Connecticut Health Policy Project

Policymaker Issue Brief

December 2012

31 Ways to Save Money in Connecticut's health care budget

Connecticut's state budget is facing a billion dollar deficit in the next fiscal year and health spending is a growing share of that budget. The state now spends $6 billion between Medicaid and the state employee health plan to cover almost 900,000 state residents.[i] Health care spending outside the state budget is also growing. The share of Connecticut's economy spent on health care rose 20% from 1999 to 2009 and Connecticut spends 27% more per capita on health care than the US average.[ii]

Over the next few months state policymakers will be making difficult decisions to cover the deficit. It is estimated that 30% of US health care spending is wasted on unnecessary services, excessive administration, fraud and missed opportunities for prevention.[iii] While that number is disappointing, it offers opportunities to control costs while improving the quality and effectiveness of care.

We have collected 31 such opportunities for Connecticut policymakers. New data from DSS has determined that one option included in the 2010 list of opportunities saved millions this year in the HUSKY program by moving from capitated managed care to self-funding and coordinated care.[iv]

Some of these options are specific to state programs and some will lower costs across all payers. Some provide immediate savings and some are long-term opportunities, however many long term options offer the biggest benefits in sustainable cost control and quality improvement. Most do not require new funding to implement. Some require redirecting current staff functions and duties. Many use the state's considerable power, as the largest funder of health coverage, the regulator of providers and payers, the main funder of public health activities, and the power inherent to government, to lead our fragmented system into sensible reforms.

Reform health care payment systems to align incentives and promote quality and value

1. **Direct the CT Health Insurance Exchange to actively purchase health insurance including but not limited to negotiating premiums with insurers on behalf of consumers.** Negotiation would allow Exchange members to enjoy the same savings that exchange members in other states and workers at large companies do.[v] The new Exchange is a very lucrative opportunity for insurers with one in ten state residents expected to buy coverage there. With negotiation, the Exchange could serve to drive cost control throughout Connecticut's insurance market; without negotiation, it would serve to entrench the current inefficient system.[vi]
2. **Purchase prescriptions in bulk across state programs.** A proposal from the Comptroller's Office could save the state $67 million each year by combining the nine

million prescriptions paid for by DSS annually with the three to four million funded through OSC. The savings result mainly from volume discounts and would not affect changes in coverage or price for consumers.[vii]

3. **Implement payment reform for all state health care purchasing and support all-payer initiatives to reduce overutilization and pay for quality.** This includes a variety of initiatives implemented in other states such as pay-for performance for both providers and managed care plans, paying for episodes, or bundles, of care in one payment across the care continuum rather than paying fees for each individual service, and eventually making global care payments for individuals, risk adjusted to account for varying levels of need.[viii] Connecticut can build on the promising Medicaid/Medicare Health Neighborhood application to the Centers for Medicare and Medicaid Services (CMS). The state should incorporate Value Based Insurance Design into coverage programs providing consumers with personalized incentives to improve their health. National health reform includes several funding opportunities for implementation of payment reform.[ix]
4. **Reward high quality providers with higher rates.** The state is the largest purchaser of health coverage in Connecticut, largely paying providers the same rates by program regardless of the quality of care provided. Twenty three percent of US employers expect to incorporate differential rates based on quality, often termed Centers of Excellence, in their benefit plans by next year.[x] Other states have included differential or tiered provider payment based on quality and efficiency in their health care purchasing, reward providers who provide better quality care, improved health outcomes, patient satisfaction and are more efficient with higher levels of reimbursement. [xi]
5. **Create a multi-payer collaboration to align incentives to improve health care quality and efficiency.** Using the state's convener authority to ease anti-trust concerns, the state should create a safe forum for payers to collaborate, align standards, quality measures, cost reporting, payment mechanisms, and payment reforms. Such collaboration could reduce the fragmentation and complexity of incentives, making them more salient for providers. Maine and Minnesota are leaders in bringing together private employers with government payers to align standards and incentives, share oversight resources, improve the quality of care and reduce rising costs.[xii]
6. **Strengthen Insurance Department rate review**. The state has great leverage in reducing the costs of insurance through the Connecticut Insurance Department's regulatory role. Massachusetts has expanded the authority of the Division of Insurance to mitigate and stabilize rate spikes.[xiii] The state could expand considerations in premium rate review to include consumer costs – out of pocket and share of premiums, direct and robust monitoring of network adequacy, provider pricing, executive compensation, and affordability.
7. **Monitor health care price variation.** A great deal of rising health costs is driven by rising prices and great variability between regions. The state could measure health care price variation, identify outliers, determine if quality justifies higher rates, and work with providers to bring prices into line with the market. If necessary, the state could

