

Ensure affordable, quality health care for all

The reform of the U.S. health system took a huge step forward in the spring of 2010 with the passage of the Patient Protection and Affordable Care Act. The law, which is still being implemented, will address some of the biggest problems in our health care system, such as high costs and the millions of Americans who lack health insurance.

States play a key role in ensuring health care reform is properly implemented and they can take additional steps to bring costs down and improve the quality of care.

The United States continues to pay much more for health care than any other developed country—\$7,960 per person compared to \$3,182 per person for the average developed country—while only getting similar results at best.¹ In short, the health care system is incredibly inefficient and in dire need of more payment and delivery reform.

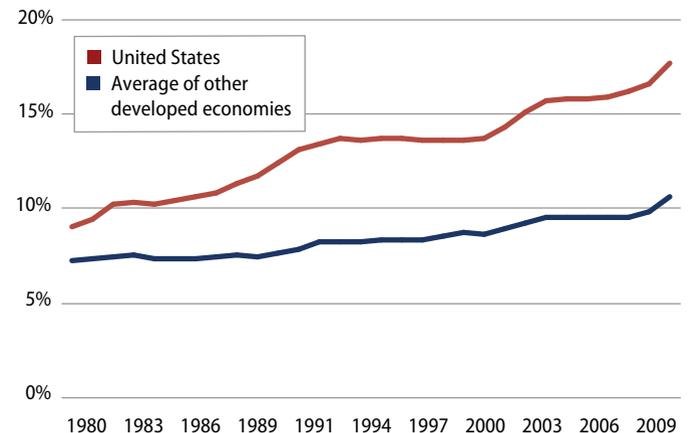
The extremely high costs of health care are harmful to the budgets of middle-class families and employers, as well as governments that bear a significant portion of overall health care expenses. As a result, reducing health care costs would be good for families, businesses, and taxpayers.

The Affordable Care Act addresses critical problems by expanding coverage to millions of Americans while taking steps to reform the health insurance industry and how we pay for health care. The implementation of these reforms will require considerable work from state governments over the next few years. Not only should

FIGURE 6

The United States spends much more on health care than other developed countries

Total expenditure on health as percent of GDP, 1980–2010



Source: OECD Health Data 2012 - Frequently Requested Data, available at <http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012-frequentlyrequesteddata.htm>

Note: "Other developed countries" are Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.

states fully implement the Affordable Care Act reforms, but they should also improve upon these reforms and address other challenges in the health care system.

Optimize the implementation of the Affordable Care Act

Background

While the federal government dominates media coverage of health care reform, much of our health care system is regulated at the state level.

By far the most significant recent legislation affecting health care delivery is the Patient Protection and Affordable Care Act of 2010. This historic legislation sets the United States on a path to provide access to health care for all Americans. Major provisions of the law prevent insurance companies from discriminating against patients based on pre-existing conditions, allow young adults to stay on their parents' insurance until age 26, significantly expand Medicaid coverage for low-income individuals and families, and provide assistance to ensure that middle-income Americans who currently do not have health insurance can afford to purchase it.

States play a major role in implementing two provisions of the Affordable Care Act:

- The creation of health care exchanges for uninsured individuals and small businesses to shop for health insurance products
- The expansion their state Medicaid programs so that low-income state residents will gain needed coverage through Medicaid

Despite strong opposition to the law by some state leaders, all states have taken some action to begin to implement the Affordable Care Act.² Already, 44 states have taken advantage of the new premium rate review system under which insurers must justify double-digit increases in health care premiums.³ But at this point, state approaches to Affordable Care Act implementation vary considerably.

Design and run a state health insurance exchange

State governments are extremely knowledgeable when it comes to local health insurance markets and should therefore design and run their own state health insurance exchanges. Effective implementation of the exchanges—whether they are run by the state or by the federal government—can reduce costs, improve quality, and enhance the consumer experience.

