



Improving the Health Care System: Seven State Strategies

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Introduction

The U.S. health system faces challenges including inefficiencies, escalating costs and variations in health care quality, access and results. Wide agreement exists that the system needs transforming. A reformed system would deliver better care at lower costs without disparities from one health organization and community to another. It would reward value before volume, quality before quantity and organized delivery over disorganized care.¹ It would also focus on patient needs and safety as top priorities.

Costs. Health care costs have grown faster than the overall economy for decades and continue to rise at a rapid rate after a brief slowdown during the Great Recession. Health spending comprises the largest share of the federal budget—more than defense spending²—and is expected to account for 20 percent of the U.S. gross domestic product by 2024.³ Globally, U.S. health spending is in a league of its own, totaling \$3 trillion. Per-person health care costs are higher than in any other country, yet Americans are not notably healthier than people in other industrialized and post-industrial nations.⁴

Health expenditures accounted for roughly 32 percent of the average state's budget in 2012 (including federal funds, most notably for Medicaid). State governments are often the largest health care purchaser within their borders. With health costs ris-

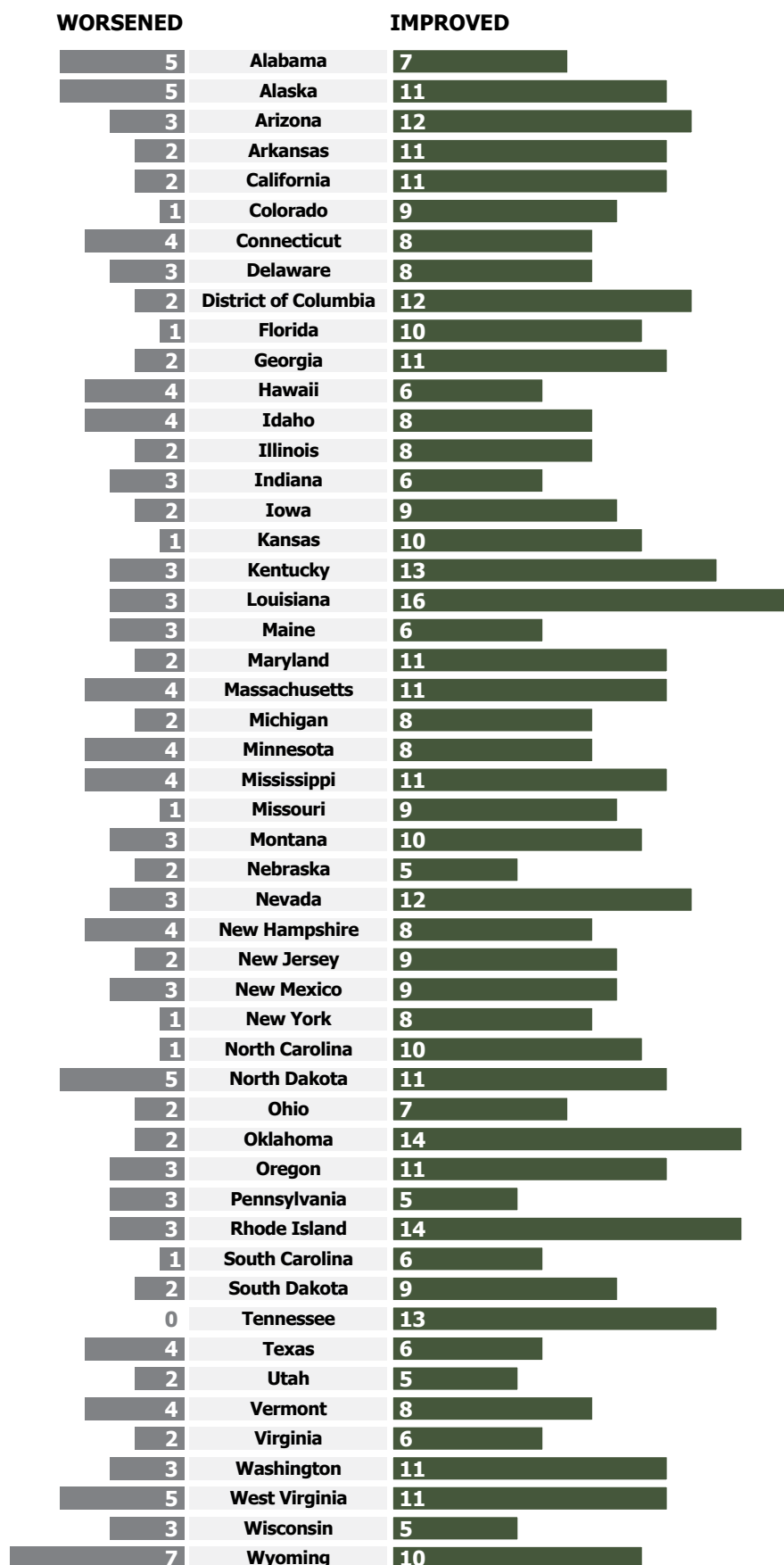
ing by two to three times the Consumer Price Index, it is difficult for states—many still dealing with budget challenges after the recession—to maintain the programs they have, let alone undertake strategies to cover additional uninsured populations.⁵

Inefficiencies. Inefficiencies in the health care system—in other words, waste—account for a big share of the cost problem. Experts suggest that addressing just a fraction of this problem, without cutting appropriate care, would go a long way toward controlling and containing costs and improving the overall health system. The American Medical Association lists six categories of waste:

- overtreatment,
- failure to coordinate care,
- failures in processes that execute care,
- administrative complexity,
- pricing failures (such as wide variations in charges for procedures and lack of transparency)
- fraud and abuse.⁶

In a 2012 report, the Institute of Medicine (IOM) calculated that about 30 percent of health care spending in 2009—or some \$750 billion a year—was wasted on “unnecessary services, excessive administrative costs, fraud and other problems.”⁷ Examples of unnecessary services or misuse include providing primary care services in emergency rooms, prescribing antibiotics for upper respiratory infections that do not respond to medications and performing cesarean-section births when not medically necessary. Variations in the rates of coronary bypass surgery, back surgery

Number of Indicators Improved or Worsened



SOURCE: THE COMMONWEALTH FUND, 2015¹⁰

State Scorecard

The Commonwealth Fund's Scorecard on State Health System Performance looks at 42 specific health indicators grouped under five broad health care areas:

- access and affordability
- prevention and treatment
- hospital use and costs
- healthy lives
- equity issues

and hip replacements often vary by geography rather than by medical indication.

The IOM report recommended, among other things, refashioning payment systems to emphasize the value and outcomes of care, rather than volume. Under the traditional fee-for-service (FFS) model, providers and hospitals set their own fees and charge for every office visit, admission, test, procedure and medication. Critics of fee-for-service reimbursement argue that it rewards providers for volume and profitability of services, rather than for quality and efficiency, thereby encouraging unnecessary treatment.

Other areas for improvement. Many other causes contribute to the high price of health care, including lack of transparency in pricing and defensive medicine, where physicians order tests and procedures not primarily to ensure the health of the patient, but as a safeguard against possible medical malpractice liability. Pressure from employers and insurers for transparent pricing is beginning to prod providers and hospitals to explain or eliminate hard-to-justify price variations—e.g., hip replacement procedures. The average cost of a hip replacement in Montgomery, Alabama was \$16,399, compared to the \$55,413 it cost in Ft. Collins-Loveland, Colorado, over a 36-month period ending in 2013.⁸ Defensive medicine also adds to the escalating cost of health care because doctors tend to order extra tests and procedures to avoid malpractice lawsuits.

Promising reforms. Incremental efforts over the years by state and federal policymakers, employers, health care providers and advocates have helped expand access, improve efficiencies and involve patients more fully in their own care decisions. Incremental efficiency efforts have focused on reducing errors, enforcing practice guide-

lines, applying information technology across the entire health system, attacking fraud and implementing malpractice reforms. Electronic health records and electronic prescriptions, although still limited, are improving outcomes and reducing costly medical errors. And, shifting the emphasis of providers and communities toward prevention and healthy lifestyles can help restrain the growth in spending while improving people's health. More recently, pioneering efforts have begun to attack bigger areas, such as reforming entire payment and delivery systems.

