

Health Policy Studies

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November 2003

State Actions to Control Health Care Costs

Summary

As forecasters continue to predict double-digit rates of medical inflation and growing state budget deficits, states are aggressively attempting to rein in health care costs by managing patients, the market, and the consumption of benefits. After a period of low growth during the economic boom of the mid 1990s, Medicaid spending growth reached nine percent in 2001,¹ 13.2 percent in 2002, and was 9.3 percent in 2003².

Medicaid spending now accounts for over 20 percent of total state spending and has become the second-largest item in most state budgets, after elementary and secondary education. When all state health-care expenditures are totaled, including Medicaid, SCHIP, public health, state employee and retiree health plans, and correctional and institutional care, health-care spending represents approximately 30 percent of state budgets.³

States attribute the growth in Medicaid spending to growth in Medicaid enrollment because of eligibility and the recent downturn in the economy, higher medical service utilization rates, growing long-term care costs, expansions, and rising prescription drug expenditures. States have used general revenue funds, rainy day funds, tobacco settlement funds, Medicaid trust funds, or transfers from other programs to cover growing Medicaid expenditures and largely have exhausted these temporary fixes.

Forty-one states were projecting shortfalls of state Medicaid funds in 2003, and states took aggressive measures to rein in costs and protect beneficiaries. States have considered or used the following strategies:

- **Improving program administration and management.** States reduced administrative costs by actively pursuing increases in efficiency, changing purchasing and/or pricing arrangements, and enhancing efforts to minimize fraud and abuse.
- **Increasing coordination with private insurance.** States changed state laws or sought federal waivers of mandatory insurance benefit requirements to create more affordable insurance products in the small group and individual markets.
- **Controlling long-term care costs.** States limited the cost of long-term care by pursuing strategies to prevent the need for nursing home care, making it easier for seniors to “age in place,” shifting more care from nursing homes to community based settings, and reducing nursing home care costs.
- **Improving care management for high cost and chronically ill patients.** States attempted to control health care spending on specific patient groups by providing care management strategies

¹ Kaiser Commission on Medicaid and the Uninsured. *State Budget Constraints: The Impact on Medicaid* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

² Kaiser Commission on Medicaid and the Uninsured. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

³ Kaiser Commission on Medicaid and the Uninsured. *State Budget Constraints: The Impact on Medicaid* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

that better engage chronically ill patients in managing their own care and by establishing disease management strategies that allow doctors to better adhere to evidence-based treatment guidelines.

- **Promoting disease prevention.** States can best limit health care costs by preventing the occurrence of high cost, chronic diseases. States pursued a range of cost savings by engaging in health promotion activities focusing on good nutrition, increasing physical activity, and preventing or stopping the use of tobacco products.
- **Restructuring benefits and eligibility, provider reimbursement levels, and purchasing arrangements.** States reduced Medicaid and state employee and retiree health plan costs by increasing cost sharing and reducing provider reimbursement rates or, as a last resort, limiting eligibility and/or eliminating or reducing benefit coverage
- **Managing prescription drug expenditures.** States managed pharmaceutical spending by establishing preferred drug lists, prior authorization, and mandatory use of generics, through efforts to consolidate purchasing power internally or by joining multi-state purchasing pools, and by enforcing prescription limits or using other tools.

Whatever package of cost containment measures a state chooses, it is important to keep a record of the savings that can be attributed to a particular approach. This gives policymakers the advantage of knowing specifically what saved the state money and whether or not such an approach leads to unintended consequences or expenditures.

The following Issue Brief outlines cost containment strategies considered and implemented in greater detail and, where possible, offers data regarding the savings that states have achieved through their implementation.

Background

This fiscal year, Medicaid will cover 47 million people—24 million children, eight million people who are disabled, five million people who are elderly, and almost 10 million adults. Although low-income children and adults comprise 73 percent of Medicaid beneficiaries, they account for only 29 percent of Medicaid spending. The bulk of Medicaid expenditures fund services for the elderly and disabled, who comprise 27 percent of Medicaid beneficiaries but account for 71 percent of Medicaid expenditures⁴. Medicaid is the largest payer of long-term care costs in the United States.⁵ Medicaid is the nation's single largest purchaser of long-term care services, accounting for about 46 percent of all nursing home spending and 38 percent of all home health care spending.⁶

Medicaid is now bigger by expenditure than Medicare, with total spending for Medicaid reaching \$258 billion⁷ versus \$247 billion for Medicare⁸. All told, Medicaid accounts for about 17 percent of all personal health care spending. Medicaid finances 17 percent of all hospital care, 12 percent of physician and other professional services, 17 percent of prescription drug spending⁹ and almost 40 percent of all births.¹⁰

⁴ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

⁵ The Georgetown University Long-Term Care Project, *Who Pays for Long-Term Care?* (Washington, DC: Georgetown University, 2003). Available at: <http://ltc.georgetown.edu/pdfs/whopays.pdf>

⁶ Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role in Long-Term Care* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2001).

⁷ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*.

⁸ Kaiser Commission on Medicaid and the Uninsured, *Medicare at a Glance* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

⁹ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*.

Medicaid is also the largest source of federal funds to the states, accounting for 43 percent of all federal grants in aid.¹¹

Medicaid spending and its associated growth varies from state to state depending upon each state's benefit package, eligibility criteria, service utilization rates, and other factors, including the effectiveness of efforts to manage care costs. In recent years, Medicaid spending has grown at around 10 percent annually. In addition (according to 2001 data¹²):

1. acute care services accounted for about half of Medicaid spending—55 percent;
 - 13.8 percent payments to managed care organizations (MCOs)
 - 13.2 percent inpatient care
 - 9.1 percent drugs
 - 6.7 percent outpatient/clinic care
 - 6.4 percent other acute care
 - 3.8 percent physician costs
 - 2.3 percent payments to Medicare
2. long-term care services accounted for 38 percent of spending;
3. payments for Medicare premiums accounted for about 2 percent of spending; and
4. DSH (disproportionate share hospital) payments accounted for about 7 percent of spending.