State insurance markets vary considerably due to differences in legal requirements, demographics, and geography. Due to these differences, the Affordable Care Act gives states the opportunity to run their own exchanges and grants states wide latitude in designing the programs. The first deadline for submitting health care exchange blueprint applications to the federal government was December 14, 2012. If a state elects not to implement an exchange or will not have one ready by 2014, the federal government will run the exchange on the state's behalf.

As of December 2012, 18 states and the District of Columbia had either passed legislation or been given an executive order to implement Affordable Insurance Exchanges.⁴ States running their own exchanges, however, will continue to refine their programs and states that are not yet ready to run their own exchange will have opportunities to do so in the future.

States implementing insurance exchanges can use this marketplace to reduce costs, improve quality, and enhance the consumer experience.⁵ In order to do so, state exchanges should:

- Use competitive bidding to secure the best premium rates and to promote payment and delivery reform
- Reward high-performing plans with bonus payments
- Create manageable choice for individuals and businesses and steer customers toward low-cost, high-value plans
- Structure exchange websites and customer-assistance programs to help customers make informed choices
- Design small-business options to protect older employees and minimize adverse selection

Massachusetts' Commonwealth Health Insurance Connector—the exchange established by the state's health care reform law of 2006—provides a powerful example of how well-functioning exchanges can improve the consumer experience. The Massachusetts state exchange uses competitive bidding to select plans based on quality and value, and as a result the premiums of plans offered by the exchange have increased at rates much lower than those of the outside market.⁶ And as a result of consumer feedback, the Massachusetts exchange now offers a limited number of standardized plans in order to increase consumer satisfaction.⁷

Expand Medicaid coverage

States should opt-in to the Affordable Care Act's Medicaid expansion, which if fully implemented would result in 17 million Americans gaining health care coverage without significantly increasing state program costs.⁸

The Medicaid expansion would provide coverage to all people with incomes up to 138 percent of the federal poverty line—which is approximately \$15,000 for an individual and \$31,000 for a family of four.⁹ Under the Affordable Care Act, the federal government would provide 100 percent of the needed funding for the expansion initially, and transition between 2017 and 2020 to requiring states to provide 10 percent of funding.

Initially, the Affordable Care Act conditioned the receipt of the states' existing federal Medicaid funds on that state's participation in the expansion program. The United States Supreme Court, however, rejected this provision of the law and now states can reject the expansion without losing any current funding.

As of December 2012 the governors of Alabama, Georgia, Iowa, Louisiana, Maine, Mississippi, Nebraska, Oklahoma, South Carolina, South Dakota, and Texas have rejected the deal expansion, often calling it too expensive.¹⁰

This is a penny-wise and pound-foolish stance. The expansion of Medicaid would allow states to increase the number of insured people by an average of 25 percent, with an increased state cost of less than 3 percent.¹¹ What's more, these increases are offset by savings on uncompensated care for the uninsured residents who are treated in their hospitals.¹² Michigan, for example, could save almost \$1 billion over 10 years if it expands Medicaid eligibility.¹³ Overall, the Affordable Care Act

would cut state spending on uncompensated care by \$18 billion if the Medicaid expansion is fully implemented.¹⁴

Lower health care costs

Background

The huge and rapidly increasing cost of health care is a significant threat not only to the health care system, but also to our ability to invest in other priorities. In 2012 spending on health care in the United States is expected to reach \$2.8 trillion, or about 18 percent of total spending on all goods and services.¹⁵ This amounts to more than \$8,000 per person on health care, more than double the average of \$3,400 per person in other developed nations.¹⁶ The Center for American Progress, together with other health care experts, outlined its plan of how to “bend the health care cost curve” in an article in the September 2012 edition of the *New England Journal of Medicine* entitled “A Systemic Approach to Containing Health Care Spending,” which we will detail shortly.¹⁷

All this spending, however, does not make a difference when it comes to health care outcomes. Health care spending varies significantly in different areas of the country. Yet looking within the United States, there is no correlation between spending and better outcomes.¹⁸

State governments oversee the purchase of billions of dollars of health care services every year both through state Medicaid programs, Children’s Health Insurance Programs, other state-only health programs, and through state employee health care plans. As such, states across the country are exploring new and creative ways to use their purchasing power to drive down health care costs and improve health care outcomes.