The Commonwealth Fund's 2015 Scorecard on State Health System Performance highlights improvements for numerous indicators between 2013 and 2014, such as increasing access to care; lowering the rate of patient deaths within 30 days of hospital discharge following heart attacks, heart failure and pneumonia; increasing childhood immunization rates; and decreasing smoking rates among adults. The scorecard lists Connecticut, Hawaii, Massachusetts, Minnesota, New Hampshire, Rhode Island and Vermont as making headway across most dimensions of care between 2013 and 2014. It also cites states that did well in individual efficiency categories. For example, Alaska, Colorado, Idaho, Montana and South Dakota scored high for reducing overall costs by avoiding unneeded hospital readmissions and other inefficien-

cies. But challenges remain. Several states showed declines in preventive care, and every state experienced higher average premiums in employer-sponsored health insurance plans.⁹

A health system that delivers quality care more affordably is possible. State legislatures play important roles in cutting wasteful spending while improving their own state's health systems. This issue brief highlights seven target areas and strategies that have demonstrated results in states that are implementing them. Policymakers may want to look at the following strategies when considering system improvements in their own states.

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1

Shift the Payment Model

FEE FOR SERVICE

The traditional fee-for-service system pays for individual services and volume, rather than emphasizing quality or results. Until recently, there has been little to discourage this expensive way of doing business or to motivate health care providers to collaborate with each other to figure out the best and most cost-effective course of treatment for patients. Providers face mounting pressure from private and government insurers, employer groups and others to contain rising costs. For 25 years, health organizations and insurers have been looking for and experimenting with ways to change the system to one that pays for the value of care rather than each service and procedure,¹ but it is a complex process that involves changing the way health care is delivered.

PAYMENT REFORM

The federal government has taken the lead in nudging the payment reform process along. Medicaid and Medicare, which are testing different payment systems, including hybrid models that sometimes include fee for service, are exerting pressure, negotiating rates at a fraction of private-plan levels. The U.S. Department of Health and Human Services (HHS) has set aggressive targets of shifting at least 30 percent of fee-for-service Medicare payments to alternative quality or value payment models by this year, and shifting 50 percent of such payments by 2018. Overall, the new approaches typically include financial incentives designed to encourage collaboration and care coordination among different providers, reduce spending on unnecessary services, and reward providers for delivering higher-quality patient care.²

States can leverage their market power as large purchasers of

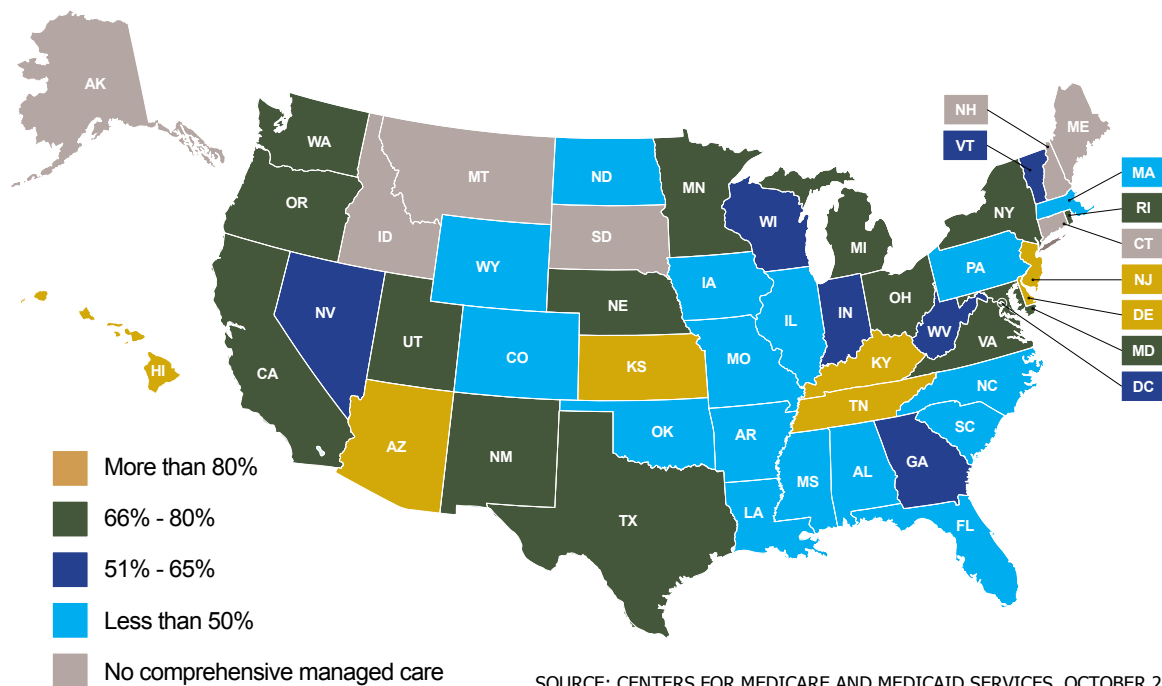
health care services to create new payment models that may simultaneously contain costs and improve care.³ Regardless of the payment model or delivery system, physicians and other providers are key stakeholders because creating a better system with good outcomes and fair reimbursement will be based on how medicine is practiced.

Performance-based reimbursements, tied to quality and efficiency metrics, offer incentives for good health outcomes and pay for coordination of a patient's care by a group of providers, such as physicians, nurses and social workers. In addition to managed care, which has been around for several decades, other payment reforms intended to improve quality and efficiency include bundled payments, global payments and accountable care organizations.

Managed care refers to health care systems that integrate financing and delivering health care services to covered individuals by arrangements with selected providers. Such systems include a comprehensive set of health care services, standards for selecting health care providers, formal programs for ongoing quality assurance and significant incentives for members to use providers and procedures associated with the plan.

Bundled payments, also known as **episodes of care**, provide a lump sum to a group of providers functioning as a team to divide among themselves for all services related to a patient's specific illness. Bundled payments are increasingly used for high-cost procedures, such as cardiac bypass surgery. Less incentive exists to over-treat, since only a certain amount of money is allocated to meet patients' needs, based on practice standards and other factors. Medicare is partnering with more than 500 hospitals

Percent of Medicaid Enrollees in Managed Care Plans, 2013



and related health care organizations to make bundled payments for all the care associated with four dozen conditions and procedures, such as strokes and joint replacements.⁴

Global payments, sometimes called **capitated payments**, are being tested as a way to pay a single health care organization for providing all needed care for a specific population, such as the employees of a large company, or people living in a certain geographic area. While early capitated payment models, such as some managed care plans, had drawbacks and may have reduced physician incentives to provide appropriate treatment, the new global payment model provides tools to make sure that the focus isn't just on saving money. Health care providers must meet certain quality criteria, such as offering timely preventive screenings and promptly following up on test results with patients. They receive bonuses if their patients stay healthy and avoid costly hospitalizations.⁵

Accountable Care Organizations (ACOs) offer a way of both delivering and paying for patient care. They have gained popularity under the Affordable Care Act and, while they are still evolving, one in 10 Americans receives care with a more holistic approach to wellness. Typically, ACOs are a partnership between a payer, such as a private or government insurer, and a network of doctors, hospitals and other providers that share responsibility for providing care to patients. ACOs create savings incentives by offering providers bonuses for efficiencies and quality care that results in keeping their patients healthy and out of the hospital, including focusing on prevention and managing patients with chronic diseases.⁶

COST-SHARING

Another strategy to make patients more attentive to costs and reduce unnecessary care, cost-sharing requires consumers to pay more for their health care through higher deductibles, co-

payments and paying more for prescription medicines. However, studies indicate this could backfire if not implemented carefully. While requiring patients to pay more for their health care may reduce spending on physician visits and medications in the near term, it can increase health spending in the long term, especially for patients with chronic conditions who avoid necessary care due to their out-of-pocket costs. A 2010 study of Medicare beneficiaries found that when their co-pays increased, their hospitalizations went up, not down, increasing spending.⁷ On the other hand, cost-sharing that encourages patients not to use emergency rooms inappropriately or that offers incentives, such as for buying generic drugs, can encourage patients to choose less-costly options.