States attribute Medicaid spending growth primarily to increased enrollment and the growth in prescription drug expenditures and also cite the following key factors¹³:

- **Enrollment Growth.** Enrollment growth averaged 8.6 percent in 2002 because of the down turn in the economy, expansions in eligibility, improved outreach, and simplified application and renewal procedures.
- **Medical Inflation and Utilization.** States cited increased utilization, managed care, technology costs, provider inflation, rate increases, and increased medical costs.
- **Long-Term Care.** Spending on nursing homes, home health, and home and community based waivers were among top causes of expenditure growth.
- **Prescription Drugs.** Drug expenditures are rising because increased utilization, newer and improved medicines that are more expensive, price inflation for existing products, and capitation rate increases for managed care organizations.

State Strategies to Address Rising Health Costs

To address these rising costs, states are restructuring benefit packages, controlling long-term care costs, improving care costs for chronically ill and high cost patients, improving administrative controls, and managing prescription drug expenditures.

Improving Program Administration, Benefits Management, and Purchasing

States have also pursued options to better manage expenditures by limiting their administrative costs and enhancing efforts to reduce fraud and abuse.

¹⁰ Cornell, Emily, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women Children, and Parents* (Washington, DC: National Governors' Association, 2003).

¹¹ National Association of State Budget Officers, 2001 State Expenditure Report (Washington, DC: National Association of State Budget Officers, 2002).

¹² Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*.

¹³ Smith et al. *Medicaid Spending Growth: Results from a 2002 Survey* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002).

Cuts in Administrative Costs

In 2002, 34 states cut administrative budgets in a range of 2 to 15 percent, and 27 states indicated they were pursuing similar reductions in 2003.¹⁴ States are reducing administrative costs through hiring freezes and layoffs, reducing the number of full time employees (FTEs), cutting office supplies, reducing or eliminating out-of-state travel, etc.

Updating Maximum Allowable Cost (MAC) Fees and other Payment Thresholds within State Claims Paying Systems

In fee-for-service rate schedules, some services, equipment, and supplies can be reimbursed at the provider's acquisition costs. While most agencies that pay for health services regularly check claims for services and supplies against the maximum limit, the maximums set by the state are often updates of the vendor's yearly rate increase. States should be certain that limits more accurately reflect vendor acquisition costs and, when appropriate, reduce these limits.¹⁵ States should also be certain that MAC lists for prescription drugs are up to date.

Ensuring Appropriate Payment by Third Party Payers

States are improving efforts to better coordinate benefits to ensure that Medicaid is not assuming payments that should be made by private insurers, Medicare, the Veterans Administration, or other payment sources. States can often find alternate payers for some services offered to Medicaid beneficiaries and can ensure that third party payers with primary responsibility to the beneficiary are being properly billed. For example, the Veterans Administration (VA) is obligated to be the primary insurer for patients in VA nursing homes. Agencies can also make certain that Medicaid beneficiaries that are eligible for Medicare are receiving benefits, and that Medicare is appropriately paying claims for the services it covers. To cross-reference dual-eligible beneficiaries, states can use the CMS Medicare Enrollment Database (EDB).¹⁶

Enhanced Efforts to Prevent Fraud, Abuse, and Waste

States are reducing costs by pursuing efforts to reduce fraud, abuse, and waste by better monitoring their utilization and claims data to manage care and recover overpayments, and by increasing their auditing functions to recover their costs.

- **Washington** increased staffing and changed policies to avoid paying claims where the Medicaid beneficiary had other coverage, which saved \$57.2 million in state funds in 2002—up 25 percent from prior years—and \$116 million altogether.¹⁷ Washington also created a data warehouse to search claims data for overpayments and to identify potential fraud and abuse by profiling Medicaid clients' service utilization and provider claims. This saved \$2.6 million for 2001 and 2002 combined. Washington also increased audit staffing to recover more overpayments to hospitals and practitioners. These actions recovered \$5.83 million in state funds in 2002.¹⁸

In the case of pharmaceuticals, states are enhancing drug utilization review to prevent waste, using technology to prevent abuse and errors, requiring providers to substitute more cost-effective medications, and auditing claims data to detect fraud, abuse, and waste. (For more information about pharmaceutical fraud, abuse, and waste, please see http://www.nga.org/center/topics/1,1188,D_2007,00.html.)

¹⁴ Smith et al, 2002.

¹⁵ Medicaid Cost Containment Report No. 1, prepared by The Lewin Group, Inc. for the Washington State Legislature, December 2002.

¹⁶ Ibid.

¹⁷ Medicaid Cost Containment Report No. 2, prepared by The Lewin Group, Inc. for the Washington State Legislature, December 2002.

¹⁸ Medicaid Cost Containment: Report No. 1, prepared by The Lewin Group, Inc. for The Washington State Legislature, October 2002.

Altering Purchasing Arrangements for Certain Services

A state can save a surprising amount of money by changing the way it purchases services such as non-emergent transportation and interpreters. This can mean a change as simple as changing current arrangements with transportation companies to true brokerage models, in which brokerage companies that arrange transport of patients are divested of any interest in provider businesses.¹⁹

Similarly, brokerage models can be enacted for purchasing interpreter services. Among other benefits, this allows the state to set its specified payment rate before contractual relationships with individual interpreters have been made.²⁰

Increasing Coordination with Private Insurance

States can change the state law or seek federal waivers of mandatory insurance benefits requirements to create more affordable insurance products in the small group and individual markets—expanding access and saving money over traditional Medicaid benefits. Several states are coordinating public programs with employer-sponsored insurance, using SCHIP or Medicaid funds to pay premiums and to keep children enrolled in employer-sponsored insurance plans. States are also coordinating efforts with counties, communities, or employers to implement “one-third” programs in which the cost of the insurance is split between the consumer, the state or county, and the employer.

