

# State-Based Approaches to Health Care Value: Cost and Quality

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## Executive Summary

It is well documented that the United States spends more on health care per capita and devotes a greater share of its Gross Domestic Product (GDP) to health expenditures than any other developed nation.<sup>1</sup> As health care continues taking larger shares of household income, state policymakers are increasingly focused on strategies to improve the value of the whole health care system by increasing quality and lowering costs. This paper examines the strategies that seven states have used to improve value—some ideas are new, while other concepts have been in place for years.

Using a variety of approaches, these states have made important progress. Even though not all of the results are in, there is much that can be learned both from the planning and implementation processes in these states and the cost and quality outcomes achieved to date. Several of these initiatives have already used innovative approaches to show it is possible to achieve cost savings or improved value (such as in Maryland, Minnesota, Colorado, and Rhode Island). A few of the initiatives (such as those in Oregon, New York, and Vermont) have taken it a step further and achieved the broad stakeholder consensus for the cultural shift needed to improve how care is delivered. All of these efforts demonstrate that positive outcomes can be achieved with inclusive and thoughtful stakeholder efforts.

Notwithstanding the significant work being done, state efforts at improving the value of health care are generally still in their infancy. While the government has always focused on efforts to improve public health insurance (e.g., Medicaid), more recent state efforts seek to improve health care value more systematically. As discussed below, the Affordable Care Act (ACA) creates important opportunities, including the flexibility for states to find their own path to a better health care system.

By studying the states that have tried new efforts and sharing the lessons learned, we hope this paper provides insights that will support the future efforts of state health care leaders.

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<sup>1</sup> Kaiser Family Foundation. April 12, 2011. *Snapshots: Health Care Spending in the United States & Selected OECD Countries*. Online at: <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/>

## I. Introduction

In 2011, health care spending in the U.S. reached \$2.7 trillion, averaging \$8,680 per person.<sup>2</sup> Hospital and physician services account for over half of total spending.<sup>3</sup> In part, these high costs are the result of a health care delivery system that does not drive *value*, defined here as higher quality care at a lower cost.

The U.S. health care delivery system is made up of a fragmented network of public and private financing, health care delivery, and quality assurance structures. There is no single national entity or set of policies guiding the health care system. Delivery system fragmentation and lack of transparency are two contributing factors to the problem. Fragmentation often rewards high-cost, intensive medical intervention over higher-value primary care, such as preventive medicine and the management of chronic illness.<sup>4</sup> Under the current system, incentives are misaligned and typically place a higher value on paying for higher utilization, not better outcomes. In addition, policymakers, patients, and even the providers themselves lack consistently transparent utilization, cost, and quality information—resulting in reduced efficiency.

Rising health care spending impacts federal and state budgets, leaving policymakers to critically examine how health care is delivered and forcing difficult budget tradeoffs. One result of the economic downturn has been a growth in enrollment for Medicaid, the federal-state partnership to offer health coverage to low-income persons. Between FY 2007 and 2011, national Medicaid enrollment rose by 10.3 million beneficiaries (from 42.3 million to 52.6 million).<sup>5</sup> Historically, the growth in Medicaid costs has meant that states placed caps on enrollment or utilization, without necessarily considering health outcomes. Today, many states have realized that successfully improving the value of Medicaid means looking at the operations of the health care system as a whole. There is also a growing sense that states must work at a system-wide level as insurance premiums for private insurance continue to go up and health care consumes even higher percentages of household income.<sup>6</sup>

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<sup>2</sup> Centers for Medicare & Medicaid Services. 2011. *National Health Expenditure 2011 Highlights*. Online at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

<sup>3</sup> Ibid.

<sup>4</sup> A. Shih, K. Davis, S. Schoenbaum, et al. August 2008. *Organizing the U.S. Health Care Delivery System for High Performance*. The Commonwealth Fund. Online at: <http://www.commonwealthfund.org/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx>

<sup>5</sup> K. Young, R. Garfield, L. Clemans-Cope et al. April 2013. *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FY 2007-2011*. Kaiser Family Foundation. Online at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8309-02.pdf>

<sup>6</sup> Ibid.

## II. Seven State Approaches to Addressing Health Costs

Across the nation, a number of cost containment strategies are in various stages of consideration, planning, and implementation. This paper highlights seven states that either have implemented or are currently implementing reforms to improve health care outcomes and reduce health care spending. Although each case study features a different strategy for consideration, many of these states are employing multiple strategies at the same time. Fundamentally, all the efforts are designed to create a more integrated (and less fragmented) care delivery and payment system, steps cited by a recent Commonwealth Fund report as critical to achieving high-performing health systems.<sup>7</sup>

In addition to outlining the details of the policies employed, the case studies provide a deeper understanding of the environment under which these changes were enacted. This includes looking at how consumer advocates were or were not able to engage in the legislative and implementation processes, evidence (or lack) of success, and the major lessons learned by state officials and consumer advocates in these states (Table 1).

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<sup>7</sup> K. Purington, A. Gauthier, S. Patel, and C. Miller. February 2011. *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*. The Commonwealth Fund and the National Academy for State Health Policy. Online at: <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Feb/On-the-Road-to-Better-Value.aspx>

**Table 1: Cost Containment Strategies of Featured States**

State	Featured Strategy	Implementation Timeline	Evidence of Effectiveness	Other Strategies Being Pursued
Colorado	Medicaid Accountable Care Collaborative (type of Accountable Care Organization)	Legislation passed in 2009, implemented in 2011	First annual report indicated lower costs, estimated \$20M in gross savings and \$2-3M in net savings	Pay for Performance, Global Payment, Patient-Centered Medical Homes
Maryland	All-Payer Hospital Rate Review	Legislation passed in 1971, waiver approved and implemented in 1977	Estimated savings are \$45B <sup>8</sup>	Accountable Care Organizations, Patient-Centered Medical Homes
Minnesota	Provider Transparency	Legislation passed in 2008, first cost data collected in 2009, first performance data collected in 2010	Pending	Accountable Care Organizations, Pay for Performance, Patient-Centered Medical Homes
New York	Medicaid Global Cap and Consensus-Driven Cost Containment	Executive Order signed January 2011, implemented April 2011	Medicaid spending fell by \$4B (\$2B net state savings) in the first year and growth in spending held constant at 4% annually <sup>9</sup>	Pay for Performance, Patient-Centered Medical Homes
Oregon	Medicaid Coordinated Care Organizations (type of Accountable Care Organization)	Legislation passed in 2009, waiver approved in 2012	Pending	Transparency, Global Payment, Patient Centered Medical Homes
Rhode Island	Expanded Insurance Rate Review	Office of the Health Insurance Commissioner created in 2004, Affordability Standards developed in 2010	Additional data needed	Patient-Centered Medical Homes and Pay for Performance
Vermont	Single Payer	Legislation passed in 2011, waiver not yet submitted	Not Yet Implemented	Accountable Care Organizations, Global Payment, Patient-Centered Medical Homes