The Center for American Progress has done a great deal of thinking about how to reduce spending and improve quality at both the federal and state level. A number of these approaches are applicable to state governments, including several that were highlighted in the *New England Journal of Medicine*¹⁹ and are outlined below.

Adopt payment rates within global targets

Under current health care payment systems, providers negotiate payment rates with multiple insurers. This fragmented system increases administrative costs and allows providers to shift costs from public to private payers and from large to small insurers.²⁰

States should adopt a model of self-regulation to streamline payment negotiations and reduce costs.²¹ Public and private payers would negotiate payment rates with providers. These rates would be a binding upper limit on all payers and providers in the state, but providers could offer rates below the negotiated rate.

These rates would also adhere to a global spending target for both public and private payers in the state. After a transition, this target should limit growth in health care spending per capita to the average growth of wages in the state. State governments could create an independent council composed of health care providers, payers, businesses, consumers, and economists charged with setting and enforcing the spending target.

Policymakers creating and implementing this policy should also ensure that the spending target is set at an appropriate level to provide quality care and access and require all health care segments to bear responsibility for cost containment. Additionally, the process for developing such limits and targets must be transparent and engage the broadest range of stakeholders.

In August 2012 Massachusetts Gov. Deval Patrick (D) signed a measure that will help his state contain health care costs through a similar mechanism. Massachusetts' new Health Policy Commission will set a state benchmark for health care spending each year and publish yearly recommendations about how to lower costs.²² The target is tied to the growth rate of the state's economy. Massachusetts is the first state to set statewide benchmarks to control health care costs, albeit with limited enforcement mechanisms.²³ The governor's office predicts the legislation will result in \$200 billion in savings, as well as \$10,000 in increased pay per worker, over 15 years.²⁴

Additionally, states could experiment with ways to meet global spending targets. For instance, states could look at Maryland's method of setting hospital payment rates. In Maryland the state's Health Services Cost Review Commission considers and sets the rates that hospitals can charge for each service. The state has received a waiver from Medicare to operate the program since 1971.²⁵

Encourage alternatives to fee-for-service payments

One leading driver of the high cost of health care is the prevalence of the fee-for-service payment system. Seventy-eight percent of employer-sponsored health care services were fee-for-service as of 2008.²⁶ Because a separate fee is paid for each item or procedure, fee-for-service payment systems often incentivize wasteful consumption of health care services—especially services with high profit margins for providers—and do not encourage care coordination across a patient’s providers. As a result, patients often receive treatments or tests that they don’t need or want, and which may cause the patient harm.²⁷

And by paying for the volume of health care delivery, rather than patient outcomes or health care quality, fee-for-service payments do not encourage low-cost, low-margin, yet valuable services such as preventive care or wellness programs.

A 2012 Center for American Progress report, “Alternatives to Fee-for-Service Payments in Health Care: Moving from Volume to Value,” profiles promising alternatives to fee for service, including:²⁸

- Bundled payments—which eliminate incentives for unnecessary services by paying health care providers a fixed amount for a bundle of services or all the care a patient is expected to need during a set time period
- Patient-centered medical homes—which are redesigned primary-care practices that reduce costs by focusing on preventative care, patient education, and care coordination between different health care providers
- Accountable Care Organizations—which are groups of health care providers who agree to share responsibility for coordinating lower-cost, higher-quality care for a group of patients

States are increasingly experimenting with these types of payment systems, but many Medicaid and state employee health plans use fee-for-service payments. States should continue to experiment with alternatives and scale up successful programs. Also, states can potentially do so by taking advantage of Affordable Care Act provisions to create a variety of Medicaid pilot and demonstration programs.

