



# Ten Strategies for Improving Health Care

Report from NCSL's Task Force on Innovations in State Health Systems

NATIONAL CONFERENCE *of* STATE LEGISLATURES | MAY 2018



NCSL’s Task Force on Innovations in State Health Systems explores the issues and opportunities faced by state policymakers as they reform their state health systems. The task force, which consists of legislators and legislative staff from across the country selected by NCSL leadership, meets two to three times per year to discuss state policy innovations. This report highlights various innovations and strategies discussed by task force members during meetings in 2017. They are not meant to provide recommendations, but rather examples of state actions.

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*Task Force membership/sponsorship does not necessarily indicate endorsement of the policy options presented in this brief.*

# Ten Strategies for Improving Health Care:

## Report from NCSL’s Task Force on Innovations in State Health Systems

Improving patient care and, at the same time, controlling escalating health costs remain two of the most important and challenging health care issues for state policymakers. As state decision-makers create and shape health system policies, they can leverage the state’s market power as both health care purchasers and stewards of quality. They can also integrate new technologies and methods in ways that improve people’s health while balancing the challenges and opportunities of federal health reform efforts.

[NCSL’s Task Force on Innovations in State Health Systems](#) explores issues and opportunities faced by state policymakers as they reform their state health systems. The task force, which consists of legislators and legislative staff from across the country selected by NCSL leadership, meets two to three times per year to discuss state policy innovations. This report highlights various innovations and strategies discussed by task force members during meetings in 2017. They are not meant to provide recommendations, but rather examples. The topics explored by the task force included:

- Addressing the Opioid Epidemic
- Medicaid for Formerly Incarcerated People
- Tackling Rural Hospital Closures
- Housing Support through Medicaid
- Improving Systems of Long-term Care
- Alternative Payment Models for Prescription Drugs
- All-payer Claims Databases
- 1332 Innovation Waivers
- New and Emerging Workforce
- Improving End-of-life Care

### 1. Addressing the Opioid Epidemic

With [42,249 U.S. deaths associated with opioids in 2016](#), many states have taken an “all hands on deck” approach in which departments, organizations and individuals who previously didn’t play a large role are stepping up to help. From police to realtors, innovative interventions are underway.

■ **Emergency Rooms.** Rhode Island created a program called [AnchorED](#) that uses certified peer recovery coaches (a type of peer support specialist) to assist people in crisis. Coaches are people in long-term recovery, or family members of someone with a substance use disorder (SUD), who connect with individuals who go to an emergency department (ED) because of an overdose or other substance-induced crisis. This program has shown promising success. [In the first 2.5 years, more than 1,400 individuals](#) have connected with a peer recovery coach, with more than 80 percent engaging in some type of recovery support.

■ **Police Departments.** In Massachusetts, the police chief in Gloucester announced he would no longer arrest people for minor crimes related to substance misuse and instead would offer them a path to treatment. The [Police Assisted Addiction and Recovery Initiative \(PAARI\)](#) allows individuals with a substance use disorder to come into a police station with their drug paraphernalia. An intake specialist then connects them with treatment resources. In one year, the Gloucester Police Department helped get more than 400 people into treatment.

■ **Schools.** Schools have also been an important partner in intervention. A number of states have trained school nurses to assess whether children and teens are at risk of a substance use disorder by using a verbal screening tool known as the Screening, Brief Intervention, and Referral to Treatment (SBIRT). Wisconsin Medicaid began covering SBIRT in 2010. In addition to SBIRT, at least 13 states have passed legislation to require or allow public school employees to obtain and administer naloxone (also known by the brand name Narcan), an opioid overdose reversal drug.