<sup>8</sup> Sun, L.H. and Kliff, S. May 25, 2013. *Maryland already sets hospitals prices. Now it wants to cap their spending.* Washington Post. Online at: <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/25/maryland-already-sets-hospitals-prices-now-it-wants-to-cap-their-spending/>

<sup>9</sup> New York Department of Health. *Monthly Global Cap Reports.* October 2013. Online at: [http://www.health.ny.gov/health\\_care/medicaid/regulations/global\\_cap/monthly/index.htm](http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/index.htm)

### III. Common Themes

In our analysis, we identified several common themes that significantly contributed to the success of each state's efforts. These include:

*Engage stakeholders early.* The importance of stakeholder participation was cited as highly critical. The convening authority that states have is an important lever to drive broader systems change. The efforts documented here all involved more than one group of stakeholders, with success contingent on fostering ongoing communication among these groups. Being inclusive and getting everyone around the table is necessary. Giving stakeholders the opportunity to provide their unique perspective helps them feel more engaged and valued, which can often decrease their resistance to exploring change and increase their willingness to be a part of the solution.

*Develop a shared understanding and vision.* Many interviewees cited the importance of first establishing shared agreement on the issues and goals. All players (consumers, policymakers, providers, and insurers) should have a common desire to reform the delivery system and, to the extent possible, an agreed upon strategy by which they want to make the change (e.g., moving away from a fragmented FFS (fee-for-service) system to integrated delivery systems). The sense of shared sacrifice among stakeholders is particularly salient for states that have, through their negotiations with the federal government, agreed to set savings goals and be subject to financial or other penalties if these goals are not met.

*Gain support from key leaders.* Gubernatorial, legislative, and administrative leadership, as well as bipartisan support, was often cited as necessary to move the conversation forward and to provide actionable policy frameworks for reforms.

*Address root causes of spending growth.* After years of cost-cutting (often through painful budget negotiations), many states have realized that cutting spending without addressing underlying causes of growth yields only temporary results. States have instead begun to identify the root causes of the spending and inefficiencies in their delivery systems in order to address cost containment over the long term.

*Align incentives with goals.* Many of the states, particularly those with efforts aimed at changing provider practice patterns through sharing of financial risk, were careful to ensure that some portion of provider payment is tied to population health outcomes. By ensuring everyone shares in the costs and the benefits of decisions, disparate providers have incentives to coordinate care and reduce duplicative services.

*Balance cost savings with outcomes and quality goals.* In several states, there was general acknowledgement that balancing cost savings with outcomes, quality, and patient experience is critical to planning and implementation

efforts. For these states, this acknowledgement came after realizations by the state and stakeholders that old approaches to cost containment, such as cutting benefits, eligibility, or provider rates, were no longer feasible.

*Establish robust data collection and evaluation strategies.* Without data, states cannot assess whether a reform strategy is working. Data allows states to make mid-course corrections where necessary. Specifically, states recommend incorporating data collection and evaluation methods directly into the early formulation of reform efforts. Virtually all of the featured states have All-Payer Claims Databases (APCDs), which streamline the collection of utilization and claims data. Additional efforts are needed to ensure that clear metrics and outcomes are used to define success.

*Recognize that change is hard and often takes longer than expected.* Delivery system and provider payment issues are complex and multifaceted. Changing market forces requires understanding, time, and patience. Health care quality and cost containment strategies are often complex and highly technical, and most consumers (and even many providers) will never understand the full spectrum of the dynamics. To ensure that a holistic view of systems change is shared, it is important to educate stakeholders on how changes to one aspect or provider group can impact other parts of the delivery system.

## IV. Case Studies

### Colorado: Embracing Care Coordination and Regional Accountability in Medicaid

#### Description of Cost Containment Strategy: Accountable Care Collaborative

Colorado's Accountable Care Collaborative (ACC) is one of the state's several delivery system reform efforts that seeks to improve the health of Medicaid enrollees and reduce costs. As a major public sector cost containment effort, its overall goals are twofold: 1) to reform healthcare payment methods by rewarding providers for achieving health outcomes rather than linking payment solely to volume of services, and 2) to integrate care. Launched in 2011, ACC has four major components: 1) patients are connected to a primary care medical provider (PCMP) to receive services through a medical home; 2) seven regional care collaborative organizations (RCCOs) help manage quality, coordination, and care access issues across providers; 3) member and provider experiences are improved; and 4) a statewide data repository was created to report on key cost, utilization, and quality performance indicators.

By June 2013, approximately 47 percent of Colorado's Medicaid enrollees (352,236 people) were participating in the ACC program, with participation expected to increase by about 30,000 enrollees per month.<sup>10</sup> The ultimate goal is that all new Medicaid beneficiaries will be enrolled into the ACC.