lower rates in public programs and subsidies to level the playing field. Massachusetts' recent cost control reforms include robust price variation monitoring.[xiv]

8. **Create a state Accountable Care Organization accreditation program available to all payers.** Accountable Care Organizations (ACOs) are integrated networks of local providers across the care continuum, including hospitals, physicians and affiliated providers that are paid based on their ability to provide quality care and restrain costs.[xv] ACOs hold great potential to improve quality and control health costs. CMS is currently granting certification to ACOs for Medicare, but New York and Massachusetts are creating state ACO certification standards applicable to all payers.[xvi] Massachusetts intends to give a preference to state-certified ACOS in state health programs.[xvii] While preserving competition and recognizing anti-trust concerns, the state should take a lead role in developing ACO arrangements in Connecticut to align incentives for efficiency and quality among providers across the care continuum.
9. **Better market federal small business tax credits.** The Affordable Care Act (ACA) includes tax credits for almost two thirds of Connecticut small businesses to offer health benefits to workers. Unfortunately, many businesses are not taking advantage of this opportunity and leaving millions in federal subsidies for health coverage on the table.[xviii]
10. **Reduce prescription drug costs with a provider education (counter detailing) campaign**, on the relative costs and effectiveness of medications, limit gifts to providers from drug companies, require disclosure of all financial ties between providers and suppliers, and prohibit direct industry funding of provider Continuing Medical Education training. All these measures have been adopted by Massachusetts in their health care cost containment reforms.[xix] Much can be done to encourage generic drug use and mail order delivery savings among Medicaid consumers.

Engage consumers and patients to improve health and control costs

11. **Tap into the wisdom of crowds.** The state should engage consumers in meaningful two-way communication about how to fix our health care system. Consumers are in the best place to help reduce costs, with the most at stake. The state should solicit ideas from consumers and other stakeholders and test policy initiatives before implementation. There are numerous examples of well-meaning initiatives in Connecticut's health care landscape that failed because no one checked with consumers to see if they were feasible or would be effective. The state must engage consumers in meaningful, long-term partnerships – more than one-time, single-issue task forces and boards. The state must rebuild trust by working together, especially at the CT Health Insurance Exchange, and share responsibility for solutions.
12. **Expand public health programs that give patients tools to take responsibility for their health** including care coordination, disease management, risk assessments, disease screenings and immunizations on a community level to prevent disease and manage chronic illness. The state should encourage community-clinical partnerships that improve health across populations.[xx] Connecticut's program providing free nicotine replacement therapies was overwhelmed and had to be shut down early because

demand outstripped the budget. Vermont's Blue Print for Health can serve as a template for Connecticut.[xxi]

13. **Develop a public education campaign about appropriate health care treatment.** Consumers facing an increasingly complex health care environment can be misled by industry interests threatened by reductions in profits. A coordinated, thoughtful campaign to educate consumers about the dangers of overtreatment and mistreatment,[xxii] that more care is not always better, the important new lessons of comparative effectiveness research to improve the effectiveness of care, and to counter misinformation about "rationing" and gatekeeping will bring the power of consumers to improving the effectiveness and value of health care. Consumers need to understand the benefits of coordinating health care through a patient-centered medical home and why they should not go to the emergency department with non-urgent issues.
14. **Use transparency and market forces to improve cost effectiveness of care by providing consumers with comparative quality and cost data.** Maine, Massachusetts, Pennsylvania and Minnesota have led states in developing publicly available comparisons among providers based on quality and cost data. Public quality reporting gives consumers tools to choose the best health care value, putting downward pressure on prices for all payers.[xxiii] Comparisons with colleagues have been very effective in motivating providers to improve.[xxiv]

