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State Options to Control Health Care Costs and Improve Quality

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Introduction and summary

The recent debate on health care reform has occurred mostly at the national level. The Affordable Care Act, or ACA, was a momentous change for the U.S. health care system. So far, 20 million people have gained health insurance coverage due to the ACA—a historic reduction in the number of uninsured people in the United States.¹

The ACA also contained several tools designed to control health care costs. It created the Center for Medicare & Medicaid Innovation, or CMMI, which is authorized to test new payment and delivery methods in order to lower costs and improve quality for individuals who receive benefits from Medicare; Medicaid; or the Children's Health Insurance Program, or CHIP.² CMMI is currently testing and evaluating many different models, including accountable care organizations, bundled payments for hip and knee replacements, and primary care medical homes. The ACA also reduced Medicare payments to Medicare Advantage plans; to hospitals with poor quality measures; and to medical providers, which has had a spillover effect on private insurance.³

Partly due to the ACA, health care cost spending growth has slowed in recent years. Before 2014, there were five years of historically low growth, and 2011 was the first time in a decade that spending on health care grew slower than the U.S. economy.⁴ Health care costs are still projected to grow faster than the overall economy, however, and health care spending already puts tremendous pressure on state and federal budgets and limits spending on other important services.⁵ More needs to be done to sustain this slowdown in growth.

The current political environment makes it unlikely that reforms to control systemwide health care costs will be achieved at the federal level in the near future. States, however, are well-positioned to take the lead on implementing cost control and quality improvement reforms. Indeed, many states are already innovating and seeing positive results.

There are several advantages to implementing reforms at the state level. State-level reforms can be tailored to work best for each state, depending on the structure of its insurance markets, the size of the state, and its demographics. States also have considerable authority over the regulation of health insurance and the provision of health care within their borders. States control their own insurance markets: They run their Medicaid and CHIP programs and state employee plans, and certain states run the exchanges for individual health insurance. States also control the rate review process, scope-of-practice regulations, physician licensing, antitrust laws, and provider and insurer regulations. Lastly, states and governors have considerable convening power to bring together diverse stakeholders, making reform efforts more politically feasible.

The innovations that some states are implementing to reduce costs while maintaining or improving quality can and should be replicated by other states. This report lays out a comprehensive summary of options, as outlined in the following table, that states can choose from to improve the quality and sustainability of their health care systems. Generally, these options relate to implementing new payment models, increasing accountability and transparency, collecting more data, increasing the use of high-value services and practices, and removing barriers to effective practices.

We have included examples from some of the most pioneering states and other examples where states are instituting similar reforms, as well as details from these states' experiences and their strategies to make the reforms successful. These examples are not an exhaustive list of all the states that may be undertaking these reforms. Other ideas and strategies have not been used before. Importantly, these reforms are not mutually exclusive; in fact, states should adopt as many as possible.

All of these reform options would help states slow the growth of health care costs, improve the quality of their health care systems, and protect their residents.

Policy options and selected state examples

Establish a cost growth goal.

- Examples from Massachusetts, Maryland, and Rhode Island

Publish a health and cost outcomes scorecard.

- Examples from Maryland and Oregon

Adopt payment and delivery system reform goals.

- Examples from Massachusetts, Maryland, Rhode Island, and California

Implement bundled payments for all payers.

- Examples from Arkansas, Tennessee, Ohio, and Delaware

Institute global budgets for hospitals.

- Example from Maryland

Launch all-payer claims databases.

- Examples from Maine, Colorado, New Hampshire, and Washington

Expand evidence-based home visiting services.

- Examples from Minnesota and South Carolina

Improve price transparency.

- Examples from New Hampshire and Massachusetts

Integrate behavioral health and primary care.

- Examples from Oregon, Washington, and Colorado

Combat addiction to prescription drugs and heroin.

- Examples from Maryland, Florida, New York, and Rhode Island

Improve the delivery of long-term care.

- Examples from California, Maryland, Montana, Oregon, Texas, and Missouri

Align scope of practice with community needs.

Institute reference pricing in the state employee plan.

- Example from California

Expand the use of telehealth.

- Examples from Maryland, New York, Virginia, the District of Columbia, and Pennsylvania

Decrease unnecessary emergency room use.

- Examples from Georgia, New Mexico, Indiana, Minnesota, Washington, and Wisconsin

Establish a cost growth goal

A cost growth goal controls health care costs by setting a cap on the growth of a state's per capita health care spending. Typically, this cap is determined by per capita growth in the state economy, as measured by the gross state product, or GSP. These goals represent a public commitment to hold health care costs below a set target, increasing accountability for all stakeholders. Even if a goal does not have sanctioning power or fines if it is exceeded, it has a powerful impact. Because states track their goal and report on progress, setting goals increases transparency and improves data collection.

In 2012, Massachusetts became the first state to establish a cost growth goal. It enacted legislation that limits the annual percentage growth in total health care spending to growth in the state economy, adjusted to remove fluctuations due to business cycles. Massachusetts calculates total health care expenditures using three components: all medical expenses paid to providers by all public and private payers; all patient cost-sharing amounts; and the net cost of private insurance, such as administrative expenses. The state then compares that total to the potential GSP of the commonwealth.⁶ This reform continued the efforts of the state's 2006 health care legislation, which focused on coverage expansion, and 2008 legislation that authorized the collection of detailed information from health care organizations.⁷

Massachusetts' 2012 legislation created the Health Policy Commission, or HPC, to establish and monitor the cost growth target, as well as the Center for Health Information and Analysis to collect health care data.⁸ Each year, the HPC sets the state's health care cost growth benchmark and monitors the performance of all hospitals, physician groups, accountable care organizations, and payers. The HPC notifies those entities if they have exceeded the cost growth goal and can require them to implement performance improvement plans.⁹ The HPC also conducts reviews of mergers and acquisitions and issues annual reports and cost reviews to inform the public.

Massachusetts was able to build consensus for a cost growth goal and greater transparency in health care costs largely because providers preferred those reforms to the stronger regulatory system that the state had initially proposed.¹⁰ Although Massachusetts did not meet its cost growth target for 2015, the monitoring and data collection enabled it to identify that it had failed the target, and not meeting the target is galvanizing efforts for additional and stronger reforms to control costs.¹¹

In January 2014, Maryland also set a cost growth goal in agreement with the Centers for Medicare & Medicaid Services, or CMS.¹² Maryland's goal builds upon the state's unique all-payer rate setting system for hospitals—meaning that all payers pay the rates that are set for each hospital—that the Maryland legislature established in the early 1970s.¹³ The goal limits all-payer annual per capita hospital growth, including inpatient and outpatient care, to 3.58 percent—the 10-year compound annual growth rate in per capita GSP.¹⁴ Maryland will also limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate for the years 2015 through 2018. The state has pledged to achieve these goals by transitioning to new payment models, as well as by implementing several other initiatives to lower costs and improve quality. For example, the state committed to reducing its Medicare readmission rate and its rate of hospital-acquired conditions.¹⁵

Recently, Rhode Island's Working Group for Healthcare Innovation—charged with proposing solutions to improve health, enhance patient experience, and reduce per capita costs—included a flexible spending target as one of its four primary recommendations for controlling health care spending.¹⁶ This would be a nonbinding, annual target for growth in medical expenditures set at no greater than Rhode Island's long-term economic growth rate. The working group endorsed a flexible target over a hard cap on health care spending growth, which also had been considered but was determined to be unnecessary unless health care cost growth remains too high. The group also recommended that Rhode Island regularly calculate and publicize total medical expenses for the state, hold hearings to understand health care cost growth, and request performance improvement plans from payers or providers if their costs are increasing unsustainably.

Options for implementation

Other states should set similar cost growth targets and monitor and enforce the goals through either existing resources—such as state health commissions—or by forming a new entity. This reform would send a strong signal that governors and states are committed to taking action to reduce health care costs; it also would not require a large amount of funding and could be established quickly. For a governor looking for a simple but effective reform, setting a cost growth goal would be a good choice.

State governments have multiple options for implementing and phasing in a cost growth goal. First, a state could follow Massachusetts' and Maryland's example but provide more cushion in the first few years. The target for per capita health care cost growth, for example, could be set at growth in the per capita GSP plus an additional 0.5 percent over the first three years, then ratchet down to match the growth in per capita GSP in subsequent years. Second, states have choices for the type of health care costs included in their goals. They could begin by setting the target for the cost of hospital care for three years and then expand the goal to cover the total cost of care in later years.