#### Legislative History and Process

In 2009, Colorado's legislature passed the Medicaid Value-Based Care Coordination Initiative.<sup>11</sup> Now known as the ACC, the program was initially developed for several reasons: 1) increases in Medicaid enrollment due to the recession and an expansion in Medicaid eligibility resulted in severe budget pressures and a desire to move away from FFS payments; 2) prior negative experiences with capitated managed care; and 3) delivery system and payment reform were a priority due to leadership from the Governor and the Medicaid agency. In 2012, the Legislature passed additional legislation related to the ACC program that required global payment or other payment reform pilots and created long-term care health homes.<sup>12</sup>

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<sup>10</sup> D. Rodin and S. Silow-Carroll. 2013. *Medicaid Payment and Delivery Reform in Colorado: ACOs at the Regional Level*. The Commonwealth Fund. Online at: [http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1666\\_Rodin\\_Medicaid\\_Colorado\\_case\\_study\\_FINAL\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1666_Rodin_Medicaid_Colorado_case_study_FINAL_v2.pdf)

<sup>11</sup> Accountable Care Collaborative Payment Reform Initiative, Solicitation # HB12-1281 PRI – Guidelines for Proposal, Colorado Department of Health Care Policy and Financing.

<sup>12</sup> S. Silow-Carroll, J. Edwards, and D. Rodin. 2013. *How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs*, The Commonwealth Fund. Online at: [http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1665\\_SilowCarroll\\_Medicaid\\_synthesis\\_FINAL\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1665_SilowCarroll_Medicaid_synthesis_FINAL_v2.pdf)



A broad range of stakeholders—Medicaid enrollees and advocates, providers, and health plans—provided input on the development and implementation of the ACC.<sup>13</sup> According to interviewees, additional input was received around implementation based on the desire to ensure that efforts around cost containment did not override clients' care needs. Ongoing input to an ACC Program Improvement Advisory Committee is provided by many parties, including RCCO staff, PCMPs, other providers, Medicaid beneficiaries and families, advocates, and state staff from the Medicaid agency.<sup>14</sup>

## Implementation Process

The Colorado Medicaid agency contracts with each of the seven RCCOs, who in turn contract with a network of PCMPs. A PCMP may be a group practice, federally qualified health center, rural health center, or clinic, among others. PCMPs provide comprehensive primary care and coordinate enrollees' health needs across specialties. The RCCOs, which are currently composed of health plans or networks of providers, provide administrative and practice support to providers to help them establish and implement medical homes. They also are responsible for ensuring that Medicaid enrollees receive coordinated care (e.g., through the use of nurses or care navigators who provide additional care management services to high-risk patients).

Colorado's Medicaid program pays a total of \$20 per-member per-month (PMPM) for care coordination. As initially implemented, this fee was divided across the entities contributing to this coordination: each RCCO received \$13 PMPM to provide care coordination services, and each PCMP received \$4 PMPM for being a medical home. The data vendor receives the remaining \$3 PMPM. Beginning in fiscal year 2013, \$1 from each PMPM given to the RCCOs and PCMPs is being withheld to fund an incentive pool—both types of organizations became eligible to receive additional incentive payments for achieving reductions in emergency department (ED) use, 30-day readmissions, and high-cost imaging.

Since most payments for health care in Colorado are FFS, the state Medicaid agency hopes to provide incentives to both RCCOs and PCMPs to achieve cost targets in the future. Colorado has other payment reform initiatives underway to move away from FFS payments and it plans to integrate a wide range of services including behavioral health, oral health, public health, and long-term care. These other initiatives include:

- Integrating behavioral health into primary care in the ACC framework as well as with private payers through a \$2 million federal State Innovation Model (SIM) design grant from CMS.
- Participating in a multi-payer, multi-state patient-centered medical home pilot.

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<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

- Participating in the federal Comprehensive Primary Care Initiative that involves major payers in the state providing care coordination payments to primary care provider networks, with an opportunity for shared savings.
- Supporting health information exchange and practice transformation teams working with providers through the efforts of two of Colorado's health information exchanges.
- Developing an all payer claims database (APCD) to illustrate health care spending and utilization. APCD data collection first began in 2012 with the majority of claims from the fully insured market and Medicaid.<sup>15</sup> The APCD is expected to be critical for delivery system reform as it will facilitate the evaluation of new payment models. Its utility will be enhanced as more and more data are included.

## Metrics and Outcomes

Colorado released its first annual report on the ACC program in November 2012 (the second annual report was due out on November 1, 2013).<sup>16</sup> Initially, four key performance measures—emergency department (ED) use, 30-day hospital readmissions, use of high-cost imaging, and average PMPM cost of care—were used to assess the impact of the ACC. The first annual report showed mixed results, but indicated potential progress toward the State Medicaid agency's goals of a 5 percent reduction in ED use, 30-day hospital readmissions, and use of high-cost imaging, and a reduction in the average cost of care to compensate for the \$20 PMPM care coordination fee.<sup>17</sup> There was a slight increase in utilization of ED services for Medicaid enrollees overall, but the increase was lower for ACC enrollees than for non-ACC-participating Medicaid enrollees. Compared to the non-ACC-participating Medicaid enrollees, there was an 8.6 percent reduction in hospital readmissions and a 3.3 percent reduction in the use of high-cost imaging for ACC enrollees.<sup>18</sup> It is unknown to what extent these reflect "better care," since reporting systems do not capture whether service utilization represents overuse, underuse, misuse, or appropriate use. There were also reductions in the rates of preventable hospitalizations and readmissions for ACC enrollees with diabetes and asthma. Total costs of

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<sup>15</sup> Center for Improving Value in Health Care and the Colorado Health Institute. 2012. *New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado*. Online at:

[http://www.coloradohealthinstitute.org/uploads/downloads/CHI\\_CIVHC\\_Payment\\_Reform\\_publication\\_sent\\_to\\_print\\_7\\_19.pdf](http://www.coloradohealthinstitute.org/uploads/downloads/CHI_CIVHC_Payment_Reform_publication_sent_to_print_7_19.pdf)

<sup>16</sup> Accountable Care Collaborative Annual Report, Colorado Department of Health Care Policy and Financing, November 1, 2012.