Reform health care delivery to be patient-centered and efficient

15. **Expand patient-centered medical homes.** Patient-centered medical homes (PCMHs) hold great potential to both improve health outcomes and control costs. PCMHs work by coordinating care, expanding access, expanding capacity through teams of providers each working at the top of their license and giving people the tools they need to keep themselves well.[xxv] In PCMHs, all care revolves around the patient who is the final decision-maker and ultimately responsible for outcomes.[xxvi] Medicaid and the state employee plan have promising PCMH programs under development but Connecticut remains behind neighboring states in the number of certified PCMHs. Connecticut should follow the roadmap included in the Medicare PCMH pilot application to expand capacity, build a learning collaborative for providers, a multi-payer collaborative to harmonize standards and payments, and include a statewide evaluation with constructive recommendations.[xxvii]
16. **Strengthen primary care capacity.** Areas with adequate access to primary care enjoy lower emergency room use for non-urgent care, improved outcomes for patients with chronic illness, and lower levels of overall health spending.[xxviii] Connecticut is facing a serious shortage of primary care capacity; reduced access to primary care has been linked to higher health costs.[xxix] Massachusetts has included expansions of physician assistant and nurse practitioner roles, loan forgiveness guarantees, and primary care residency programs in their cost control law.[xxx] Reforms go beyond the need for more practitioners to include support for new skills, team based care, expectations that every provider work at the top of their license, and reforming payment policies to maximize the effectiveness of all team members.[xxxi]

17. **Assess areas of over and under capacity in Connecticut's health care workforce.** The nursing shortage has been a significant driver of hospital costs, in particular, while there is evidence that an over-abundance of physicians, especially specialists, in an area can increase costs.[xxxii] As our population ages, chronic diseases multiply, and the practice of medicine changes, it is critical that Connecticut monitor and regulate its health care workforce. It is critical to move beyond contentious scope of practice battles and match workforce planning to current and future needs.[xxxiii] The federal WISH grant report by the Connecticut Employment and Training Commission and the Allied Health Workforce Policy Board provides a roadmap to thoughtful health care workforce development keeping labor costs in check, preserving quality care and growing jobs.
18. **Expand alternative provider resources including urgent care centers, retail clinics and health.** Between 14 and 27 percent of all emergency department visits could be safely provided at urgent care centers or retail health centers[xxxiv] costing less than half or one third than at emergency departments with comparable quality.[xxxv] Connecticut hospital emergency departments are increasingly overcrowded, particularly with Medicaid patients, driving state budget costs. It is critical to ensure safe, quality care at urgent care centers and retail clinics by requiring certification by national accrediting bodies. Electronic linkages to area primary care providers should be required of all clinics and centers, including the ability to make appointments, and incentives to divert patients back to appropriate care. To save money in the state's growing Medicaid budget, urgent care clinics and retail clinics should be rewarded for building capacity in underserved areas. Half of physicians say payment for electronic consults could substitute for many in-office visits and some assessments and history taking can be done remotely. Some insurers are now paying for electronic consults, saving money and improving access to care.[xxxvi]