A state also could negotiate an agreement with the federal government to share the significant federal savings that meeting the goal would bring—an idea that the Center for American Progress has previously proposed.¹⁷ If states meet a target for growth in total health care spending per capita, the federal government also would realize savings in Medicare, Medicaid, Affordable Care Act subsidies, and other federal health care programs. Therefore, a state could negotiate an agreement with the federal government, under a waiver with CMS, to share 50 percent of the federal savings that would occur if the state meets the cost target while also meeting quality measures. This increased savings to the state could help get buy-in from the legislature and other stakeholders for the cost growth goal.

If establishing a cost target with enforcement authority through legislation is not possible, a governor could establish a nonbinding cost growth goal to put pressure on hospitals and providers to hold down costs—like Rhode Island did. In this way, the governor would use convening authority and the power of the bully pulpit to shine a public spotlight on excessive providers and encourage voluntary compliance with the target.

Publish a health and cost outcomes scorecard

Publishing a state scorecard on health and cost outcomes is another simple but important initiative that all states should institute. This reform would require only limited funding and could be accomplished absent new legislation but would emphasize that the state is focused on addressing health and cost issues. A scorecard would enable state stakeholders to understand the current state of the system and let the state publicly track progress toward goals, increasing the accountability of providers, payers, and other stakeholders. States also could use the scorecard as a management dashboard for their highest priorities. Additionally, states would have the option to build on the statewide scorecard by publishing similar, more specific scorecards with relevant measures for individual hospitals and physician groups.

A potential list of measures for a state scorecard is shown below; other lists—which overlap somewhat—have been recommended recently by the Institute of Medicine and implemented in Maryland and Oregon.¹⁸ Such measures would provide an excellent assessment of the health of the state’s population as well as the quality and affordability of care delivered to residents. Additional measures could be added and existing measures could be updated over time to reflect the state’s priorities. In general, measures should be understandable, measure broad system impact, and be validated and readily available.

To the extent possible, measures should show trends over the previous five years and should be broken down by county, race and ethnicity, and socio-economic status. For each measure, states should adopt both absolute targets—performance compared with the national median or 75th percentile—and improvement targets, in terms of percentage change.

A public comment period can help with public engagement and acceptance of the measures. When Maryland established a scorecard in 2011, more than 350 public comments were received. The state now makes data on its measures available on an interactive website, with data broken down by county and by race and ethnicity where possible.¹⁹

Example health care scorecard

Health measures

- Life expectancy
- Rate of infant mortality
- Rate of age-adjusted mortality from heart disease
- Rate of age-adjusted mortality from cancer
- Rate of diabetes
- Rate of clinical depression
- Rate of children and adults who are overweight and obese
- Rate of births with low weight
- Rate of preterm birth
- Self-reported well-being

System quality measures

- Rate of immunization for children
- Rate of influenza immunization
- Rate of hospital-acquired infections
- Rate of avoidable hospitalizations (for diabetes, chronic obstructive pulmonary disease, congestive heart failure, and asthma)
- Rate of hospital readmission
- Rate of tobacco use and alcohol and drug misuse or poisoning deaths
- Screening for clinical depression
- Elective delivery before 39 weeks
- Rate of developmental screening up to age 3
- Emergency department utilization
- Percentage of all-payer provider revenue that is not fee for service
- Surveys on access to care and satisfaction with care
- Adoption of electronic health records

Community measures

- Rate of child poverty
- Rate of teen pregnancy
- Air quality and drinking water quality index

Cost and affordability measures

- **Family spending burden:** median individual health care spending—premiums and out-of-pocket costs—as a share of median individual income
- **Population spending burden:** health care spending in the state as a share of gross state product
- **State spending burden:** health care spending by the state as a share of the state budget

Adopt payment and delivery system reform goals

Setting goals to change payment and delivery systems to reward high-value care is another way for states to increase transparency and signal a commitment to system transformation.

Value-based payment goals

Alternative payment models are a transition away from volume-based care—where providers are paid based on the quantity of services provided—to value-based care, where payments to providers are based on the health and well-being of their patients as well as their total cost of care. Secretary of health and human services Sylvia Burwell recently announced a national target of making 50 percent of Medicare payments through alternative payment models and linking 90 percent of payments to value or quality by 2018.²⁰ States should adopt similar targets for their Medicaid programs and all payers and should identify and annually report the percentage of payment in the state that is value based. States could set these targets through legislation or a publicly stated goal. Massachusetts' 2012 cost control legislation, for example, created a requirement for 80 percent of its Medicaid beneficiaries to be in alternative payment contracts by July 2015 and for commercial plans to implement alternative payment models as much as possible.²¹ The Massachusetts Health Policy Commission reports annually on the percentage of alternative payment models by payer type.

In Maryland's agreement with the Centers for Medicare & Medicaid Services, the state agreed to transition at least 80 percent of hospital revenue in the state to population-based payment methods.²² Similarly, Rhode Island's Working Group for Healthcare Innovation recommended that all of the state's payers move away from fee-for-service payment toward alternative payment models and that they align around the federal goals.²³

DSRIP waivers

Delivery System Reform Incentive Payment, or DSRIP, waivers offer another way for states to access significant federal funding and take concrete actions to support payment and delivery system reform, yet only a few states so far have taken advantage of these waivers. DSRIP waivers are part of Medicaid's broader Section 1115 waiver program, which gives states flexibility in testing payment and delivery system reforms and offering a broader set of services in their Medicaid program.²⁴ The waivers provide funding to support health care providers in changing the payment and delivery system for Medicaid beneficiaries.²⁵

DSRIP waivers provide millions of dollars to health care providers that meet performance metrics in four general areas established by CMS.²⁶ Over the first three years, these metrics focus on process—system redesign and infrastructure development. In the later years, the metrics are based on outcomes—clinical outcome improvements and population health. The specific metrics for each of the four areas vary by state. Under California's DSRIP waiver, for example, its public hospitals are implementing 15 care-delivery reform projects, and the hospitals have seen positive progress in decreasing wait times, reducing hospital-associated infections, and improving patient interactions.²⁷

While DSRIP waivers must be budget neutral to the federal government, they allow states to frontload federal funding given that early investments are needed to realize savings in later years.²⁸ These waivers also can be used in effect to re-purpose safety net payments to hospitals for delivery system reform and to smooth a financial glide path for providers, increasing provider participation in and acceptance of reform.

The funds available under DSRIP waivers are substantial and vary by the size of the projects—states such as New York and Texas have received more than \$6 billion and \$11 billion, respectively, over a five-year period, while New Jersey received \$167 million for a smaller initiative.²⁹

Implement bundled payments for all payers

Under the predominant fee-for-service payment system, health care providers are paid separately for each individual service. In contrast, a bundled payment compensates all of a patient's health care providers with a single, fixed, comprehensive payment that covers all of the clinically recommended services related to a patient's episode of care, or all treatment and services provided to treat a particular condition over a defined period of time. These payments can be adjusted based on the patient's health status. Bundles can enable care coordination, reduce variation in spending and clinical treatments, provide greater transparency and accountability on price and quality, and allow providers to transition to wider-scale payment reforms.³⁰ They are also associated with quality measures to assure that the quality of care that patients receive is preserved or enhanced.

The federal government is currently testing several new approaches for bundled payment models, but states also have a great opportunity to implement bundled payments. Several states are adopting bundled payment models to shift the focus of care—from providing more services to improving quality and reducing the cost of care. Arkansas initiated this effort, and Tennessee, Ohio, and Delaware are among other states that have since adopted bundled payments. The most common approach is to use the bundles as widely as possible across providers and payers within the state. Thus, there is an effort to require the bundles in both Medicaid and private insurance, or at least with those insurers on the exchange and providing coverage to state workers.

The Arkansas Health Care Payment Improvement Initiative is the only statewide payment reform that involves all major public and private payers. The initiative aligns bundled payments across Medicare; Medicaid; private insurers; and some self-insured employers, including Wal-Mart. Arkansas' initiative also focuses on expanding access to medical homes.³¹ The state projects that the initiative will save \$1.1 billion over three years and \$8.9 billion by 2020.³²

Arkansas initially launched five multipayer episodes: upper respiratory infection; total hip and knee replacement; congestive heart failure; attention deficit hyperactivity disorder; and perinatal care. Currently, the state has launched or started work on 16 episodes of care,³³ and it has set a goal of applying bundled payments to 50 percent to 70 percent of total health care spending in the state over the next few years.³⁴

In the Arkansas initiative, providers are still paid on a fee-for-service basis. Payers designate a principal accountable provider, or PAP, who is the main decision-maker for most care and coordinates with other providers during an episode. Payers track quality and costs across all episodes during a time period. If a PAP keeps the average cost below a threshold and meets quality standards, then it can keep a share of the savings. But if the average cost is above the threshold, then the PAP must pay back a share of the excess costs. Since performance is measured based on the average cost across all episodes, rather than the cost of an individual episode, providers have less incentive to stint on care in any given case. Other protections include patient risk or severity adjustments to the thresholds; patient outlier exclusions; and stop-loss adjustments, or maximum downside risk.

