number of legislatures across the country, large numbers of people remain in a kind of no-man’s land.

The Kaiser Family Foundation, in a December 2013 report, estimated 5 million adults are not poor enough for Medicaid coverage under the old rules in their home states that have not acted on expansion. These 5 million adults, about half men and half women, are also ineligible for federal subsidies to purchase health insurance through the exchanges under the Affordable Care Act. Subsidy eligibility is set in the law for incomes between 100 and 400 percent of the federal poverty line—between $23,850 and $95,400 per year in 2014 for a family of four.

Congress did not intend to leave these individuals out of health care coverage. The coverage gap is a direct result of the decision by the U.S. Supreme Court that put the decision to expand Medicaid eligibility to 138 percent of poverty in the hands of each state.

In the vast majority of states, Medicaid eligibility for certain groups—adults and mostly those who do not have children—had remained fixed at the eligibility levels for the old welfare program that was replaced by President Clinton’s welfare reform in 1997. The old eligibility levels were established as dollar amounts, which became progressively lower percentages of poverty each year after 1997.

For instance, in Missouri, a parent can make no more than 19 percent of the poverty level—about $4,500 a year for a family of four—to qualify for Medicaid. Eligibility for children is much higher under Medicaid and CHIP. Childless adults don’t qualify at all.

Todd Foltz, a Missourian who has lost his job and his employer-provided insurance because of his multiple sclerosis, has been to Jefferson City to tell his story. “For me, it’s becoming not just a gap, but a crevasse, and it’s becoming not just frightening but terrifying,” he said at a House committee hearing, according to the Kansas City Star.

Twenty-six states—the latest is New Hampshire—and the District of Columbia are moving forward with Medicaid expansion; 19 states are not. The remaining five states are still debating the issue and could submit a state plan amendment to the federal government in 2014.
ENROLLMENT EXTENDED FOR THOSE ‘IN LINE’

Just one week before the March 31 deadline for enrollment in health insurance plans available through the health insurance exchanges, the Obama administration issued guidance allowing those “in line” to have more time to complete their applications and make their first premium payment for coverage to start May 1. The guidance issued by the Department of Health and Human Services will apply to the federal health exchanges as well as those run in partnership between a state and the federal government. Consumers with special cases also received a delayed sign-up provision.

After a slow start when the exchanges opened in October 2013, enrollment picked up and reached 7.5 million, exceeding by half a million people the original projections by the Congressional Budget Office. About half of those people enrolled in March. Those people “in line” will add to the final tally.

Several states, including Maryland, Minnesota and Nevada, had taken similar steps of offering extensions as the end of March deadline loomed.

NEW HAMPSHIRE »
After a two-year logjam and a governor’s election, Gov. Maggie Hassan signed a bill into law on March 27, 2014, extending Medicaid coverage to 50,000 people. The compromise involves using federal funds to buy private insurance as Iowa and Arkansas are doing. The plan will require approval by the federal government.

INDIANA»
Gov. Mike Pence met with then-Health and Human Services Secretary Kathleen Sebelius on a plan to use the existing Healthy Indiana Plan to further expand Medicaid coverage in the state. Healthy Indiana Plan is a consumer-directed Medicaid waiver plan with about 10,000 low-income members. The members contribute the first $1,100 of their health care costs per year.

MISSOURI »
Proponents of Medicaid expansion were still holding out hope in late March that some proposal would move forward before the legislature adjourns in late May. But Senate leaders said it was not going to happen.

PENNSYLVANIA »
Outgoing Gov. Tom Corbett submitted a plan in February to the Department of Health and Human Services to use federal dollars to purchase private insurance. The plan is under federal review and isn’t scheduled to begin until Jan. 1, 2015, if approved by HHS. Some candidates for governor are calling for expansion of the traditional Medicaid program.

UTAH »
Gov. Gary Herbert is proposing a three-year pilot program called the Healthy Utah Plan. Subsidies would be provided to individuals and families based on their household incomes and access to health care through their employers. Enrollees would contribute an average of $420 per year. The plan requires those who can to work and includes skills assessment and employment training classes.

VIRGINIA »
The legislature is locked in debate with new Gov. Terry McAuliffe over the budget and Medicaid expansion. If they are tied together and no agreement can be reached, state operations face a possible shutdown July 1.
In health policy, we aspire toward the “triple aim” of better health, better care and better cost for our country. Indeed, the cost-growth of health care has slowed profoundly over the past half decade. Studies show this is in part due to the economic downturn, but more substantially reflects structural changes that are checking increased resource use. What may be less obvious is that the care itself is better, and that better care is almost always less expensive.

Performance measures providing transparency and accountability foster evidence-based practice, leading to more efficient care delivery. Avoiding complications not only prevents harm, but also prevents unnecessary expenditures. What may be less obvious is that discontinuities in insurance coverage that lead to discontinuities in care are also inefficient. In short, it is easier, less expensive and certainly more compassionate to address health risks and treat disease early than to wait for catastrophe. Thus, our march toward the triple aim demands a true system of care that aspires to promote health, prevent disease and manage chronic illness.

Long before the passage of the Affordable Care Act, hospitals across the country were working to improve fragmented care delivery. As we realized our focus has been more on “sick care” than “health care,” we realized our need to revise our compact with patients. The familiar sign depicting a white “H” on a blue field has always symbolized hospitals’ commitment to be there for illness. Reinventing the “H” and delivering on the promise of the triple aim requires that we be there in both sickness and in health. This vow requires the continuing support of our legislators and policymakers.

At the onset of the economic downturn, nearly 50 million Americans had no health insurance and hospitals were admitting sicker patients. At the same time, this meant providing more charity care, which in turn increased the level of uncollectible debts. Insurance premiums and out-of-pocket costs were increasing, while an aging population, changing communities and disparities in care posed additional challenges.

But with these challenges came new opportunities. Better information technology created the means for hospitals to analyze patient data and tap into our collective knowledge to define best practices. Hospitals also began to more accurately measure performance and work tirelessly to develop and share ways to improve quality, such as through protocols that minimize infections that are now understood to be preventable.

The American Hospital Association has played a leadership role in this process by providing a hub for exploration and information sharing, and for leading quality improvement efforts. Through “Hospitals in Pursuit of Excellence,” its strategic platform to accelerate performance improvement, the AHA provides field-tested practices, tools, education and other resources that support hospital efforts to meet the Institute of Medicine’s Six Quality Aims—care that is safe, timely, effective, efficient, equitable and patient-centered.

The new requirements for demonstrating value are bringing profound cultural change to health care and hospitals. Boundaries that once separated clinicians from administrators, hospitals from medical offices and medical offices from patient homes are increasingly dissolving. Still, the business case for a full system of health care is incomplete and it cannot be built successfully as a derivative of sick care. Achieving the triple aim requires an evolution of care model—and the business model—from episodic to continuous.

A Shared Vision

The AHA consulted with hospitals, patients, physicians and other stakeholders across the country to create a framework to transform America’s health care. Called “Health for Life,” its five essential elements have guided the AHA’s policy development regarding health care reform. They are:

» Focus on wellness. Good health—physical, mental and oral—is essential for a productive and vibrant America. A focus on wellness must be integrated into our policies and communities.

» The highest quality care. Doctors, nurses, hospitals, nursing homes and others must work together with patients and families toward zero avoidable harm and use of the best science to achieve optimal outcomes.

» The best information. Informing the decisions of patients and caregivers across settings and over time coordinates the team. It also creates a platform for measuring and assuring performance and for a learning health system that advances the science of health care.

» The most efficient, affordable care. We cannot be satisfied until the cost of health insurance and health care are affordable. Reliable, science-based, patient-centered and continuous care is most efficient.

» Health coverage for all, paid for by all. Health coverage for all is everyone’s shared responsibility, and individuals,
businesses, insurers and governments must play a role in expanding and paying for it. Not having insurance or being functionally underinsured is not a low cost model; it is a “sick care” model, and cost-shifting to those with coverage fails to solve the inherent inequity and inefficiency.

Additional information on the five essential elements of “Health for Life” and details for implementing them may be found at the AHA website, www.aha.org/advocacy-issues/healthforlife/index.shtml.

Major Commitment

Hospitals began implementing new regulations and preparing for increased coverage almost as soon as Congress passed the Affordable Care Act. Hospitals already are becoming more integrated as systems. Yet at the same time, funding for hospital services has been cut by more than $100 billion since 2010, putting a significant financial burden on the hospital industry.