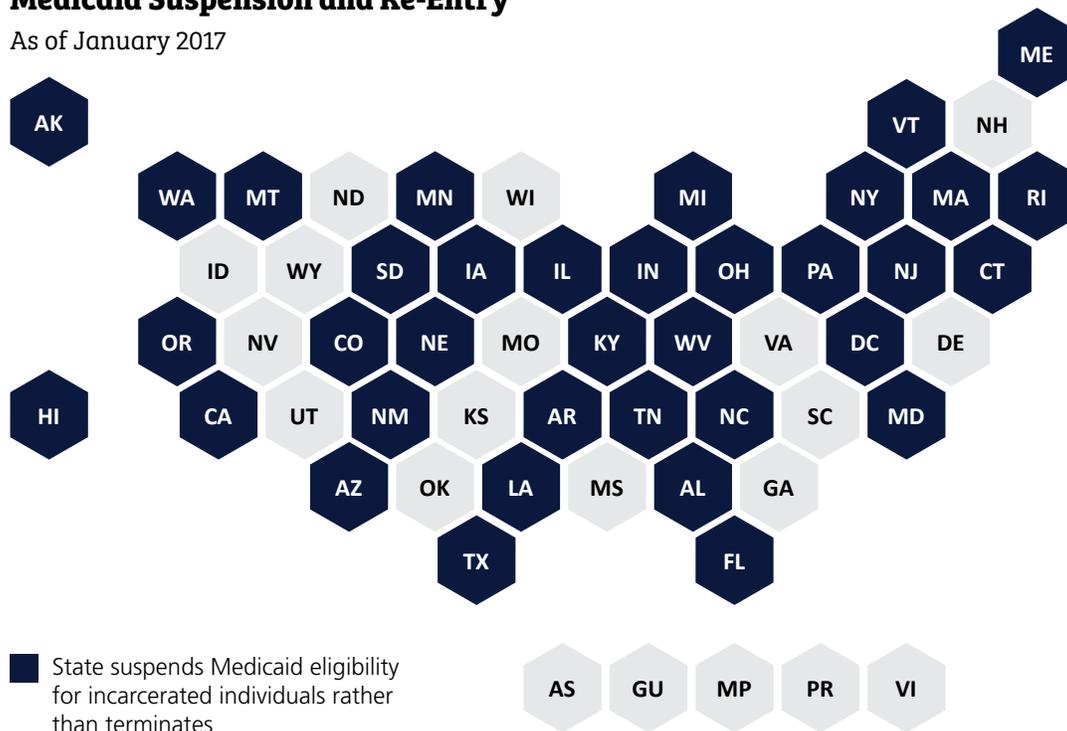
## 2. Medicaid for Formerly Incarcerated People

Nearly two-thirds of all prisoners are addicted to drugs or alcohol. After release, they are at a high risk of using again. Inmates also report having higher rates of high blood pressure, diabetes, hepatitis C, HIV and mental health problems than the general population. Medicaid does not cover incarcerated people, which leaves a gap in coverage for people when they leave jail or prison. As of 2017, lawmakers in at least 35 states and the District of Columbia adopted policies that suspend, rather than terminate, Medicaid eligibility for qualified inmates while they're incarcerated, though some do so only temporarily. Suspension allows Medicaid coverage and services to resume immediately upon release from prison, avoiding the lengthy re-application process—which can take anywhere from 45 to 90 days. Inmate coverage enables continuity of care for chronic conditions such as diabetes, mental illness or substance use disorders.

■ **Medicaid Suspension.** In 2016, Alabama lawmakers passed Medicaid-suspension legislation through [Senate Bill 268](#) “to stop the revolving door for people with serious mental illnesses in our jails and prisons, and to reduce prison medical costs to the state,” said the bill’s sponsor, Senator Cam Ward (R). “In short, if the state terminates Medicaid coverage upon incarceration, the state loses the ability to [capture federal funds]” since funding for Medicaid is a shared state-federal responsibility.