- Under the Omnibus Budget Resolution Act of 1990, states were directed to enact programs identifying cases where enrollment of a Medicaid eligible individual in a group health plan would be cost effective. As a result, **Pennsylvania** developed the Health Insurance Premium Payment Program (HIPP). Under the authority of the Bureau of Financial Operations within the Department of Public Welfare, the state looks for cases where it would be cheaper to pay the premiums and cost sharing for a Medicaid beneficiary with access to a group health plan than to cover those benefits through traditional Medicaid.²¹ Today, the program serves at least 21,000 residents and saves the state approximately \$4.5 million per month.²²

Controlling Long-Term Care Costs

Long-term care is a major component of Medicaid coverage and spending. Neither private health insurance nor Medicare cover long-term care services to any significant extent and few older adults currently have private long-term care insurance.²³ The primary funding sources of Long-Term Care are Medicaid (38 percent), out of pocket spending (30 percent), Medicare payments for skilled nursing care (18 percent), and private long-term care insurance (8 percent).²⁴

Over two-thirds of Medicaid spending for long-term care costs is for institutional services. Medicaid finances care for 60 percent of nursing home residents. All states also have home and community based

¹⁹ Medicaid Cost Containment Report No. 2, prepared by The Lewin Group, Inc. for the Washington State Legislature, December 2002.

²⁰ Medicaid Cost Containment: Report No. 1, prepared by The Lewin Group, Inc. for The Washington State Legislature, October 2002.

²¹ <http://www.dpw.state.pa.us/oa/oaRdHipp.asp>

²² National Conference of State Legislatures, available at <http://www.ncsl.org/programs/health/buyin03.htm>

²³ Josua M. Weiner with David G. Stevenson and Jessica Kasten, *State Cost Containment Initiatives for Long-Term Care Services for Older People* (Washington, DC: Congressional Research Service, Library of Congress, 2000).

²⁴ Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role in Long-Term Care*.

services (HCBS) waivers to deliver community based care, but states lack adequate resources to meet the demands for community-based care.²⁵

States employ four primary strategies to control long-term care spending 1) preventing the need for nursing home care; 2) providing services to help seniors to “age in place” without moving to nursing home care; 3) shifting more care from nursing homes to community based settings; and 4) mitigating nursing home care costs by reducing reimbursements, eligibility, and nursing home beds, along with improving care management to reduce care costs and increasing patient use of other sources for financing long-term care costs.

Preventing the Need for Nursing Home Care

Strategies to promote better health and prevent injuries can prevent unnecessary nursing home and hospital use. A recent report, *The Aging States Project: Promoting Opportunities for Collaboration between Public Health and Aging Services Networks* describes promising practices in prevention for older adults in eight states. The report highlights initiatives that employ how health promotion collaborations can improve health outcomes in three areas:

- **Physical activity.** Increasing physical activity is the single most important step that older adults can take to improve their overall health. Thirty minutes of physical activity a day can prevent or reduce disabilities from chronic diseases, improve mobility and balance—which helps prevent falls—and improve mental health.²⁶ Seventeen states provide physical activity programs, including walking or resistance training programs for older adults.²⁷
- **Immunizations.** Increasing efforts to immunize seniors reduces the risk of death from vaccine preventable diseases. Pneumonia and influenza account for more than 50,000 deaths annually of people 65 and older. Immunizations can reduce the incidence of these diseases in older adults by as much as 80 percent, but many older Americans do not receive these vaccinations.²⁸ Seven states reported immunization programs for older adults.²⁹
- **Fall prevention.** Making environmental adaptations, increasing physical activity and improving medication management can reduce the risk of falls. Each year one in every three Americans 65 and older falls, and 20 to 30 percent of these people sustain moderate to severe injuries that reduce mobility and increase the likelihood of premature death. Six states report offering medication management assistance, and four states report fall or injury prevention efforts.³⁰ (For more information see www.nasua.org).

Helping Seniors to Age in Place

Several states also have documented successful cost saving programs that delay or prevent hospital and nursing home admissions. These programs provide seniors with supportive services that allow the elderly to age in their homes and communities.

Georgia implemented Service Options Using Resources in a Community Environment (SOURCE) to provide case management services for frail elderly and disabled beneficiaries. The program is designed to

²⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, *Medicaid At-a-Glance 2002: A Medicaid Information Source*, (Washington, DC: HHS, 2002).

²⁶ The Aging States Project: Promoting Opportunities for Collaboration Between Public Health and Aging Services Networks, Chronic Disease Directors and National Association of State Units on Aging, , January 2003, p. 5

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

mitigate preventable hospital and nursing home admissions by integrating primary medical care with supportive services. Patients are connected with case managers who make home visits, assess medical status and social supports, monitor patient health, and relay information to primary care physicians. Services also include home-delivered meals, adult day health services, personal support services, home health services, and 24-hour medical access.³¹

As a result of Georgia's Source program, total Medicaid costs over two years were lower for SOURCE participants than comparable beneficiaries who received home care services that were not coordinated with primary care. Average costs for two years were \$15,350 for SOURCE participants and \$19,751 for non-SOURCE beneficiaries. SOURCE participants also have fewer nursing home placements and shorter lengths of hospital stays than do the less closely monitored participants in the regular home and community based services programs.³²

New Hampshire implemented similar programs for seniors in elderly and public housing through funding from HUD, Medicaid, and grants from the United Way and other organizations. The services include two meals a day, personal care, housekeeping and laundry service, transportation to medical appointments, and personal emergency response. Nurses also staff a health clinic for two hours per week, and participants may visit the clinic free of charge.

New Hampshire's program results include delayed admission to nursing homes and reductions in hospital readmissions attributed to inadequate nutrition, lack of fluids, or falls that often occur within 24 hours of a hospital discharge. An evaluation by the University of New Hampshire found that the initial implementation of the programs achieved cost savings of \$8,100 per participant and prevented several admissions to nursing homes.³³

Shifting More Care to Community Based Settings

The most widespread reform to the public long-term care system has been the effort to shift the delivery system towards home and community-based care and away from institutional care. States can fund home and community based services through the Medicaid program with coverage of home health (a mandatory benefit) and personal care (an optional benefit).³⁴ Alternatively, states can fund these services through home and community-based services waivers that allow states to limit their financial liability by requiring that they provide these services only to a pre-approved number of people instead of establishing an open-ended entitlement benefit.³⁵

Shifting care to community based settings is intended to help states avoid the high cost of institutional care. However, some research indicates that providing home care may increase spending since some community members who would never elect to go into a nursing home may decide to take advantage of community-based care. States are limiting these increased costs by restricting the number of slots available for community based care.