Overall, new payment designs are driving innovation in how the United States pays for and delivers health care, improving the chances that smart investments in health will move the overall health system toward better outcomes, lower costs and more overall access to care.

POLICY OPTIONS TO CONSIDER

- Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.
- Examine the current payment and delivery system and identify opportunities for improving access, quality and efficiency. Some states have appointed commissions or task forces to make recommendations and guide implementation of new payment systems.
- Examine state oversight of accountable care organizations (ACOs) that accept risk. Some states require licensure for health maintenance organizations (HMOs), while others require a special license or certificate.



STATE EXAMPLES

A 2012 law adopted by the **Massachusetts** General Court, "Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation" (Chap. 225), launched the Centered Care initiative.

Under the initiative, five-year health plan contracts implemented payment reform and changed the health care delivery system for all state and many public employees. The state encourages plans, through incentives and penalties, to contract with providers on a global payment basis instead of the standard fee-for-service method. Primary care providers play a central role while health plans act as state agents to contract with doctors and hospitals who agree to be Centered Care providers. Annual budget targets over the five-year period (2013-2018) allow for 2 percent rate increases in the early years, followed by flat and then falling rates in the final years. The initiative achieved an overall 0.8 percent premium increase for all employee and Medicare plans for FY 2015, with no benefit cuts; the smallest increase in more than 10 years.⁸



In **New Jersey**, Horizon Healthcare Services set out to change how health care is delivered. A few years into its initiative, the company runs the largest commercial "episodes of care" program in the country, and reports positive results in quality, patient experience and cost reduction. The

current program includes more than 900 physicians and completed more than 12,000 care episodes, making it the largest commercial bundled payment program in the country. Data on outcomes across 200,000 Horizon Healthcare Services members found significant quality improvements from its collective value-based programs in 2014:

- 6 percent higher rate of improved diabetes control
 - 3 percent higher rate of cholesterol management
 - 3 percent higher rate of breast cancer screenings
 - 8 percent higher rate of colorectal cancer screenings
- Results also showed that physicians delivered more active care at a lower cost:
- 5 percent lower rate of emergency room visits
 - 8 percent lower rate of hospital admissions
 - 9 percent lower total cost of care.

In 2016, the program is expanding to cover additional episodes of care in gastroenterology, cardiology, orthopedics, gynecology and oncology.⁹



2

Dig Up the Data

A mountain of data exists in the health care field, but actual cost and outcome numbers remain elusive to payers, consumers and even providers. Without knowing actual costs and outcomes, the goals to cut waste and deliver more efficient, patient-centered care remain a shot in the dark. The \$3 trillion annual price tag for U.S. health care reflects the amount hospitals and other health providers charge, but not necessarily the actual cost of care.

Costs and charges. Currently, there is little science behind the charges printed on a hospital bill. A study in the *Harvard Business Review* found that most hospitals and other health organizations have little or no accurate information on their actual costs. Often, cost allocations are based on negotiated charges between a hospital and government and private insurers, plus a markup for profit.¹ Pricing and rate-setting can depend on many factors, from a hospital's bed capacity to its teaching status to whether or not it has a monopoly in its service area.²

Current pricing methods allow for extreme variations among providers and geographic areas for the same service or procedure. For typical knee and hip replacement surgeries, one national study found that charges can vary by as much as 313 percent among and even within states, depending on where the surgeries are performed. For comparable total knee replacement procedures, the study found that average prices (over a 36-month period ending in 2013) varied widely among states. For example, in Fresno, California, the cost averaged \$19,653; in Green Bay, Wisconsin, it was \$37,638; and in Casper, Wyoming, it

averaged \$52,541. Within several states and even cities, charges varied widely. For example, the lowest price in Dallas, Texas was \$16,772, compared with a maximum charge of \$61,584.³

Health care consumers often share financial responsibility for everything from routine sick care to some of the most frequently performed procedures in the U.S. For example, the average total price of a pregnancy and delivery is about \$6,500, a colonoscopy procedure averages \$2,500, and a knee arthroscopy procedure averages \$7,000. However, these prices are just averages. As a result, information on the predicted price for the treatment of an illness, injury or condition has become all the more important for health care consumers. Many employers recognize this and are working to deploy information on health care prices to their employees.

As health spending escalates, providers are coming under increasing pressure to lower costs and report outcomes. Some major hospitals have begun to review prices and to uncover actual costs of providing services in an effort to identify inefficiencies and improve care. For example, the University of Utah Health Care system is a leader in mining data for actual costs. It invested in a state-of-the-art cost accounting software system to track every penny for every pill, procedure and person in the four-hospital system, including each clinician's time. Simultaneously, the hospital is monitoring outcomes, including days in the hospital and readmissions.⁴ The project has generated numerous efficiencies, including eliminating unnecessary MRIs for back pain and reduc-

ing the number of unused expensive surgical instruments in the operating room.

By identifying actual costs, the University of Utah Health Care is delivering more efficient, patient-centered care, with an estimated 30 percent reduction in annual costs amounting to tens of millions of dollars—\$15.3 million in savings for pharmacy supply costs alone.⁵ In addition, the system reports that its volume of patients has risen substantially since the cost study was reported.⁶

Price transparency. In the past decade, health care price transparency or disclosure has emerged as a hot topic in state legislatures as a strategy for containing health costs. States, the federal government and the private sector have enacted requirements and initiated programs that aim to shed light on the costs of health care services and that enable the comparison of cost, quality and patient satisfaction.⁷

A growing number of hospitals have started reporting their charges for common procedures in an effort to satisfy those who want more transparency and want to compare prices. As of 2013, a database from the Centers for Medicare and Medicaid Services was made available to compare the charges for the 100 most common inpatient services and 30 common outpatient services across the nation. It includes the “list prices” on initial submitted bills, as well as the actual amounts paid by Medicare nationwide, covering 3,300 hospitals, with more than 170,000 price datapoints.⁸

The call for greater transparency in pricing is growing louder. State and federal governments, organizations and stakeholders can play an important role in nudging health organizations to publicly communicate exactly what they are giving patients, employers and insurers for their money. Harvard economists say they believe providers are beginning to get the message that without a change in their business model, they can only hope to be the last iceberg to melt.⁹

POLICY OPTIONS TO CONSIDER

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All-Payer Claims Databases*

At least 18 states have adopted legislation to establish databases that collect health insurance claims information from all health care payers (including both public and private payers*) into a statewide information repository. The databases are designed to inform cost-containment and quality-improvement efforts and to report cost, use and quality information. The data consist of “service-level” information, including charges and payments, the providers receiving payments, clinical diagnoses and procedure codes, and patient demographics. To mask the identity of patients and ensure privacy, states usually encrypt, aggregate and suppress patient identifiers.

Utah’s All Payer Claims Database, established and funded by the Legislature in 2007, receives continuous payer claim submissions, estimated at between 50 million and 65 million claims annually. Utah became the first in the country to analyze complete episodes of care, from the initial diagnosis through treatment and follow-up, from statewide health insurance claims. The database allows analysis of the “what, when, where, how much and who paid” for health procedures, with the goal of reducing or eliminating disparities in cost analysis and allowing for more accurate comparisons.¹³

* In March 2016, the U.S. Supreme Court (*Gobeille v. Liberty Mutual*) ruled that states may no longer require self-insured health plans, which are covered by the federal Employee Retirement Income Security Act (ERISA), to submit claims data to their all-payer claims databases. Nationally, more than half of workers with employer coverage are in self-insured plans, although percentages vary widely among states.

money. All-payer claims database (APCD) systems gather data from medical, pharmacy and dental claims to create a comprehensive collection of information on cost, utilization and quality of health care. State policymakers use these data to inform funding decisions. Explore the status of state databases at www.apcdouncil.org/state/map.