### Medicaid Suspension and Re-Entry

As of January 2017



Sources: Council of State Governments, Families USA, National Association of Counties, National Conference of State Legislatures

### 3. Tackling Rural Hospital Closures

Because of their geographic isolation and other factors, residents in rural communities often face challenges accessing health care services. Providers are increasingly scarce, and many hospitals in rural areas struggle to keep their doors open. Rural hospitals tend to have low patient volume, [a high portion of patients on Medicare and Medicaid, and a high number of uninsured patients](#), leading to significant financial challenges. More than 75 rural hospitals have closed since 2010, [according to the Sheps Center](#) at the University of North Carolina. When a rural hospital closes, it not only threatens residents' access to health care, it hurts the local economy. These challenges have driven policymakers to explore various strategies to keep these hospitals open.

■ **Payment Reform.** Pennsylvania and the Centers for Medicare & Medicaid Services (CMS) recently adopted a value-based payment reform strategy for rural hospitals, which aims to transform their payment system from one that pays for volume of services, to a system that pays for value. This global budget pilot for rural hospitals in the state allows a hospital to receive a fixed amount for all inpatient and outpatient services for a period of time, such as a year. This practice provides more budget certainty because revenues are set in advance, based on previous budgets, and funded by participating payers, such as Medicaid, Medicare and private insurers. Pennsylvania began this initiative in January 2017 and CMS intends to provide \$25 million in funding over four years.

■ **Coordinated Care Delivery Model.** Georgia's Rural Hospital Stabilization Committee—comprised of legislators, health care professionals and other stakeholders—issued a report in 2015 that recommended a “hub and spoke model.” This model designates a rural hospital as the hub, with other access points of care as the spokes, such as Federally Qualified Health Centers, local primary care offices, school clinics, and telehealth-equipped ambulances. The Georgia General Assembly has appropriated funds to support various pilot sites for this model.

### 4. Housing Support through Medicaid

Homelessness is a strong predictor of poor health status. In June 2015, the Centers for Medicare & Medicaid Services (CMS) enabled states to use Medicaid funds to help chronically homeless people and others with long-term disabilities to find and maintain permanent housing, though CMS does not provide funds for room and board. Some states, like [California, Hawaii, New York, Texas and Washington](#), included access to supported housing services in their 1115 Medicaid waivers, which target people experiencing homelessness. Other states have used home- and community-based services waivers and state plan authority to deliver supportive housing services to other populations, such as people with disabilities and older adults.

■ **Mercy Maricopa Integrated Care.** [Mercy Maricopa](#), a nonprofit health care plan in Phoenix, manages behavioral health care for Medicaid-eligible adults and children. For its members with serious mental illness, Mercy Maricopa provides permanent supportive housing services in 3,400 housing units. It also subsidizes various additional sites through a partnership with Housing and Urban Development (HUD).