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251864215634&ssbinary=true>

<sup>17</sup> S. Silow-Carroll, J. Edwards, and D. Rodin. 2013. *How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs*, The Commonwealth Fund. Online at:

[http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1665\\_SilowCarroll\\_Medicaid\\_synthesis\\_FINAL\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1665_SilowCarroll_Medicaid_synthesis_FINAL_v2.pdf)

<sup>18</sup> A. Abrahamson. 2012. *Potential opportunities for LeadingAge members and the Accountable Care Collaborative (PowerPoint)*. Medicaid Colorado Access. Online at:

<http://www.leadingagecolorado.org/custdocs/session%20302%20leading%20age%20and%20rcco%20may%202013finalabrahamson.pdf>

care were also lower for ACC participants, with the state estimating net savings of \$2 to 3 million for the ACC program overall.<sup>19</sup>

## Lessons Learned

According to interviewees, Colorado engaged a diverse set of stakeholders, including providers and patients, early in the process. Interviewees credited these efforts with helping foster widespread support for the ACC program. The Colorado Medicaid agency also recognized that care is provided locally in communities and organized the state into seven regions, each of which is led by an RCCO. These regional organizations have the flexibility to tailor reforms to meet local needs, cultures, and circumstances. One interviewee noted that regardless of regional flexibility, there can sometimes be a disconnect between excellent policy ideas and what individual consumers need or want, and that it is important to assess whether a particular strategy is meeting the needs of the consumers affected by the strategy (e.g., need to carefully assess whether a Patient-Centered Medical Home (PCMH) is the right strategy for most healthy adults vs. people with chronic conditions vs. children). Engaging consumers in their care was also important.

Since the ACC reform efforts were ambitious, interviewees noted that it was important to develop a realistic implementation timeline that allowed for the specification of data that would be used to evaluate the program. There were delays in provider contracting, which proved to be more complex than expected, and it also took more time to understand the health IT infrastructure needs that a statewide initiative requires. Interviewees stated that there is a strong focus on and investment in robust data collection as part of ACC, which they believe is needed to establish accountability and understand the impact of the initiative.

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<sup>19</sup> *Medicaid Reform: Challenges and Opportunities for Colorado*. 2012. Colorado Health Institute. Online at: [http://www.coloradohealthinstitute.org/uploads/downloads/X\\_Medicaid\\_Reform\\_fact\\_sheet.pdf](http://www.coloradohealthinstitute.org/uploads/downloads/X_Medicaid_Reform_fact_sheet.pdf)

## Maryland: Containing Hospital Costs through All-Payer Rate Setting

### Description of Cost Containment Strategy: All-Payer Hospital Rate Setting

Since 1977, Maryland's signature health care cost containment method is prospective hospital rate-setting,<sup>20</sup> in which all payers within the hospital system, including public payers, private payers, and uninsured individuals, pay the same rates.<sup>21</sup> Under this system, the Maryland Health Services Cost Review Commission (HSCRC) has broad authority to set rates for inpatient, outpatient, and emergency services at a hospital. The HSCRC's rate setting authority applies to 47 acute general, three specialty, and three private psychiatric hospitals.<sup>22</sup> The HSCRC does not regulate rates for any other health care services.

Rates are required to reflect underlying costs, including a subsidy for uncompensated care and adjustments for severity of patient illness and regional differences, in order to yield more efficient resource allocation. The system seeks to control hospital costs, but does not specifically limit hospital profits. Rates are set prospectively with "per unit of specific services" as the basis of payment (e.g., ICU charges per day).<sup>23</sup> The HSCRC has broad flexibility on how it sets rates and, in recent years, has implemented various initiatives to contain costs and improve quality, including bundled payment structures, variable and fixed cost adjustments, and incentives for improved quality.<sup>24</sup>

Maryland maintains the only remaining all-payer model of hospital rate regulation in the nation<sup>25</sup> and has operated this system for more than three decades under the authority of state law and a Medicare waiver.<sup>26</sup> This waiver exempts Maryland from being subject to Medicare's payment system, which allows the state to spread the cost of uncompensated care across all payers, including Medicare.

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<sup>20</sup> Prospective payments are payments made to health care providers that are based on a predetermined, fixed amount for a specific service or set of services.

<sup>21</sup> L. Sun, and S. Kliff. May 25, 2013. *Maryland already sets hospitals prices. Now it wants to cap their spending.* Washington Post. Online at: <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/25/maryland-already-sets-hospitals-prices-now-it-wants-to-cap-their-spending/>

<sup>22</sup> Maryland Health Services Cost Review Commission. Online at: <http://www.hscrc.state.md.us/aboutHSCRC.cfm>

<sup>23</sup> R. Murray. 2009. *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience.* Health Affairs, 28, no.5, 1395-1405.

<sup>24</sup> Maryland Department of Health and Mental Hygiene. September 2013. *Draft Application to CMS for modernization of Maryland's All-Payer Model.* Online at: <http://dhmh.maryland.gov/docs/Maryland%20Model%20Design,%20Waiver%20Application,%20Revised%20September%202013%20with%20cover%20letter.pdf>

<sup>25</sup> Other states that had regulated hospital rates through rate setting include Connecticut, Massachusetts, New Jersey, New York, Washington, Wisconsin and West Virginia. Sommers et al. May 2012. *Addressing Hospital Pricing Leverage through Regulation: State Rate Setting.* National Institute for Health Care Reform. Online at: <http://www.nihcr.org/1t192>

<sup>26</sup> According to the [Maryland's All-Payer Model Proposal to the Center for Medicare and Medicaid Innovation](#), the waiver allows Maryland to set rates for both inpatient and outpatient services and exempts Maryland from Medicare's inpatient and outpatient prospective payment systems. In exchange for this waiver, Maryland must pass a "waiver test" which stipulates that the cumulative growth in Medicare inpatient payment per admission in Maryland since January 1, 1981 cannot "exceed cumulative growth in Medicare inpatient payment nationally." If Maryland fails to meet the test, it has approximately 36 months to come into compliance. If compliance is not met, Maryland may be required to transfer into the national Medicare payment system.

## Legislative History and Process

Hospital rate regulation was first established by the Maryland legislature in 1971, following a period of escalating hospital costs and serious financial losses by hospitals treating growing numbers of the uninsured. Initially proposed by the Maryland Hospital Association to provide a financing mechanism for rising uncompensated care, hospital trustees were looking for a system that would provide both “financial stability and constrain hospital costs.”<sup>27</sup> This system continues to receive widespread support from policymakers and stakeholders statewide, despite recent concerns of the system’s limitations in controlling volume and total cost of care.