In Minnesota, for example, lawmakers in 2008 enacted a requirement to standardize definitions of seven “baskets of care,” including asthma, knee replacements, and

lower back pain. Hospitals and providers can then set rates for a bundle of care, and patients and other payers can compare rates for the bundle of care they choose.²⁹

Likewise, Oregon lawmakers passed legislation in 2011 to encourage the delivery of Medicaid health care services through coordinated-care contracts that use alternative payment methodologies to focus on prevention, improving health equity, and reducing health disparities. The program utilized patient-centered primary care homes, evidence-based practices, and health information technology. A third-party analysis found that implementing this program could save the state a large portion of its projected Medicaid costs in both the short and long term—potentially more than \$1 billion within three years and more than \$3.1 billion over the next five.³⁰

Finally, in Arkansas Gov. Mike Beebe (D) began moving away from fee-for-service in 2011 by developing global payments for certain conditions and “episodes of care”—all clinically related services for a patient for a condition from the onset of symptoms until treatment is complete—and identifying best practices for those episodes.³¹ The state is starting off with bundled payments for five diagnoses, but will be scaling up in the hopes of being 90 percent to 95 percent free of fee-for-service rates within three years. Significantly, the state’s two largest insurers, Blue Cross Blue Shield and QualChoice, will also use these episodes as the basis for their payments.³²

Expand the use of nonphysician providers

Many states have restrictive scope-of-practice laws that prevent nonphysician health care providers from offering the full range of care in which they have been trained. Case in point: advanced practice nurses, who are prohibited in 34 states from practicing without supervision by a physician.³³

The stated purpose of these laws is to protect patients by ensuring that health care workers are practicing in areas for which they are properly trained. But these laws are too often woefully outdated or have been used to protect the interest of one group of health care professionals by restricting other professionals from providing competent, affordable, and accessible care.³⁴

States should adopt scope-of-practice reforms that would expand the pool of health care providers, offer patients more options, expand competition, and lower costs.³⁵

Former Pennsylvania Gov. Ed Rendell (D) included scope-of-practice reform as a plank in his “Prescription for Pennsylvania” comprehensive health care reform package. The reforms, announced by the governor in 2007, removed unnecessary restrictions that prevented licensed health care providers—including advanced nurse practitioners, physician assistants, physical therapists, and public health dental hygiene practitioners—from offering the full range of care in which they have been trained.³⁶ And a number of states—including New Mexico, Iowa, Virginia, and Minnesota—have adopted scope-of-practice review processes and boards to rationalize and remove bias from these debates about who and who cannot provide care.³⁷

Improve integration of care for “dual-eligible” patients

More than 9 million Americans are eligible for both Medicare and Medicaid, including some of the sickest and poorest Americans who are in need of a range of primary, acute, long-term, and behavioral health services.³⁸ Medicare and Medicaid share responsibility for these patients—together spending approximately \$300 billion on dual eligible patients per year.³⁹ These patients face significant challenges navigating two systems with different eligibility, coverage, payment, appeals, and consumer-protection requirements.

Despite the hefty price tag, little has been done to reduce costs by coordinating and simplifying care across programs. Approximately 90 percent of spending on dual-eligible patients is fee-for-service.⁴⁰ And the dual-eligible structure creates a number of inefficiencies by splitting responsibility for these beneficiaries between Medicare and Medicaid. The Medicare Payment Advisory Commission—an independent congressional agency—has noted that the dual-eligibility structure creates incentives to shift costs between the two payers, hinders efforts to improve quality and coordination of care, leads to coverage conflicts that are difficult to resolve, and creates barriers to access.⁴¹

Currently, a number of state governments are experimenting with small pilot programs to improve quality of care and reduce government costs for dual-eligible patients. Massachusetts’ Senior Care Options program, which enrolls Medicaid-enrolled and dual-eligible seniors, is one example. Individuals who choose to participate in the program receive all of their Medicare- and Medicaid-covered services through participating special-needs plans, which are paid by the state. Data show that beneficiaries enrolled in the Senior Care Options program have

fewer hospital days and lower total monthly costs than the fee-for-service, dual-eligible population.⁴² And a survey of Senior Care Options beneficiaries also found high member satisfaction.⁴³

A similar program in Wisconsin also shows that the program helps to reduce hospitalizations, nursing home stays, and emergency room visits, and as in Massachusetts, survey results show high satisfaction among beneficiaries.⁴⁴ Also, the Medicare-Medicaid Coordination Office—created by the Affordable Care Act—is scheduled to begin a series of demonstration projects to be funded in 2013.