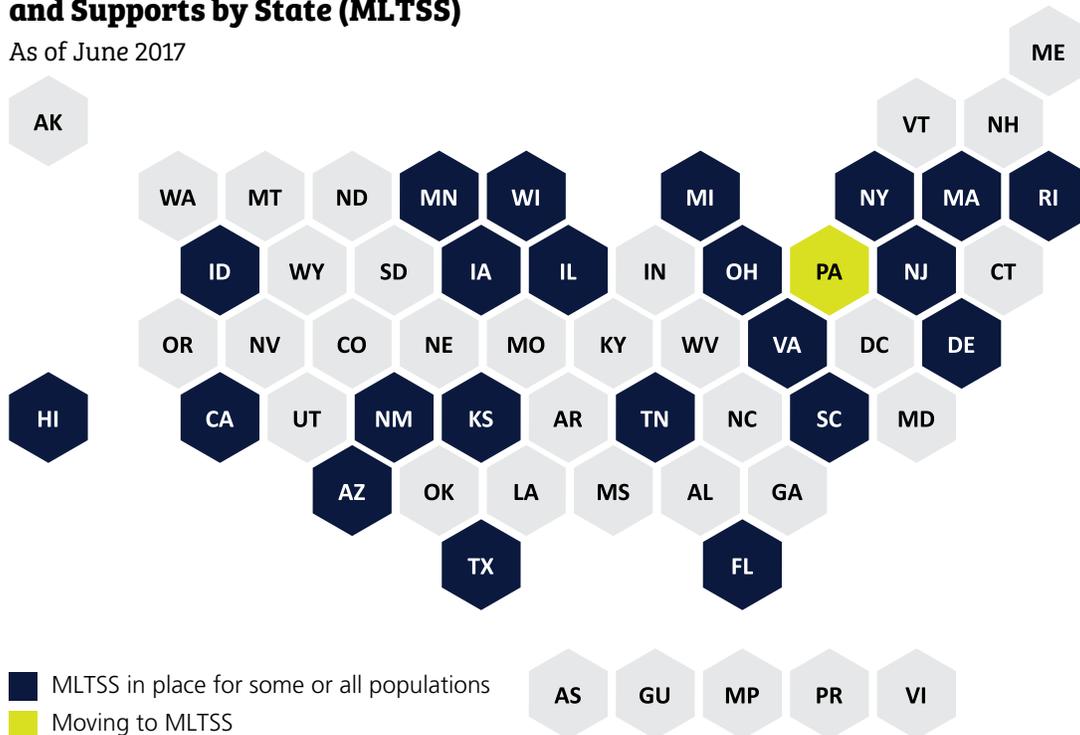
### 5. Long-term Services and Supports

With changing demographics and rising costs, states have a keen interest in improving their systems of long-term care, which provide daily assistance to older adults and people with disabilities. State legislators consider how to ensure that the growing population in need of such services has access to affordable and high-quality long-term services and supports (LTSS). They also focus on how to control the rising strain on state budgets.

■ **Support for Family Caregivers.** [Approximately 40 million Americans](#) provided unpaid care to adults with long-term care needs, translating to an estimated \$470 billion value in unpaid services, according to AARP. This represents roughly six times the value of home- and community-based care paid for by Medicaid.

## Medicaid Managed Long-Term Services and Supports by State (MLTSS)

As of June 2017



Source: Center for Health Care Strategies, June 2017

AARP’s model bill, called the Caregiver Advise, Record, Enable Act (CARE Act), aims to provide caregivers with more information, and support them in taking on certain tasks their care recipient may need, particularly as they transition from a hospital back to their homes. The model bill requires hospitals to: 1) provide the care recipient with the opportunity to designate a family caregiver; 2) inform the caregiver when the care recipient is to be discharged to another facility or back home; and 3) consult with the caregiver on the medical tasks he or she will need to perform at home. Some form of the CARE Act has been enacted in 36 states, and the District of Columbia, U.S. Virgin Islands and Puerto Rico.

■ **Managed Long-term Services and Supports.** Under a managed care model, state Medicaid programs provide a capitated payment model (a per-patient monthly payment rather than a fee for each health service). This aims to control costs while improving the quality of services. States can implement Medicaid managed LTSS through a variety of Medicaid waivers or state plan amendments, including 1115 demonstration waivers or 1915(b) managed care waivers. As of 2017, 22 states had MLTSS programs and Pennsylvania planned to implement MLTSS. In [Wisconsin’s Family Care program](#), managed care organizations (MCOs) work with Wisconsin’s Aging and Disabilities Resource Centers to ensure that enrollees have a team to coordinate the various services they may need.

■ **Self-directed Care.** State Medicaid programs increasingly offer opportunities for self-directed long-term services and supports. [Self-directed care](#) means that the individual plays the key role in creating and managing his or her care plan and choosing the setting or provider that delivers their services. Under this option, eligible individuals can employ family or friends as their caregiver as long as they meet their state's eligibility and income requirements, which vary across states. [State Medicaid programs](#) enable consumers to self-direct their long-term services and supports through waivers and state plan authority. For example, Colorado's [Consumer-Directed Attendant Support Services Program \(CDASS\)](#) allows participating individuals to choose their personal care attendant, who then receives reimbursement for providing approved services. This program operates under the authority of four 1915(c) Home- and Community-Based Services added to end of service waivers for specific populations, including those with spinal cord injuries, brain injuries, and people who are elderly, blind or have other qualifying disabilities.