Last year was a demanding one for hospitals, and 2014 continues to bring even more profound change—but we are pleased to be changing. We are implementing electronic health records while simultaneously navigating new penalty programs and payment models and a host of other new regulations, most with very ambitious timelines. Many hospitals have been helping their communities enroll in the new health insurance marketplaces and are treating newly covered patients. We continue to focus on quality and patient safety, implementing more evidence-based improvement efforts. These are costly changes that must be made by all hospitals, whether or not we see coverage gains.

As we move toward a more coordinated system of care, we are committed to working harder to keep people healthier and find ways to change in order to better meet the needs of our communities. We will work to identify and eliminate costly treatments that don’t improve patient outcomes and move care into our communities in nontraditional ways. Some hospitals will merge with others to benefit from economies of scale that can help provide the latest treatments, access to new technologies and preserve the presence of caregivers at the bedside in America’s communities.

New Partnerships

As American hospitals navigate toward a new future, expect us to step up our outreach efforts to individuals, families and entire communities—and to our elected representatives. Outreach at the community level will encourage people to get the preventive care they need. We will partner with organizations that help patients stay healthy after discharge from our facilities. And, we will turn to our legislators to work with us to support our efforts to keep health and health care where they belong—in our communities.

We will work together to redefine the “H” seen in that familiar, blue, hospital sign. That “H” has always been America’s national symbol for “hospital” to let everyone know that if they were sick, hospitals are there to care for them. We are striving to redefine that “H” for the future, for it to become a symbol, not only of American hospitals’ commitment to the triple aim, but of America’s commitment to the complete health of its citizens. We must do this not just because we are a compassionate country; we must do this because it is most efficient.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI, is chair-elect of the American Hospital Association. He is president for clinical services and chief medical officer for Hospital Corporation of America.

NEW MODEL OF HEALTH CARE

PEORIA, ILL.—Patient Rose Bush receives treatment from Dr. Leon Yeh in the emergency room at OSF Saint Francis Medical Center. The efforts are part of the biggest experiment yet to fix the costly and error-plagued U.S. health care system. The new models of care, part of the Affordable Care Act, encourage providers to form networks to coordinate care and cut costs. The models involve close monitoring of the sickest patients to address budding health problems before they cause a costly trip to the emergency room or an extended hospital stay. © JIM YOUNG/Reuters/CORBIS
While the federal government will pick up 100 percent of the costs for expanded Medicaid through 2016, states will be required to provide matching funds starting in 2017. By 2020, states would pick up 10 percent of costs for the expansion population, significantly less than the match on “traditional Medicaid,” which ranges from 26.4 percent in Mississippi to 50 percent in 13 states. Since half the states have so far chosen not to expand Medicaid, 5 million adults fall in the coverage gap between those eligible for traditional Medicaid and those eligible for subsidies for private insurance under the Affordable Care Act. The map at right shows the numbers of people in those states not expanding Medicaid who would otherwise be eligible for Medicaid under expansion. That includes nearly 4 million people who suffer from serious mental illness and substance abuse disorders fall in that gap, according to the American Mental Health Counselors Association. The percentage of uninsured adults—of the entire Medicaid expansion-eligible population—with mental health conditions that would be eligible for Medicaid under expansion ranges from 27 percent in Georgia to 62 percent in Indiana.

States that chose to expand Medicaid will see economic benefits because of that decision, according to data compiled and analyzed by the Kaiser Commission on Medicaid and the Uninsured. States that do not expand Medicaid forgo increased federal funds and associated new jobs.

**Non-expansion states with the highest and lowest percentage of Medicaid expansion eligible individuals with a mental illness or substance abuse disorder**

Source: American Mental Health Counselors Association

**Medicaid Expansion Colorado**

Gov. John Hickenlooper signed Medicaid expansion into law last May. Sen. Irene Aguilar, MD, sponsored the legislation that’s expected to add 160,000 adults to public health care assistance.

© AP Photo/Brennan Linsley
Falling in the Coverage Gap

States that chose not to expand Medicaid have another gap to consider—the jobs estimated to be generated by expansion that will be left on the table. The Kaiser Commission on Medicaid and the Uninsured analyzed data from state economic impact studies of the benefits of Medicaid expansion. The states used different analytical models to develop estimates on the economic impact and employment impact. The Kaiser Commission found Medicaid expansion would generate more state economic activity, such as increases in state output, gross state product, and state and local revenues. It also determined Medicaid expansion would have a positive effect on jobs and earnings. Here are the expected number of new jobs based on the state impact studies Kaiser used in its analysis.

*States that have expanded Medicaid. Michigan’s private option plan is pending. Source: The Kaiser Commission on Medicaid and the Uninsured
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Note: All conference sessions are open to registered attendees unless listed as invitation only. If you have any questions regarding the conference, please contact (800) 800-1910 or Alaska2014@csg.org.

SATURDAY, AUG. 9
Registration & Information Desks Open
7 a.m.–5 p.m.
Buffet Breakfast Open (all attendees) 7–9 a.m.
CSG Policy Academies (all policy academy sessions are by invitation only) 8 a.m.–5 p.m.
• Pensions
  For more information, contact Jennifer Burnett, program manager, fiscal and economic development policy, (859) 244–8114, jburnett@csg.org
• U.S. Workforce Development
  For more information, contact Pam Gains, director, education policy, (859) 244–8142, pgains@csg.org
CSG West Committee Meetings 9 a.m.–Noon
• CSG West Fiscal Affairs Committee
• CSG WESTRENDS
Buffet Lunch Open (all attendees) Noon–2 p.m.
CSG West Executive Committee
(lunch provided) Noon–2 p.m.
CSG Investment Subcommittee 2–4 p.m.
CSG West Committee meetings 2–5 p.m.
• CSG West Economic Development & Trade Committee
• CSG West Nominating Committee
• CSG West Water & Environment Committee
Welcome to Alaska Reception 6:30–9 p.m.
Alaska Native Heritage Center

SUNDAY, AUG. 10
Registration & Information Desks Open
7 a.m.–5 p.m.
Buffet Breakfast Open (all attendees) 7–9 a.m.
CSG Finance Committee 8–10 a.m.
CSG Associates Advisory Committee
8:30–10 a.m.
CSG West Canada Relations Committee 9 a.m.–Noon
CSG & CSG West Education Workshop 9 a.m.–Noon
Joint policy workshop will be presented from 9–11 a.m., business sessions for the CSG Education Public Policy Committee & CSG West Education Committee will take place 11 a.m.–Noon
Innovation Events 9 a.m.–Noon
• Health Innovations Showroom open
• Innovation Classroom Sessions (topics TBD)

MONDAY, AUG. 11
Registration & Information Desks Open
7 a.m.–5 p.m.
Buffet Breakfast Open (all attendees) 7–9 a.m.
Policy Workshop Presented by CSG Energy & Environment Public Policy Committee
8–10 a.m.
CSG & CSG West Health Policy Workshop 9 a.m.–Noon
Joint policy workshop will be presented from 9–11 a.m., business sessions for the CSG Health Public Policy Committee & CSG West Health Committee will take place 11 a.m.–Noon
Innovation Events 9 a.m.–Noon
• Health Innovations Showroom open
• Innovation Classroom Sessions (topics TBD)
Policy Workshop Presented by CSG Federalism Task Force 10 a.m.–Noon
General Session Luncheon Noon–2 p.m.

CSG Policy Workshops 10 a.m.–Noon
• Policy Workshop sponsored by CSG Fiscal & Economic Development Public Policy Committee
• Policy Workshop sponsored by CSG Transportation Public Policy Committee

General Session Luncheon Noon–2 p.m.
CSG Leadership Council (invitation only) 2–3:30 p.m.
CSG West Future of Western Legislatures 2–5 p.m.
CSG West Energy & Public Lands Committee 2–5 p.m.
CSG National Conference Committee 2–3:30 p.m.
CSG West Higher Education Task Force 2–3:30 p.m.
CSG SSL Committee (Part I) 2–5 p.m.
Women in Politics Sponsored by CSG West 2–5 p.m.
Innovation Events 2–5 p.m.
• Health Innovations Showroom open 2–4:30 p.m.
• Innovation Classroom Sessions (topics TBD)

SUNDAY, AUG. 10
Morning Segway Tour #1 8 a.m.–9:30 a.m.
Morning Segway Tour #2 10–11:30 a.m.
Port of Anchorage Policy Tour 9:30 a.m.–Noon
Alaska Dessert & Dance 9 p.m.–Midnight

MONDAY, AUG. 11
Morning Coastal Trail Walk 7–8 a.m.
Crow Creek Mining: Alaska Wildlife Conservation Center 8:45 a.m.–3 p.m.
Elmendorf NORAD Center Policy Tour 9 a.m.–1:30 p.m.
Wildberry Products, Sourdough Mining Co. & Luncheon 11:30 a.m.–3:30 p.m.
Anchorage Museum Reception 6:30–9 p.m.