Maryland established the HSCRC as an independent body financed by user fees under the umbrella of the Maryland Department of Health and Mental Hygiene. It is governed by seven volunteer commissioners appointed by the Governor, four of whom cannot be connected to a hospital.<sup>28</sup> The HSCRC is responsible for: 1) containing growth in hospital costs; 2) ensuring access to hospital services; 3) ensuring rates are equitable among all purchasers; 4) maintaining hospital solvency/stability; 5) developing methods to finance uncompensated care; and 6) providing public access to hospital-related health care data.<sup>29</sup>

The legislature did not believe that the market would achieve all of these goals on its own, so the HSCRC was given broad powers regarding public disclosure of hospital data and operating performance, and the ability to set rates prospectively. Instead of prescriptively detailing the rate setting methodologies, the authorizing statute established broad principles under which the HSCRC must operate, which provided significant flexibility to the HSCRC.

## Implementation Process

The HSCRC’s regulatory approach requires hospitals and payers to provide timely and accurate data. To meet this charge, the HSCRC collects, analyzes, and makes public a wide variety of hospital data through a uniform reporting system. The HSCRC monitors the following data: 1) monthly and annual revenue; 2) expenses and volume reports; 3) wage and salary surveys; 4) inpatient and outpatient medical record abstracts; and 5) claims.<sup>30</sup>

In recent years, the HSCRC worked with industry professionals to develop clear, attainable, and strong financial incentives that hospitals could earn if they demonstrated improvement in meeting quality performance metrics. Currently, hospitals receive payment adjustments for:

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<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> Overview of HSCRC Databases. *The Maryland Health Services Cost Review Commission*. Online at: [http://www.hscrc.state.md.us/hsp\\_Data1.cfm](http://www.hscrc.state.md.us/hsp_Data1.cfm)

- **Quality Based Reimbursement Project (QBR):** The HSCRC incentive payments are made based on improvements in 21 clinical processes of care measures and eight patient experiences of care measures. From 2008 to 2010, variation between hospitals narrowed substantially on almost all measures and all aggregated statewide measures showed improvement.<sup>31</sup>
- **Maryland Hospital Acquired Conditions (MHAC):** Each hospital is evaluated based on its ability to decrease the rate of 51 potentially preventable complications. In SFY 2010 and 2011, statewide complication rates declined by 20 percent, and the state Medicaid agency estimated a total cost savings of \$105.4 million due to reductions in complication rates.<sup>32</sup>

## Metrics and Outcomes

Maryland delivers hospital care at per admission rates that grow more slowly than anywhere else in the country.<sup>33</sup> From 1977 through 2010, Maryland hospitals experienced the lowest cumulative growth in cost per adjusted admission of any state in the nation.<sup>34</sup> Over four decades, Maryland estimates it has saved an estimated \$45 billion.<sup>35</sup> Maryland has no cost shifting from public to private payers, and all residents have access to needed hospital services.<sup>36</sup>

## Lessons Learned

Maryland's savings have not come without consequences. According to the Maryland Hospital Association, the HSCRC has only authorized minimal increases in hospital rates that fail to keep up with the rate of inflation over the past five years, and have the potential to push hospital operating margins into negative territory.<sup>37</sup>

Although costs per admission have been well controlled, "the same cannot be said for hospital admissions and overall hospital volume,"<sup>38</sup> in part because rate regulation cannot oversee or influence individual physicians' decision making.<sup>39</sup> The current price setting structure is limited to hospital services only, and has limited control over the

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<sup>31</sup> Maryland Report on Hospital Payments Linked with Performance Initiatives and Hospital Value Based Purchasing Program Exemption Request. September 30, 2011. *HSCRC Letter to CMS*.

<sup>32</sup> *Ibid.*

<sup>33</sup> The Baltimore Sun. *Health Care Catch-22*. June 14, 2012, Online at: [http://articles.baltimoresun.com/2012-06-14/news/bs-ed-hospital-waivers-20120614\\_1\\_hospital-costs-uncompensated-care-cost-review-commission](http://articles.baltimoresun.com/2012-06-14/news/bs-ed-hospital-waivers-20120614_1_hospital-costs-uncompensated-care-cost-review-commission)

<sup>34</sup> HSCRC FY2012 Annual Report to the Governor. Maryland Health Services Cost Review Commission. Online at: [http://www.hscrc.state.md.us/documents/HSCRC\\_PolicyDocumentsReports/AnnualReports/GovernorsReport2012-MD-HSCRC.pdf](http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/AnnualReports/GovernorsReport2012-MD-HSCRC.pdf)

<sup>35</sup> *Ibid.*

<sup>36</sup> Cohen, H.A. Maryland's all-payer hospital payment system. Online at: [http://www.hscrc.state.md.us/documents/HSCRC\\_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayerHospitalSystem.pdf](http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayerHospitalSystem.pdf)

<sup>37</sup> Hospitals Again to be Paid Less than Cost of Providing Care. June 5, 2013, June 5. *Maryland Hospital Association News Release*. Online at: <http://www.mhaonline.org/news--events/press-releases/hospitals-again-to-be-paid-less-than-cost-of-providing-care>

<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*

volume of hospital services.<sup>40</sup> The HSCRC does not have the authority to establish regional hospital spending limits, which would be needed to curtail case volume increases under this model.<sup>41</sup> Because only hospital rates are managed, critics claim that hospitals have shifted patients into non-regulated outpatient settings and purchased outpatient clinics and physician practices as ways to skirt around the restrictions inherent in rate setting.