Options for implementation

Given bundled payments' potential to save money for states while improving the quality of care, all states should act to implement bundled payments statewide, ideally with the participation of all payers. However, states also could initially start with bundled payments in their Medicaid program, require Medicaid managed care companies to include bundles in their contracts, or use bundles in the state employee plan.

To streamline work and allow rapid deployment of the bundles, states should utilize bundles that have already been developed in other states or for Medicare. These bundles include: hip replacements; knee replacements; prenatal care and delivery; asthma hospitalizations; coronary artery bypass graft surgery; stent placement; coronary catheterization; and breast cancer adjuvant therapy.

Institute global budgets for hospitals

Global budgets are a tool to control health care costs and encourage hospitals to focus on the health of their community rather than only the provision of health care services. Instead of separate payers reimbursing hospitals for each individual service or procedure, under a global budgeting system, a state agency sets a fixed budget for each hospital each year based on factors including past expenditures, past clinical performance, and projected changes in levels of services, wages, and population growth.

Global budgets control costs by eliminating the incentives for hospitals to increase their volume of services because the amount of revenue they receive each year is fixed and predictable and does not depend on the number of patients served or services performed. Within preset limits, at the end of the year, hospitals keep money left over. If they overspend their budget, the hospitals are responsible for these extra costs and do not receive additional revenue.

Maryland is the only state that has established global budgets. In 2010, 10 rural hospitals in Maryland signed onto the state's global budget pilot because they wanted to transform their care delivery systems and improve the health of their communities, but they required a stable revenue base while doing so. Then, in 2014, Maryland established global budgets for all of its hospitals as part of an agreement with the Centers for Medicare & Medicaid Services.³⁵ Although the statewide effort was voluntary, all 46 hospitals in the state had signed on within six months.³⁶

Hospitals in Maryland supported the transition to global budgets.³⁷ Payers also supported global budgets because they help contain health care costs by reducing volume and avoidable hospital use. Importantly, the state understood that it would be critical to build consumer support for this reform, which it accomplished in part through a consumer engagement task force.³⁸

The Maryland Health Services Cost Review Commission, or HSCRC, has the authority to set each hospital's total annual revenue at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted

to reflect a number of factors, including inflation, population change, infrastructure requirements, changes in levels of uncompensated care costs, and quality. Annual revenue also may be modified for changes in service levels, market share shifts, or shifts of services to unregulated settings.³⁹ The HSCRC also collects and distributes patient-centered data to hospitals monthly on potentially avoidable utilization and on high-utilization patients.

Since the introduction of statewide global budgets in Maryland, outcomes have improved across the board. Potentially avoidable hospital utilization, Medicare readmission rates, and inpatient admissions have all declined.⁴⁰ Furthermore, in 2014, all-payer hospital spending growth per capita grew just 1.47 percent, which is lower than the 3.58 percent limit set by the state's cost growth goal. Therefore, the state saved Medicare more than \$100 million in just the first year.⁴¹

Maryland's unique all-payer rate setting system helped facilitate the state's transition to global budgets. But global budgeting is possible without centralized rate setting, and other states are investigating this model.

Options for implementation

Additional states should consider setting global budgets for hospitals. An initial step would be to convene a group of hospitals, payers, physicians, and consumers to assess global budget setting within the state and determine what would be needed for effective implementation.

A second step would be to pilot global budgets for hospitals in a few regions to build support for a statewide initiative, as Maryland did. A state could use its convening authority to encourage payers and a few hospitals to implement global budgets voluntarily. Hospitals struggling to maintain volumes of patients and revenue levels, such as rural hospitals, are good candidates for global budgets; freed from fee-for-service incentives, these hospitals can focus on reducing avoidable admissions and improving outcomes.

To move forward, the state would need a mechanism to set a target budget for each hospital, develop an approach to enforce it, and promote payer participation. A waiver from CMS would be necessary for Medicare participation. A state also could incentivize participation and help prepare hospitals for the transition to global budgets by providing grants for infrastructure and new staffing needed for global budgets. Maryland provided such grants when it introduced global budgets.⁴²

Launch all-payer claims databases

All-payer claims databases, or APCDs, are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims, and eligibility and provider files from private and public payers in a state.⁴³ The data include the actual prices that health plans have negotiated with providers. Currently, 18 states have enacted laws to create APCDs.⁴⁴

APCDs are usually created by a state mandate, which requires all payers in a state to submit their data. There are also a few voluntary APCDs that are established without legislation; with these, the state cannot compel all payers to submit their data, and the state has no authority to assess penalties for nonreporting.⁴⁵

All states should have an APCD, as they are instrumental in enabling cost control and quality improvement efforts. APCDs can help states understand cost, utilization, and quality baselines from which to evaluate the impact of reforms. They enable states to understand the health of their citizens and the health care that is being provided to them. States can identify variation between high- and low-cost providers and differences in costs for treatment options for a given condition; they also can detect disparities in access to services in different parts of a state.

Data provided by APCDs can help consumers choose high-quality care and make informed decisions.⁴⁶ Insurers can use APCD data to negotiate appropriate rates and steer their consumers toward high-value care.⁴⁷ Finally, APCDs are used in premium rate-review processes to allow states to verify if proposed rate increases are in line with increases in claims or changes in the risk pool.

The efficient use of APCD data can lead to significant cost savings. For example, a study based on data from Maine's APCD found that if potentially avoidable hospital admissions and the use of other hospital services that are high cost and have wide variation in cost—as identified through the APCD—were reduced by 50 percent, medical spending by commercial payers could be reduced by 11.5 percent, and Medicaid spending could be reduced by 5.7 percent.⁴⁸

Another example from Colorado shows how states can identify trends through APCD data, calculate potential savings, and target interventions. The Center for Improving Value in Health Care—a nonprofit that administers Colorado’s APCD—analyzed data on the prevalence of cesarean deliveries, which can pose health risks and also are more expensive than vaginal deliveries. The United States has pledged to decrease the rate of cesarean deliveries in low-risk women by 10 percent by 2020.⁴⁹ They found that the rate of cesarean deliveries was increasing in Colorado, as well as that people with commercial insurance were significantly more likely to have cesarean deliveries than Medicaid enrollees. Although the data could not reveal why the rates of cesarean deliveries differed by type of coverage, they showed areas that policymakers could target to reverse the trend of increasing cesareans—therefore preventing unnecessary health risks to mothers and children. The analysis also found that reducing the rate of cesarean deliveries only 10 percent would save the state \$6.5 million per year.

The costs to develop and operate an APCD vary depending on the size of the state, the scope of the data collected, and other factors. In the states that already have APCDs, the average cost to develop and implement them was \$1.1 million, and annual ongoing costs average \$600,000.⁵⁰ States use a variety of sources to fund the development and operation of their APCDs, typically funding part of their APCDs through general appropriations or fees assessed on health plans or providers.⁵¹ Many states also receive grant funding to support APCD development.⁵² Some states have included APCD development and improvement as a component of federal rate review grants, while others have used the federal Beacon Community Program—which supports communities in adopting electronic health records and health information exchanges—to obtain funds. New Hampshire has leveraged Medicaid funding for its APCD. Finally, states can fund their APCDs in part through selling data to researchers and other stakeholders.

There are many resources to help states establish an APCD, and the best practices from other states can be applied to address stakeholders’ concerns. For example, health care providers may be concerned about data protections in an APCD—such as making public the discount arrangements that providers have with payers.⁵³ It is important to include payers and providers in the APCD creation process and gain their input on the best way to structure data collection and release in order to build buy-in. The APCD Council—a nonprofit that helps states with APCD development—has created model legislation for APCD development, as well as a model for states to follow when setting up an APCD, and it can provide guidance on data collection and data release rules.⁵⁴

Options for implementation

An APCD is an important tool for all states. The 2016 U.S. Supreme Court decision *Gobeille vs. Liberty Mutual Insurance Company* ruled that the Employee Retirement Income Security Act of 1974 exempts self-funded insurers from reporting data to APCDs.⁵⁵ Therefore, statewide mandatory APCDs may no longer be possible, unless the U.S. Department of Labor issues new rules to require self-funded plans to submit data, but states can still establish statewide APCDs with required reporting except for self-funded insurers. States then could ask self-funded insurers to submit data to the APCD voluntarily.