Because of the diversity within the dual-eligible program and differing state health care infrastructure capacity, there is no one-size-fits-all approach to improving coordination of care for this group. States should continue to fund and experiment with these programs with the goal of designing programs that maintain program quality and fit the needs of their dual-eligible population. Demonstration programs should be evaluated and show evidence of positive outcomes before being expanded. Further, as these programs ramp up, they should remain “opt-in” programs in order to preserve patient choice.

Lower prescription drug costs

Background

Prescription drugs make up a large share of total health care spending in the United States. Retail prescription drugs accounted for 10 percent—or \$259 billion—of aggregate national health expenditures in 2010, according to the Centers for Medicare & Medicaid Services.⁴⁵

Health insurance often masks the pain of these costs due to fairly reasonable co-pay costs. And thanks to the passage of the Affordable Care Act, far fewer Americans will be forced to pay the full price of prescription drugs. The new health care law, however, does not entirely resolve the problem of high out-of-pocket spending on prescriptions for consumers. As a consequence, state governments will continue to shoulder a significant portion of the costs of providing prescription drug benefits to state employees, Medicaid enrollees, and beneficiaries of other prescription drug assistance programs.

In order to drive down these costs, state governments have adopted innovative reforms to produce cost savings to government. States use multiple methods of negotiating lower prescription drug prices with pharmaceutical companies and encourage the use of safe and effective generics whenever possible. As a result, Medicaid uses generic drugs—when there is an equivalent—89 percent of the time.⁴⁶

Still, there is more that can be done to lower prescription drug prices. The Center for American Progress' analysis of American Enterprise Institute data finds that maximizing generic drug substitution could save Medicaid overall up to \$7.6 billion over 10 years—and that is just one example of savings.⁴⁷ States should continue experimenting with ways to negotiate lower prescription drug prices and increase the use of generics.

Negotiate lower prescription drug purchase prices

States engage in a number of strategies to reduce prescription drug prices negotiated with pharmaceutical companies. Federal law requires pharmaceutical companies to provide rebates to states for drugs dispensed to Medicaid patients in exchange for state Medicaid coverage, but states are permitted to negotiate even greater rebates and should consider if these supplemental rebates might lower costs.⁴⁸ States already have experience doing this and typically negotiate rebates and discounts for prescription drugs covered under state employee health plans and other prescription drug assistance programs.

Negotiation strategies to reduce prescription drug prices include:

- **Forming purchasing pools with other states to negotiate lower prices or rebates for prescription drugs:** ⁴⁹ Louisiana estimated their savings from participating in such a pool to be \$27 million in 2006, while Maryland expected to save \$19 million, and West Virginia \$16 million that year.⁵⁰
- **Negotiating directly with the pharmaceutical company:** States maximize their savings by negotiating directly with pharmaceutical manufacturers, rather than negotiating through a pharmacy-benefits manager—a third-party administrator of prescription drug programs.⁵¹
- **Using preferred drug lists:** Preferred drug lists include prescription drugs covered under a benefits plan and can thereby promote the use of effective,

but less expensive drugs. At least 48 states have some form of a preferred drug lists.⁵² Most state lists apply to Medicaid, and as of 2009, at least 17 states have expanded their lists to other programs, such as offering reduced-price drugs to the elderly or disabled.⁵³ And in 2009 Oregon enacted legislation to create a statewide drug list that will eventually include 850,000 residents.⁵⁴

There is no one single best approach to contain state spending for drugs. And some of these strategies are mutually exclusive. To the extent allowed under federal law, and ensuring that these discounts do not come out of dispensing fees paid to pharmacies, states should continue to experiment with news programs to find what methods for purchasing drugs work best.