In response, the HSCRC established several programs and incentives like MHAC and QBR to reduce unnecessary care, including a 2011 payment reform strategy implementing enforceable global budgets for 10 rural hospitals and episode-based payment for an additional 25 hospitals.<sup>42</sup> These interventions and incentives have worked to lower inpatient volume somewhat, but have led to a new problem of higher patient acuity as these patients tend to be sicker and require more treatment resources, raising their per patient unit cost. This phenomenon is threatening the state's Medicare waiver, which relies on keeping rates of growth in per patient costs lower than the national average.<sup>43</sup>

In recognition of these identified deficiencies with the existing all-payer model, Maryland has recently submitted a proposal to CMS to move to a new all-payer model that focuses on overall hospital expenditures using capitated global budgets and shifts away from FFS reimbursement.<sup>44</sup> Under this new waiver proposal, Maryland will shift virtually 100 percent of hospital revenues into population-based models—either tying hospital reimbursement to projected services of a specific population or specific residents, or establishing fixed global budgets for hospitals over the next five years.<sup>45</sup> If the new waiver demonstration fails, the waiver agreement with CMS mandates that Maryland hospitals transition to the national Medicare payment systems. While their existing all-payer approach has served Maryland for the last few decades, it is not able to promote coordinated care across various healthcare settings or address Maryland's overall health care spending going forward.<sup>46</sup>

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<sup>40</sup> E. Porter. August 27, 2013. *Lessons in Maryland for Costs at Hospitals*. New York Times. Online at: [http://www.nytimes.com/2013/08/28/business/economy/lessons-in-maryland-for-costs-at-hospitals.html?pagewanted=all&\\_r=1&](http://www.nytimes.com/2013/08/28/business/economy/lessons-in-maryland-for-costs-at-hospitals.html?pagewanted=all&_r=1&)

<sup>41</sup> Ibid.

<sup>42</sup> Under episode based payment, hospitals are paid one set amount related to an episode or incident (e.g., all charges related to a hip replacement). Should readmissions related to the same incident be required, the hospital does not receive additional payments for that readmission.

<sup>43</sup> In exchange for this waiver, Maryland must pass a "waiver test" which stipulates that the cumulative growth in Medicare inpatient payment per admission in Maryland since January 1, 1981 cannot exceed cumulative growth in Medicare inpatient payment nationally.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

## Minnesota: Moving Provider Transparency Beyond Cost and Quality

### Description of Cost Containment Strategy: Provider Peer Grouping

Minnesota has been at the forefront of provider transparency efforts related to cost and quality, albeit separately, over the past decade. The State's most recent initiative, Provider Peer Grouping (PPG), brings these efforts together to address overall value of care.

PPG is a system for public comparison of provider performance across all patient populations. It uses measures that incorporate provider risk-adjusted<sup>47</sup> cost and quality.<sup>48</sup> Data used to develop these measures include:<sup>49</sup>

- **Quality measures**, e.g., outcomes, processes, and patient experience;
- **Utilization of health services**, amount and types of services; and
- **Pricing information**, the amount that a provider was paid from both third-party payers and health plan enrollees, including data on Medicare and Medicaid patients.<sup>50</sup>

PPG creates two primary measurements: 1) total care, and 2) care for specific conditions, including pneumonia and total knee replacement (collected from hospital settings only), asthma, coronary artery disease, congestive heart failure, and diabetes (collected from physician clinics only).<sup>51</sup> Results are intended for public reporting about hospitals, clinics and medical groups, not by the individual physician, and distributed to providers by the Minnesota Department of Health (MDH). Under the model, providers and stakeholders have input on methodological topics throughout the development process and the opportunity to review their reports confidentially during a four month period; results can be appealed based on any concerns related to the accuracy of the data or errors in the application of the methodology.<sup>52</sup>

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<sup>47</sup> Risk adjustment refers to the process by which provider or health plan payments are adjusted based on the underlying health status of the population served, thereby limiting the provider or plan's risk of covering people with high-cost conditions. For more information, refer to: American Academy of Actuaries. *Risk Assessment and Risk Adjustment: Issue Brief*. May 2010. Online at: [http://www.actuary.org/pdf/health/Risk\\_Adjustment\\_Issue\\_Brief\\_Final\\_5-26-10.pdf](http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf)

<sup>48</sup> S. Gildemeister. April 9, 2012. *Provider Peer Grouping Monthly Updates*. Minnesota Department of Health PowerPoint Presentation. Online at: <http://www.health.state.mn.us/healthreform/peer/ppgcall040912.pdf>

<sup>49</sup> J. Golden. February 10, 2011. *E-Health Provider Peer Grouping Health Coverage and Spending*. Minnesota Department of Health PowerPoint Presentation. Online at: <http://www.house.leg.state.mn.us/comm/docs/MDH-GoldenOverveiw.pdf>

<sup>50</sup> States in Action Archive. August/September 2008. *Minnesota: Payment Reform and Price Transparency*. The Commonwealth Fund. Online at: <http://www.commonwealthfund.org/Newsletters/States-in-Action/2008/Aug/August-September-2008/Snapshots--Short-Takes-on-Promising-Programs/Minnesota--Payment-Reform-and-Price-Transparency.aspx>

<sup>51</sup> S. Gildemeister. March 1, 2012. *Transparency on Cost and Quality: Understanding Value in Health Care Through Provider Peer Grouping*. Minnesota Department of Health PowerPoint Presentation. Online at: <http://mn.gov/health-reform/images/Task-Force-2012-03-01-MDH-on-PPG.pdf>

<sup>52</sup> Ibid.



## Legislative History and Process

In a bi-partisan effort, the Minnesota Legislature passed a series of broad health reform laws in 2008,<sup>53</sup> including policies to promote quality and transparency. They tasked the Minnesota Health Commissioner with developing a method to provide consumers, payers, and providers with information to help them assess value of health care services<sup>54</sup> using a consistent and transparent methodology that reflects community input and consensus.<sup>55</sup>

The successful passage of the 2008 legislation was built on a past history of provider transparency efforts. In 1993, the Institute for Clinical Systems Improvement (ICSI) was established to develop quality guidelines for practicing providers, which included patient outcome objectives. Reports were kept confidential and only other providers could access them, which engendered trust and made physician groups more willing to participate.<sup>56</sup> A few years later, one HMO began compiling quality data by physician group and publishing results in attempts to foster competition among groups and build consumer awareness.<sup>57</sup> By the early 2000s, all other health plans were using their own confidential internal measures for assessing quality, which spurred the need for one common set of measures across all plans, simplifying provider reporting. There was some initial hesitation by providers, but once they saw the assessment was "valid, fair and transparent,"<sup>58</sup> the pilot was a success and a new nonprofit, Minnesota Community Measurement (MNCM), was created to continue these efforts.<sup>59</sup>