## 6. Alternative Payment Models for Prescription Drugs

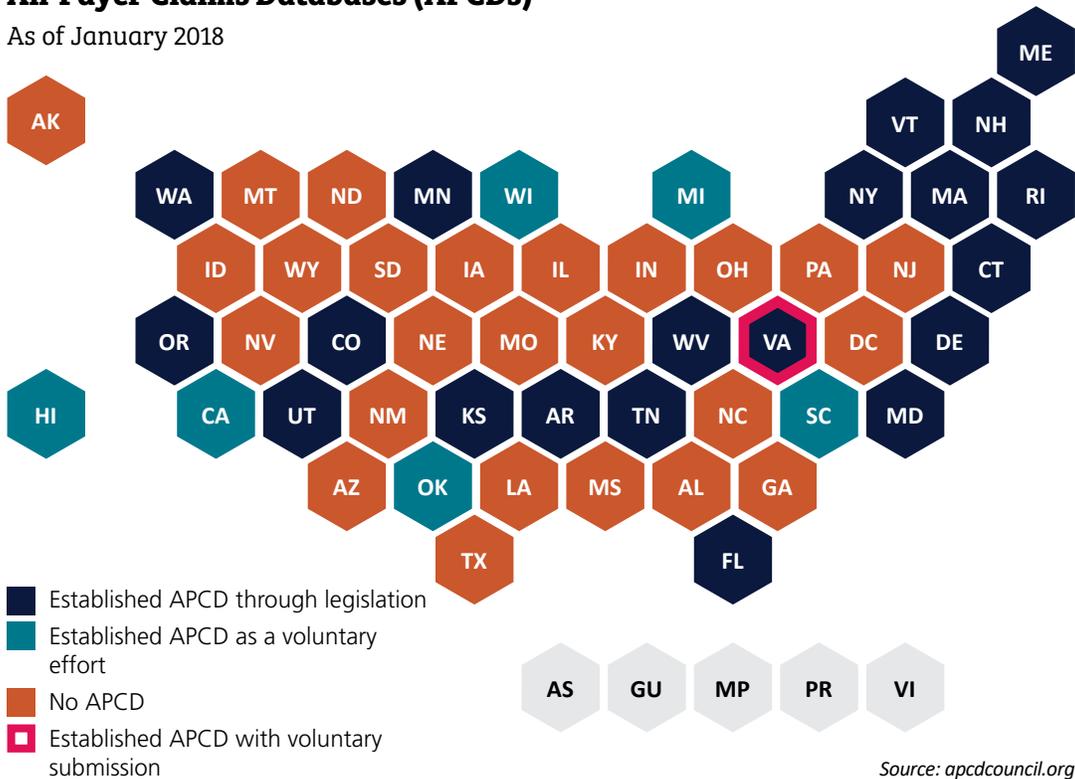
The accelerating pace of developing innovative drugs presents opportunities to improve health and save lives. At the same time, high prices for new therapies pose a challenge for all health care payers, especially state Medicaid programs. States are exploring whether alternative payment models for purchasing prescription drugs may help improve patient access to evidence-based therapies while allowing states to predict and manage prescription drug policies and costs.

■ **Value-based Purchasing.** Value-based purchasing contracts between insurance carriers and pharmaceutical companies can take a variety of forms. The principle behind them is essentially the same. A pharmaceutical company enters into a contract with a buyer (e.g., health insurance carrier or Medicaid program) that includes the company's drug on its formulary. If patients who use the drug do not sufficiently improve or have poor health outcomes, the company will provide discounts, rebates or refunds to the payer. For example, Amgen, which manufactures Repatha to treat high cholesterol, signed a value-based contract in 2017 with Harvard Pilgrim Health Care, an insurance carrier based in Boston. In addition to negotiated discounts, Amgen promised additional rebates if patients did not experience reductions in cholesterol levels comparable to results found in the clinical trials. Another provision specified that if a Harvard Pilgrim subscriber who is prescribed Repatha suffers a heart attack or stroke while taking the drug, Amgen will provide Harvard Pilgrim a full refund for the carrier's costs to cover the drug for that patient.

