Opinion

The Promise—and Politics—of State Innovation for Health

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THE NOVEMBER 2018 MID-TERM ELECTIONS BROUGHT DIVIDED government to the nation's capital—and delivered new, highly motivated governors to state capitals around the country. Maine Governor Janet Mills campaigned on a pledge to expand Medicaid; Michigan Governor Gretchen Whitmer ran to protect health care access; and Minnesota Governor Timothy J. Walz announced, just after being sworn in, that “health care is a basic human right.” In his first official act, California Governor Gavin Newsom proposed offering coverage to undocumented immigrants, expanded the state's ability to negotiate prescription drug prices, and created a new position of Surgeon General to “address health inequity as early as possible in all Californians' lives.”¹

Even as the federal government sputtered and shut down for more than a month, states were awash in activity on health care. Three deep red states—Utah, Nebraska, and Idaho—approved ballot initiatives to expand Medicaid. Two blue states—Delaware and Rhode Island—followed the lead of Massachusetts to establish benchmarks for total health care spending growth. Pennsylvania created global budgets for rural hospitals, and North Carolina began implementing a landmark program that helps enrollees find housing, access healthy food, and avoid situations at risk for violence.

A new era of state experimentation in health care is dawning. What may be less apparent is the critical role that federal support plays in many of these innovations. As the 2020 national elections approach, it will be essential to keep reform efforts from getting caught in the wringer of partisan politics.

There has long been a strong economic logic to broad state engagement in health care. State taxpayers are major payers for health care, with Medicaid alone accounting for about one-fifth of state spending (when both federal and state revenues are included, the amount rises

to about one-third of the overall state budget). Health expenditures for state employees and those in detention push the costs even higher.

The traditional state strategy for dealing with these costs has been to reform the Medicaid program. However, many approaches, such as engaging with managed care organizations and lowering provider rates, have had the effect of shifting costs to private payers. These moves engender opposition from physicians, hospitals, and other providers, as well as from businesses that face rising costs of private insurance.

As a result, state leaders are increasingly setting their sights on the entire health care system, aiming to reduce costs and improve outcomes across the board. To succeed, states can draw on a number of policy tools.² These include the ability to collect data necessary for systemic reform (eg, through health information exchanges and all-payer claims databases), the authority to regulate the content and sale of health insurance, and the responsibility for determining the scope of practice and licensing of health professionals, including nurse practitioners and other primary care clinicians.

States are especially well positioned to manage the local politics of health reform. Governors and legislative leaders can help the public recognize that rising costs and poor outcomes are not abstractions. They can explain that the failures of the health care system are why so many households have trouble paying their bills, why so many companies are struggling to offer comprehensive coverage, and why so many neighbors are suffering and dying before their time.

With greater public awareness of the need for reform, states can then work with local leaders of health care to design solutions. In Maryland, where hospital rate-setting has had a 40-year history, the first step forward was to adopt global budgets for hospitals; the state's efforts have now expanded to engage physicians and other health care providers. In Arkansas, where the leading insurer was interested in collaborating around bundled payments, a public-private partnership was quick to emerge. In Vermont, where providers were already coalescing into an integrated delivery system, state health officials proposed a state-wide accountable care organization.

Critical support for all of these efforts, and for many others, has come from the federal Centers for Medicare and Medicaid Services (CMS). CMS has allowed states to bring forward compelling reforms with substantial local support and then share in the risk and potential savings from their implementation.

In Medicaid, for example, the Delivery System Reform Incentive Payment Program has allowed states to develop their own models of investing in primary care, behavioral health, and other essential services needed for health system transformation. With billions of dollars in play, the federal government has shared in the economic and health benefits that result from averted preventable hospital admissions.

Under the Affordable Care Act, Medicare has been able to make similar arrangements with states. The opportunity to work with the \$700 billion federal program has been a game-changer for state reform efforts. Previously, a state that developed initiatives to reduce preventable admissions in the Medicare program could only watch as 100% of the savings returned to the federal treasury. Now, a state with a waiver from the CMS Innovation Center can take some of the anticipated savings up front as an investment and share more on the back end as costs decline.

Far more than just a bank, CMS also plays the critical role of a fair and independent judge of reform ideas. Federal officials “kick the tires” of reform proposals to assure that they’re based on sound evidence and reasonable assumptions, and CMS actuaries run the numbers. CMS can even help states find creative solutions to problems such as the high cost of drugs to treat hepatitis C and the immense challenge of the opioid crisis.^{3,4}

Despite the promise of this partnership, however, there are several clouds on the horizon. One is a classic challenge: When reforms happen one state at a time, reforms happen one state at a time. To accelerate the pace of national progress, CMS should seek to turn the results of one state’s extended reform process into a model that is readily available around the country.

A second cloud is that several of the Trump administration’s political priorities threaten the success of state-led reform. The concerted campaign to weaken or repeal the Affordable Care Act and turn Medicaid funding into block grants threatens gains in coverage; ideological efforts to defund Planned Parenthood risk reducing access to reproductive health care; and draconian immigration policies push preventable and treatable health problems into the shadows. Limiting the damage from this agenda is now an extra burden on states.

A third cloud is that state reform proposals themselves become intertwined with partisan politics. Partisan calls for the approval—or the rejection—of state models risk dragging the process down the drain of the electoral cycle, with promotional slogans on the one hand, and fear

mongering on the other. The alternative? Dialogue based on objective analyses. There is ample space, for example, for a meaningful assessment of state single-payer proposals without the imposition of political litmus tests. Similarly, the review of Medicaid waiver proposals that impose work requirements should be based on analysis and data, not erroneous stereotypes about people who live in poverty.

Federal officials should take pride (and their fair share of credit) in seeing states make progress in improving health. State officials should appreciate the need for federal review and the support of federal agencies in making change happen. The shared goals of improving population health and controlling costs provide plenty of reason to propel today's era of state innovation forward.

References

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