STATE EXAMPLES



Arizona law requires the state to implement a uniform patient reporting system for all hospitals, outpatient surgical centers and emergency departments, including average charge per patient and average charge per physician. The state also must publish a semiannual comparative report of patient charges, and simplified average charges per stay for the most common diagnoses and procedures.¹⁰



Nebraska enacted its own Health Care Transparency Act in 2014. It requires creation of a health care database to “provide objective analysis of health care costs and quality, promote transparency for health care consumers, and facilitate the reporting of health care and health quality data.” The law also provides for the use of “value-based, cost-effective purchasing of health care services by public and private purchasers and consumers.”¹¹



New Hampshire’s Comprehensive Health Care Information System was created by statute to make health care data “available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.” Its consumer site, www.nhhealthcost.org, provides information about the price of medical care by insurance plan and by procedure.¹²



Emergency room visits and preventable hospital readmissions plummeted for patients participating in a medical home environment, while patient satisfaction scores rose significantly.

3

Put the Patient First

A growing body of evidence shows that patient-focused health care yields maximum benefits. In its ideal form, it not only is “respectful of and responsive to individual patient preferences, needs, and values” as defined by the Institute of Medicine, but it is economically beneficial to clinicians, hospitals and others providing the care.¹ Specifically, compassion has an impact on high-quality, high-value patient-centered care.²

A patient-centered system involves practitioners working as a team to help patients gain access to critical information, understand treatment options and medications, and receive responsive, compassionate service. Several studies document higher rates of diagnostic tests, hospitalizations, prescriptions and referrals among doctors who do not communicate well with their patients. This phenomenon has been explicitly studied in a randomized study of more than 500 patients. The study found that patient-centered care was correlated with fewer hospitalizations, fewer diagnostic tests and specialty referrals, and lower overall medical costs.³

Patients who report specific good experiences have more trust and are less likely to switch providers or health plans, allowing for more continuity in care. Patient-centered care reforms also have demonstrable technical benefits. For example, studies have shown that patients treated for a heart attack in hospitals with better patient-centered care have fewer symptoms and are more likely to survive a year later. And patients treated in hospitals that perform well on patient surveys are less likely to require readmission in the month after they go home.⁴

Many states are keeping an eye on the concept of patient-centered care as evidence shows that it can help improve quality of care and reduce costs. Patient-centered care could replace today’s fragmented system, in which every local provider independently offers a full range of services, with a system in which services

for particular medical conditions are concentrated, coordinated and strategically located to deliver high-value care. However, one study warns that the popularity of this type of care and the rush to become more patient-centered has resulted in a misplaced focus on the aggregated preferences of different patient populations rather than on individual needs.⁵

MEDICAL HOMES

Within the patient-centered philosophy of care is the so-called “medical home” model of transforming the delivery and organization of primary care. The name does not mean that care occurs in a “home,” but rather in a community setting, preferably outside of a hospital. The model involves a primary care provider who delivers and coordinates comprehensive health care for the patient across the continuum of providers and services. It involves a team of physicians, nurses, nutritionists, pharmacists, social workers and others working together to meet a patient’s health care needs using an evidence-based, person-focused treatment model.

Studies show that the medical home model’s attention to the whole person and integrating all aspects of health care offer the potential to improve health, management of chronic conditions and access to community-based social services.⁶ For example, the majority of report cards collected by the Patient-Centered Primary Care Collaborative in early 2015 found that emergency room visits and preventable hospital readmissions plummeted for patients participating in a medical home environment, while patient satisfaction scores rose significantly.

Transitioning to a medical home model takes time and increases primary care costs, but overall health system savings can be enormous by reducing or eliminating more expensive care, such as emergency room visits, hospitalizations and non-primary medi-



cal care.⁷ Forty-six states and the District of Columbia have adopted policies and programs to advance medical homes in their Medicaid and/or CHIP programs.⁸

Michigan is among the states where medical homes have been shown to improve care and cut overall health costs when serving patients with chronic conditions. Missouri has included community mental health centers in its testing of medical homes.⁹ Arkansas, North Carolina, Ohio and Oklahoma are among other states working to advance medical homes.¹⁰

POLICY OPTIONS TO CONSIDER

- Consider policies that include medical homes for Medicaid or Children's Health Insurance Program beneficiaries.
- Explore investments in health infrastructure that support the patient's responsibility in his or her own care, and the efforts of patients, families and their clinicians to work together in a coordinated way.
- Examine the ability of Health Information Technology to enhance patient-centered care; applications that are important tools for strengthening patient- and family-centered care include systems for coordinated care, patient registries, performance reporting, referral tracking and electronic prescribing.

STATE EXAMPLES

The **Arkansas** Health Care Independence Act, adopted in 2013, requires Qualified Health Plans offered on the health exchange to participate in the Arkansas Payment Improvement Initiative, a collaborative effort between the state's Medicaid program and private insurance plans to reform the state's payment system. The state also obtained a federal "State Innovation Model (SIM)" grant that supports patient-centered medical homes (PCMHs). Patients are assigned to a primary care clinician and providers have access to clinical performance data that help assess whether patients receive appropriate care, such as asthma medications, immunizations or cancer screenings. In 2014, the Arkansas General Assembly approved a Medicaid expansion through a "private option" that allows the state to use federal funding to buy plans for low-income people from the state's Insurance Marketplace. By January 2015, about 80 percent of the state's Medicaid beneficiaries were covered by a patient-centered medical home.



Oregon established a primary care infrastructure that includes 450 patient-centered medical home practices and clinics serving 600,000 Medicaid patients. Through its Coordinated Care Organizations (CCOs), the program has increased the use of outpatient care to promote prevention; increased well-care visits for adolescents to reduce unnecessary emergency room (ER) visits; and provided follow-up care to patients within a week of being discharged. Between 2011 and 2013, the results include:

- 17 percent reduction in emergency ER visits,
- 18 percent to 32 percent fewer ER visits for chronic disease patients with congestive heart failure, chronic obstructive pulmonary disease (COPD) and asthma,
- 19 percent reduction in ER visit spending,
- 58 percent increase in children screened for mental/behavioral health risk.



SOURCE: OREGON HEALTH AUTHORITY

4

Focus on the Sickest Patients

The sickest and frailest people generally require the most intense and expensive care. This subset of the health care population comprises people with multiple chronic conditions, which may include mental illness; people with significant disabilities; and older, frail people with chronic and complex conditions ranging from diabetes to heart disease. These patients need immediate and longer-term care from a specialized assortment of health care providers.¹

The top 5 percent of patients, ranked by their health care expenses, accounted for half of the nation's health care expenditures in 2012.² Due to the complexity of their illnesses or conditions, their care was the costliest. For example, heart disease treatment for patients in this 5 percent group cost \$74.1 billion and accounted for 73.4 percent of the overall spending on heart disease.³

Although the average cost of care per patient with four or more medical conditions added up to \$78,198 in 2012, the cost did not always result in patients receiving the best care. Indeed, in 2015, Institute of Medicine President Victor Dzau described much of the care for high-needs patients as “fragmented, uncoordinated, and ineffective.”⁴

A recent survey by The Commonwealth Fund found that 24 percent of U.S. primary care doctors say their practices are not well prepared to manage care for patients with multiple chronic illnesses, and 84 percent are not well prepared for patients with severe mental illnesses, who, along with patients with chronic illnesses, are among the sickest patients.⁵

Major efforts are underway by states—working through Medicaid and Medicare and encouraged by federal matching funds under the Affordable Care Act—to coordinate services and better meet such patients' needs in noninstitutional settings. Many chronically ill people are eligible for both Medicare and Medicaid, also known as “dual eligible” patients. The programs emphasize