■ **State Medicaid Alternative Reimbursement and Purchasing Test for High-Cost Drugs (SMART-D).** This project is housed at the [Center for Evidence-based Policy](#) at the [Oregon Health & Science University](#) and includes state partners from across the country. SMART-D works to test alternative payment models (APMs) to "help improve patient access to evidence-based therapies while allowing states to predict and manage prescription drug costs." The program works with states to test payment models through a multiphase approach. This includes gathering information on promising models, identifying state interest and readiness, and providing technical assistance to make the alternative payment models operational. For more than a decade, the [Drug Effectiveness Review Project](#), another initiative of the Center for Evidence-based Policy, has partnered with states to develop evidence-based reimbursement options for 13 state Medicaid programs.

## All-Payer Claims Databases (APCDs)

As of January 2018



## 7. All-Payer Claims Databases

As states strive to achieve the triple aim of better care, smarter spending and healthier people, many increasingly use data to guide health care innovations and improve transparency.

Policymakers, health care providers and other stakeholders recognize all-payer claims databases (APCDs) as a promising tool that can help achieve this objective. Most APCDs gather claims and eligibility data from medical, pharmacy and dental payers to create a comprehensive collection of information on costs, quality of care and patient demographics. As of 2018, at least 25 states have [established all-payer claims databases](#) and other states have introduced legislation to create an APCD or to study the feasibility of creating such a database.

Policymakers, payers, providers and state agencies can access APCD data to inform their decisions on how they deliver and pay for health care. For example, a recent report from the Minnesota Department of Health provides information about state spending on chronic disease care, which was significantly higher than for those without chronic illnesses. The report gathered this information from the state's APCD, which was created by the Minnesota Legislature in 2008. The report used claims data from Medicaid, Medicare and commercial payers to find the overall chronic disease prevalence, cost and geographic variation. With the data, [the report aims](#) to help allocate health resources more efficiently, inform health policy spending decisions, and measure initiatives that intend to reduce health care spending and improve quality of care.

## 8. 1332 Innovation Waivers

Beginning Jan. 1, 2017, a new state option within the Affordable Care Act (ACA), known as [Section 1332 State Innovation Waivers](#), took effect. This new waiver process enables states to request to modify key parts of the health law within the waiver's boundaries. For example, a state may seek to alter required essential health benefits (EHBs) or change requirements related to the individual and small group marketplaces, as long as the changes comply with the ACA's intent.

To obtain a 1332 waiver, a state must pass authorizing legislation. As of December 2017, at least [24 states](#) had considered legislation to “kick-off” the 1332 waiver application process.

■ **Alaska.** [Alaska’s 1332 state innovation waiver](#), approved in July 2017, establishes a reinsurance program intended to stabilize Alaska’s individual insurance market. The Alaska Reinsurance Program aims to lower marketplace premiums by tapping another funding source to pay for costs that exceed a certain amount for high-cost enrollees. As part of the waiver approval, the state will receive federal funds to help cover the cost of claims for high-risk individuals. Both Oregon and Minnesota were approved to implement similar reinsurance programs through 1332 waivers.

## 9. New and Emerging Workforce

Rural and underserved communities face significant challenges accessing health care services. In many areas, the supply of health care providers cannot keep up with the demand for services. The shortage or inadequate distribution of the health care workforce can create barriers to accessing timely and appropriate care, lead to poor health status and create significant costs for states. Several states have explored policies to expand the current workforce by supporting new or alternative provider types.

■ **Peer Support.** State budgets feel the strain caused by costs associated with untreated mental illness and substance use disorders, including those related to overcrowded emergency rooms and jails. The shortage and maldistribution of behavioral health workers contribute to treatment access challenges.