Implement health care quality reforms and preventive care that save money

19. **Integrate Comparative Effectiveness Research into all state health purchasing.** Too many new, expensive treatments and technologies are adopted and gain wide use before a careful analysis of their effectiveness in treating the condition or cost effectiveness compared to other options. This is a significant driver of health costs with little connection to quality.[xxxvii] The federal government is spending billions on research on both quality and cost effectiveness comparisons of treatments, however it often takes years for that research to be translated into clinical practice. Enlightened payers, including some states, are building Comparative Effectiveness Research into their payment incentives with impressive results.[xxxviii] Academic detailing programs, providing unbiased, noncommercial marketing of Comparative Effectiveness Research to providers, also hold great promise in reducing costs while improving quality.[xxxix]
20. **Reduce overtreatment.** There is growing evidence that too often Americans receive more care than they need, up to one third of all health care according to some

estimates, causing both physical harm and rising costs. [xl] Over thirty medical societies have collaborated to develop lists of overused, often unnecessary treatments and tests that should be used rarely.[xli] States can begin reducing overtreatment by limiting early elective deliveries without medical need and double chest and abdominal CT scans which should be rare. Both carry extensive risks and costs.[xlii]

21. **Improve patient safety.** Thousands of Connecticut hospital patients die every year from preventable, adverse events. Hospital acquired infections cost as much as $45 billion annually and falls in hospitals and nursing homes another $43 billion.[xliii] Improving patient safety and avoiding medical errors could significantly reduce health costs by preventing needless complications and possibly reducing medical malpractice costs.[xliv] The state licenses and funds health care providers. Requiring redesign of systems to measure and prioritize commonsense safety protections will improve quality and lower expenses.[xlv]
22. **Support employer wellness programs.** About 25% of employers' medical costs are caused by eleven alterable risk factors: lack of exercise, alcohol use, overweight, current or former tobacco use, depression, stress, blood pressure, cholesterol, weight, and blood glucose.[xlvi] Well-designed employer wellness programs can reduce sick leave absenteeism by 28%, reduce health care costs by 26%, and increase overall employee satisfaction.[xlvii] On average, every per dollar invested in wellness programs returns $3.27 in lower medical costs and $2.73 in lower absenteeism.[xlviii] The ACA includes incentives for wellness programs for employers and payers.[xlix] The success of the State Comptroller's Health Enhancement Program for state employees provides a head start for incorporating effective wellness in all state health programs.[l] As part of their cost control law passed earlier this year, Massachusetts instituted a wellness tax credit up to $10,000 per employer, is creating a "model guide" for business wellness programs, and included stipends to businesses to create wellness programs. Massachusetts also requires insurers to reduce premiums for small businesses that provide wellness programs.[li]
23. **Invest in preventing disease.** Seventy percent of US deaths are due to behavioral or environmental, often preventable, causes but only five percent of health spending is devoted to prevention.[lii] Sixty percent of high-risk Connecticut adults did not get flu shots in 2009.[liii] One in three young children in Connecticut have not received the six key immunizations.[liv] As part of their cost control bill, Massachusetts will invest $60 million over four years in community-based prevention, public health, and wellness efforts to reduce the rates of chronic illness.[lv] Connecticut can also invest in community public health resources such as substance prevention, smoking prevention/treatment, and school-based drug and alcohol prevention programs.[lvi]

Create a learning health care system that identifies best practices, and responds with appropriate changes in policies and practice

24. **Implement robust evaluations of all state health programs.** Too many state programs are implemented with the best intentions, but are not successful. Many could

have been effective with constructive monitoring combined with the political will to follow through and make modifications. Connecticut is entering an exciting period of health reform involving significant changes, especially in payment structures. Robust, constructive evaluations are critical to ensuring that reforms work to improve care and lower costs and do not become part of the problem. Evaluations ensure that scarce resources are maximized and should be designed and integrated from the beginning of every initiative. Evaluations should focus on consumer perspectives, access to care, impact on racial and ethnic disparities and long term health outcomes. If we don't learn from what works and what doesn't as we transform our health care system, and modify programs accordingly, we will never control costs or improve quality.