Promote safe and generic alternatives

Moving from purchasing name-brand pharmaceuticals to safe generic alternatives offers enormous savings potential for states. On average, a generic drug is \$45 less than the brand-name equivalent.⁵⁵ Currently, the substitution rate for name-brand drugs when a generic is available is 89 percent in Medicaid—while this number is quite high, more can be done. The Center for American Progress’ analysis of American Enterprise Institute data finds that maximizing generic drug substitution could save Medicaid overall up to \$7.6 billion over 10 years and that is just one example of savings.⁵⁶

States should reexamine their policies governing generics in both Medicaid and state employee health plans in order to maximize their use.⁵⁷ To the extent allowable under federal law, legislatures should review both the requirements on doctors prescribing name-brand drugs and how much the state will reimburse for drugs with equivalent generics (ensuring that generic reimbursement rates are not artificially inflated by the inclusion of brand-name drug costs).⁵⁸ State governments should also be very wary of arbitrary “carve out” laws, which prohibit generic-substitution laws from including certain categories of drugs.

Finally, the Affordable Care Act provides an abbreviated licensure pathway for generics for biologics—medicinal preparations made from living organisms and their products, such as vaccines—called biosimilars.⁵⁹ As these products come to the market, state governments should consider how to encourage their use.

States that have increased their purchasing of generics are realizing significant cost savings. After Massachusetts' state Medicaid program instituted the requirement that doctors justify the need for name-brand pharmaceutical when a generic equivalent existed, state spending on brand-name drugs with generic equivalents dropped from between \$10 million and \$11 million per month to between \$200,000 and \$300,000 percent month.⁶⁰ Each 1 percent increase in generic prescriptions generated \$7.4 million in savings for the state.⁶¹ And Texas saved more than \$223 million a year simply by changing its prescription pads to make it easier for doctors to prescribe generics.⁶² The law requires physicians write “brand necessary” or “brand medically necessary” on the prescription pad when no substitutions were appropriate.⁶³

Create a prescriber education program

The pharmaceutical industry employs more than 90,000 “detailers”—representatives, armed with samples and marketing materials, who make personal calls to doctors' offices to recommend their products. Detailers are not required to have any clinical training, but rather are hired for their sales ability. The number of detailers has doubled in the last 10 years. In addition to pharmaceutical marketing, industry detailing also drives up costs by promoting the use of name brands over less expensive generic alternatives.⁶⁴

As a response, more states are considering “academic detailing”—employing objective representatives to share the latest credible, independent drug reviews with doctors. Programs are usually based in a public medical or pharmaceutical school, and employ highly trained medical professionals, including pharmacists, nurses, and other physicians. Rather than sorting through competing marketing materials and academic detailing, prescribers can access the most current clinical information about drug effects, interactions, and side effects.

Academic-detailing programs currently exist in Maine, Massachusetts, New York, Oregon, Pennsylvania, South Carolina, Vermont, and the District of Columbia with pilot programs also underway in Idaho and Oregon.⁶⁵

Address mental health coverage

Background

Mental health disorders are extremely common and affect an estimated 57.7 million Americans in a given year, according to the National Alliance on Mental Illness.⁶⁶ Suicide is the 10th most common cause of death in the United States,⁶⁷ and approximately 90 percent of adults who commit suicide are associated with mental or addictive disorders.⁶⁸ Most mental illness is highly treatable, yet only half of adults and less than one-third of children with a diagnosable mental health condition receive treatment.⁶⁹

Historic lack of attention, misunderstanding, and years of stigma has helped make mental illness a hugely neglected public health issue. And even though large numbers of Americans face a mental health disorder every year, longstanding stigmatization means that many individuals do not seek diagnosis. Adding to the urgency to address mental health treatment is the fact that troops returning home from Iraq and Afghanistan do so increasingly with serious mental illness.⁷⁰

State governments facing severe budget shortfalls have made the problem worse by significantly cutting funding of mental health services in recent years. States cut more than \$1.6 billion in general funds for mental health services between fiscal year 2009 and fiscal year 2012.⁷¹

State legislatures should work to restore funding for mental health services. In fact, the Medicaid expansion of the Affordable Care Act will help alleviate some of the burden on state programs, since many of the people currently using those services will be newly eligible for Medicaid. States should evaluate whether this savings should be reinvested into mental health services.