If a statewide APCD is not possible immediately, a state also could recruit one large health system to agree to work with the state in establishing an APCD; this would create more pressure for other health systems to similarly sign onto an APCD. States also could think about starting with a voluntary APCD and transitioning later to a required APCD. Washington took this approach in 2004 and is now implementing an APCD with mandatory reporting.⁵⁶ States that are interested in creating an APCD should use existing resources and organizations in their states, such as academic or other health care institutions, with expertise in health care data to help with the creation or running of the APCD.

Expand evidence-based home visiting services

Home visiting programs connect parents with nurses, social workers, or other professionals who provide coaching and guidance on healthy child development and link families with other important services. These programs are among the most effective government programs ever studied in terms of consistently producing both positive outcomes and cost savings, and they are an important tool to reduce rising income inequality.⁵⁷ Randomized controlled trials testing the impact of home visiting services have found that the most effective models reduce the risk of infant death; reduce the need for payments from the Supplemental Nutrition Assistance Program, or SNAP, and Temporary Assistance for Needy Families, or TANF; lower criminal offenses and substance abuse; prevent child abuse and maltreatment; increase breastfeeding and immunization; and increase family economic security.⁵⁸

In addition to improving the lives of the families that participate, evidence-based home visiting services actually pay for themselves. A CAP analysis of extensive research on the return on investment of the Nurse-Family Partnership, or NFP—one of the most widespread and studied home visiting programs—found that, even accounting for the costs of providing the program, a state can expect average savings of more than \$7,400 from each birth enrolled in NFP by the time a child is 18 years old.⁵⁹

However, evidence-based home visiting programs serve only a small portion of the eligible families, largely due to funding challenges. In 2015, the largest federal funding source for home visiting programs—the Maternal, Infant, and Early Childhood Home Visiting Program, or MIECHV—was only able to serve about 115,000 parents and children, a small fraction of the children and families who live in poverty in the United States.⁶⁰ States must piece together multiple funding sources, which is administratively complicated and time-consuming, inhibiting states from providing these important services to all eligible families. Home visiting also requires investments in the first few years of a child’s life that are paid off later in savings—a challenge for states because they are required to balance their budgets on an annual or a biannual basis.

Despite these challenges, states should act quickly to expand home visiting programs and provide coverage to all eligible families, rather than spending money in the future on costly services. Combining current funding sources and using innovative financing methods can provide the investment needed now to realize significant savings and improved outcomes for families in the future. If states were to offer home visiting services consistently to eligible residents, the savings from providing these services would more than cover the costs after the first few years.⁶¹

Options for implementation

States have several options to expand the reach of their home visiting programs. First, states can work to increase Medicaid funding for their home visiting programs. Greater Medicaid reimbursement would require that states employ home visiting administrators with expertise in Medicaid benefits and reimbursement but would provide a stable funding source. States would also save more than their share of the costs of funding increased home visiting through Medicaid. Home visiting activities that states have found to be eligible for Medicaid coverage and payment include: assessments; developing care plans and monitoring progress; referrals; family planning activities; and providing mental health services.⁶² Recent guidance from the Centers for Medicare & Medicaid Services and the Health Resources and Services Administration outlines the Medicaid financing mechanisms available to states for home visiting programs.⁶³ However, Medicaid funding is insufficient to fund the entire range and duration of home visiting programs, so states would need to supplement Medicaid with other funding sources.

Second, states could encourage or require Medicaid managed care organizations to offer home visiting services as a benefit to all eligible Medicaid beneficiaries. All Medicaid managed care organizations in Minnesota, for instance, voluntarily offer home visiting programs because they recognize the cost effectiveness of these programs.⁶⁴

Third, states could negotiate a Medicaid waiver with CMS to provide federal matching funding and frontload funding for home visiting. Medicaid Section 1115 waivers—which give states flexibility to test innovations and offer services not usually covered by Medicaid—would allow states to fund the full range of home visiting services completely through Medicaid and offer these important services to every eligible family. Section 1915(b) waivers—which allow states to implement services that are not otherwise available through managed care orga-

nizations, target specific populations, and restrict the choice of providers—are another option. South Carolina recently received approval for a 1915(b) waiver from CMS that the state will use to launch a pilot program for NFP.⁶⁵

Lastly, states could use innovative Pay for Success models to fund home visiting, as several states are in the process of doing.⁶⁶ In these models, also known as social impact bonds, local banks, community foundations, national foundations, and investment banks put up capital to scale home visiting programs, and the government pays these investors back only if results are achieved and savings materialize. In South Carolina, Gov. Nikki Haley (R) is pioneering such a social impact bond model—in conjunction with the 1915(b) waiver—to fund home visiting and expand these important services to more mothers and children.⁶⁷ This type of payment model can solve the timing issue inherent to home visiting services: Capital is needed upfront, but savings accrue over a longer time period.

Improve price transparency

The U.S. health care system, especially health care prices, is characterized by a lack of transparency. This impedes market competition and prevents patients and their providers from making informed health care decisions. Consumers do not know how much a procedure, medication, or hospital stay will cost. Prices for the same service can vary significantly by provider, and providers charge different payers different amounts for the same service.

However, there is no consistent evidence that higher prices are correlated with higher-quality health care services.⁶⁸ Even when prices are listed, those are often not the prices that patients actually will be charged. Prices may differ, for example, because of the patients' insurance coverage or because of the costs of other providers who may be involved in the patients' care. Doctors make referrals without knowing the prices charged by other providers and prescribe medication and medical devices without knowing their prices. Widespread price variation, which is enabled by the lack of price transparency, adds about \$36 billion to the expenses of people with employer-sponsored health insurance.⁶⁹

Price transparency provides consumers with accurate and timely information that they can use to make informed health care choices.⁷⁰ Transparency also can expose market conditions and make markets more competitive, resulting in prices that reflect the cost and value of the health care services that are provided.⁷¹ Despite the challenges to achieving price transparency—including the variety of insurance benefit designs and legal barriers to disclosing prices—all states should expand price transparency efforts by offering consumer-friendly estimates of common health care services and quality information.

New Hampshire is a pioneer in price transparency and is the only state to have received an “A” grade for state transparency from Catalyst for Payment Reform, a nonprofit working to promote higher-value health care in the United States.⁷² New Hampshire uses its all-payer claims database to publish the actual costs that

consumers can expect to pay for health care services.⁷³ The state recently added additional procedures, quality data, and a consumer-friendly interface to encourage consumers to shop around for the best-value services.

Massachusetts also has been a leader in price transparency. Since 2014, Massachusetts has required insurers and health plan administrators to offer consumers provider-specific estimates of their out-of-pocket costs for specific hospital stays or procedures.⁷⁴ These prices include costs for both doctors and health care facilities instead of discrete services. These estimates are binding, unless the patient receives additional services that were not anticipated to be part of the treatment.⁷⁵ The Massachusetts law also requires providers to give patients information that their insurer might need to calculate their out-of-pocket costs.

In addition to these consumer-focused requirements, health care providers in Massachusetts also must disclose their estimated charges. The state has instituted initiatives aimed at studying prices and increasing access to quality and cost data—the Health Policy Commission studies price variation, and all health care organizations must submit annual cost and quality data to the commission. A public website lists data about the relative costs of different providers, increasing consumers' access to crucial information.

Integrate behavioral health and primary care

Behavioral health issues are associated with poor physical health outcomes. Patients with both Type 2 diabetes and mental illness, for example, have a higher mortality rate than those with just diabetes or just mental illness.⁷⁶ Individuals with severe mental illness, depression, dementia, and substance use disorders have reduced chances of survival after a cancer diagnosis, independent of the cancer stage at diagnosis.⁷⁷ People with mental disorders have a lower age of death by an average of 8.2 years.⁷⁸

Those with comorbid behavioral and medical health issues do not only have worse health outcomes—they also produce substantial costs to the health care system. Milliman, an actuarial and consulting firm, conducted an analysis that found that those with chronic medical and comorbid mental health conditions or substance use disorders can incur costs that are 2 times to 3 times the costs of those without comorbid mental health conditions or substance use disorders.⁷⁹ Because Medicaid is the largest payer for behavioral health treatment, states shoulder significant costs from behavioral health issues.⁸⁰

Behavioral health services are often provided completely separately from the physical health system. Additionally, many patients prefer to seek care for behavioral health issues from their primary care doctors, who are often ill-equipped to deliver appropriate care.⁸¹ However, the effective integration of behavioral and medical services can help improve health outcomes and lower costs. For example, the Milliman analysis found that the effective integration of care could save about 9 percent to 16 percent of the additional spending on those with comorbid mental health conditions or substance use disorders.⁸²

There is a continuum of approaches to integrate physical and behavioral health care.⁸³ In an integrated care practice—the most integrated on the continuum—a team of primary care and behavioral health providers work together to address behavioral health issues that present in primary care.⁸⁴ Other less fully integrated but still helpful approaches include coordinated care—such as universal screening for behavioral health disorders in primary care, or co-location—where physical and behavioral health care services are provided at the same location.