TUESDAY, AUG. 12
Alaska Tour Day 6:30 a.m.–10 p.m.
Registration & Information Desks Open 7 a.m.–5 p.m.
All Attendee Breakfast & Pathways to Prosperity Service Project 8–10 a.m.
CSG Policy Academy: Solar Energy 9 a.m.–5 p.m.
For more information, contact Rebekah Fitzgerald, program manager, energy and environmental policy, (859) 244–8254, rfitzgerald@csg.org
CSG West Executive Committee 10 a.m.–Noon
CSG SSL Committee (Part II) 10 a.m.–Noon
Policy Workshop Sponsored by CSG Interbranch Committee 10 a.m.–Noon
CSG West Executive Committee 10 a.m.–Noon
Policy Workshop Sponsored by CSG Interbranch Committee 10 a.m.–Noon
General Session Luncheon Noon–2 p.m.
CSG Pathways to Prosperity Policy Workshop: Workforce Development 2–4 p.m.
CSG National Center for Interstate Compacts Workshop 2–5 p.m.
CSG West Annual Legislative Training Assembly (ALTA) & Toll Fellow Alumni Session 2–5 p.m.
CSC Executive Committee 4–5 p.m.
2015 Kickoff Event 6–8 p.m.

ALASKA HOST STATE SPONSORED GUEST ACTIVITIES

To register or to learn more about the host state sponsored activities, visit csg2014.org.

SATURDAY, AUG. 9
Morning Fun Run 7–8 a.m.
Mat-Su Valley Tour 8:30 a.m.–2 p.m.
Alaska Native Heritage Center 6:30–9 p.m.

SUNDAY, AUG. 10
Alaska Toll Fellows & CSG West WLA Alumni Reception (invitation only) 5–6 p.m.
Anchorage Museum Reception 6:30–9 p.m.
The Anchorage Museum at Rasmuson Center

MONDAY, AUG. 11
Alaska Toll Fellows & CSG West WLA Alumni Reception (invitation only) 5–6 p.m.
Anchorage Museum Reception 6:30–9 p.m.

TUESDAY, AUG. 12
Alaska Toll Fellows & CSG West WLA Alumni Reception (invitation only) 5–6 p.m.
Anchorage Museum Reception 6:30–9 p.m.

STATE SPONSORED ACTIVITIES

CSG SSL Committee (Part I) 10 a.m.–Noon
CSG SSL Committee (Part II) 10 a.m.–Noon
Policy Workshop Sponsored by CSG Interbranch Committee 10 a.m.–Noon
CSG West Executive Committee 10 a.m.–Noon
Policy Workshop Sponsored by CSG Interbranch Committee 10 a.m.–Noon
General Session Luncheon Noon–2 p.m.
CSG Pathways to Prosperity Policy Workshop: Workforce Development 2–4 p.m.
CSG National Center for Interstate Compacts Workshop 2–5 p.m.
CSG West Annual Legislative Training Assembly (ALTA) & Toll Fellow Alumni Session 2–5 p.m.
CSC Executive Committee 4–5 p.m.
2015 Kickoff Event 6–8 p.m.

Note: All conference sessions are open to registered attendees unless listed as invitation only. If you have any questions regarding the conference, please contact (800) 800-1910 or Alaska2014@csg.org.
HOTELS

The majority of all conference sessions will take place at the **Dena’ina Civic and Convention Center** located at 600 W. Seventh Ave. For more information about the convention center, visit [www.anchorageconventioncenters.com](http://www.anchorageconventioncenters.com).

**PLEASE NOTE:** CSG has room blocks at the properties listed below on a first-come, first-served basis. Conference group rates are available at each property only for the nights indicated. CSG cannot guarantee availability or rates for those rooms reserved after the hotel cutoff date has passed or once the room block has filled at a particular property. Book as early as possible to ensure you receive accommodations at your desired property and rate. If you have any questions regarding any of the CSG room blocks, please call (800) 800-1910.

**HILTON ANCHORAGE**
500 W 3rd Ave. | Anchorage, AK 99501
ph (907) 272-7411 | fax (907) 265-7044
www.hiltonanchorage.com

- 4 blocks from Convention Center
- Room Rate: $199 plus 12% room occupancy tax; all major credit cards accepted
- Dates Available: Aug. 9–13 (limited number of rooms available on Aug. 8)
- Cutoff Date: July 11, 2014
- Reservations: Reserve online at [www.csg.org/2014annualconference](http://www.csg.org/2014annualconference) or call (800) 445-8667, Group Name: CSG

**HOTEL CAPTAIN COOK**
939 W. 5th Ave. | Anchorage, AK 99501
ph (907) 276-6000 | fax (907) 343-2298
www.captaincook.com

- 3 blocks from Convention Center
- Room Rate: $205 plus 12% room occupancy tax; all major credit cards accepted
- Dates Available: Aug. 9–13 (limited number of rooms available on August 8)
- Cutoff Date: July 11, 2014
- Reservations: Reserve online at [www.csg.org/2014annualconference](http://www.csg.org/2014annualconference) or call (800) 843-1950, Group Name: CSG

**ANCHORAGE MARRIOTT DOWNTOWN**
820 West 7th Ave. | Anchorage, AK 99501
ph (907) 279-8000 | fax (907) 279-8005
www.marriott.com/ancdt

- 1 block from Convention Center
- Room Rate: $209 plus 12% room occupancy tax; all major credit cards accepted
- Dates Available: Aug. 9–13 (limited number of rooms available on August 8)
- Cutoff Date: July 11, 2014
- Reservations: SOLD OUT

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CSG HEALTH INNOVATIONS SHOWROOM

The explosion of innovation has the potential to change the face of health care, improving lives of millions of Americans along the way. In the current economic climate, state government leaders are turning to the private sector for information, inspiration and ingenuity.

The CSG Health Innovations Showroom will provide attendees the chance to learn more about the latest health innovations in testing, medical devices and more! Companies interested in exhibiting should contact Maggie Mick, director of development, (859) 244-8113, mmick@csg.org.

Booth spaces will be assigned in the order contracts are received. Preference will be given to those who commit early. Companies or organizations that exhibit in the Health Innovations Showroom receive a 10X10 booth, a full conference registration, two showroom floor-only passes, listing in the Health Innovations Showroom Guide as part of the conference welcome packet, listing on showroom map and listing in the CSG Health Innovations Showroom marketing e-blast.

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TRANSPORTATION

The Ted Stevens Anchorage International Airport (ANC) is approximately six miles/10–15 minutes to the downtown area. Transportation to downtown is convenient by shuttle, taxi or rental car. Visit [www.csg.org/2014annualconference](http://www.csg.org/2014annualconference) for complete information.
REGISTRATION


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<th>2014 CONFERENCE REGISTRATION RATES</th>
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Dr. James Mold believes the health care profession can learn a lot from farmers.

When farmers have a problem, many times they’ll look to the network of cooperative extension agents spread across counties in a state. Mold believes creating a similar extension service network can provide that same support for health care providers.

Mold, director of the research division in the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center, is using a federal grant to help physicians in rural areas improve their primary care practices.

“Most of the work has to be done locally through personal relationships,” Mold said. “Practices need to work with someone they trust, someone who knows their particular situation and practice.”

Oklahoma Rep. Doug Cox, a physician who practices primarily emergency medicine during the legislative sessions, said such a network would help rural physicians, who often find it difficult to get away for continuing education because of a heavy workload.

“It’s going to implement a program that encourages physicians to work together and share resources in rural areas so they’re able to provide services that a small rural practice or a solo practitioner, or even a two-man group, could not afford to do,” Cox said.