In addition, states should adopt high standards for private insurance mental health coverage, improve statewide data collection and outcomes measurement, and address the growing needs of veterans and youth.

Require insurance plans to provide complete mental health coverage

Advocates of people living with mental illness won a major victory with the passage of the Affordable Care Act. The law significantly expands mental health coverage by increasing access to Medicaid and providing assistance to those purchasing insurance through the new exchanges. All health insurance plans offered in the exchange and expanded Medicaid programs must cover mental health and substance-abuse services as an “essential health benefit.” New and modified private plans outside of the exchanges must follow this requirement as well. And no plan may impose annual or lifetime dollar limits on these services.

Insurance policies must cover these benefits in order to be certified and offered in the exchanges, and all Medicaid state plans must cover these services by 2014.⁷² States, however, have a lot of flexibility in determining the scope of services that must be offered.

States are required to select a “benchmark plan” that sets the minimum standards for essential health benefits levels that other insurers must provide. Mental illness coverage quality varies considerably among private insurers, however, so selection of a benchmark plan will have a large effect on coverage quality within the state. There are many gaps in coverage of eating disorders across the benchmark plans, for example. To date, 25 states have selected a benchmark plan.

States should set high standards to ensure that these plans provide an array of effective and evidence-based mental health services. State governments should also consider how to provide public education and outreach so that those who suffer from mental illness come forward to receive the care they need.⁷³

Improve data collection and outcomes measurement

States must collect accurate and thorough data on mental health treatment and outcomes in order to demonstrate service success, avoid negative health outcomes, inform policy decisions, and maximize return on investment. Yet, the accuracy of data and outcomes measurement in the mental health sector has long been inadequate according to a 2011 report from the National Alliance on Mental Illness, “State Mental Health Cuts: The Continuing Crisis.”

The National Committee for Quality Assurance is developing quality measures on schizophrenia, mental health treatment for children and adolescents, and integration of mental and behavior health care.⁷⁴

In Arkansas all community mental health centers use a standard data-collection tool to report uniform data to the state. Additionally, mental health centers are required to screen for substance-abuse disorders, and substance-abuse providers are required to screen for mental illness.⁷⁵

California used federal and state grants to improve their county-level data collection to report on evidence-based practices and to better track patients who are receiving integrated treatment for mental health and substance use disorders.⁷⁶

Address growing needs of veterans

The nation's veterans from Iraq and Afghanistan share characteristics that distinguish them from groups of veterans of previous wars. Their large numbers and recent demographic changes have challenged state and federal service delivery systems, according to the National Alliance for Mental Illness. Half are from the National Guard or are Reserve members of the regular forces.⁷⁷ Compared to veterans of previous wars, they tend to be older, and are more likely to have families.⁷⁸ More hail from rural America, and many have served multiple tours.⁷⁹ Nearly 19 percent of returning troops currently suffer from a post-traumatic stress disorder or depression.⁸⁰

As such, states must develop coordinated strategies to respond to veteran's needs.

Mental health agencies in 10 states have created thorough service delivery and referral initiatives, and another 13 were either beginning or planning to provide significant services to National Guard members as of 2009.⁸¹ States are also partnering across agencies, together with the federal government and with the private sector, to reduce barriers to access.⁸² Colorado, for example, is increasing mental health services at community centers in rural areas through cooperative agreements with the Veterans Health Administration and private funders.⁸³ New York state is also partnering with the Veterans Health Administration to offer mental health screening as part of its New York National Guard Yellow Ribbon Reintegration Program.⁸⁴

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