The 2008 legislation built upon failed attempts from prior years. The Governor created a Health Care Transformation Task Force to advise on ways to improve affordability, quality, and access in health care. The Task Force recommendations included requirements to measure providers on quality and cost, publish results for consumers, and change payment structures to reward providers who provide better quality care for lower costs.<sup>60</sup> Since the efforts of ICSI and MNCM had already helped spur a culture shift among providers in Minnesota around quality assessment, these recommendations received widespread bipartisan support from the legislature and Governor and were signed into law the following year.<sup>61</sup>

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<sup>53</sup> Other provisions aimed at improving access and quality and containing health care costs included bonus payments to providers to incentivize higher quality care for lower costs. W. McClure and T. McDonald. 2012. *Looking back: Minnesota's growing health reform strategy. A history of health care system reform in Minnesota*. The Center for Policy Studies. Online at: <http://www.centerforpolicy.org/files/Looking-Back-Minnesotas-Health-Reform-Strategy.pdf>

<sup>54</sup> Provider Peer Grouping Fact Sheet. *Minnesota Department of Health*. Retrieved from <http://www.health.state.mn.us/healthreform/peer/ppgfactsheet082012.pdf>

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.

<sup>58</sup> Ibid.

<sup>59</sup> MNCM has since expanded the number of conditions included in the quality assessment. Its board membership includes not only plans and providers, but also labor and business representatives. Ibid.

<sup>60</sup> Ibid.

<sup>61</sup> Ibid.

## Implementation Process

Minnesota had a well-developed assessment process to measure quality alone, but there was no practical measurement tool to assess value.<sup>62</sup> To address this need, MDH solicited input and technical expertise through a stakeholder engagement process, which included identifying key questions and issues with developing the methodologies.<sup>63</sup>

Even with widespread industry participation, there were still challenges. Specifically, the technical application of PPG methodology had a number of obstacles. Some of the challenges MDH experienced in creating the metrics included developing a rigorous methodology with community input, ensuring validity, displaying results in a meaningful way for consumers and providers, and making results actionable.<sup>64</sup> Providers identified an additional challenge with the narrow timelines for reporting and appealing results.<sup>65</sup> The first results, issued to hospitals only in 2011, also had shortcomings in their technical methodology. The legislature responded to these issues with subsequent legislation to incorporate modified timelines and new requirements to assure validity and reliability of results, and to clarify the appeals process. An additional advisory committee was established in 2012 to further refine and implement the system over the next two years.<sup>66</sup> A new metric has since been introduced by one of Minnesota's HMOs; it was created using a modified version of their organization's own internal total cost of care metric, which has now been endorsed by the National Quality Forum.<sup>67</sup>

## Metrics and Outcomes

Evaluating providers on value of care is still in its infancy. Minnesota's goal is to provide actionable information to payers, consumers, and providers to drive health care purchasing decisions and improve quality. PPG reports are intended to be used by all payers, including Medicaid, managed care organizations, and consumers.<sup>68</sup> However, recent implementation challenges noted above have kept the reports from being released publicly. MDH released a Hospital Total Care Report on March 25, 2013 to individual facilities only, stating that the results would be

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<sup>62</sup> The total cost of care includes not only charges paid to the provider but also the efficiency with which the provider utilizes services for a patient's benefit, risk adjusted for the acuity of the patient population. Ibid.

<sup>63</sup> The project has also received guidance from several technical advisory groups, including a Rapid Response Team of stakeholders to solicit input on detailed methodological issues, and a Reliability Workgroup to ensure reliability and usefulness of peer grouping results. Minnesota's Health Care Reform Initiative: Request for Information on Provider Peer Grouping Methodologies Health Economics Program. *Minnesota Department of Health*. Retrieved from <http://www.health.state.mn.us/healthreform/peerrfi090320.pdf>

<sup>64</sup> Ibid

<sup>65</sup> S. Smith. March 18, 2010. *Commissioner opposes peer grouping timeline change*. Minnesota Medical Association. Online at:

<http://www.mnmed.org/News/NewsItem/TabId/4673/ArtMID/11704/ArticleID/3557/Commissioner-opposes-peer-grouping-timeline-change.aspx>

<sup>66</sup> Ibid.

<sup>67</sup> Ibid.

<sup>68</sup> Ibid.

aggregated and used for a larger summary report to be released later in 2013.<sup>69</sup> MDH also indicates that recommendations from the ongoing work of the Advisory Committee and Rapid Response Team, as well as lessons learned from the previous confidential release, will be incorporated into a second version of the Hospital Total Care Report to be released to the public towards the end of 2013.<sup>70</sup>

According to key informants, many consumers are unaware of PPG and other provider data. Consumer advocates have had limited resources to spend on the impact of cost containment and payment reform efforts, and were focused on the more immediate issues of coverage and access. Stakeholder participants have largely been from the health care industry and payers.

## Lessons Learned

Past efforts have allowed Minnesota providers to see the value in using quality measures to improve patient care, and MDH has worked to ensure that providers have the opportunity to come to consensus on which measures are valid.<sup>71</sup> The many opportunities for stakeholder input and the ongoing efforts to refine PPG methodology have been critical to continued provider acceptance. Although PPG has conceptual support from all stakeholders, the technical details and program's design are challenging to implement, particularly the total cost of care measure. Key informants shared that the total cost of care measure is particularly complex, since it must be calculated across various data sources and must be defined consistently across providers; it also currently has more limited stakeholder support. However, the years of quality and cost reporting through ICSI made the transition to public reporting much easier for providers to support PPG. However, additional education and engagement of consumers is clearly needed.

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<sup>69</sup> MN Provider Peer Grouping Hospital Total Care Report Frequently Asked Questions (and Answers), May 3, 2013. Online at <http://www.health.state.mn.us/healthreform/peer/mnpeergrouphospfaq0513v2.pdf>

<sup>70</sup> Ibid.