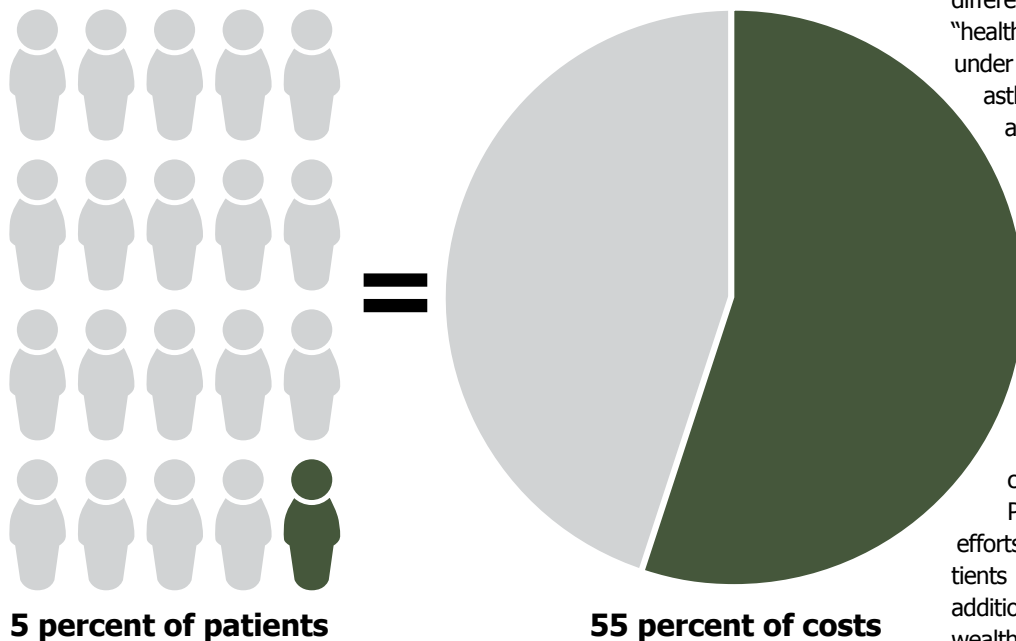
Testing a New Care Model

A pilot effort by Medicare called **Independence at Home** is designed to test whether delivering primary care to the sickest patients in their homes for five years could bring about better-quality care and a higher quality of life while lowering costs.⁸ The test program involves doctors and nurses from 17 medical practices in more than a dozen states, including Michigan, Ohio and Texas. The practitioners spend time in each patient's home asking basic questions about overall health and medications and performing basic primary care tasks tailored to a patient's needs, including adjusting medications as needed and recording blood pressure.

The Centers for Medicare and Medicaid Services is tracking each beneficiary's experience through quality measures in an effort to determine if home visits result in better and less-expensive care than that provided in hospitals or nursing homes. In the program's first year, which ended in June 2013, health care professionals treated 8,400 patients in their homes and saved Medicare \$25 million—or \$3,070 per patient.⁹ The American Academy of Home Care Medicine, which advocated for the demonstration, estimates that 1.5 million Americans would be eligible for the program if it were expanded nationwide, and would result in savings of \$4.5 billion a year, or \$45 billion over 10 years.

coordinated care in a patient's home or in the community, which could bring substantial savings by lowering the rate of emergency room use, reducing hospital admissions and readmissions, reducing health care costs and decreasing reliance on long-term care facilities.

Super-Utilizers



SOURCE: KAISER COMMISSION ON MEDICAID AND THE UNINSURED, 2012

HEALTH HOMES

Another effort by Medicaid establishes "health homes" to coordinate both medical and behavioral health care for people who have specific chronic physical and mental conditions. This is different from medical homes in that the name "health home" refers to a service delivery option under Medicaid for patients with mental illness, asthma, diabetes, heart disease, substance abuse issues, or who are overweight. Services include all primary, acute, behavioral health and long-term services and supports.

With health homes, all of a person's caregivers communicate with one another and share health records so that all of a patient's needs are addressed in a comprehensive way. The hope is that by facilitating access to and coordinating services, patient care and outcomes will improve.

Preventive medicine is an important part of efforts to stabilize and meet the needs of patients with complex conditions and to prevent additional costly complications. The Commonwealth Fund and other major research organizations are supportive of home- and community-based care, if properly managed, as opposed to institutional settings, which they say "frequently fail to meet the needs of patients and caregivers and may be both risky and expensive."⁶

POLICY OPTIONS TO CONSIDER

- Explore the relative cost benefit of high-quality home- and community-based services. Access to home-based care can encompass a wide array of funding, workforce, informational or other strategies designed to meet local and state needs.
- Track progress toward achieving quality, funding and other state-defined goals. To ensure that home- and community-based services are accessible, affordable and high-quality, state policymakers can require the lead state agency to submit performance and quality data that demonstrate progress toward benchmarks and goals.
- Establish Medicaid subcommittees, task forces or work groups with diverse representation to address program design and implementation. Cost-saving programs include those that address the needs of "super-utilizers." It is important to consider the relative cost and benefit of building and maintaining the data systems that track the expenses of these patients.

STATE EXAMPLE

New Jersey's "hot-spotting" initiative, under the Camden Coalition of Healthcare Providers, tracks "super-utilizers" (a term used for people who overuse emergency rooms and hospital inpatient services). The coalition identifies "hot spots" in the community that have a high concentration of high-needs health patients in order to improve their care and reduce costs. AmeriCorps volunteers help connect super-utilizers to outpatient resources and accompany patients to appointments, coordinate medications, determine benefit eligibility and offer emotional support. The coalition's founder, Dr. Jeffrey Brenner, reported a 50 percent drop in avoidable hospitalizations among patients the Camden Coalition has helped. Several other organizations also have been mapping hot spots. These include the Metro Community Provider Network in Aurora, Colorado; Health Care Access Now in Cincinnati, Ohio; and the Multicultural Independent Physicians Association in San Diego.⁷



5

Treat the Whole Person

A national survey indicated that about 17 percent of American adults had co-occurring medical and mental health conditions within a 12-month period. Costs for Medicaid enrollees who have combined behavioral health and chronic conditions are 60 percent to 75 percent higher than for those with chronic conditions without mental illness. For those who also have a substance use disorder, costs average nearly three times higher.¹

Fragmentation

Historically, the health care system has cared for a person's physical needs separately from his or her behavioral health needs, and charged for patient care under different payment structures. But with so many physically ill people suffering from dual diagnoses, efforts are underway by states and the federal government to integrate care.

For the most part, our physical and behavioral health care systems continue to operate independently, without coordination between them. As a result, patients may experience gaps in care, inappropriate care and increased costs. People with dual diagnoses may also have difficulty adhering to treatment instructions, such as taking medications properly, without additional support.

Care integration

A large body of evidence shows that integrating care of a person's physical illness with his or her behavioral health needs saves states money while improving patient outcomes. Integration has long been recommended, but has been difficult to achieve be-

cause restrictive payment methods and practice patterns have impeded collaboration.

Primary care settings have become the gateway to the behavioral health system, but primary care providers need support and resources to screen and treat people with behavioral and general health care needs.² By some estimates, 60 percent to 70 percent of patients with behavioral health conditions who seek

care in emergency rooms or primary care clinics leave these settings without receiving treatment for their mental health or substance abuse needs. This lack of treatment increases the odds that they will have difficulty recovering from their other medical conditions.³

Even without a direct source of reimbursement, several health systems, hospitals and community health centers are working to integrate behavioral health services into primary and specialty care practices, emergency departments and hospital units in an attempt to improve outcomes and reduce costs.⁴ States, the federal government and providers have all made significant investments to build and expand evidence-based integration models, such as the collaborative care

model, to reduce fragmentation and improve care.⁵

Some states are integrating physical and mental health care under Medicaid's primary care-based health home model (see previous section). Using an evidence-based collaborative care approach, primary care providers, care managers and psychiatric consultants work together to provide care and monitor patients' progress. These programs have been shown to be both clinically

Behavioral health
care is the name
used to describe the
combination of mental
health services and
services that treat
substance abuse.



Telehealth

Telehealth is a tool that capitalizes on technology to provide health services remotely, such as through video consultation with a specialist or transmitting data from at-home blood pressure monitoring. Emerging evidence demonstrates that telehealth services and provider teleconsultation may be viable alternatives that can deliver equal or better care when compared to traditional in-person care for people with behavioral health needs. While telehealth is often framed as a tool to improve access in rural settings, patients in urban settings may also benefit. It can increase patient choice and expand the scope of services individuals can receive at their usual care site—including primary care clinics, mental health centers and correctional facilities. These programs may also build primary care systems' capacity to treat mild-to-moderate behavioral health conditions.