That, he said, can help to alleviate some of the challenges facing health care in rural areas, a primary one being access because of the growing shortage of physicians.

**Improving Rural Health Care**

The program, Primary Care Extension in Oklahoma, funded through the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality, also helps physicians see where they can make improvements, said Andy Fosmire, executive director, Rural Health Projects/Northwest Area Health Education Center in Enid, Okla. He said some primary care physicians don’t realize they have performance issues.

“They don’t have time to look around and see that they have opportunities for improvement,” he said.

One of the first steps in the research process was the development of community health improvement organizations. Those organizations employ a practice enhancement assistant who is specifically trained in identifying barriers for improvement, said Fosmire. That individual reviews how a primary physician practices medicine and then assists him or her in finding ways to improve.

“They (health care providers) have the opportunity for cross-pollination,” he said. “They have an opportunity to see what other practices are doing.”

Oklahoma was one of four states to receive the research grants called IMPaCT, for Infrastructure for Maintaining Primary Care Transformation, from HHS. The grants went to established programs looking at model state-level initiatives using primary care extension agents to improve primary care. New Mexico, North Carolina and Pennsylvania also received the grants.

The grants, Fosmire said, focus on quality of care. But addressing that quality in rural health care will require addressing other major issues affecting the broad spectrum of health care in the U.S.

**Workforce Shortages**

“One of the biggest things that can be done to improve the quality of rural health
is, A, improve access to primary care and, B, improve the quality of primary care,” he said.

Access is a major issue across health care, but especially in rural areas. The American Association of Medical Colleges estimates the U.S. will face a shortage of more than 91,500 physicians by 2020. While the association says medical schools are increasing enrollment to address the shortage, Fosmire said it will take time to graduate the number of physicians needed.

“It’s not going to be something that’s going to be fixed tomorrow,” he said.

But access is just one challenge—albeit a big one—in providing quality care in rural areas. Brock Slabach, senior vice president for member services at the National Rural Health Association, relates access to care to the workforce shortage. But the other challenges of reimbursement, infrastructure and health disparities make providing quality care in rural areas difficult.

Many states are using a managed care model for Medicaid programs, and that could hurt reimbursement rates for rural physicians. Lower reimbursement rates could harm the recruitment of providers to rural areas, affecting access to care, Slabach said.

Infrastructure in rural communities—including buildings built in the 1940s, ’50s and ’60s, and lower rates of health information technology adoption—makes providing quality care difficult, Slabach said.

Problems related to access, reimbursement and infrastructure contribute to the disparity in health care for rural areas. “As you fix the other three, the disparities could decrease because of the attention to these other three areas,” Slabach said.

Possible Solutions

He offered several possible solutions to those health care challenges.

For infrastructure, Slabach said while state government may not be able to address these challenges specifically, it could look at some creative solutions through bond programs, particularly for public hospitals in rural areas.

States can address the reimbursement issue, he said, by protecting rural providers’ reimbursement rates when moving to managed care.

While access can be impacted by the other challenges, Slabach said fully funding and utilizing area health education centers, which are used to educate and recruit people in rural areas into medical fields, and developing loan repayment programs for physicians to practice in rural areas can go a long way.

So can allowing advanced practice nurses to fully practice, said Janet Haebler, associate director for state government affairs at the American Nurses Association. Only 17 states and the District of Columbia allow advanced practice nurses full practice authority. In the other states, nurses must work with a collaborating physician.

“All licensed health professionals are accountable for the care they deliver, so supervision and oversight is unnecessary and inappropriate,” she said. “The definition of primary care is consistent with that which (advance practice registered nurses) have the capacity to deliver.”

In fact, Haebler said, nurse practitioners came about during a previous physician shortage, and many of them served rural areas because of the absence of physicians there. She believes that could be a solution once again.

Cox of Oklahoma believes states can learn how to improve rural health care through programs like the one at the University of Oklahoma. The Affordable Care Act includes funds for states to improve the condition of their health care infrastructure. Many conservative states like Oklahoma, Cox said, won’t take advantage of those funds because they are part of the Affordable Care Act.

“Politics aside, as a physician, I hate to see us not take advantage of those federal grants to help improve the health care of our state,” he said. “I hate to see other states take advantage of it while we wither on the vine.”

Whatever solutions states consider for improving health care, Slabach has one piece of advice: “Be very aware that rural communities are different than urban in terms of the need to find solutions,” he said. “Don’t assume a one-size-fits-all program is going to be helpful for a rural community and its delivery of health care.”

—OKLAHOMA REP. DOUG COX, MD
At a time when more people need health care, the shortage of physicians across the country is growing.

That dynamic is making telemedicine, or telehealth—the use of electronic telecommunications technology to diagnose or treat a patient in need of care, service or monitoring—ever more important.

State leaders increasingly are recognizing that importance. Twenty states and the District of Columbia have telemedicine parity laws, which require private insurance providers to cover telemedicine the same as they cover in-person services. Fourteen states considered telehealth parity bills during the 2014 legislative session, according to Latoya Thomas, director of state telehealth policy for the American Telemedicine Association. In addition, 35 are considering 50 other bills that would improve telemedicine policies or introduce new ones this year.

Missouri is one state looking at the benefits of telemedicine.

Rep. Diane Franklin, the wife and mother of physicians, believes telemedicine ultimately can save money for the Show-Me State and others across the country. That’s because patients become more engaged in their health care, according to research Thomas cites.

“Patients who don’t move forward—noncompliant patients—are one of the things that cost our medical system so much money,” Franklin said. “So the compliance piece of this is so important.”

Thomas said research indicates telemedicine can do just that.

“When you provide (patients) access and you give them choice as to how they would like to communicate with their provider or who they’d like their provider to be, … patients have a tendency to be more engaged and willing to adhere to the course of treatment that has been prescribed by their health care providers,” she said.

An Evolving Field

Telemedicine began nearly four decades ago with the primary goal of connecting medical specialists with primary care providers in remote areas. Today, telemedicine practices are being used to deliver patient monitoring and care services to clients regardless of their location—rural or urban, near or far—to improve access and quality of care.

“There are still many places that do not necessarily have rural populations but still have health disparities, still have access issues in which telemedicine can be the catalyst to help improve those things,” said Thomas.

Across the country, there are 200 telemedicine networks, with 3,500 service sites, according to American Telemedicine Association statistics. More than half of all U.S. hospitals now use some form of telemedicine.

As quickly as technology is evolving, so, too, are the ways in which technology can be used to deliver and manage health care.

Originally used to connect health care providers by phone or email, telemedicine now allows home health care providers to remotely monitor the vital signs of patients. Neurologists, working with attending physicians and nurses, can conduct a neurological assessment of a stroke.

NEW BEDSIDE MANNER

CARMICHAEL, CALIF.—Dr. Alan Shatzel, medical director of the Mercy Telehealth Network, is displayed on the monitor RP-VITA robot at Mercy San Juan Hospital. The robots enable physicians to have a different bedside presence as they “beam” themselves into hospitals to diagnose patients and offer medical advice during emergencies.

© Rich Pedroncelli/AP
victim in an emergency room hundreds of miles away. It is now even possible for surgeons to conduct remote surgery via robotics.

Through a new text-messaging program in Massachusetts, the clinical team at the Lynn Community Health Center is able to reach young, at-risk pregnant women, providing both informational and supportive text messages throughout their pregnancies and up to two months after their deliveries. The goal of the program is to encourage patient choices that promote a healthy pregnancy among younger women with limited support systems. Women who participate receive an average of one to four texts per week, including educational messages about pregnancy and fetal development, as well as reminders of upcoming appointments.

According to the Center for Connected Health at Partners HealthCare, which helps run the program, initial results of the program are encouraging. Women who participated were 9 percent more likely to receive the recommended level of prenatal care than pregnant women who did not.

In Georgia, students who need health care can receive it at school through secured telecommunications with physicians and therapists working with a school-based nurse or other care provider. This arrangement provides services such as mental and behavioral health, speech language pathology, autism treatment and even teledental treatment.

**Telehealth as Economic Development**

While the direct provision of teledmedicine is an important factor in solving the growing health care needs across the country, Dr. Sanjeev Arora, a gastroenterologist specializing in hepatitis C disease management at the University of New Mexico, argues that is not enough.