Moving to community based care also eliminates the economies of scale available in caring for patients in an institutionalized population. Also, often home and community-based services are lacking and there is an insufficient supply of affordable housing and transportation services that could support people wishing

³¹ Robert Mollica and Jennifer Gillespie. *Care Coordination for People with Chronic Conditions* (Baltimore, MD: Partnership for Solutions, Johns Hopkins University, 2003).

³² Ibid.

³³ Ibid.

³⁴ Congressional Research Service, The Library of Congress, *State Cost Containment Initiatives for Long-Term Care Services for Older People*.

³⁵ Ibid.

to live in a community setting. Despite these barriers, some states have reported that programs have reduced care costs. **New York** claims its home and community based services clients cost only half as much as nursing home residents, and **Alabama** claims its waiver beneficiaries cost \$17,000 less per year than nursing home clients.³⁶

To help states address the barriers to a successful program, the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) offer grants designed to assist states in working with individuals and their families on selecting community-based alternatives to nursing facilities. These agencies also help states provide opportunities for individuals to make a transition from nursing facilities to community-based care settings. Beginning in 1998, CMS provided grants to states that focus specifically on transitioning nursing home residents back into the community.

CMS recently has made additional nursing home transition grant awards to the States under the Systems Change for Community Living Grants. Under these grants for FY 2001 and FY 2002, CMS has provided funding to 23 states to implement state sponsored nursing home transition programs. While many of these grants provide funding to support programs for disabled persons of all ages, some of the grantees have emphasized efforts to assist frail seniors.

In addition, on May 9, 2002, in a letter to State Medicaid Directors, CMS indicated that federal Medicaid matching funds could be used for community transition services such as:

- security deposits, essential furnishings, and moving expenses;
- set-up fees for utility services; and
- health and safety assurances such as one-time cleaning.

Allowing states to use federal matching funds for these services encourages the development of nursing home transition programs.

Mitigating Institutional Care Costs

States can mitigate institutional care costs by limiting eligibility for nursing home care as well as the availability of nursing home services, by reducing care costs when institutionalization becomes necessary, and by increasing outside sources of financing (sources other than Medicaid) to cover long-term care costs.

- **Cutting eligibility and availability of services.** States can reduce the costs of nursing home care by cutting eligibility to reduce demand and by using certificate-of-need restrictions or moratoria on nursing home construction to reduce the supply of services. Eligibility standards for nursing home care vary widely across states. States with minimal standards have larger caseloads of people qualifying for nursing home care, while states with restrictive eligibility standards minimize their enrollment and thereby limit their cost liability.

The state of **Washington** estimates that by raising functional eligibility standards for qualifying for nursing home care in order to move standards more toward the national median they can eliminate 15.1 percent of the nursing home caseload (3,423 people) and generate \$41.5 million in savings per year. Other states are capping enrollments to limit care costs and reducing nursing home beds.

- **Reducing Care Costs.** Some states are pursuing strategies to reduce the costs of caring for patients once those patients enter a nursing home. These states are reducing provider reimbursements and/or pursuing improved care management to reduce care costs. Improving access to in-house physician care can prevent residents from being discharged to a hospital unnecessarily.

³⁶ Ibid.

Washington is exploring the option of contracting with a vendor that places physicians on site in the nursing home setting to improve medical management, continuity of care, and reduce unnecessary hospital and pharmaceutical use. Vendors such as Matrix are projecting savings of 5-20 percent of nursing home costs. A year in a nursing home is estimated to cost an average of \$56,000 (Figure from 1998).³⁷

- **Increasing Other Sources of Financing for Long-Term Care Costs.** States are also pursuing options to entice more citizens to make better plans for their own long-term care and retirement income needs. At present, only 8 percent of long-term care expenditures are paid for with Long-Term Care Insurance. To increase private insurance coverage, states have experimented with tax incentives, offering state employees and retirees the opportunity to purchase individual long-term care policies, establishing self-funded programs for state employees, and combining aspects of long-term care insurance and Medicaid coverage.³⁸

Nineteen states provide tax incentives to individuals or employers for purchasing long-term care insurance.³⁹ Most state tax deductions share some features with federal rules—allowing all or part of premiums and expenditures to be deducted. A few states provide tax credits to employers providing long-term care insurance as part of an employee benefit package.

Nineteen states either offer or are planning to offer programs through state personnel offices that provide state employees and retirees and sometimes their parents and parents-in-law the opportunity to purchase long-term care policies.⁴⁰ Despite their availability, the take-up rates for these policies have remained well under 5 percent of eligible individuals, except in California where the rate is higher.⁴¹ To improve utilization, **Michigan** and Met Life also ran a \$2.7 million multi-media public education campaign to increase employee participation in purchasing policies. After the campaign, Michigan attained a 16 percent participation rate among employees and retirees, which is a high volume of participation given that average participation rates in group long-term care plans is between 5-8 percent.

At least one state offers a self-funded nonprofit program offering long-term care coverage to all state employees and retirees. Some states have established partnership programs that combine aspects of long-term care insurance and Medicaid coverage. However, developing further state partnership programs between Medicaid and long-term care insurance is precluded by federal law.

For more information, please see the NGA Center's web page on aging and long-term care at: www.nga.org/center/topics/1,1188,D_611,00.html.

³⁷ Josua M. Weiner with David G. Stevenson and Jessica Kasten "State Cost Containment Initiatives for Long Term Care Services for Older People," CRS Report for Congress, May 8, 2000.

³⁸ Braunstein, Diane. "Long-Term Care Insurance." Washington, DC" National Governors Association, 2003.

³⁹ Ibid.

⁴⁰ Congressional Research Service, The Library of Congress, *State Cost Containment Initiatives for Long Term Care Services for Older People*.

⁴¹ Ibid.