25. **All payer claims database.** An All Payer Claims Database (APCD) offers the ability to identify trends, hotspots and beacons of innovation across our fragmented health care system. We must build it, but more importantly we must use it. The APCD can be an important tool providing Connecticut consumers and payers pricing transparency, can identify trends and outliers for better planning, compare provider quality and cost to improve quality, reduce duplication of services and medical errors, detect problems and help identify their roots, identify hotspots of utilization – e.g. by geography, "frequent flyer" patients, providers with high or low utilization – and allows policymakers to target interventions effectively. It is important to support providers in using their data to improve performance and support payers in using the data to reward value.
26. **Create a Health Care Quality and Cost Council.** Massachusetts's comprehensive cost containment package was the result of a Council of stakeholders, dedicated to finding a feasible, realistic package that worked for their state. In 2009 the Council authored a Roadmap to Cost Containment that served as the foundation for this year's law that is expected to save the state $200 billion over fifteen years. The Council engaged all the relevant stakeholders, giving them ownership of both the problem and the solution. State agencies served as non-voting members -- there to support good ideas.[lvii] Connecticut has a history of creating one-time task forces to address narrowly focused issues. An exception to that history is the Medical Assistance Program Oversight Council, meeting since 1995, that includes key stakeholders and serves as a constructive platform to gather diverse input, test proposals, and move the programs toward innovation. This precedent serves as a model for a larger effort addressing Connecticut's entire health system.

Remove waste and excessive administrative spending

27. **Promote and require the use of health information technology tools,** including provider electronic medical records and consumer personal health records, for all state coverage programs. Health Information Technology offers an important opportunity to integrate the best clinical knowledge into care decisions.[lviii] Massachusetts has made significant investments in Health Information Technology infrastructure with the expectation of controlling costs.[lix] Support the development of a secure, sustainable, user-friendly health information exchange for all state residents. Strong privacy

protections, including opt-in consumer consent policies, are critical to the integrity of health information exchange and a viable statewide system.[lx] Competence in health information technology is gaining interest as a component of physician licensure and renewal standards.[lxi]

28. **Increase monitoring of anti-competitive practices** of health care organizations and insurers. Like the rest of the US, Connecticut's health care market is increasingly concentrated with fewer insurers and larger provider groups forming over time. Consolidation serves to reduce competition for business and raises costs.[lxii] The state must rigorously monitor provider and insurer mergers, for-profit conversions, and physician practices merging with hospital systems to maximize competition in Connecticut's health care market. In addition, the state should support new entrants into the market.
29. **Engage consumers in identifying and reporting fraud, waste and abuse in all state programs** and in generating ideas for innovation. The successful Medicare Senior Patrol program developed by the US Administration on Aging provides an important guide.[lxiii] Use the wisdom of crowds and the network of 900,000 consumers covered by state programs to drive improvement.
30. **Ease provider administrative burdens.** US physicians average 43 minutes each day on health plan administrative functions; their staff spends far more time on administration. Administrative simplification could reduce these costs by as much as $29,000 per physician. Reforms include adoption of electronic transactions, a common provider enrollment and credentialing system, and standardized reporting requirements.[lxiv] Administrative hassles are a crucial barrier to Medicaid participation for Connecticut physicians.[lxv]
31. **Create robust and reasonable fraud monitoring systems.** The US General Accounting Office estimates that 8.1% of US Medicaid payments were improper in 2011.[lxvi] If that rate applies to Connecticut, it amounts to $324 million.[lxvii] Using new technological tools to reduce fraudulent payments before they are made is critical to capturing these costs and the ACA includes new tools to eliminate fraud.[lxviii] However, the state must also reduce the burden of audits, and eliminate counter-productive, overly-aggressive provider auditing to remove barriers to Medicaid participation.[lxix]

Bottom line: There is no shortage of realistic, tested opportunities to control Connecticut's health care costs that do not harm our health. Improving quality doesn't have to cost more.