Arora has developed a new model called Project ECHO, which integrates telemedicine into a larger capacity-building effort to train primary care physicians and other health care providers to diagnose and treat complex health conditions in rural and underserved areas.

According to Arora, the Project ECHO model serves as a force multiplier that enables a network of specialized health care providers to build the capacity of primary care physicians, nurse practitioners, community health workers and others providing care to underserved populations through case consultation and continuing education.

The ultimate goal, he said, is to “demopolize the knowledge of specialists,” to improve access to health care in rural and underserved areas, enhance the quality of care and increase cost-effectiveness of the health care system, while at the same time providing primary care providers with the knowledge to provide specialty care.

“What ECHO does is serve as a workforce training tool and force multiplication. It’s like we’re not giving people fish, we’re teaching them to fish,” said Arora.

With ECHO, primary care providers participate in regular teleclinics through which multidisciplinary teams of specialists provide continuing education at no cost. The specialist teams also provide case consultation, which empowers primary care providers to treat complex diseases and conditions in their communities using evidence-based best practices and building their capacity to provide specialty care.

To distinguish it from traditional telemedicine, Arora refers to the Project ECHO model as “telementoring.”

Evaluations of the program demonstrate positive outcomes for patients. A recent study of the use of the Project ECHO model with hepatitis C patients indicated that patients receiving care by primary care clinicians at Project ECHO partner sites in rural New Mexico had equal, and in some cases slightly higher, cure rates when compared to individuals who received care at university specialty clinics.

Project ECHO has expanded to dozens of sites across the country and is being used to provide treatment for psychiatric disorders, chronic diseases and addiction, among other conditions.

Franklin hopes to bring this model to Missouri. She was among several representatives who traveled to New Mexico to learn about the Project ECHO model. She was impressed with the model’s ability to improve access to and quality of care while reducing costs, while also providing physicians with an opportunity to increase their knowledge base, all using basic technologies.

“You’ve got a laptop and a (Web) camera and then, with that, you can connect in with a specialist team. That’s pretty simple technology to put that wealth of knowledge through,” she said.

Since her site visit to New Mexico last year, Franklin has worked to replicate the model in Missouri. At press time, $1.5 million in funding is included in the proposed budget that takes effect July 1.

“We’re really thrilled,” she said.
Population growth, aging baby boomers and a dramatic rise in the number of insured Americans resulting from the Patient Protection and Affordable Care Act are stressing America’s health care system like never before. Demand for care is increasing dramatically, but access to a variety of health professionals has remained largely static.

Research published by the American Association of Medical Colleges estimates the United States will need an additional 91,500 primary care physicians by 2020 to keep up with growing demands on the health care system. Licensing medical professionals in multiple states could help ease the access burden, but only 6 percent of doctors are licensed in three or more states, according to Lisa Robin, chief advocacy officer for the Federation of State Medical Boards.

“Being licensed in multiple states is both costly and time-consuming for doctors,” Robin said.

One possible solution may be an increased emphasis on license portability through a series of medical licensing compacts. Such agreements could allow providers in several medical fields to significantly increase access to care in rural and hard-to-serve areas, which in turn has the potential to reduce costs for patients, states and the federal government. Such agreements also could allow providers to take advantage of improving technologies and offer more telehealth services.

“In an increasingly global world, interstate licensing agreements provide a means to ensure access to high quality care, while promoting continuity between patients and health care providers,” said Mark Lane, vice president of the Federation of State Boards of Physical Therapy.

Licensing compacts ensure state regulatory agencies can maintain their licensing and disciplinary authority, while also providing a framework to share information and processes essential to licensing and regulation across a variety of medical professions.

Each state and U.S. territory separately license medical professionals. That means practitioners, regardless of discipline, seeking a license in more than one state must go through each individual state’s licensing process. This process could be streamlined through the use of an interstate compact.

“States are looking for guidance with respect to licensing, while also seeking ways to maintain continuity of care and protect patient safety,” said former Wyoming Gov. Jim Geringer. “A series of medical licensing compacts may be one way for states to achieve that goal.”

Interstate compacts are unique tools that encourage multistate cooperation and innovative policy solutions while asserting and preserving state sovereignty.

The Council of State Governments’ National Center for Interstate Compacts is working with several groups in determining the feasibility of a compact related to their particular profession. These medical licensing compacts are in various stages of development.

EMS LICENSING COMPACT

States have had the authority to license emergency medical services personnel since the 1970s. States issue licenses based on individual state practices procedures. While there is overlap between the licensing requirements, there is also considerable variation among the states. It is becoming more common for EMS emergency services personnel to cross state lines to provide services in nondeclared states of emergency, which is making interstate cooperation for EMS licensing all the more urgent.

What a Compact Would Do: An interstate compact would allow member states to work cooperatively to address interstate licensing challenges. It also would dramatically reduce the risk incurred by EMTs who are forced to cross state lines as a result their day-to-day work.

Compact Partner: Federation of State Medical Boards

Stage of Development: Compact drafting is underway with the goal of having language ready for legislative consideration beginning in 2015.

PHYSICAL THERAPY AND TELEPSYCHOLOGY LICENSING COMPACTS

The Federation of State Boards of Physical Therapy and the Association of State and Provincial Psychology Boards have begun exploring license portability compacts for their respective organizations. The advisory phase is underway for both compacts, with drafting expected to begin later this summer and continue through the fall.
A HELPING HAND
MOORE, OKLA.—EMT Bryan Elwell takes a break in a neighborhood devastated by a tornado in May 2013. Elwell is from Philadelphia and drove to Moore to volunteer. A new EMT Licensing Compact would make it easier for people like Elwell to cross state lines for work. © AP Photo/Tulsa World, Mike Simons

MEDICAL LICENSING COMPACT

Several factors—including changing demographics, the need for better and faster access to medical care in rural and underserved areas, the passage of the Affordable Care Act and the rise of telemedicine—have created unprecedented demand for health care services. Former Wyoming Gov. Jim Geringer proposed the compact.

What a Compact Would Do: The compact calls for physicians to declare and be licensed in a home state, then establishes a system and standards that would allow the physician to seek an expedited license to practice in other member states. The new system is expected to significantly reduce barriers to the process of gaining licensure in multiple states, thus helping facilitate telemedicine and widen access to physicians in underserved areas of the country as the Affordable Care Act is implemented.

Compact Partner: Federation of State Medical Boards

Stage of Development: Compact drafting is underway with the goal of having language ready for legislative consideration beginning in 2015.

COMPACT RESOURCES

CSG’s The National Center for Interstate Compacts
www.csg.org/ncic

The National Association of State EMS Officials
www.nasemso.org

The Federation of State Medical Boards
www.fsmb.org

The Federation of State Boards of Physical Therapy
www.fsbpt.org

Association of State and Provincial Psychology Boards
www.asppb.net/
The typical workday for Carolyn Duff and Beth Mattey is what you might call hectic.

Duff, who serves as president of the National Association of School Nurses, is the nurse at an elementary school with 425 students in South Carolina’s Richland County School District One. One-third of those children are international students and about 60 percent of them are on free- or reduced-price meals, a common indicator of student poverty.

“My typical day, I start running from the minute I get to my school,” Duff said. “Often I have parents waiting to see me when I unlock my office door. Usually, they’re there because their child has been sick for the past couple of days and they don’t know what to do.

“I fill my days with students. If I’m not treating them for something, I’m pulling them into my office to do vision and hearing screenings. I work with a partnership outside of my school and, through that program, I can connect my uninsured students with vision care, dental care, episodic care. … It’s not a medical home I’m connecting them to, but if a child fell on the playground and has an injury and needs to be seen, through the partnership I can provide free care for that.”

Mattey, president-elect of the association, is the nurse at the 1,100 student Mount Pleasant High School in Delaware’s Brandywine School District.

“When I got there (at school) today, I had two students who came in just after I came in,” Mattey said. “One had a really bad headache, had a bad headache all night. … I
checked him out. I had another student, she had brought in information because she’d been to the doctor about an injury that she had. We had to make accommodations for her.

“The concern was more about the reduction of RN positions with unlicensed health aids or licensed practical nurses or licensed vocational nurses,” she said.

Pennsylvania’s Struggle

One state that has been hit hard with education budget cuts recently is Pennsylvania. According to Forbes, a 12-year-old girl died on her way to the hospital from an asthma attack that began at school. No nurse was on duty at the school at the time.