Improving Care Management for the Chronically Ill

Chronic diseases, such as cardiovascular disease—principally heart disease and stroke—asthma, cancer, and diabetes, are among the most prevalent, costly, and preventable of all health problems.⁴² Seventy-eight percent of the nation’s total medical care costs, including almost 80 percent of total Medicaid expenditures, can be attributed to the treatment of chronic conditions.⁴³

Disease management (DM) strategies provide states with the opportunity to improve patient health outcomes and limit health care spending by identifying and monitoring high-risk populations; by helping patients and providers better adhere to proven interventions; by engaging patients in their own care management; and by establishing more coordinated care interventions and follow-up systems to prevent unnecessary health complications.

More than 20 states currently are developing and implementing Medicaid DM programs.⁴⁴ Although there is limited quantitative research to assess the impact of state efforts, early reports indicate that DM programs have contributed to quality improvements in Medicaid and to limited cost savings.⁴⁵ States pursuing disease management solutions can either contract with vendors, build their own strategies, or work with pharmaceutical companies to develop appropriate solutions.

Vendor Based Disease Management Strategies

States can “buy” or outsource DM programs by contracting with vendors, also known as Disease Management Organizations (DMOs). Vendors make outsourcing DM strategies appealing by absorbing the startup costs of their programs and placing their fees at risk in contracts that guarantee savings of 1-percent to 5 percent of the cost of caring for the diseases they manage.⁴⁶

“Build” Disease Management Strategies

States can “build” DM programs by developing their own in-house systems. Build strategies provide states with the opportunity to pursue systemic reforms into their care systems that can reduce costs and produce continuous improvements in care quality. States that have built disease management strategies are reporting improved patient satisfaction and reduced costs through lower emergency room use and fewer hospitalizations. These reductions in acute care are due largely to improved health outcomes.

Targeting High Utilizers

Apart from targeting specific diseases for care management, some states target high utilizers in general to look for opportunities to improve patient outcomes and cost-effectiveness as well as community partnerships. As with Disease Management programs, states can contract with vendors or build their own capability to review utilization and then target those patients for intervention by case managers. These managers help patients and physicians meet the complex needs of high utilizing patients.⁴⁷

⁴² U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *Unrealized Prevention Opportunities, Reducing the Health and Economic Burden of Chronic Disease* (Washington, DC: HHS, November 2000).

⁴³ Partnership for Solutions, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, MD: Johns Hopkins University, 2002).

⁴⁴ Wheatley, Ben. “Disease Management: Findings from Leading State Programs, Vol. III, No. 3.” (Washington, DC: State Coverage Initiatives, 2002).

⁴⁵ Ibid.

⁴⁶ Lewis, Al, Executive Director, Disease Management Purchasing Consortium and Advisory Council, telephone conversation with author.

⁴⁷ Medicaid Cost Containment: Report No. 1, prepared by The Lewin Group, Inc. for The Washington State Legislature, October 2002.

Working with Pharmaceutical Companies

Pharmaceutical companies also help some states afford new DM ventures by providing or financing cost saving strategies, including DM services, and guaranteeing the resulting Medicaid savings. Most companies are willing to finance these efforts in lieu of offering states supplemental Medicaid rebates on their prescription drugs.

For more information on state disease management and case management programs, please see http://www.nga.org/center/topics/1,1188,D_3877,00.html.

Promoting Disease Prevention

Chronic diseases, such as diabetes, cancer, heart disease, and obesity, account for 80 percent of health care costs and can be prevented largely through behavior modification. The medical care costs of people with chronic diseases account for more than 75 percent of the nation's \$1 trillion medical care costs.

- The direct and indirect costs of diabetes are nearly \$100 billion a year.
- Each year, arthritis results in estimated medical care costs of \$15 billion and estimated total costs (medical care and lost productivity) of almost \$65 billion.
- The estimated direct and indirect costs associated with smoking exceed \$68 billion annually.
- In 2001, approximately \$300 billion was spent on all cardiovascular diseases. Over \$129 in lost productivity was due to cardiovascular disease.
- The direct medical cost associated with physical inactivity was nearly \$76 billion in 2000.
- The direct medical cost associated with physical inactivity was \$29 billion in 1987 and nearly \$76 billion in 2000. Engaging in regular physical activity is associated with taking less medication and having fewer hospitalizations and visits to a physician.

Studies indicate that chronic diseases and their resulting complications often can be prevented through better diet, exercise, and the cessation of tobacco use. States considering progressive cost containment strategies should consider efforts to target obesity, tobacco related illnesses, and diabetes prevention and control.

Targeting Obesity

States are considering a variety of tools to promote healthy eating and physical activity. They are exploring public education campaigns; taxes on unhealthy foods, subsidies for fruit and vegetable purchases, discounted health insurance for people who participate in weight loss programs; restricting access to soft drinks and fast food in schools; mandating physical education and improving nutritional standards in schools; and improving community design to encourage walking and biking.

Through a partnership with the University of Colorado Health Sciences, the **Colorado** Physical Activity and Nutrition Program is implementing two community interventions in Peetz, Colorado, which has a large rural population, and in cooperation with the Denver Metro Black Churches, which allows program coordinators to work in an already established urban and African American setting to reach high-risk populations. These interventions focus on a physical activity component to encourage participants to walk 2,000 steps a day more than they walked before the program. Pedometers are offered to assist participants in their efforts. Additional work sites and community sites throughout the state are also participating. The intervention will introduce a nutrition component as well, most likely promoting a 5-A-Day campaign, which encourages people to eat at least five servings of fruit and vegetables a day. The program has been named *Colorado on the Move*,TM and researchers at the University of Colorado plan to expand this effort beyond the currently funded program as additional money becomes available. In addition, four task forces

were formed to guide the expansion of this program by assessing the burden of obesity and the impact of the other task force efforts (work site, school, and community) to promote *Colorado on the Move*TM and other initiatives.

Tobacco Prevention and Control

States are establishing Comprehensive Tobacco Prevention and Control Programs designed to reduce disease, disability, and death related to tobacco use by preventing the initiation of tobacco use, promoting cessation, eliminating exposure to second-hand smoke, and identifying and working to eliminate the disparity of tobacco use among different populations. As part of these efforts, states are using media campaigns to increase awareness of the dangers of tobacco use, engaging youth in anti-tobacco campaigns, increasing taxes on cigarettes, banning smoking in public places, and working to identify alternative crops for tobacco-growing communities.