CT Health Policy Project
203.562.1636
www.cthealthpolicy.org

[i] Office of State Comptroller, personal communication; Active Assistance Units Report for October 2012, DSS, November 8, 2012
[ii] National Health Accounts, CMS
[iii] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Institute of Medicine, September 2012
[iv] DSS Presentation, Care Management Committee, Medical Assistance Oversight Council, December 12, 2012
[v] Connecticut's Health Insurance Exchange Must Negotiate on Behalf of Consumers, CT Health Policy Project, November 2012
[vi] E Emanuel, et. al., A Systemic Approach to Containing Health Care Spending, New Eng J Med 367:949-954, September 6, 2012
[vii] Bulk purchasing of medication can reduce state budget deficit, Comptroller says, CT Mirror, Nov. 26, 2012; Comptroller Lembo identifies $66.5 million savings through joint drug purchasing with DSS, OSC News Release, Feb. 3, 2011
[viii] Strategies for Curbing Health Insurance Costs for State Employees: Benefit Design, Wellness Programs and Data Mining, National Governors Association, October 2012
[ix] Patient Protection and Affordable Care Act, (P.L. 111-148) Title II, Subtitle I
[x] 17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, 2012
[xi] Strategies for Curbing Health Insurance Costs for State Employees: Benefit Design, Wellness Programs, and Data Mining, National Governors Association, October 2012
[xii] Value over Volume, Council of State Governments/Eastern Regional Conference, February 2010
[xiii] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[xiv] J Ayanian, et. al., Tackling Rising Health Care Costs in Massachusetts, New Eng J Med, 367: 790-793, August 30, 2012
[xv] Accountable Care Organizations, Candidate Briefing Book, CT Health Policy Project, September 2012
[xvi] National Academy for State Health Policy, December 2012
[xvii] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[xviii] Report: Underused Health Insurance Tax Credit Could Bring $166M To CT Small Firms, Hartford Courant, May 9, 2012
[xix] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[xx] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, IOM, September 2012
[xxi] http://healthvermont.gov/blueprint.aspx
[xxii] R Gibson and JP Singh, The Treatment Trap: How the Overuse of Medical Care is Wrecking your Health and What You Can Do To Prevent It, Ivan R. Dee, Chicago, 2010
[xxiii] E Emanuel, et. al., A Systemic Approach to Containing Health Care Spending, New Eng J Med 367:949-954, September 6, 2012
[xxiv] Value over Volume, Council of State Governments/Eastern Regional Conference, February 2010, www.valueovervolume.org
[xxv] Patient Centered Medical Home Advisory Committee Final Report to the SustiNet Board, July 2010
[xxvi] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, IOM, September 2012
[xxvii] Connecticut's Patient-Centered Medical Home Medicare application, CT Health Policy Project, September 2010
[xxviii] Flattening the Trajectory of Health Care Spending: Foster Efficient and Accountable Providers, RAND, 2012