Mississippi and New Mexico are among the states using telehealth programs to build provider capacity and increase access for both behavioral and physical health services. Early evidence indicates that these programs result in equal or better care when compared to traditional in-person services and may result in cost savings.¹³

effective and cost-effective for a variety of mental health conditions, such as anxiety and depression. This has been done in a variety of settings using several different payment mechanisms.⁶ Community mental health centers are among the providers designated as health homes for Medicaid beneficiaries with serious mental illnesses.

Many state legislatures and health providers recognize the need to continue to reform their health care delivery systems to include strategies that integrate primary and behavioral health care—creating incentives that promote behavioral health prevention and effective treatment. New payment models that reward providers for simultaneously improving health outcomes and reducing health care spending may provide an impetus for integrating behavioral health and primary care services.

Providing integrated health care is a growing concern, gaining attention among both state and federal policymakers. Governments and other stakeholders can work in tandem to build the capacity, data-sharing system and other tools to help the growing number of people with complex health care needs. The best strategy or combination of strategies will depend on a state's political and health care environment.⁷

POLICY OPTIONS TO CONSIDER

- Explore policy options for integrated care models that address physical, behavioral and oral health in primary care settings. Examine existing reimbursement policies to identify barriers or options. States may want to examine existing

mental health coverage laws to assess whether they create barriers to coverage or access.

- Ensure that state investments in mental health and substance abuse support evidence-based practices. Resources such as the Substance Abuse and Mental Health Services Administration (SAMHSA)'s "The Guide to Evidence-Based Practices" identify best practices for treating and preventing mental health disorders.⁸
- Consider legislation to address prescription drug abuse, overdose and misuse. State policies include: deterring people from obtaining multiple prescriptions inappropriately; immunity for people seeking medical assistance; controlling sale of over-the-counter ingredients and medications; requirements for physical examination before prescribing controlled substances; and prescription drug monitoring programs that report all filled prescriptions for controlled substances.
- Examine existing reimbursement and licensure policies for telehealth services. Several states have adopted reimbursement and/or portable licensure policies to remove practice barriers for health care practitioners who provide telehealth services.
- Examine opportunities to use telehealth to reduce costs and improve care for inmates. To address the rising costs and public safety risks associated with transporting and guarding inmates who travel for primary and specialty care, at least 31 states used telehealth in 2011 for some portion of correctional health care.⁹

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Iowa's legislature required the Department of Public Health to collaborate with Iowa Medicaid and child health specialty clinics. They are charged with integrating the activities of the "1st Five" initiative, which supports health providers in efforts to detect social-emotional and developmental delays in children from birth to age 5, and coordinates referrals, interventions and follow-up. The law calls for "the establishment of patient-centered medical homes, community utilities, accountable care organizations, and other integrated care models developed to improve health quality and population health while reducing health care costs." (Chapter 137 of 2015)



In **Minnesota**, a demonstration project in Minneapolis and Hennepin County reported promising results in 2013 after forming a Social Accountable Care Organization. The plan brought together more than 120 local nonprofit organizations that partnered with social services to care for consumers with high needs. Among the project's more than 6,000 patients, 45 percent had chemical dependencies, 42 percent had mental health needs, 32 percent had unstable housing and 30 percent reported at least two chronic diseases. The capitated Medicaid demonstration project, built on the concepts of a primary care medical home, also addressed social needs. Mental health specialists worked directly in the health clinic with primary care providers and care coordinators. In its first year, the project reported increased primary care visits, reduced medication costs and a 20 percent reduction in emergency department visits.¹⁰

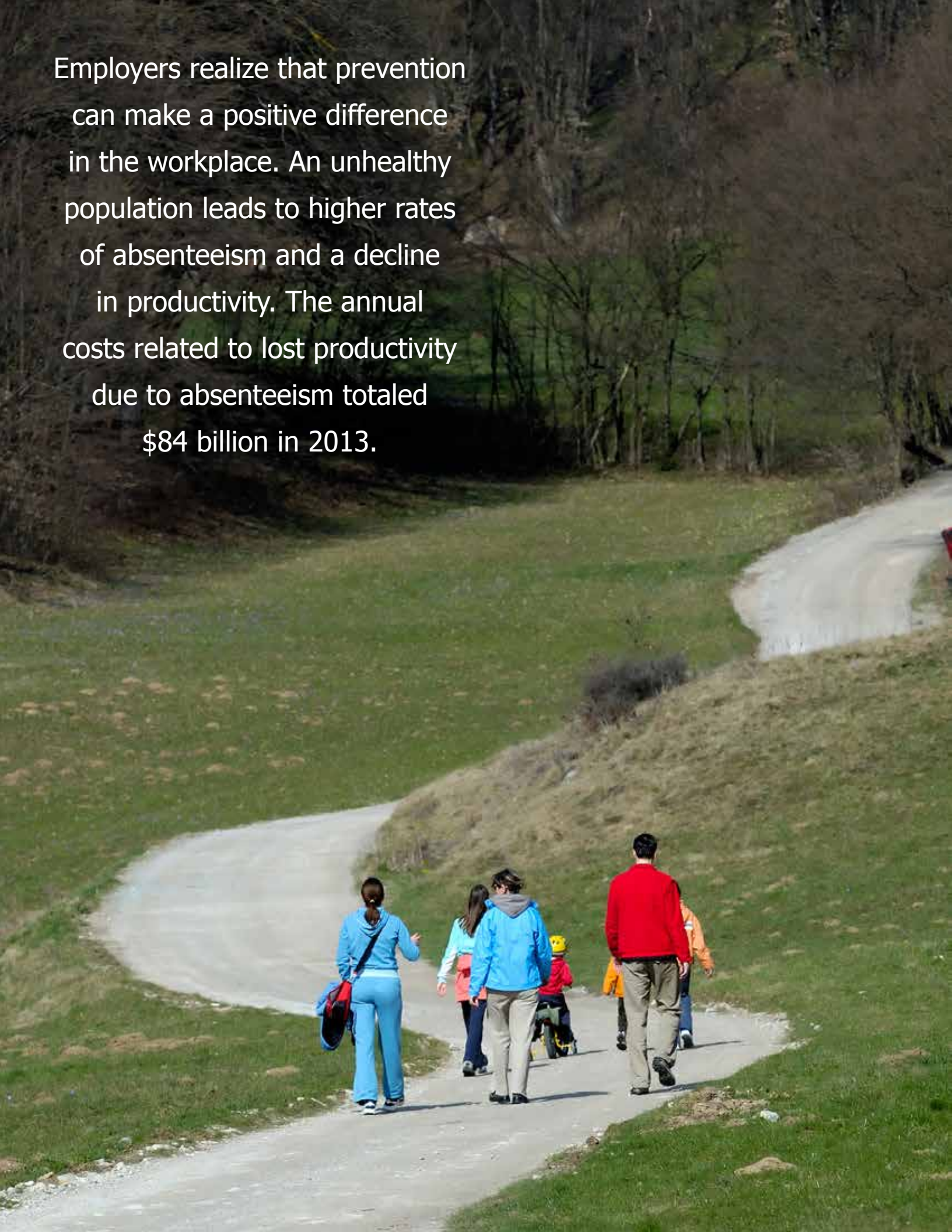


Missouri pioneered a program for Medicaid beneficiaries with severe mental illness, based in community mental health centers (CMHCs). The CMHC Healthcare Homes program provides care coordination and disease management to address the "whole person," including both mental illness and chronic medical conditions. In creating the program, administrators noted that behavioral health issues drive a dramatic portion of Medicaid spending. Both patients and the state benefit when the system links individuals with severe mental illness to case management that ensures access to community supports, transportation and primary care.¹¹



In Deschutes County, **Oregon**, which obtained federal approval to add primary care to its mental health facilities, hospitalizations for people with serious mental illness declined by 41 percent, emergency room visits dropped by 20 percent, and more people showed up for primary care appointments (an 83 percent increase).¹²

Employers realize that prevention can make a positive difference in the workplace. An unhealthy population leads to higher rates of absenteeism and a decline in productivity. The annual costs related to lost productivity due to absenteeism totaled \$84 billion in 2013.