One example of an integrated care intervention is the Improving Mood—Promoting Access to Collaborative Treatment, or IMPACT, care management program developed at the University of Washington that is designed to treat late-life depression in primary care. This model is also known as Collaborative Care. Depression is a common and expensive condition in older adults—one that often occurs with other health problems.⁸⁵ However, few older adults receive effective treatment, often because they are not diagnosed. Additionally, more than 90 percent of older adults with depression prefer to receive care from their primary care provider rather than a mental health specialist, even though primary care doctors do not have the same expertise in mental health.⁸⁶

With the IMPACT intervention, patients have a depression care manager, supervised by a psychiatrist, who works directly with the patient’s primary care provider. This team systematically tracks the patient’s outcomes and adjusts the treatment if the patient is not improving.⁸⁷ The patient also receives education, an antidepressant medication when recommended, and individual counseling sessions. In contrast, usual care for patients diagnosed with depression in primary care consists of just a prescription for an antidepressant or a referral to a mental health provider.⁸⁸

A randomized controlled trial of the IMPACT intervention—across 18 diverse primary care clinics in five states—showed that it more than doubled the effectiveness of depression treatment for these older adults in primary care settings, increased patient satisfaction, improved physical functioning, and saved about 10 percent of total health care costs for the intervention patients.⁸⁹ The IMPACT program has since been expanded to include adolescents and nonelderly adults, as well to other behavioral health conditions, including anxiety and substance abuse.⁹⁰ This model of care has now been implemented in hundreds of organizations across the country.⁹¹

Several states are implementing new payment models or innovative models of care to promote the effective integration of behavioral and physical health.

Oregon is piloting an Alternative Payment Methodology at three community health centers, which is allowing for better integration of behavioral health and primary care.⁹² The Alternative Payment Methodology pilot is designed to promote comprehensive care for a population by paying the community health centers a per-member-per-month, or PMPM, fee instead of on a fee-for-service basis. The practices are able to look broadly at how they treat their patients and have the flexibility to use some of the PMPM payment on behavioral health services. For

example, some of the practices are embedding behavioral health doctors in primary care teams, so that the primary care physicians can immediately refer patients to the behavioral health providers in person at the end of a primary care visit.

In several states, Medicaid managed care organizations are implementing programs to coordinate care for patients with comorbid behavioral and physical health conditions.⁹³ For example, Community Health Plan of Washington, which is a nonprofit plan serving the Medicaid population, has implemented the IMPACT model. The Washington health plan supports the creation of the treatment teams that are required as part of IMPACT and invests in additional training for the providers to implement the model. After the health plan expanded the model from two pilot sites to statewide, it achieved savings of about \$11 per member per month in just the first 14 months.

Colorado is using a State Innovation Models grant from the Centers for Medicare & Medicaid Services to implement a statewide behavioral health initiative. The initiative aims for 80 percent of Colorado residents to have access to integrated care for behavioral health and primary care in primary care settings by 2019, and projects that this will save \$330 million over five years.⁹⁴ As part of this effort, the state will implement integrated care in Medicaid and the state health employee plan to spur broader adoption of integrated care across the state, and it will provide practice transformation support to 400 primary care practices to enable them to integrate behavioral and physical health services.⁹⁵

Private insurers also have instituted programs to help coordinate behavioral and physical health care. Aetna, for example, developed a Depression in Primary Care Program to support primary care physicians in diagnosing and monitoring patients with depression.⁹⁶ This program provides primary care physicians with a diagnostic tool and reimburses them for their time spent screening for depression and follow-up monitoring.

Options for implementation

These examples show how states can take a lead role in integrating behavioral health and primary care. First, a state could enact legislation to require primary care providers to screen all patients for mental health issues and then refer them

for appropriate care. This approach would not integrate care fully, but it would require the state to assess patients' access to mental health providers and take steps to improve access as needed.

Second, states could facilitate and operationalize the integration of behavioral and physical health by removing payment barriers that hinder the integration of care. For example, some states do not allow health centers to bill for the costs of multiple services—such as both a physical health and a behavioral health service—to the same person in the same day, which discourages the co-location of these services.⁹⁷ In some states, Medicaid will not reimburse for health behavior and assessment intervention codes at Federally Qualified Health Centers.⁹⁸ Some states do not utilize billing codes that were established for Medicaid payment for Screening, Brief Intervention, and Referral to Treatment, or SBIRT—a method of screening for substance use disorders. Another issue is that in some states, most payers do not reimburse for community health workers to support care management of behavioral and physical health issues.⁹⁹ And the fee-for-service payment system does not allow for reimbursement of the type of care coordination that Oregon is promoting with its Alternative Payment Methodology pilot.

Third, states could implement, with a pilot or with a statewide expansion, an effective integrated care model, such as the IMPACT intervention described above. Health Homes, which is a treatment model that was established by the Affordable Care Act to coordinate care for Medicaid beneficiaries with more than one chronic condition, can be used to implement collaborative care programs such as IMPACT.¹⁰⁰

Fourth, states could reduce barriers to the sharing of information between primary care and behavioral health providers. Confidentiality laws for behavioral health are often more restrictive than those for physical health—for example, if a patient's consent is required to share data on mental health treatment across providers.¹⁰¹ States with restrictive confidentiality laws should amend these laws to permit greater sharing of information while still protecting patient privacy. States can, for example, permit the sharing of data on behavioral health for treatment purposes. However, states do not have the authority to overcome restrictive federal law around the sharing of data related to addiction treatment, though the U.S. Department of Health and Human Services is proposing to modify these regulations.¹⁰²

Combat addiction to prescription drugs and heroin

Drug overdose deaths, addiction, and emergency department visits related to substance use disorders have surged in recent years, and the Centers for Disease Control and Prevention has labeled it an epidemic.¹⁰³ Addiction to prescription opioids and heroin, which is found across all demographic and income groups, is driving this epidemic. From 2002 to 2013, there was a 286 percent increase in the number of heroin-related overdose deaths.¹⁰⁴ Often, people become addicted to prescription opioid painkillers, obtained both legally and illegally, and then become addicted to heroin, which is much cheaper.¹⁰⁵ The costs associated with drug overdose and addiction are large and growing, and Medicaid bears a large percentage of these costs.¹⁰⁶

The federal government has taken steps to implement policies to reduce drug addiction and overdose, such as providing greater training on opioid prescribing for federal health care professionals.¹⁰⁷ But states have the ability to effect greater change because they regulate the practice of medicine within their states.¹⁰⁸ However, states must overcome several barriers to reducing prescription drug and heroin use.

Stigma and misconceptions surrounding addiction are common and present a serious barrier to effective treatment. Addiction is a chronic disease—a fact that is commonly misunderstood and that contributes to stigma. Stigma, in turn, can prevent access to effective treatment. For example, the use of medication-assisted treatment,* or MAT, has been shown to produce substantial cost savings as well as reduce drug use, disease rates, and criminal activity among addicted people, and it is more effective than short-term managed withdrawal treatment, or detoxification.¹⁰⁹ The Institute for Clinical and Economic Review has found that for every additional dollar spent on MAT, \$1.80 in savings are realized.¹¹⁰ Yet a judge or parole officer may order an offender to end MAT because he or she believes the person is not truly in recovery.

* With MAT, medications are used in conjunction with behavioral therapy to reduce the symptoms of substance use withdrawal. Three medications are approved by the Food and Drug Administration to treat opioid use disorders: methadone; buprenorphine; and naltrexone. See Cindy Mann and others, "Medication Assisted Treatment for Substance Use Disorders" (Baltimore: Centers for Medicare & Medicaid Services, 2014), available at <http://www.medicare.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.