Using peer support specialists to improve access to treatment has gained attention as a promising strategy across the country. A [peer support specialist](#) is “a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind body recovery and resiliency,” according to the Substance Abuse and Mental Health Services Administration (SAMHSA). This umbrella term can include peer recovery coaches, or other specialists who work with specific populations. Proponents of peer support specialists believe they have the potential to expand access to care, prevent hospitalizations and lower health care costs. As part of health care teams, they may help extend the reach and capacity of existing providers. In addition, due to their shared experiences, people in recovery may find peer providers especially approachable and trustworthy.

At least 36 states offer providers the opportunity to bill Medicaid for mental health peer support services. They can do so through mechanisms such as a state plan amendment, the rehabilitation services option or a Medicaid waiver, according to a [2014 report](#) from the Texas Institute for Excellence in Mental Health and a 2015 [University of California report](#).

■ **Community Paramedicine.** Community paramedics are trained to provide non-emergency services to patients in their homes or other community-based settings and perform an expanded role within their scope of practice. They aim to connect high-risk and underserved patients (e.g., frequent emergency department users) with primary care services. Community paramedics usually work in rural and isolated areas where physicians are scarce. Patients are often from underserved populations, meaning they are typically, but not always, low-income, elderly people. Some states have created pilot programs to support community paramedicine and examine reimbursement mechanisms to support them.

Minnesota lawmakers passed legislation ([2011 Minn. Laws, Chap. 12](#)) defining community paramedics and establishing a certification process. In order to become certified, community paramedics must meet training and clinical requirements, such as completing a training program from an approved college or university. The law authorizes community paramedics to provide services, such as disease management and referrals, as directed by the patient’s primary care physician. Minnesota lawmakers subsequently adopted [2012 Minn. Laws, Chap. 169](#), which authorized Medicaid reimbursement for community paramedicine services to certain high-risk patients, such as frequent users of the emergency department.

## 10. Improving End-of-life Care

Polls show that a vast majority of Americans agree on the benefits of advance care planning—the process of discussing end-of-life options with physicians and loved ones. However, few people have had such conversations.

State legislatures have enabled people to take more control over their end-of-life health care decisions through planning tools such as living wills, advance directives and health care powers of attorney. State legislators have supported these efforts in a number of ways, including support for electronic registries to create a centralized location for providers to access such end-of-life planning tools. According to the American Bar Association (ABA), Louisiana was the first state to authorize a statewide advance directive registry by statute. As of 2016, a number of states had joined Louisiana, including Arizona, California, Idaho, Maryland, Michigan, Montana, Nevada, North Carolina, Oklahoma, Vermont and Washington.

Physician Orders for Life-Sustaining Treatment (POLST), another advance care planning tool, complement advance directives and are intended solely for people who are seriously ill or frail. POLST forms detail decisions that are made between a patient and medical provider, with a person’s current diagnosis in mind—allowing a patient to record whether he or she wants certain interventions, such as artificial feeding, antibiotics, cardiopulmonary resuscitation (CPR) and mechanical ventilation. As of 2016, 46 states had or were developing POLST programs. Some states have enacted legislation to establish guidelines for POLST programs or remove barriers to implementation. All states require a designated medical provider to sign POLST forms and in some states, only physicians may legally do so. California passed legislation in 2015 to authorize nurse practitioners and physician assistants—acting under the supervision of a physician—to sign POLST forms.

In addition to these actions, some state legislatures have designated April 16 as annual “National Healthcare Decisions Day” as a way to encourage and publicize the importance of completion of advance directives.

## Conclusion

NCSL’s Innovations in State Health Systems Task Force strives to promote policy innovation and communication among state legislatures. The task force will continue to monitor, discuss and learn about these and other new and innovative ideas as they meet throughout 2018.



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NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

- Improve the quality and effectiveness of state legislatures
- Promote policy innovation and communication among state legislatures
- Ensure state legislatures a strong, cohesive voice in the federal system

The conference operates from offices in Denver, Colorado and Washington, D.C.

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