Smokers who successfully quit smoking reduce the anticipated medical costs associated with heart attack and stroke by an estimated \$47 in the first year and \$853 during the following seven years.

Recent studies have concluded that reducing smoking prevalence among pregnant women by one percentage point over seven years would prevent 57,200 low-birth-weight births and save \$572 million. Studies suggest that every \$1 invested in an effective school-based tobacco prevention program saves \$19.90 in associated medical costs.

An economic assessment found that a health care plan's annual cost of covering treatment to help people quit smoking ranged from \$0.89 to \$4.92 per smoker, whereas the annual cost of treating smoking-related illness ranged from \$6.00 to \$33.00 per smoker.

In 1988, **California** became the first state to pass a voters' approved initiative to raise tobacco taxes and dedicate a portion of the revenue for a comprehensive tobacco use prevention program. Smoking rates in California have been declining more rapidly than in the rest of the country since the late 1980s. Smoking prevalence among adults decreased from 22.8 percent in 1998 to 18 percent in 1999, and California's lung and bronchial cancer incidence rates decreased by 14 percent, while in other selected and combined U.S. regions the rate declined by only 2.7 percent from 1997 to 1998. Among women in California, lung and bronchial cancer rates decreased by 4.8 percent, while there was a 13.2 percent increase in other selected and combined U.S. regions. California estimates that their program has resulted in an overall cost savings of \$8.4 billion. For every \$1 spent on the program between 1990 and 1998, an estimated \$3.62 in direct medical costs were avoided.

Following the establishment of the **Massachusetts** Tobacco Control Program, rates of smoking during pregnancy in the state dropped sharply, from 25 percent in 1990 to 13 percent in 1996. Eliminating smoking during pregnancy could reduce the percentage of infants with low birth weight to 17 percent from 26 percent.

Preventing Diabetes Complications

States are implementing programs to prevent complications from diabetes.⁴⁸

- Intensified blood pressure control can cut health care costs by \$900 (in 2000 US dollars) over the lifetime of a person with Type 2 diabetes. It can also extend life by six months.
- In just five years, a foot care program can save \$900 (in 2000 US dollars) in health care costs for a person with diabetes who has had foot ulcers. Such care prevents amputations.

⁴⁸ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Preventing Chronic Diseases: Investing Wisely in Health, Preventing Diabetes and Its Complications* (Washington, DC, 2003).

- Outpatient training to help people self-manage their diabetes prevents hospitalizations. Every \$1 invested in such training can cut health care costs by up to \$8.76.
- Preconception care for women with diabetes leads to healthier mothers and babies. Every \$1 invested in such care can reduce health costs by up to \$5.19 by preventing costly complications.

The **Minnesota** Diabetes Control Program⁴⁹ (MDCP) along with HealthPartners, a large Minnesota health plan, has developed a program called IDEAL (**I**mproving **D**iabetes **C**are **T**hrough **E**mpowerment, **A**ctive **C**ollaboration, and **L**eadership) to improve the quality of diabetes care at primary care clinics. With IDEAL, the following benefits for people with diabetes have occurred:

- **Improvements in blood glucose tests.** Patients' A1C blood glucose levels dropped from 8.6 percent in 1994 to 7.4 percent in 1999; the A1C test measures the average level of glucose that has been in a patient's blood over the last three months and shows if blood sugar is under control (7 percent or less) or too high. This decline represents a 75 percent achievement of the target goal of 7 percent and translates into a 40 percent reduction in complications that can lead to blindness, kidney failure, and amputation.
- **Improvements in cholesterol levels to reduce heart complications.** "Bad" cholesterol (LDL, or low-density lipoprotein) levels have dropped from 132 to 116, a 12 percent decrease, and "good" cholesterol (HDL, or high-density lipoprotein) levels have risen from 44 to 55, a 25 percent increase. These changes can reduce heart-related complications by as much as 50 percent.
- **Increases in preventive care medical exams.** Increases have been documented in the percentage of patients having annual foot exams (from 45 percent in 1994 to 90 percent in 1999), annual kidney function testing (0 percent to 82 percent), and annual eye exams (27 percent to 60 percent). These exams lead to the early detection and reduction of costly complications such as blindness, kidney failure, and amputation.

Restructuring Benefits and Eligibility, Provider Reimbursement Levels, and Purchasing Arrangements

States have taken measures to reduce costs by restructuring benefits, both in terms of design and delivery systems, increasing premiums and co-payments for beneficiaries and, as a last resort, adjusting eligibility criteria and/or reducing or eliminating coverage of certain benefits. Concurrently, states are also examining strategies to cut costs by freezing or reducing provider reimbursement and by taking full advantage of potential coordination with private insurance.

Maximizing Enrollment in Managed Care

For a decade, states have been taking advantage of various managed care arrangements to increase the value received for their health care dollars, both in terms of the numbers of beneficiaries reached as well as the access to services for those beneficiaries. Expansions of managed care enrollment have provided some states with greater cost containment tools by allowing Managed Care Organizations to selectively contract with providers and to exercise utilization controls.

- **Washington's** HealthyOptions program requires beneficiaries in 31 counties to enroll in capitated managed care programs and allows voluntary enrollment in seven other counties. Approximately 460,000—or 51 percent—Medicaid beneficiaries are enrolled in HealthyOptions. The state estimates that between 2001 and 2003, it saved \$147 million by providing healthcare through Managed Care rather than through a fee for service arrangement.⁵⁰

⁴⁹ Ibid.

⁵⁰ Medicaid Cost Containment: Report No. 1, prepared by The Lewin Group, Inc. for The Washington State Legislature, October 2002.