“Tragedy struck in Philadelphia last year when, according to Forbes, a 12-year-old girl died on her way to the hospital from an asthma attack that began at school. No nurse was on duty at the school at the time.”

“I think everything in Pennsylvania is defined within the reality of budget and lack of resources,” said Rep. James Roebuck, who represents part of Philadelphia and is minority chair of the Education Committee. “It makes no sense to me that you can have a situation where the (nurse-to-student) ratio is, I believe, 1-to-1,500 students and where there is not a nurse in every school building every day. You can’t get sick on the day the nurse is not there. … It doesn’t make a lot of sense, but it’s become the reality we live with.”

“Then we had a meeting. I meet with the counselors and the psychologists … every other week to talk together about students who are at high risk so we all know that we’re concerned. When we do see them, we’ve got our antennas up a little more, do a little more digging on referral. … Then I needed to check on the young man I sent home the other day because of asthma. I needed to check and see if his asthma was better, if he was under control.”

These pretty typical days exemplify the overwhelming need many schools have for registered nurses on site to help take care of a growing number of students with chronic medical conditions. Even though the need may be great, full-time school nurses are a vanishing breed due to steep funding cuts many school districts faced following the Great Recession.

Decreasing Services

The National Association of School Nurses recommends one registered nurse for every 750 students in the general population. For students who require daily services, the group recommends one nurse for every 225 students. That ratio drops to one nurse for every 125 students if the children have complex medical needs.

But, the nurses association notes, only 45 percent of all public schools have a full-time school nurse on site. Duff said the association did an informal survey in 2011 and found limited pockets where states such as Pennsylvania and Maryland had been eliminating school nurses.

“The concern was more about the reduction in services or in quality of services due to the replacement of RN positions with unlicensed health aids or licensed practical nurses or licensed vocational nurses,” she said.

Delaware’s Requirement

Mattey said Delaware is the only state in the country that has a statute requiring at least one nurse for each school.

“An elementary school may have 500 students and one nurse,” Mattey said. “I’m in a high school with one nurse with 1,000 students. While we have a nurse in every school, the number of students per nurse isn’t really at the recommended level.”

But, Mattey noted, the Delaware legislature has been very supportive of school nurses. This legislative session, Rep. Earl Jacques introduced House Bill 263, which requires state funding for school nurses. Currently, some districts have to cover the gap between the amount of funding they get from the state formula for a nurse and the actual cost of the nurse’s salary if there is a shortfall.

“We had a case in our state about a year ago where we had a student, I think she was about 12 years old, had a cardiac arrest,” Jacques said. “Luckily, we had a school nurse there in that building who brought her back. That child is alive today because of that school nurse.

“My bill will make sure the state pays. That way, there’s no question as to how it’s being done. We wanted to be sure there’s nowhere where they have an administrator, a teacher or someone (else) performing the role of school nurse.”

To read about how the Austin Independent School District became the first district to partner with a local hospital to provide school nurses, visit the Capitol Ideas website.
Seth Hyman wakes up each day on edge. He ends it the same way. “We are always on edge—24/7,” said Hyman.

The reason: His 8-year-old daughter Rebecca is considered medically complex, which means she has a lot of medical issues. She’s nonverbal. She can’t walk. She is fully dependent on others at all times of the day. Still, Hyman said, Rebecca is mobile in the sense that she likes to do things like play with her special toys. “Even with all her disabilities and challenges, she is the greatest little inspiration in our life,” Hyman said. “She is full of so much love and joy and willingness to do things, even with her disabilities.”

The most significant struggle she faces, he said, is seizures, which started about four years ago. Some are minor; others are more serious. The Hymans don’t bother counting each seizure because there are so many every day. They believe medical marijuana could help Rebecca.

About 1,000 miles north of Hyman’s Weston, Fla., home, Jill Haas can relate.

SMOKING MARIJUANA TO SLOW ALS
PARRISH, FLA. — While sitting at her dining room table, Cathy Jordan, 63, of Parrish, inhales a marijuana joint held by her husband, Robert Jordan, 65. Cathy was diagnosed 27 years ago with ALS, also known as Lou Gehrig’s disease. She has been smoking marijuana ever since and says it has slowed the progression of her disease.

© Cherie Diez/ZUMA Press/Corbis
Sitting in her Lexington, Ky., home, Haas saw the benefits of medical marijuana when a family she knew in nearby Indiana moved to Colorado to get treatment for their daughter, who was medically very similar to her daughter Sylvia.

“They saw a reduction in seizures almost immediately when they started giving the marijuana oil,” said Haas. “Throughout the next months, they started seeing these changes in their daughter. … She used to have 30, 40 seizures a day and she was down to one or two a week.

“Suddenly I was realizing this is a child that used to be exactly like my daughter and now, since starting this treatment, she’s making big gains and making big progress. We’re still not making any progress.”

Haas contemplated moving from Kentucky to Colorado, which legalized marijuana for both medical and recreational use. But she and her family just moved to Kentucky from Oregon a few years ago to be closer to family. So she got involved in the effort to pass medical marijuana legislation in the Bluegrass State.

Hyman is backing similar legislation in Florida. Their voices are having an impact.

Help for Children

“Our watershed moment in Florida was when we brought parents from Colorado to our state to testify before our legislature,” said Rep. Matt Gaetz, who sponsored medical marijuana legislation in the Sunshine State. “They talked about the transformation of their children in front of Florida parents who suffer daily when they watch their children agonize through incredibly damaging seizures.”

Gaetz’s legislation is one of four bills Florida legislators considered, but his would affect only the cannabis that has 0.8 percent of THC, the active ingredient in cannabis that gives user a high, and 10 percent or more of cannabidiol. This substance, often referred to as CBD, comes in an oil form and is administered in droplets.

Kentucky legislators approved a bill to legalize those strains of marijuana, and Florida lawmakers were considering similar legislation. Legislation in six of the 19 states that considered medical marijuana this year focused on the use of cannabidiol, according to ProCon.org, which provides resources on both sides of controversial issues.

But use of the plant for these children has its limits, said Ben Pollara, campaign manager for United for Care, an advocacy group pushing for a constitutional amendment for the use of marijuana for broader medical purposes in Florida.

“There are hundreds of thousands of Floridians who suffer from debilitating diseases and medical conditions who are suffering, who are in pain, many of whom are terminal, who are looking to medical marijuana for relief and for treatment of those symptoms,” Pollara said.

The ‘Science’ of Treatment

But not everyone is convinced.

David Evans, special adviser to the Drug Free America Foundation, warns that legalization of cannabis for any purposes—even the oil for children—sets a “very dangerous precedent.”

“It’s not done on the basis of effectiveness.”

Evans is particularly concerned about the broad legalization of marijuana for medical treatment. He believes there is no scientific evidence, no clinical trials, which support its use.

“I’m certainly sympathetic to anybody that has a sick child,” Evans said. “But we have to follow good medical procedures. We’ve learned over hundreds of years of experience that if we don’t follow proper research procedures, people get hurt. They get medicine that is either not helpful to them or it’s harmful to them.”

Florida Rep. Gayle Harrell cast the lone dissenting vote when the Florida House Subcommittee on Criminal Justice approved the cannabidiol bill in March. She, too, questioned the intelligence of approving marijuana for medical use without clinical trials or research to protect patients.

“I really think we need to address this using science,” Harrell said at the hearing. She suggested a pilot program to study and test the effectiveness of the low THC/high CBD strain. The problem with testing, advocates for
and Drug Administration approved the study three years ago, but researchers were stymied by federal requirements that the only marijuana that could be used in such experiments must come from one government-run farm in Mississippi. That’s because the National Institute on Drug Abuse, which runs the farm, has been hostile to research that examines possible benefits, according to an article in Governing. The lack of FDA-sanctioned studies hasn’t stopped nearly half the states as they’ve approved marijuana for medicinal purposes over the past two decades. California was the first state to legalize medical marijuana in 1996. Since then, 19 other states and the District of Columbia have provided for such use.

Most of the research on the efficacy of medical marijuana is taking place overseas. States were engaged in these types of studies as late as the mid-1980s, according to Paul Armentano, deputy director of NORML, a nonprofit organization based in Washington, D.C., working to reform marijuana laws.