6

Invest in Prevention

Seventy percent of the top 10 causes of deaths in the United States are linked to preventable conditions. Heart disease, stroke, some forms of cancer, diabetes, obesity and arthritis are among the most common, costly and preventable of all health problems. Physical inactivity or lack of exercise, poor nutrition, tobacco use and excessive alcohol consumption cause much of the illness, suffering and early death related to these chronic diseases and conditions.¹

Americans spend twice as much on health care as citizens of other developed countries, yet have shorter life expectancies and higher rates of infant mortality and diabetes.² As a nation, a major focus has been on treating disease rather than preventing it before costly medical care is needed. Prevention accounts for only between 5 percent and 9 percent of the \$3 trillion in national health expenditures. Most of the balance goes to treat disease and injuries after they occur.³

Reducing or preventing tobacco use, eating a nutritious diet, and increasing physical activity are known to protect against and reduce the incidence of chronic disease. Early intervention also pays dividends. For example, with an illness such as heart disease, if caught early, it can mean the difference between short-term treatment and prolonged health problems.⁴ Early detection and intervention can also mean reduced spending on complex, advanced diseases, such as diabetes.

Military leaders have called attention to the nation's difficulty with recruiting young people fit enough to serve. Data indicate that 20 percent of all male recruits and 40 percent of female recruits are too overweight to enter into the military ranks.⁵ Employers also realize that prevention can make a positive difference in the workplace. An unhealthy population leads to higher rates of absenteeism and a decline in productivity. The annual costs related to lost productivity due to absenteeism totaled \$84 billion in 2013, accord-

ing to the Gallup-Healthways Well-Being Index.⁶

Investing in cost-saving interventions can both improve health and save money. According to the Association of State and Territorial Health Officials, the following public health initiative examples help reduce total health care expenditures:

- Childhood immunizations,
- Vision screening for seniors,
- Tobacco use screening, advice and assistance, smoking cessation programs for women, and comprehensive tobacco prevention programs,
- Lead abatement in public housing,
- Screening and follow-up counseling for problem drinking,
- Fluoridated community water systems,
- Family planning,
- The Women, Infants and Children (WIC) program.

Policymakers can play important roles to encourage use of evidence-based information to develop effective programs and to implement a health agenda for their state. The Guide to Community Preventive Services provides evidence-based recommendations for promoting health, including proven strategies that reduce birth defects, improve mental health and prevent cardiovascular disease. Policymakers also can use County Health Rankings from the Robert Wood Johnson Foundation and the University of Wisconsin. These rankings offer a snapshot of community health, comparing people's health in their districts to the population's health in other counties in their state and national benchmarks. Data can help target limited resources for more cost-efficient interventions, such as cancer screenings or teen pregnancy prevention in areas of high incidence.

All 50 states and the District of Columbia receive federal grant money to help prevent chronic diseases as well as funding for to-

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A number of states have implemented incentives in their Medicaid programs to encourage healthy behaviors, with mixed results.

The “Healthy **Indiana** Plan” rewards enrollees for completing recommended preventive services with financial incentives that assist with their cost-sharing requirements. Between 2010 and 2012, from 56 percent to 60 percent of program participants received preventive services.⁸



Florida’s Medicaid managed care plans provided credits for enrollees who participated in 19 designated healthy behaviors, such as getting a flu shot, attending a smoking cessation class or adhering to prescribed drug regimens. The majority of earned credits, which could be used to purchase health-related products, were earned for childhood preventive care (45 percent), while the fewest were earned for participating in weight loss or tobacco cessation programs (less than 1 percent).⁹



More than 75,000 Medicaid-enrolled smokers participated in a **Massachusetts** smoking cessation program between 2007 and 2009, which included counseling and cessation medications. The program contributed to a 10 percent reduction in the smoking rate among Medicaid enrollees and a reduction of more than 45 percent in hospitalizations for heart attacks and other coronary heart disease. Every \$1 in program costs was associated with \$3.12 in medical savings.¹⁰

bacco prevention and cessation efforts. Kansas, Mississippi and North Dakota are among 21 states that receive federal dollars for oral disease prevention programs. State anti-smoking campaigns have contributed to reduced smoking rates. As of 2015, the rate of smoking among adults has declined to 15 percent, compared with 42 percent in 1965.⁷

Prevention efforts are not without critics, some of whom are concerned that prevention will increase health care spending without positive results. A 2010 study in the journal *Health Affairs* calculated that if 90 percent of the U.S. population used proven preventive services, it would save only 0.2 percent of overall health care spending. For example, when screening programs detect cancer, follow-up treatments are expensive. Some also view certain prevention initiatives as government meddling in private affairs. For example, efforts to regulate food and beverage portions have met with resistance. Penalties that target overweight or obese students or employees could result in stigmatization or unjust discrimination.

Policymakers face challenges while weighing the costs and benefits of prevention programs, but can reap substantial rewards with a healthier population. Policies that encourage or enable healthy activities, such as providing safe places to exercise and walk within neighborhoods, tend to be more widely supported. Moving forward, promoting a culture of health can help prevent or delay some of the chronic conditions that lead to high health costs and early death. As

the nation strives for a top-performing health system, many health experts and prevention advocates recommend that Americans embrace Benjamin Franklin’s axiom, “An ounce of prevention is worth a pound of cure.”

POLICY OPTIONS TO CONSIDER

- Assess the cost-effectiveness of health and wellness programs at schools, workplaces, and health care and community-based settings.
- Consider current policies and investments that prevent tobacco use among youth and adults, protect people through smoke-free policies and provide access to smoking cessation for smokers.
- Consider the value of efforts to educate the public about their health and prevention of chronic illness.
- Explore policies that support healthy choices and healthy environments. These include programs that increase access to fresh produce in schools, businesses and communities. Others can create and maintain safe neighborhoods for physical activity by improving access and conditions in parks and playgrounds; promoting dedicated lanes for bicycles and public transit; and promoting walk-to-school and work initiatives.



Promote Safety and Prevent Medical Harm

Tens of thousands of people each year die needlessly in hospitals due to medical errors, infections acquired in a health setting, avoidable delays in treatment and other preventable incidents.

Medical errors are the third leading cause of death, after heart disease and cancer, killing more than 250,000 people in the U.S. annually, according to Johns Hopkins patient safety experts.¹ In addition to the loss of human life, one study put the economic impact of preventable medical errors at up to \$1 trillion a year in "lost human potential and contributions."² Another study concluded that the annual national cost of treating conditions caused by measurable medical errors was \$17.1 billion in 2008.³ Thousands more patients are harmed due to complications stemming from medical errors.⁴

About 75,000 deaths were related to infections acquired in U.S. acute-care hospitals in 2011. On any given day, about 1 in 25 patients becomes infected while hospitalized—roughly 722,000 such incidents in 2011. National headlines about infections spread by improperly cleaned medical equipment raise public awareness about infections associated with health care. For example, in a Virginia Mason Medical Center case, 32 patients were infected and 11 people died in 2014 after endoscopes remained contaminated even after cleaning.

Other headlines have brought good news. The National and State Healthcare-Associated Infections Progress Report reveals that overall infections associated with health-care have dropped significantly since 2008. For example:⁵

- Central-line bloodstream infections decreased 50 percent and selected "surgical site infections" declined by 17 percent between 2008 and 2014.
- Between 2011 and 2014, hospital MRSA infections (Methicillin-resistant *Staphylococcus aureus*) decreased by 13 percent.