Limiting Enrollment

According to the recent Kaiser survey on Medicaid spending growth, enrollment growth averaged 8.6 percent in FY2002 and was listed second to prescription drugs as the primary driver of Medicaid expenditure growth⁵¹. To reduce enrollment growth in Medicaid, 18 states planned eligibility cuts or restrictions in FY 2003, up from eight states in 2002.⁵² Changes in eligibility imposed or considered include efforts to:

- **Delay Expansions.** States can postpone implementation of previously approved eligibility expansions to new populations or of newly authorized programs such as Ticket to Work or Medicaid Buy-in options.
- **Freeze or Cap Enrollment.** SCHIP enrollment can be frozen or capped and a waiting list or open enrollment period can be created for the newly eligible. Five states capped enrollment in 2002, and at least two included enrollment caps as a possible option on list of cuts in 2003.⁵³
- **Limit Outreach and Eliminate Automatic Renewals.** To reduce enrollment in Medicaid and SCHIP, states are reducing their marketing campaigns to enroll more beneficiaries, eliminating automatic enrollment renewals without verifying continued eligibility, and/or increasing the frequency with which eligibility must be verified.
- **Reduce Income Eligibility.** Eligibility levels for adults, pregnant women, dual eligible low-income seniors, and children currently covered as “optional populations” can be rolled back to federal mandatory levels. Mandatory eligibility levels vary by state, but are generally 40 percent of the FPL for adults and 133 percent of the FPL for pregnant women and children, and 74 percent of FPL for dual eligible seniors. States also can restore asset limits and income-reporting requirements, reduce eligibility or eliminate the medically needy program, and restrict spend-down eligibility.
- **Reduce Transitional Benefits.** Eligibility coverage can be reduced from two years to one for families transitioning from TANF to work.

Cutting Benefit Coverage

To lower costs, states are pursuing changes in benefit coverage, increasing the availability of lower cost treatment services, and increasing patient enrollment in managed care. Eight states passed benefit reductions in 2002 and 15 states passed benefit reductions in 2003.⁵⁴ Options for consideration include efforts to:

- **Reduce or eliminate certain benefits.** States are reducing benefits or imposing an annual cap on optional, adult benefits including dental, vision, prosthetic devices, podiatry, occupational and physical therapy, and hearing services. The most common reduction was in dental services for adults.
- **Redesign optional benefits.** States can seek a federal HIFA or Section 1115 waiver and reduce or redesign benefits for optional populations, reducing the per-person per-month cost, while simultaneously expanding benefits to new populations.
- **Increase enrollment in managed care.** States can enroll more populations into managed care vs. fee-for-service, or expand primary care case management, which reduces unnecessary hospital admissions, reduces hospital stays, and reduces unnecessary ER visits.

Increasing Cost Sharing

States can save money by imposing co-payments on prescriptions and medical services, establishing premiums, and partnering with employers to subsidize private insurance. Fifteen states proposed co-

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

payments or increased cost sharing for non-pharmacy benefits in 2003.⁵⁵ Options for increasing cost sharing include:

- **Co-payments.** Fifteen states proposed co-payments or increased cost sharing for Medicaid enrollees in 2003.⁵⁶ States are imposing co-payments for transportation services, doctor visits, non-emergent emergency room visits, and other services as well as waiver populations.
- **Premiums.** Two states recently implemented monthly premiums instead of co-payments.

Implementing Provider Cuts or Freezes

Twenty-two states implemented provider cuts or freezes for hospitals, physicians, managed care organizations, and nursing homes in 2002. However, 45 states indicated that they also increased rates for some of those providers. (Most frequently, rates were increased in FY 2002 for nursing homes, inpatient hospitals, and managed care organizations). In 2003, 29 states will implement cuts or freezes and only 34 states indicated any increases in provider rates. Most often these increases were automatic cost adjustments tied to an economic price index for hospitals or nursing homes.⁵⁷ The types of changes being imposed or under consideration include efforts to:

- **Cut reimbursement rates.** States can implement across-the-board or targeted reductions, in payment rates or postpone, freeze, or reduce scheduled increases for hospitals, nursing homes, physicians and other providers.
- **Hospital payments rates.** Twenty states plan to cut or freeze hospital rates in 2003.⁵⁸ States are reducing hospital costs by cutting payment rates and/or decreasing the expected increase in payment by “rebasin” the calculated increase. This new increase is intended to more accurately reflect operational costs instead of making an automatic adjustment upward each year. **Virginia** projects general fund savings of \$4.2 million in 2004 as a result of reducing outpatient hospital rates from 95 percent to 80 percent of allowable costs; \$3 million in general fund savings by moving from a cost-based reimbursement methodology to a prospective reimbursement methodology for outpatient rehabilitation providers; and \$2.6 million in savings from reducing reimbursement for inpatient and outpatient hospital capital payments to 80 percent of allowable costs. Virginia will also “rebase” their hospital rates for 2005.
- **Nursing home rates.** Sixteen states will cut or freeze nursing home rates this year.⁵⁹ Virginia projects savings of \$5.4 million in 2004 from reducing the expected nursing home rate increase.
- **Cutting or freezing reimbursement rates to physicians.** Seventeen states plan to cut or freeze physician rates in 2003.⁶⁰
- **Cutting managed care organization (MCO) rates.** Twelve states plan to cut or freeze MCO rates in 2003.⁶¹ **Virginia** is projecting 19.1 million in general fund savings from reducing the rate increase from 10 percent to 4.7 percent for their two HMO programs.
- **Reducing pharmacy dispensing fees.** Five states plan to cut dispensing fees in 2003.⁶²

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Ibid.

Increasing Provider Taxes

States are increasing revenues by imposing new taxes or increasing existing taxes on nursing homes, hospitals, intermediate care facilities for the mentally retarded (ICF/MRs), and/or psychiatric residential treatment facilities.

Leveraging State Purchasing Power

States can use their purchasing power to obtain better rates and discounts by combining purchases for Medicaid, state employees, retirees, and public health programs as a block. “Selective contracting” or preferred provider contracts can be negotiated for inpatient hospital and psychiatric services, and for procurement of medical supplies and transportation.