[xxix] CT State-wide Primary Care Access Authority, http://www.cga.ct.gov/ph/PrimaryCare/informational.asp
[xxx] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[xxxi] Flattening the Trajectory of Health Care Spending: Foster Efficient and Accountable Providers, RAND, 2012
[xxxii] Dartmouth Atlas project, www.dartmouthatlas.org
[xxxiii] E Emanuel, et. al., A Systemic Approach to Containing Health Care Spending, New Eng J Med 367:949-954, September 6, 2012
[xxxiv] R. Weinick et. al., Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics, Health Affairs 29:1630-1636, September 2010
[xxxv] M Thygeson et. al., Use and Costs of Care in Retail Clinics Versus Traditional Care Sites, Health Affairs 27:1283-1292, September/October 2008; Flattening the Trajectory of Health Care Spending: Facilitate High Value Innovation, RAND, 2012
[xxxvi] 17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, 2012; Medical Cost Trend: Behind the Numbers 2013, Health Research Institute, May 2012
[xxxvii] Technological Change and the Growth of Health Care Spending, CBO, January 2008
[xxxviii] D Howard et. al., Evidence of No Benefit from Knee Surgery for Osteoarthritis Led to Coverage Changes and is Linked to Decline in Procedures, Health Affairs 31:2242-2248, October 2012; Wellpoint CE Study Results in Coverage Adjustment for Oral Asthma Drugs, F-D-C Reports, August 31, 2009; Joan M. Kapowich Oregon's Test Of Value-Based Insurance Design In Coverage For State Workers *Health Affairs*, 29:2028-2032, November 2010; Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, IOM, September 2012
[xxxix] M Fischer and J Avorn, Academic Detailing Can Play a Key Role in Assessing and Implementing Comparative Effectiveness Research Findings, Health Affairs, 31: 2206-2212, October 2012
[xl] Many Common Medical Tests and Treatments are Unnecessary, Consumer Reports, June 2012
[xli] Choosing Wisely, ABIM Foundation
[xlii] Rosemary Gibson, What States Can Do About Health Care Overuse, CSG/ERC webinar, December 2011 and personal communications
[xliii] Jean Rexford, CT Center for Patient Safety, Testimony to the US Senate Committee on Aging, July 2, 2012
[xliv] Flattening the Trajectory of Health Care Spending: Foster Efficient and Accountable Providers, RAND, 2012
[xlv] Crossing the Quality Chasm, Institute of Medicine, March 2001
[xlvi] Anderson DR, et. al., The relationship between modifiable health risks and group-level health care expenditures, Am J Health Promot. 15: 45–52, 2000
[xlvii] Parks, KM and L Steelman, Organizational wellness programs: A meta-analysis, Journal of Occupational Health Psychology,13: 58-68, 2008
[xlviii] K Baicker et. al., Workplace Wellness Programs Can Generate Savings, Health Affairs 29:1, February 2010
[xlix] Workplace Wellness Programs, Health Affairs, May 2012
[l] Fiscal Year in Review, CT Office of State Comptroller, September 2012
[li] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[lii] Flattening the Trajectory of Health Care Spending: Promote Population Health, RAND, 2012
[liii] State Snapshots, AHRQ, 2011
[liv] Child Health Scorecard, Commonwealth Fund, 2011
[lv] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012

[lvi] Flattening the Trajectory of Health Care Spending: Promote Population Health, RAND, 2012
[lvii] J Ayanian, et. al., Tackling Rising Health Care Costs in Massachusetts, New Eng J Med 367:790-793, August 30, 2012
[lviii] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, IOM, September 2012
[lix] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[lx] Public comment submitted to the CT Health Information Technology and Exchange, CT Health Policy Project, June 23, 2010
[lxi] H Chaudry, Federation of State Medical Boards: Maintenance of Licensure and Health IT, Health Affairs Blog, August 5, 2010; K Weiss and S. Horowitz, American Board of Medical Specialties: Aligning Maintenance of Certification and Meaningful Use, Health Affairs Blog, August 5, 2010
[lxii] How Competitive are State Insurance Markets?, Kaiser Family Foundation, October 2011; T Bodenheimer, High and Rising Health Care Costs: Part 1 – Seeking an Explanation, Ann Int Med 142:847-854, May 2005
[lxiii] http://www.aoa.gov/AoAroot/AoA_Programs/Elder_Rights/SMP/index.aspx
[lxiv] D Cutler, et. al., Reducing Administrative Costs and Improving the Health Care System, New Eng J Med 367:1875-1878, November 2012
[lxv] E Andrews, et. al., Fixing Medicaid: Healing Connecticut's Largest Health Care Program, CT Health Policy Project, May 2011
[lxvi] Medicaid Integrity Program, GAO-13-50, November 2012
[lxvii] Calculated from Fiscal Accountability Report, Fiscal Years 2013-2016, OPM, November 15, 2012
[lxviii] Eliminating Fraud and Abuse, Health Policy Brief, Health Affairs, July 2012
[lxix] E Andrews, et. al., Fixing Medicaid: Healing Connecticut's Largest Health Care Program, CT Health Policy Project, May 2011