But there are some studies in the United States. University of California medical researchers found smoking marijuana could provide some relief from pain for patients with AIDS and HIV. The Center for Medicinal Cannabis Research found in studies over a dozen years that pot offered broad benefits in selected pain syndromes caused by injury or diseases of the nervous system, and possibly for painful muscle spasticity due to multiple sclerosis, according to a report presented to the California legislature in 2010.

Similar trials also are getting ready to restart in Arizona. The Obama administration in March paved the way for a researcher at the University of Arizona to examine whether the drug can be used to help veterans cope with post-traumatic stress disorder. The Food and Drug Administration say, is that it takes time.

“The people who are desperate for medical marijuana now cannot wait for this research,” Pollara said. “They’re going to be dead by the time it happens. Clinical trials at the FDA level take years and years and years. Because of the legal status of medical marijuana, they’re very difficult to conduct. There are not a lot of active studies going on in this stuff.”

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Treatment with Marijuana
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Most of those laws cover more than just the cannabidiol. They allow the possession of
specific limited amounts of processed marijuana, ranging from 1 ounce usable in Alaska, Montana and Nevada, to 24 ounces usable in Oregon and Washington, according to ProCon.org. Two states—Connecticut and Massachusetts—set the limit by length of supply, one month and 60 days. The laws also stipulate the number of immature and mature plants a person can have in his or her possession.

States that have approved medical marijuana allow it to treat a range of ailments, including, cancer, chronic pain, epilepsy, glaucoma, HIV/AIDS, multiple sclerosis, severe nausea and seizures.

But Evans said marijuana is not always helpful for these conditions and, in fact, can be harmful. He points out that the National Multiple Sclerosis Society deems medical marijuana harmful to people with the disease.

In fact, the society, on its website, cites recent trials that led it to come to its conclusion that more research is needed to better understand the benefits and potential risks for patients using the drug to deal with MS. The Glaucoma Research Foundation deems marijuana a poor choice in treatment of the disease because of the side effects generated by long-term use of marijuana, according to its website.

Evans and others who oppose medical marijuana legalization also point out that it would be easy for people who don’t need the drug medically to access it.

“Most of the people who are getting it are getting it for recreational use,” Evans contends. “The way these bills are written, it’s very easy to get marijuana for almost any condition.”

That’s one reason Gaetz, while supporting the CBD bill, is opposed to the proposed Florida constitutional amendment that would approve marijuana for broader medical use. “We’re concerned that no state has really cracked the code on how to limit abuse and recreational use of those strains,” he said of the plants with the higher THC content. “My proposal is to legalize forms of noneuphoric marijuana, (which) has a very low likelihood of abuse because there’s no real street value to that substance. “Not all medical marijuana is created equally,” Gaetz said.

“Use of marijuana by people who are not truly ill is a concern and, also, I don’t want to have a pot shop on every corner and in every strip mall.”

He’s also concerned that medical marijuana could prompt unscrupulous doctors to open shop simply to dispense the drug, similar to the pill mills that set up for prescribing Oxycontin.

Support for Medical Marijuana

While advocates and policymakers see the differences in limiting medical marijuana to specific strains, voters across the country strongly support medical marijuana for a broad range of ailments. A Fox News Poll last May found 85 percent of those surveyed nationally favored allowing people to use marijuana for medical purposes. Several Quinnipiac polls in February showed strong support for medical marijuana in various states—88 percent in New York, 87 percent in Ohio and 85 percent in Pennsylvania. In Florida, where voters will consider a constitutional amendment in November, the support was 82 percent.

“You’re not going to find a region of this country or a demographic where you’re not going to find support for legalization of medical marijuana,” Armentano of NORML said.

Pollara hopes the polls hold in Florida. He said approval there could address some concerns opponents have about efficacy of the drug.

“The more marijuana is accessible as a medicine and the more the legal status changes as a result of laws like the one we’re trying to pass, the more research will be conducted,” he said.

As for parents Haas and Hyman, they’ll take what they can get from state laws that might offer some relief for their children.

“I’m not the FDA, but knowing all these parents, hearing their journeys, seeing the results in their children, that’s evidence for me,” Haas said. “I think that’s evidence that can’t be ignored, especially when you’re looking at treating patients like my daughter, whose quality of life is so severely affected by her condition.”

Hyman knows details must be addressed to set out the parameters even if the law is passed in Florida. He also supports the broad medical marijuana amendment because he sees potential limits with the cannabidiol legislation.

“Because these types of bills are so limited and restrictive,” he said, “there are many other children out there who need more who won’t be able to get more from this.”

20 STATES AND THE DISTRICT OF COLUMBIA ALLOW PATIENTS WITH A VARIETY OFAILMENTS TO USE MEDICAL MARIJUANA UNDER A DOCTOR’S SUPERVISION.

“NOT ALL MEDICAL MARIJUANA IS CREATED EQUALLY.”

—FLORIDA REP. MATT GAETZ
WHAT IS THE MOST EFFECTIVE THING STATE GOVERNMENT OFFICIALS CAN DO TO IMPROVE THE HEALTH OF THEIR CONSTITUENTS?

FOCUS ON WELLNESS PROMOTION

“Legislatures as they are developing health policy need to focus on wellness promotion and individual responsibility for taking care of self. Medicaid, state employee health coverage and programming for families and children ... can identify programs that work to promote positive lifestyles. ... Legislation (such as) as banning texting, helmet legislation, speed zones or even how roadways and bike trails are planned all lead to creating a healthy work and recreational environment. ... It is the thoughtful process that surrounds passing legislation and recognizing the impacts of that legislation that creates all the opportunities to promote positive lifestyles.”

SEN. JEAN HUNHOFF
South Dakota
Chair of the Health and Human Services Committee

PROVIDE LOCAL ACCESS TO CARE

“Providing local access to care and a comprehensive benefits package is driving healthy behaviors for Iowans that will enroll in the Iowa Health and Wellness Plan. The ... plan is Iowa’s innovative answer to Medicaid expansion. ... Members are divided into two categories based on income. Members receive Medicaid services or enroll in a commercial health (plan). Premiums, which can be waived based on the completion of certain healthy behaviors, drive accountability and help improve the health of Iowans. More than 80,000 people have enrolled in the plan. Iowa is a leader in health care and it is remarkable that our state has been able to gain approval by the federal government and implement this bipartisan plan in under a year.”

REP. LINDA MILLER
Iowa
Chair of the Human Resources Committee
WHAT IS THE MOST EFFECTIVE THING STATE GOVERNMENT OFFICIALS CAN DO TO IMPROVE THE HEALTH OF THEIR CONSTITUENTS?

GET AFFORDABLE HEALTH INSURANCE

“We must help constituents get adequate and affordable health insurance, as well as improve access to health providers. Equally important, we must encourage public and private efforts to lower costs and improve health care quality. The expansion of Medicaid in Colorado and the Colorado Health Exchange begins to offer coverage for the previously uninsured. We still need to recruit, retrain and keep providers to serve rural and low-income communities. To keep health care affordable, we have set a goal of reducing Medicaid costs by $280 million. Finally, we must advance payment reform in the public and private sectors and push the use of electronic health records.”

PATIENT-CENTERED MEDICAL HOMES

“Access to a patient-centered medical home through policies and funding is the most effective thing state government can do to improve the health of their constituents. The (patient-centered medical home) can be a private practice or a qualified health care center. When patients feel welcome, respected and comfortable with everyone from support staff to direct care providers at a facility, they are more apt to seek medical care. This means good health care delivered in a cost-effective manner that benefits the constituent community as a whole.”

ADDRESS ACCESS AND AFFORDABILITY

“The most effective tool state government officials possess that would lead to improved health of their constituents is addressing access to and affordability of medicines and all forms of health care. Far too many Michiganders lack the basic medical resources and attention that they deserve. While a complex issue, economics combined with politics too often dictate who receives health care. The legislature must encourage a competitive market place where medical costs are transparent and providers and insurers are held accountable. Appropriate solutions do exist. It is incumbent upon state government officials to work together in a bipartisan collaboration to find one.”
FAST FACTS »

HEALTH CARE REFORM

46% OF AMERICANS HAVE AN UNFAVORABLE VIEW OF THE AFFORDABLE CARE ACT;

38% HAVE A FAVORABLE VIEW.