Second, access to effective treatment is limited. Only 10 percent of Americans with addictions and substance use disorders receive any care each year.¹¹¹ An estimated 65 percent of people in prison have a drug or alcohol addiction, yet only 11 percent receive professional treatment while incarcerated. Shortages of clinicians who care for individuals with substance use disorders and limited spots available for treatment restrict the number of people who can access treatment. People who are uninsured also have trouble affording treatment.

Even those who are able to access treatment find it hard to access effective treatment. As of 2014, only 13 states included all approved addiction medications on their Medicaid preferred drug lists, many insurers impose onerous requirements on addiction treatment—such as quantity or lifetime limits—and many private insurers do not cover methadone treatment.¹¹² For example, in order to prescribe buprenorphine—an effective medication approved to treat opioid addiction—doctors must take an eight-hour course and apply for a special license, which limits the number of doctors permitted to prescribe this addiction medication.¹¹³ These restrictions mean that only 2.2 percent of doctors met the requirements to prescribe buprenorphine in 2012.¹¹⁴ Since addiction is a chronic disease, limits on how long an individual can receive treatment misunderstand drug addiction, are counterproductive, and can result in higher long-term costs.

Third, many states lack access to timely and comprehensive data. Many states track overdose deaths but with significant lag time and without detailed information. Additional data on overdose deaths and on nonfatal overdoses can help states, local jurisdictions, police departments, and health professionals pinpoint trouble areas and where to launch interventions strategically.

State strategies for combating addiction and overdose deaths

Examples from four states illustrate how states are using some of the available tools to counter drug addiction and overdose deaths.

In 2014, former Gov. Martin O'Malley (D) of Maryland signed an executive order to establish an Overdose Prevention Council to reduce the number of overdose-related deaths in the state. The state also created a statewide plan and another plan for correctional institutions. Gov. Larry Hogan (R) continued this work by establishing the Heroin and Opioid Emergency Task Force and an Inter-Agency Coordinating Council in 2015.¹¹⁵ Other actions the state has taken include:

- Adding a requirement for education on opioid prescribing for all doctors as a condition of licensure.¹¹⁶
- Making naloxone, which reverses a heroin overdose, available without prior authorization.¹¹⁷
- Authorizing via state legislation family members and others to carry naloxone.¹¹⁸
- Launching a major campaign to link people to treatment and to educate on overdose and addiction. The state also is working with the State Department of Education to include education on the consequences of prescription painkillers and heroin in school curricula.¹¹⁹
- Promoting evidence-based treatment and increasing capacity at treatment centers.¹²⁰
- Working with hospitals on a voluntary reporting system for nonfatal overdoses so that the state can offer treatment to prevent fatal overdoses.¹²¹
- Releasing detailed annual and quarterly reports, which include data on deaths by types of drug- and alcohol-related intoxication deaths.¹²²

Maryland heavily focuses on data and undertook a project to link data across multiple state agencies to make policy improvements.¹²³ The Overdose Prevention Council was able to coordinate activities among different state agencies, break down silos, overcome legal barriers to sharing data, and develop a comprehensive data set of individuals who died of an overdose. These steps helped the state and local jurisdictions identify patterns of overdose activity and target their public health responses and planned interventions. For example, the state was able to identify that individuals released from corrections facilities were at much higher risk of overdose death following release. As a result, the state corrections agency took on a greater role in educating inmates on overdose prevention and treatment, and the Department of Public Safety and Correctional Services made recommendations to improve access to treatment.

In recent years, Florida was home to a large number of “pill mills,” or pain management clinics that were improperly prescribing and dispensing prescription drugs. In 2010, 93 of the top 100 oxycodone dispensing doctors were in Florida; the number of people dying from oxycodone overdoses in the state was skyrocket-

eting. People across the country were flooding into Florida to obtain prescriptions.¹²⁴ Beginning in 2010, state officials, with assistance from the federal Drug Enforcement Administration, acted to stop these abuses. The state:

- Required pain management clinics to register with the state and be owned by doctors¹²⁵
- Required physicians to register in prescription drug monitoring programs, or PDMPs¹²⁶
- Disallowed physicians from dispensing prescription painkillers from their offices¹²⁷
- Increased penalties for doctors who overprescribed drugs¹²⁸

These initiatives have been successful: The number of oxycodone pills in Florida and the number of pain clinics have been halved, and the number of oxycodone deaths in 2012 was less than half the number in 2010.¹²⁹

In 2012, New York passed legislation to make changes to its PDMP in order to increase its effectiveness and utilization. PDMPs are statewide electronic databases that collect data on controlled prescription drugs dispensed in the state. New York made the system more user friendly, included greater detail in reports to encourage doctors to use them, allowed doctors to designate staff to access the system to run reports for them, and allowed access for licensed pharmacists.¹³⁰ New York also now requires physicians to consult the PDMP before prescribing certain controlled substances.¹³¹ Additionally, beginning in 2016, there is mandatory electronic prescribing for all prescriptions in the state—making New York the first state to require this.¹³² Electronic prescribing connects doctors and pharmacists electronically and allows for easier communication and detection of fraud.¹³³

Rhode Island has instituted detailed reporting of both fatal and nonfatal drug overdoses; the level of detail and timeliness of the data are rare.¹³⁴ For every opioid-related overdose, a hospital is required to notify the state health department and provide demographic information on the patient, as well as state whether naloxone was administered and at what dose, where the overdose occurred, and whether the person died. The state also quickly publicizes the number of drug overdoses and what drugs were involved in the overdose, such as by heroin mixed with the powerful painkiller fentanyl. This information helps the state identify risk factors for overdoses, informs its policies, and draws greater public attention to the problem.

Options for implementation

Although none are a silver bullet, key components of effective strategies for states to combat addiction to prescription drugs and heroin include the following actions.

Improving data collection and utilization

- Improve the data collection and analysis of measures related to addiction and overdose. Real-time data help health professionals understand where overdoses are occurring and allow them to pinpoint where to deploy resources. Data also help overcome partisan differences and stigma around addiction by allowing people to understand the extent of the problem and what is happening in their own communities.
- Establish an effective PDMP. PDMPs can be used to analyze prescribing practices by physicians and pharmacies and identify the utilization of high-risk patients. Most states currently have PDMPs, but they differ in their funding, use, and capabilities, and PDMP participation by providers is very low in most states.¹³⁵ For instance, only 16 states currently require doctors to use PDMPs.¹³⁶ In a sample of states where doctors can choose whether to consult their state's PDMP before prescribing an opioid, they did so only 14 percent of the time in 2015.¹³⁷ Funding is available from the U.S. Department of Justice to plan, implement, and enhance PDMPs.¹³⁸
- Collaborate and link data with other states. For example, Maryland recently announced that its PDMP will now link to Virginia's, and eventually to other states, to identify whether patients are filling prescriptions outside Maryland.¹³⁹

Increasing access to evidence-based treatment

- Reimburse for Screening, Brief Intervention, and Referral to Treatment—an evidence-based practice used to identify, reduce, and prevent abuse of and dependence on alcohol and illicit drugs.¹⁴⁰ States could obtain federal grant funding for SBIRT through the Substance Abuse and Mental Health Services Administration, or SAMHSA, and also draw down Medicaid matching funds.
- Increase access to treatment by expanding Medicaid. The Affordable Care Act requires coverage for substance abuse treatment for all insurers, including Medicaid, but many adults in the 19 nonexpansion states still lack access to

insurance and, therefore, substance abuse treatment.¹⁴¹ A recent report from the Department of Health and Human Services found that about 1.9 million uninsured people with a mental illness or substance use disorder live in states that have not yet expanded Medicaid.¹⁴²

- Increase Medicaid reimbursement rates for outpatient treatment and provide additional funding to treatment centers to help increase centers' capacity.
- Leverage available federal funding to increase the accessibility of naloxone and increase access to MAT.¹⁴³ In March 2016, the Obama administration announced that SAMHSA is releasing new funding opportunities for states to expand their MAT services and for states to purchase and distribute naloxone.¹⁴⁴

Training and education

- Develop policies to improve the prescribing of opiates, involving physicians, patients, insurers, pharmacies, and licensing boards. Licensing boards could, for example, require education of doctors for controlled substances licensure. Insurers and pharmacies could establish lock-in programs that limit certain patients' access to prescriptions at particular pharmacies and allow providers to monitor patients' medication utilization.
- Create public awareness and education campaigns to encourage the responsible use of opioid medications, prevent addictions, and reduce stigma. Lack of public awareness is a major driver of opioid addiction; almost half of users of opioid painkillers do not know that they are as addictive as heroin.¹⁴⁵ And those addicted to opioid painkillers are 40 times more likely to become addicted to heroin than those who are not dependent on opioid painkillers.¹⁴⁶ For example, the Rhode Island Department of Health recently launched a media campaign called "Addiction is a Disease. Recovery is Possible" that highlights eight residents' stories of addiction and recovery.¹⁴⁷
- Require that medical schools in the state include instruction on addiction and substance abuse. Currently, the Hospital of the University of Pennsylvania is the only medical school in the country to require this, but more than 60 medical schools have pledged that they will require their students to take some form of prescriber education beginning in fall 2016.¹⁴⁸