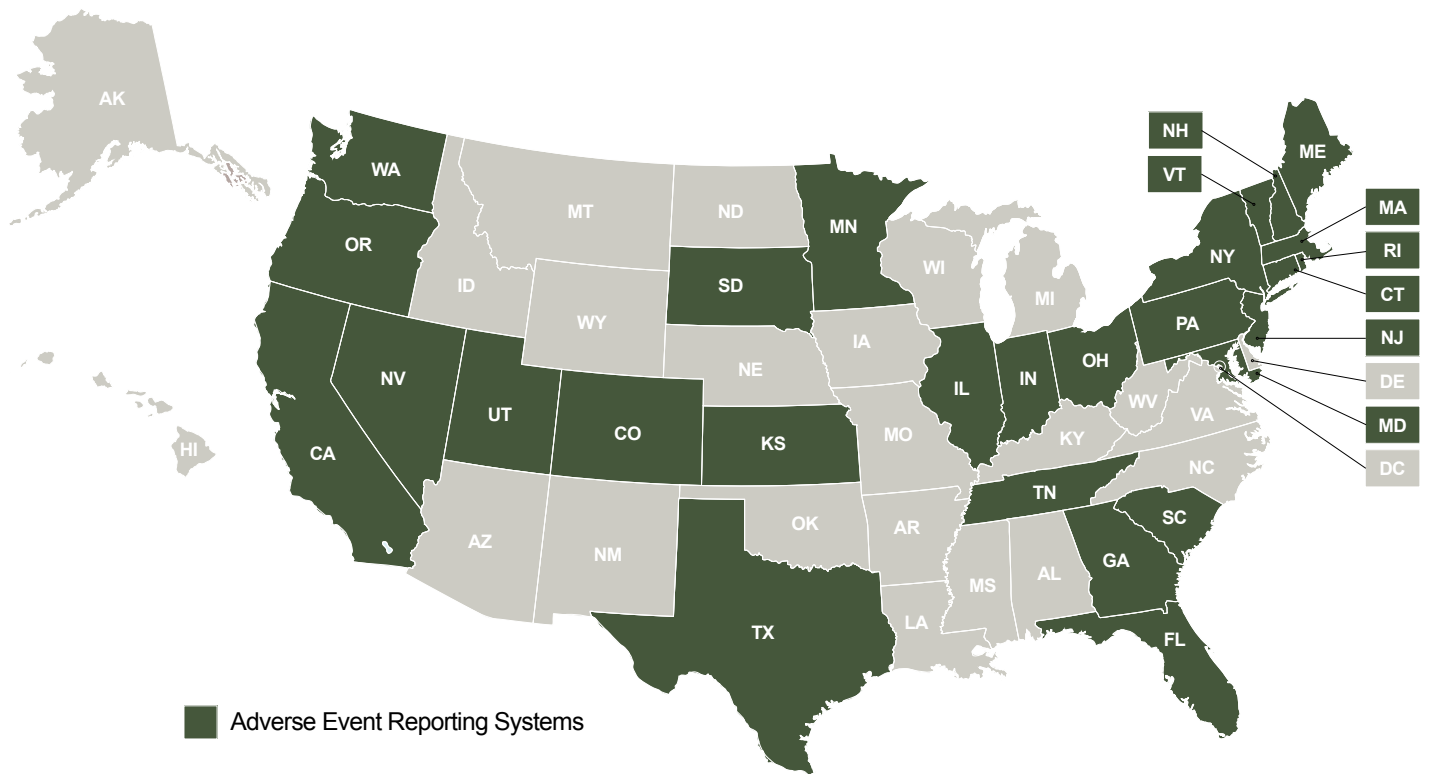
Many hospitals are making headway in addressing errors, accidents, injuries and infections that kill or hurt patients. But challenges remain and overall progress in improving patient safety is slow, according to a 2013 Hospital Safety Score, which grades more than 2,500 general hospitals.⁶ For example, the rate of catheter-associated urinary tract infections did not improve between 2009 and 2014.

The National Institutes of Health acknowledges that while isolated examples of improvement in patient safety show impressive results, when measured against the magnitude of the problems, the overall impact has been underwhelming.⁷ Medical errors that cause harm or death persist across the country. At a 2014 meeting of the U.S. Senate Subcommittee on Primary Health and Aging, experts testified that overall, patients are no safer today than they were 15 years ago, when the Institute of Medicine drew attention to the problem, and that improvements have been "limited, sporadic and inconsistent."⁸

Federal policy now requires state Medicaid programs to implement nonpayment policies for provider-preventable conditions, including health-care-acquired conditions. The Affordable Care Act created the Partnership for Patients, under which 80 percent of hospitals participate in a quality improvement collaborative. Medicare no longer pays the extra costs of treating patients who develop eight serious, preventable conditions after they've been hospitalized.

As far back as 1999, the Institute of Medicine called for a national system of mandatory reporting of adverse events that result in death or serious harm, but health care providers balked and the recommendation has yet to be realized.⁹ Many states, however, have taken action. The District of Columbia and 27 states have established reporting systems, with all but one—Oregon's—mandated by state policy. Twenty-two of those states disclose the information to the public. Nine states report increased levels of provider and facility transparency and awareness of patient safety

Adverse Event Reporting Systems, 2015

NATIONAL ACADEMY FOR STATE HEALTH POLICY, 2015¹⁶

as a result of their reporting systems.¹⁰

The National Quality Forum, which was established in 1999 after a recommendation by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, has outlined 29 serious events as a guide for reporting. The list includes operating on the wrong patient, leaving a foreign object inside a patient after surgery, and administering medications or oxygen that have been contaminated. The list is intended to facilitate public accountability and drive improvement, not merely to record the events or punish the health care organizations.¹¹

Medical liability

Medical malpractice reform remains a prominent state legislative issue in patient safety discussions. State laws include strategies to limit medical malpractice costs, deter medical errors and ensure that patients who are injured by medical negligence are fairly compensated. Tort reform has the potential to reduce health care expenditures by reducing the number of malpractice claims, the average size of malpractice awards and tort liability system administrative costs. It also may lead to fewer instances of defensive medicine, where physicians order tests and procedures not primarily to ensure the health of the patient, but as a safeguard against possible medical malpractice liability.

Reform proponents argue that tort reforms not only reduce overall medical care spending, but also increase access to care. Opponents dispute these claims, arguing that a crackdown on malpractice, not a campaign to roll back the rights of patients who are injured, is needed instead.

Various patient advocacy groups are trying to help move the needle in the direction of patient safety. Late last year, the National Patient Safety Foundation, a panel of health care experts, called for the creation of a total systems approach and a culture of safety to combat the serious issue of patient safety.¹²

POLICY OPTIONS TO CONSIDER

- Consider policies that ensure mandatory reporting of adverse events that result in death or serious harm.
- Explore policies related to medical malpractice reform to limit costs, deter medical errors and ensure that patients who are injured by medical negligence are fairly compensated.
- Explore the potential for tort reform as a way to reduce health care expenditures by reducing the number of malpractice claims, the average size of malpractice awards and tort liability system administrative costs.

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As of 2011, **Alabama** law requires health care facilities to collect data on inpatient health-care-associated infections (HAIs) and report monthly to state and national agencies. HAI data must be reported from central line-associated bloodstream infections, surgical site infections and catheter-associated urinary tract infections.¹³



The **New York** Legislature enacted Public Health Law 2819 in 2005 to require hospitals to report select hospital-acquired infections to state and national agencies. Their annual reports provide extensive details by treatment, including colon surgical site infections, hip replacement surgical site infections, coronary artery bypass graft surgical site infections, central line-associated bloodstream infections in intensive care units and umbilical catheter-associated infections. The report also contains information on infection control resources in hospitals and describes HAI prevention projects supported by the department of health. The law was adopted by the National Conference of Insurance Legislators (NCOIL) as a national example of hospital infection reporting laws.¹⁴



In 2015, **Texas** (Chapter 183) authorized expanded oversight by the Department of State Health Services of hospitals that commit preventable adverse event violations. If a hospital has committed a violation that results in a reportable potentially preventable adverse event, the state requires the hospital to develop and implement a plan to address the deficiencies.¹⁵

Conclusion

States continue to innovate to improve their health systems, motivated by rising costs, inefficiencies and consumer demands for better care. States can achieve more effective and efficient health systems by partnering with the federal government, businesses, insurance plans, providers and consumers.

A common theme for many states remains flexibility—to go beyond a minimum standard or to make changes voluntarily at their

own pace. The goals for innovations often begin with lofty multiple aims: improving quality, expanding access and saving money.

Health systems will continue to see innovations for years to come, with states helping lead the way and learning from each other.

“If we want to solve the cost problem, we have to do it by improving performance, by getting more value for every dollar we invest.” -- David Blumenthal, M.D., president, The Commonwealth Fund

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