10% WANT THE AFFORDABLE CARE ACT TO STAY AS IT IS;

49 PERCENT WANT CONGRESS TO KEEP THE LAW AND IMPROVE IT;

11 PERCENT WANT THE LAW REPEALED AND REPLACED;

18 PERCENT WANT IT REPEALED AND NOT REPLACED.

53% OF AMERICANS ARE TIRED OF THE DEBATE ON THE AFFORDABLE CARE ACT AND BELIEVE IT IS TIME TO MOVE ON TO OTHER ISSUES.

POPULAR FEATURES OF THE AFFORDABLE CARE ACT

» KEEP CHILDREN ON PARENTS’ PLAN UNTIL AGE 26
» CLOSE MEDICARE “DOUGHNUT HOLE”
» SUBSIDY ASSISTANCE TO INDIVIDUALS
» ELIMINATE OUT-OF-POCKET COSTS FOR PREVENTIVE SERVICES
» MEDICAID EXPANSION
» PROHIBITION ON DENYING COVERAGE BASED ON PRE-EXISTING CONDITIONS
» MEDICAL LOSS RATIO
» INCREASE MEDICARE PAYROLL TAX ON UPPER INCOME INDIVIDUALS

UNPOPULAR FEATURE

» INDIVIDUAL MANDATE THAT REQUIRES ALL AMERICANS TO CARRY HEALTH INSURANCE

72% OF THE PUBLIC GIVES THE FEDERAL GOVERNMENT A RATING OF “ONLY FAIR” OR “POOR” FOR IMPLEMENTATION OF THE AFFORDABLE CARE ACT.

59% GAVE THAT RATING TO STATE GOVERNMENTS.

Source: Kaiser Family Foundation, Health Tracking Poll: March 2014
FOLLOW BASIC RULES.
Madden tells all her patients to begin with the basics to remain healthy. Eat a balanced diet. Get a good night’s sleep. Find time to exercise, even if it’s only 10 minutes. “Those are the basic things I tell everybody that comes into my office,” she said.

SCHEDULE GOOD HEALTH.
While most everyone knows the basic rules for good health, it’s sometimes difficult to actually follow those rules, Madden said. That’s why people should schedule the time needed to eat right, exercise and go to bed at a decent hour. “By making it a deliberate choice,” Madden said, “it becomes a little easier to do.” She has some patients who have found a specific way to turn off the stressors of the day. “They leave work and when they hit three blocks from their home, they basically switch into home mode,” she said. For the next two hours, for instance, they’re only available to family and that’s scheduled into their day.

RECOGNIZE PURPOSE.
When she served as doctor of the day for the Maine legislature, Madden observed that it’s a hard job. “Often you don’t hear the thanks that would be nice to hear, but I’m sure you’ll also hear about the things that aren’t going well,” she said. To alleviate that added stress, she suggests recognizing the purpose for serving. “Some people find it helpful to reflect on what it was that originally made them want to be a legislator ... and use that to ground themselves when they’ve had a particularly tough day.”

TURN IT OFF.
“You’re a legislator 24-7,” Madden said. That makes it difficult to turn off the position. “How do you find time to just be you, yourself, and not you, the legislator?” she said. Some people meditate, others do yoga, while others accomplish that goal through exercise or hobbies. “Find some time during your day to reconnect and recharge, because it’s got to be pretty all-consuming to be a legislator,” she said.

FOLLOW GOOD GROUND RULES.
Legislators often are faced with conflicts over legislation and their bodies can react physically. “Your body kicks into high gear and that will exhibit itself in different ways,” Madden said. “You see people’s faces turning red or they start to shake.” People who are successful at avoiding the stressors of such conversations, she said, follow good communication ground rules. “If the conversation is getting personal or when it starts to become about the person instead of about the issue, you’re able to redirect that and say, ‘let’s get back to what we’re really talking about,’” she said.

Dr. Amy Madden chairs the legislative committee for the Maine Medical Association, which sponsors House (and Senate) calls for physicians each day of the legislative session for its “doctor of the day” program. Madden has served in this role several times and sees how important—and often how stressful—being a legislator can be. She offers some tips on how legislators can take care of themselves in order to better serve their constituents.
Aeronautics in the South
The Council of State Governments’ Southern Legislative Conference recently released a new SLC Regional Resource examining the increasing number of aeronautics companies that are locating, relocating or expanding their manufacturing operations in the South. The trend is particularly discernable in the aftermath of the Great Recession.
Read the full report at www.slcatlanta.org

Check This Out!
CSG’s Pathways to Prosperity Initiative
http://www.csg.org/pathwaystoprosperity.aspx

Kalisa to Lead CSG’s Overseas Voting Initiative
Kamanzi Kalisa, a former director of Georgia’s Help America Vote Act, will lead The Council of State Governments’ Overseas Voting Initiative, an effort to improve the election administration for members of the military and other U.S. citizens living abroad. CSG is working with the U.S. Department of Defense’s Office of the Under Secretary of Defense for Personnel and Readiness through a four-year, $2.9 million cooperative agreement on the effort.
Kalisa has long been interested in public service, politics and public policy issues. His mother, a South Carolina native, and father, a native of Rwanda, have long been involved in helping to make their communities better. His mother is an educator in the Atlanta area, while his father returned to his home country in the 1990s and heads up the development bank in the efforts to rebuild the nation.
Kalisa majored in political science when he attended Tufts University in Boston, then interned in then-U.S. Sen. John Kerry’s office, working with local law enforcement officials in the state to educate them on new funding available for homeland security.
He was appointed as director of Georgia’s Help America Vote Act after working on several campaigns, including the campaign of then-Georgia Secretary of State Cathy Cox.

May 29 is College Savings Day
The College Savings Plans Network (CSPN) wants everyone to pause on May 29 (5/29) to consider their college savings plans. Are you contributing funds toward a loved one’s future education needs? May 29 is 529 College Savings Day, a day to raise awareness of the importance of saving for future college expenses. For details about how you can contribute to or establish a 529 plan, visit the CSPN website.

BLC Talks Economic Competitiveness
The first of four Regional Economic Competitiveness Forums scheduled along the U.S.-Mexico border by the Border Legislative Conference and members of the Congressional Border Caucus was held March 20-21 in San Diego. This forum focused on the states of California and Baja California, a mega region now often referred to as Cali-Baja, its ports of entry infrastructure, regional economy innovation and cross border economic clusters.
Obama Congratulates NEMA on 40th Anniversary

The National Emergency Management Association was extremely honored to receive a video message from President Barack Obama highlighting the 40 years of excellent work being done by the organization and its members. The video was unveiled at the NEMA 2014 Mid-Year Forum held in March in Alexandria, Va. This marks the third time in NEMA’s history to be acknowledged by a president—the other two were former Presidents Bill Clinton and George W. Bush. Watch the presidential message to NEMA—http://www.youtube.com/watch?v=OcGZ0XOtA&feature=youtu.be.

Bray to Lead CSG’s International Affairs

Catherine Bray has joined The Council of State Governments as director of international affairs and director of the State International Development Organizations, known as SIDO. Bray will represent state governments to the foreign embassy community, the academic and think tank community, and relevant federal agencies such as the departments of Commerce and State. Bray will assist state governments as they build international capacities by fostering exchanges with counterparts abroad, with a special focus on Canadian provincial government and Mexico border states. Bray will work closely with the CSG Federal Affairs team, as well as regional leaders, to build understanding in Congress on the value of state export promotion programs.

Bray has spent the last seven years in Washington, D.C., specializing in international outreach programs for various think tanks, other nonprofit organizations and corporations.
Legislators in the medical profession can bring a unique perspective and outlook to office, Wisconsin state Sen. Leah Vukmir said. “We come from a research environment and we make decisions based on the research that is before us,” she said. “For me, I tackle public policy from that same perspective.” Vukmir worked for 25 years as a registered nurse and certified pediatric nurse practitioner. She takes that nurse’s mentality into the state capitol when she’s working on public policy. “As a nurse, you advocate for your patients and, as a legislator, I advocate for my constituents,” she said. “It was a very simple transition.” Vukmir brings that health background into the Wisconsin State Senate after serving four terms in the Wisconsin Assembly. While she isn’t active in nursing now, Vukmir uses her experiences every day in the legislature as chairman of the Senate’s Committee on Health. “I like being able to use my experience in a different manner now in the arena of health care public policy,” said Vukmir.
GET SOCIAL WITH CSG!