Improve the delivery of long-term care

Long-term care is a range of services and supports to meet a person's daily personal care and health needs over an extended period of time.¹⁴⁹ Today, more than 12 million elderly or disabled Americans rely on long-term care, and the demographics of many states create significant challenges for their long-term care systems.¹⁵⁰ In particular, the number of elderly Americans is increasing—and projected to continue to increase—at a faster rate than the nonelderly population. Given these trends, the need for long-term care is projected to double over the next few decades.¹⁵¹ Because Medicaid is the largest financer of long-term care, state budgets will bear a significant amount of the costs from this increased need for long-term care.¹⁵²

Reforms to states' current long-term care delivery systems can not only improve access and quality but also lower costs. Policymakers have recently focused increased attention on these challenges. Some states took advantage of the Balancing Incentive Program in the Affordable Care Act to increase access to home and community-based services and to rebalance the system toward non-institutional settings.¹⁵³ However, this funding expired in September 2015.

Options for improving long-term care

States can choose from several options to increase the sustainability of their long-term care systems.

Rebalancing toward home- and community-based services

Policymakers should initiate or build on current efforts to rebalance their states' long-term supports and services toward home- and community-based services. Services provided in community settings are far less expensive than services provided in nursing homes.¹⁵⁴ This focus is particularly important as states increasingly move toward managed care delivery for these services.

The Community First Choice Option for Medicaid programs, established by the ACA, offers enhanced federal matching funds for providing home- and community-based attendant services and supports.¹⁵⁵ In order to qualify for the enhanced 6 percent matching rate, these services must be offered throughout the state and without a waitlist. This enhanced matching rate can generate a significant amount of new funding for a state.¹⁵⁶

Five states—California, Maryland, Montana, Oregon, and Texas—currently have approved state plan amendments for this option.¹⁵⁷ All states should modify their Medicaid programs to include the Community Choice First Option, which would make permanent the types of incentives that were available on a temporary basis under the Balancing Incentive Program or under waivers from the Centers for Medicare & Medicaid Services, which allow states to adopt Medicaid policies that differ from standard Medicaid requirements.

Offering Health Homes to patients with multiple chronic conditions

State Medicaid programs also should offer Health Homes, which are an optional Medicaid state plan benefit that lets states coordinate care for Medicaid beneficiaries with chronic conditions, such as people who suffer from serious mental health conditions, substance use disorders, asthma, diabetes, heart disease, or obesity.¹⁵⁸

Health Homes can help integrate and coordinate acute, primary, mental health, and long-term care for these high-risk participants.¹⁵⁹ This intensive care coordination aims to reduce emergency room use, hospital admissions and readmissions, and reliance on long-term care facilities. In Missouri, Health Homes have reduced blood pressure and cholesterol, reduced hospitalizations, and saved \$15.7 million in the first two years.¹⁶⁰

Health Homes have designated health care providers working with a health care team, which could include a nurse coordinator, a mental health professional, and a pharmacist. They receive a fee for providing the following services:¹⁶¹

- Care management
- Prevention and screening of mental illness and substance use disorders
- Transitional care from inpatient to other settings, such as discharge planning

- Referral to community and social services
- Use of health information technology
- Reporting data on patient outcomes

The ACA offers significant funding for states that wish to implement this program for their Medicaid enrollees. For the first two years of the program, the federal government will pay for 90 percent of the costs.¹⁶² States retain flexibility in designing payment methodologies and choosing eligible Health Home providers. Currently, 19 states have approved Health Home state plan amendments with CMS.¹⁶³

States with managed long-term care should require insurers to offer similar Health Homes to Medicaid-eligible individuals with chronic conditions.

Encouraging the purchase of private long-term care insurance

Most Americans are not able to pay for their long-term care and incorrectly assume that Medicare, private health insurance, or retirement plans will cover the costs.¹⁶⁴ States should encourage the purchase of private long-term care insurance by offering refundable tax credits to people who purchase minimum levels of private long-term insurance. These tax credits would be an upfront investment that would over time help lower costs in the Medicaid program because individuals may have otherwise relied entirely on Medicaid to fund their long-term care. Compared with the current, limited federal tax deduction, a refundable, sliding-scale state tax credit exclusively for the purchase of long-term care insurance would offer far greater assistance for those who wish to buy these products.

Individuals would qualify for a credit if they bought a qualified long-term care insurance policy. To protect consumers, these policies would be guaranteed issue and would include a minimum level of benefits that could not vary based on age or health status and have protection against inflation. To protect against adverse selection—people waiting to buy long-term care insurance until they begin to need it—there also would be a five-year waiting period. The new tax credit would be available to those who first purchase a policy when they are ages 60 and under; this would further reduce adverse selection and keep premium amounts affordable.

Align scope of practice with community needs

Scope of practice refers to the services that a health care professional is legally allowed to provide for a patient in a particular setting.¹⁶⁵ In particular, scope-of-practice laws regulate the role of nurse practitioners and physician assistants. Nurses make up the largest segment of the health care workforce in the United States, yet many of them face barriers to utilizing their training to the fullest extent possible.¹⁶⁶ Removing these barriers would improve the productivity of the health care system. In addition, systematic reviews of randomized controlled trials have found that nurse practitioners and physicians provide similar quality care and that patients are satisfied with the care provided by a nurse practitioner.¹⁶⁷

Inappropriate or overbearing scope-of-practice regulations can prevent trained health care professionals from utilizing their full set of skills, limit patients' access to care and choice of providers, and increase health care costs.¹⁶⁸ Allowing nurse practitioners and physician assistants to practice with more independence would increase market competition and increase the supply of primary care providers, thereby improving patients' access to providers.¹⁶⁹ In 2014, more than 58 million Americans lived in areas with primary care physician shortages.¹⁷⁰ States with large rural populations face particular challenges: One-fifth of all Americans live in rural areas, but only one-tenth of physicians practice in these communities.¹⁷¹

As a 2010 report from the Institute of Medicine on the future of nursing stated, "The tasks nurse practitioners are allowed to perform are determined not by their education and training but by the unique state laws under which they work."¹⁷² Most states, for example, require a physician's supervision for nurse practitioners to see patients.¹⁷³ In many states, nurse practitioners are limited or prohibited from prescribing medications, admitting patients to a hospital, assessing patient conditions, and ordering and evaluating tests. Nurse practitioners also face payment issues. In some states, nurse practitioners are certified instead of licensed, which creates billing obstacles with insurance companies and prevents nurse practitioners from establishing their own practices.¹⁷⁴

A 2013 study of the scope-of-practice laws that govern nurse practitioners working in retail clinics, which provide quick diagnosis or treatment for common conditions in retail settings such as grocery stores, found that eliminating restrictions on scope of practice could result in large cost savings.¹⁷⁵ The study found that the cost per episode treated in a retail clinic was lower in states where nurse practitioners were allowed to practice and prescribe independently. It also found that care provided by nurse practitioners was of similar quality to care provided by physicians.

States also have conducted analyses that show potential cost savings from expanding the scope of practice for nurse practitioners and physician assistants in primary care. For example, Florida's Office of Program Policy Analysis and Government Accountability found that the state's health care system could annually save \$44 million in Medicaid and \$2.2 million in the state employee health insurance plan by expanding scope of practice.¹⁷⁶

Options for implementation

Progress is being made: By the end of 2015, 21 states had changed their laws to give nurse practitioners full practice and prescriptive authority, and another six states had expanded their scope-of-practice laws.¹⁷⁷ However, more progress is possible, especially in the mid-Atlantic and Southern states, where scope-of-practice regulations tend to be more restrictive. Other states should amend their state laws to remove burdensome barriers for nurse practitioners. For example, states should require payers to directly reimburse nurse practitioners who are practicing within their scope of practice as determined by state law.¹⁷⁸

Apart from modifying scope of practice through legislation, state officials can take additional actions. States can review current scope-of-practice regulations and recommend modifications. States also can set up independent commissions to review evidence and make determinations or recommendations to the legislature and governor on scope-of-practice issues.