Managing Prescription Drug Expenditures

While still significantly lower than hospital and other provider expenditures, prescription drug expenditures constitute one of the fastest growing components of state Medicaid budgets—growing at about 17 percent annually. Better managing these costs often presents the greatest opportunity for achieving savings of a significant magnitude and protecting access to this important benefit. Florida, for example, reports savings of almost \$500 million through its preferred drug list, a four-brand limit, clinical prior authorization and other tools.⁶³ Forty states planned some type of pharmacy control in 2003.⁶⁴

Mail-Order Pharmacy

Both to save money and enhance access for rural beneficiaries to prescription drugs, some states offer a mail-order pharmacy option to their Medicaid beneficiaries. Expenditures are lower on mail-order pharmaceuticals because the dispensing fee is decreased by providing three month supplies of drugs and because of over-all lower cost of drug ingredients available via mail-order.⁶⁵

Prior Authorization

At least 35 states require providers to obtain approval from a state pharmacist or contractor before an enrollee can receive certain drugs. These drugs most commonly include anti-ulcer drugs, anorexants, and drugs used to treat impotence. States are required to respond within 24 hours and must provide a 72 hour supply in emergencies. **Idaho** reports a savings of \$850,000 million per month through this approach.

Preferred Drug Lists and Supplemental Rebates

More than a third of the states have or are considering Preferred Drug Lists (PDLs) to steer beneficiaries toward drugs that they think are the most efficacious choice for treating a particular condition. When no demonstrated advantage exists between one drug and another, generally the more cost-effective drug is selected for the list. Some states also will consider another manufacturer’s drug for the list if the manufacturer gives the state a supplemental rebate, usually equal to or close to the difference in price between that drug and the preferred drug. Drugs not on the list usually require prior authorization. Mental health, HIV-AIDS, and cancer drugs are normally excluded from prior authorization requirements. **Michigan** reports saving \$32 million per year—\$8 million from supplemental rebates—and **Vermont** reports saving \$2.8 million in the first six months.

⁶³ http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/

⁶⁴ Elam, et al., *Medicaid and the Prescription Drug Benefit; Cost Containment Strategies and State Experiences* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002).

⁶⁵ Medicaid Cost Containment: Report No. 1, prepared by The Lewin Group, Inc. for The Washington State Legislature, October 2002.

States such as **Washington** also report that as the process drives providers towards prescribing drugs on the evidence based list, state time spent performing prior authorization activities is diminished. Washington reports savings of \$2.4 million.⁶⁶

Mandatory and Encouraged Generic Substitution

When available, the average price of a generic is 70 percent less than that of a brand name drug. States can either mandate that pharmacies substitute generics for brand-named drugs when available or encourage substitution by giving them higher reimbursement rates or fees or by requiring higher co-payments from consumers for brand name drugs. At least 16 states require generic substitution.⁶⁷

Prescription limits and Drug Exclusions

At least 40 states limit the amount of a medication dispensed to a patient at one time, 24 limit the number of refills that an enrollee can receive, 12 limit the number of monthly or annual prescriptions a patient can receive, and one uses a spending cap. Other options include requiring poly-pharmacy users to establish a medical and pharmacy home to reduce the over utilization or misuse of drugs by individuals who use many prescriptions, providers, and pharmacies.⁶⁸

At least 40 states exclude lifestyle drugs such as those prescribed for hair-loss and fertility. States are permitted by law to exclude some other specific categories of drugs such as those for smoking cessation, weight loss or control, investigational drugs, and drugs for which there is a high risk of abuse.⁶⁹

Inter- and Intra-State Purchasing Alliances

Michigan, South Carolina, and Vermont have announced that they will become partners in negotiating supplemental rebates from pharmaceutical manufacturers in their Medicaid programs using a Pharmacy Benefits Administrator (PBA) to establish a new bidding system for drug companies. While four states already partner to purchase drugs for state employees, this marks the first time that states will become partner to purchase drugs for Medicaid.

Some states use a single Pharmacy Benefits Manager (PBM) to purchase drugs across all state agencies (Medicaid, state employees, public health, Corrections, etc.) and use that bigger market share to negotiate better prices for some programs.

Other pharmacy management tools

Other tools that a state can use to control utilization and costs include prospective drug utilization review, beneficiary cost-sharing (although cost sharing is not enforceable under federal law), fail first policies that require enrollees to try older, less-expensive drugs within a class before moving on to a newer, more-expensive drug, and reductions in pharmacy reimbursement rates and dispensing fees. Others also have explored the use of mail order pharmacy to fill prescriptions. Washington estimates the cost of mail order pharmaceuticals to be 16 percent less than retail.

⁶⁶ Medicaid Cost Containment Report No. 1, prepared by The Lewin Group, Inc. for the Washington State Legislature, December 2002.

⁶⁷ Elam, et al., *Medicaid and the Prescription Drug Benefit; Cost Containment Strategies and State Experiences* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002).

⁶⁸ Ibid.

⁶⁹ Ibid.

Conclusion

Projections indicate that health care costs will continue to grow at double-digit rates of inflation over the coming decade. States must take a comprehensive approach to containing these rising costs. Such strategies should include efforts to better manage growing benefit costs by adjusting the breadth and scope of benefit packages; increasing cost sharing with individuals, businesses, and federal and county governments; controlling provider payment rates; limiting the costs of program administration; enhancing efforts to reduce fraud, abuse, and waste; and better managing the pharmacy benefit.

In addition to these cost management strategies, states will need to pursue more innovative strategies aimed at reducing the cost of caring for the elderly and the chronically ill. States need to design more effective systems to engage seniors in efforts to prevent the need for nursing home care and increase the capacity and supportive systems that allow seniors to age in place. States need to pursue innovative solutions to improve the health outcomes of those with costly chronic conditions, including efforts to better engage medical providers in adhering to evidence-based treatment guidelines and strategies that better educate and engage patients in their own care management.

States must also move their cost-containment efforts upstream to focus on reducing the incidence of costly chronic conditions. Investing in prevention through promoting exercise, nutrition, and the cessation of tobacco use will help states to mitigate the high costs of health complications caused by heart disease, cancer, diabetes, obesity and other chronic ailments.

Whatever package of cost containment measures a state chooses, it is important to keep a record of the savings that can be attributed to that particular approach. This gives policymakers the advantage of knowing specifically what saved the state money and whether or not such an approach led to unintended consequences or expenditures.

*This issue brief was written by Lydia Faulkner and Brendan Krause with contributions from Diane Braunstein.