Institute reference pricing in the state employee plan

Health care benefits for state employees and retirees account for a majority of the growth in state and local government health care spending. Spending on these benefits grew 61 percent in just the past six years.¹⁷⁹

With reference pricing, insurers or employers set a maximum price for what they will pay for a particular procedure, and patients are encouraged to shop around to choose a high-value provider.¹⁸⁰ If patients choose a provider with a higher price than the reference price, they must pay the difference. Reference pricing also can help consumers make informed decisions on their treatment options because accurate price and quality information is more available.¹⁸¹

This reform has shown success in controlling health care costs for a state employee plan. The California Public Employees' Retirement System, or CalPERS, initiated reference pricing for knee and hip replacement in 2011. Before the program, the price for these procedures ranged from \$15,000 to \$100,000 with no difference in quality.¹⁸² CalPERS designated 41 hospitals with prices for these procedures below \$30,000 and that met quality standards.¹⁸³ Enrollees received a letter describing the program and information for the selected facilities where they could receive these services.¹⁸⁴ Enrollees who do not choose to have the procedures at these high-value hospitals must pay the cost difference out of pocket.

Reference pricing increased referrals to the high-value hospitals by 19.2 percent, and the average price for the procedures dropped from \$34,742 to \$25,611—a decline of 26.3 percent.¹⁸⁵ California estimates that it saved \$5.5 million in just the first two years. Significantly, this price reduction was driven primarily by price reductions at hospitals that had not been designated as high value. Furthermore, there were no significant changes in average cost sharing, and patient outcomes—including complication, infection, and readmission rates—improved.¹⁸⁶

CalPERS also instituted reference pricing for colonoscopies in 2012 and found a 21 percent reduction in price with no change in complications.¹⁸⁷ The utilization of low-priced facilities for colonoscopies by CalPERS members increased from 69 percent in 2009 to 91 percent in 2013. Therefore, CalPERS saved \$7 million on spending for colonoscopies in the first two years after reference pricing was implemented.

Implementation

To replicate California's cost savings, other states could similarly use reference pricing for their state employee plans. Such reference pricing should apply to procedures that are easily shoppable—meaning that patients have the time to make choices based on price and performance—and that have wide variation in prices, such as MRIs, CT scans, knee replacements, and hip replacements.¹⁸⁸

Expand the use of telehealth

Telehealth is defined as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.¹⁸⁹ In other words, telehealth is when providers use technology to provide remote care to patients. Telehealth facilitates communication between patients and providers and is especially promising for areas with physician shortages and rural areas with fewer doctors and hospitals. Remote care also can play a crucial role in providing behavioral and mental health services, where there are commonly provider shortages and long wait times for appointments.

Telehealth services are both high quality and cost saving. A broad review of the research on telehealth shows that clinical outcomes do not differ between in-person and phone or video treatment. Meanwhile, hospital admissions and readmissions are reduced, substantial cost savings are achieved, and patient satisfaction is high.¹⁹⁰ For example, one study found savings of \$45 for each telehealth visit covered by Medicare and savings of \$126 for each visit covered by commercial insurance.¹⁹¹ Another recent study found that 69 percent of patients who had recently had general surgery and then follow-ups by video, by phone, or in person preferred the telehealth visits to the in-person visits.¹⁹²

Even though the use of telehealth has expanded dramatically in recent years, regulatory and payment barriers still limit its broader adoption.¹⁹³ As of February 2016, 29 states and the District of Columbia have laws for private payer policies for telehealth, and 23 states have parity laws that require insurers to cover telehealth services at the same rates as in-person services.¹⁹⁴

Options for implementation

States can facilitate the expansion of telehealth by modifying licensure and practice rules. Health care professionals are licensed on a state-by-state basis, and most states do not allow licenses to transfer across states. Only Maryland, New York,

Virginia, and the District of Columbia allow licensure reciprocity from bordering states.¹⁹⁵ A few other states allow conditional or telehealth licenses to out-of-state physicians, but these are often issued with restrictions. For instance, Pennsylvania issues extraterritorial licenses to physicians in adjoining states, but the physician's practice must extend into Pennsylvania, and the adjoining state must extend the same privileges to Pennsylvania physicians—two limitations that undermine the effectiveness of the policy. All states should allow physicians licensed in neighboring states to practice telehealth within them. An independent commission of experts could certify that the licensure standards of neighboring states are adequate to ensure the quality of care.

Second, states should take all available steps to increase reimbursement for telehealth services and to require insurers in the state to cover these services. Only 22 states and the District of Columbia have laws that require parity for telehealth services for private health insurers, meaning that telehealth services have reimbursement rates on par with those for face-to-face services.¹⁹⁶ Additionally, although almost all states cover some telehealth services through Medicaid, states have different standards for Medicaid reimbursement and restrictions placed on coverage for telehealth.¹⁹⁷ And only about half of the states have coverage for telehealth under the state employee plan.¹⁹⁸

Decrease unnecessary emergency room use

States can implement innovations in their Medicaid programs to lower costs and improve health outcomes without restricting access to care. For example, several states have implemented emergency room, or ER, diversion programs to reduce unnecessary ER room use and provide care in a more appropriate setting. These programs typically focus on expanding access to primary care services, focusing on populations that frequently use the ER, and targeting the needs of people with behavioral health issues, who are often ER superutilizers.¹⁹⁹ All states should implement robust ER diversion programs using the practices that have been successful in other states. Several examples are described below.

Using a grant from the Centers for Medicare & Medicaid Services, Georgia implemented an ER diversion project that established four primary care sites in rural and underserved areas of the state with extended or weekend hours. The state also hired case managers to steer frequent ER users who are Medicare and/or Medicaid beneficiaries to these sites. This project saved the state about \$7 million over three years while serving 33,000 patients.²⁰⁰

New Mexico established a statewide 24/7 nurse advice hotline that is available to any state resident.²⁰¹ The state has saved more than \$68 million since 2006, with 65 percent of callers diverted from the ER and about 75 percent of the state's residents using the advice line.

Indiana and Minnesota identified the Medicaid beneficiaries who use the most ER services, and they now provide care coordination to those beneficiaries in order to improve their health. Indiana's Medicaid managed care plans all participate in the state's Right Choices Program, where primary care providers coordinate all specialty care, hospital, and prescription services for the Medicaid beneficiaries who use the most services.²⁰² In Minnesota, the Hennepin County Medical Center's Coordinated Care Center provided enhanced outpatient care to ER superutilizers or members with high rates of hospitalizations. Hennepin County saw a 37 percent decrease in ER visits and a 25 percent decline in hospitalizations among these patients in just one year.²⁰³

Washington, meanwhile, passed legislation that requires hospitals to adopt seven best practices aimed at reducing unnecessary ER use. This initiative, combined with a transition to Medicaid managed care, saved the state about \$34 million in 2013.²⁰⁴ These best practices include requiring hospital ER departments to share patient information electronically, providing patients with instructions on the most appropriate setting for care upon discharge from the hospital, making primary care appointments for frequent ER users within 72 hours to 96 hours of an ER visit, and adopting strict guidelines for narcotics prescribing.²⁰⁵

In Wisconsin, the Milwaukee Health Care Partnership identified frequent ER users and made primary care appointments for them, as well as educated them on proper ER use. In 2012, the partnership reduced ER use by 44 percent among those beneficiaries who kept their primary care appointment.²⁰⁶

Conclusion

Additional improvements to the U.S. health care system would build upon the Affordable Care Act and accelerate the slowdown in health care cost growth. Controlling health care costs is necessary for the sustainability of the federal and state health care systems and to prevent health care spending from crowding out spending on other important services. Because gridlock at the federal level will preclude significant new federal reforms, states should take the lead. Fortunately, states have significant incentives to implement health care reforms and numerous available tools with which to do so.

The reforms outlined in this report offer states many options to reduce health care costs while also improving the quality of care that their health systems provide. Many of these reforms—such as setting a health care cost growth goal or establishing a statewide scorecard—can be accomplished at little to no cost but are capable of making a big impact. Others, such as scaling evidence-based home visiting statewide, require upfront investments but then pay for themselves in future cost savings. Common among the options are the need to collect more data, improve transparency, ensure care coordination, and pay for the quality—not the quantity—of health care. We encourage states to adopt as many of these reforms as possible based on their priorities and tailor them to work best within their states.

States should seize these opportunities to make changes to their health care systems. Doing so will ensure progress toward lower costs, better care, and a more efficient overall health care system.

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