<sup>71</sup> Ibid.

## New York: Cutting Costs by Consensus

### Description of Cost Containment Strategy: Medicaid Global Cap

In 2011, New York's Medicaid program was the nation's largest, spending twice the national average on a per enrollee basis.<sup>72</sup> In quality, New York ranks in the middle of the pack (22<sup>nd</sup> nationally). However, this overall score masked problems such as avoidable hospital use, where New York ranks 50<sup>th</sup> in the nation, and major disparities in health status among racial, ethnic, and socioeconomic groups.<sup>73</sup> Since the State faced a gaping budget hole, New York underwent a comprehensive Medicaid reform redesign and planning process to develop ideas to close the budget gap while improving quality and efficiency. Known as the Medicaid Redesign Team (MRT) process, these efforts resulted in, among other things, an agreement among stakeholders to impose a "global cap" on Medicaid spending. The global cap is tied to the long-term medical Consumer Price Index, currently estimated at 3.9 percent, and is intended to reduce Medicaid spending by two percent per year.<sup>74</sup> New York is the first state in the nation to establish a hard cap on state Medicaid spending.<sup>75</sup>

The global cap is the cornerstone of the MRT effort, serving as a firm limit on the State's share of Medicaid spending. It has changed the way the State and stakeholders think about changes to the Medicaid program. Given finite Medicaid resources, every policy change is viewed in the context of its impact to the global budget, and the State Departments of Health and Budget (DOH and DOB, respectively) must actively monitor and report Medicaid spending on a monthly basis to determine if spending growth is expected to exceed the cap. In the event that spending is projected to exceed the cap, the DOH and DOB are tasked to develop and implement "Medicaid Savings Allocation plans" to bring spending in line with the cap.<sup>76</sup> Such actions could include modifying/suspending reimbursement rates, changing benefit levels, or implementing utilization controls to rein in spending.

While a spending cap can be viewed as a blunt instrument, New York paired it with a series of initiatives that are designed to improve quality while mitigating the chances of hitting the cap. There is significant incentive for providers to innovate and work together to deliver care more efficiently to avoid budgetary actions triggered by

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<sup>72</sup> A Plan to Transform the Empire State's Medicaid Program. *MRT Final Report and Action Plan*. Online at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrtfinalreport.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf)

<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> *New York State may cap Medicaid costs at \$15.1 billion*. February 25, 2011. Reuters. Online at: <http://www.reuters.com/article/2011/02/25/us-ny-state-cap-medicaid-costs-151-billi-idUSTRE71O5DP20110225>

<sup>76</sup> Since the global cap was enacted, Medicaid spending has stayed within budget. The State has never used its authority to enact a Medicaid Savings Allocation plan. *Monthly and Regional Global Cap Report*. October 2013. New York Department of Health. Online at: [http://www.health.ny.gov/health\\_care/medicaid/regulations/global\\_cap/](http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/)

hitting the global cap. The DOH has acknowledged that industry actions to curtail spending growth are an important part of ensuring fiscal neutrality under the cap.<sup>77</sup>

## Legislative History and Process

Governor Cuomo established the MRT by Executive Order upon taking office in January 2011 and tasked the MRT with developing Medicaid budget recommendations. Driven by the DOH, the MRT included a wide array of stakeholders, including representatives from hospitals, clinics, various provider groups, insurers, business and consumer leaders, labor unions, and members of the State Legislature.<sup>78</sup> The goal of this effort was for stakeholders and experts to work together to reform the system and reduce costs while maintaining quality and access. The MRT received over 4,000 ideas through a series of public meetings held in every region of the state. Meetings were webcasted and made available online. The work was done in two phases:

- **Phase 1: Develop a blueprint to lower Medicaid spending in the 2011 budget year by \$2.2 billion.** Completed in February 2011 upon submission of an initial report, this phase produced 79 recommendations to redesign and restructure Medicaid to meet the governor's spending target. The 78 recommendations adopted into the state budget by the legislature focused on: 1) not imposing higher cost-sharing, cutting eligibility, or cutting benefits; 2) making Medicaid more patient-centered; and 3) accelerating the shift from FFS Medicaid to managed care while giving providers flexibility to implement needed reforms.
- **Phase 2: Develop a multi-year action plan that, when fully implemented, will improve health outcomes and bend the cost curve.** During Phase 2, the MRT monitored implementation of Phase 1 recommendations and established 10 workgroups to address complex, systemic, and long-term issues impacting the state. This process included an additional 175 stakeholders, and each workgroup produced a final report of recommendations.<sup>79</sup>

In addition to the global cap, major elements of the MRT plan include:

- Care Management for All, to move from FFS to capitated or bundled arrangements over the course of three years;
- Health Homes, which includes intensive care management, and patient navigation for high need and high cost Medicaid patients, as well as dual eligibles;

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<sup>77</sup> According to the April 2011 Medicaid Global Cap report, industry led contributions (\$640 million in 2011-12; \$1.5 billion in 2012-13) represents the total amount of additional savings/system efficiencies that may be required (without additional State/Legislative action) to achieve fiscal neutrality under the cap. Ibid.

<sup>78</sup> *Medicaid Redesign Team Members*. August 2011. New York Department of Health. Online at:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/members.htm](http://www.health.ny.gov/health_care/medicaid/redesign/members.htm)

<sup>79</sup> J. Helgerson. August 12, 2013. Medicaid Redesign and Its Focus on Super Users. *NYS Department of Health Powerpoint Presentation*. Online at: <http://www.nga.org/files/live/sites/NGA/files/pdf/2013/1308SuperUtilizersHelgerson.pdf>

- Universal Access to High Quality Primary Care, with a goal for every Medicaid enrollee to have access to, and fully take advantage of, patient centered medical homes; and
- Initiatives to target the social determinants of health, including addressing issues such as housing and health disparities.<sup>80</sup>

The global cap was supported by a wide range of health care leaders and organizations that have historically competed for limited Medicaid dollars and represent competing interests. According to hospital and labor leaders, stakeholders across the board recognized that everyone needed to do more with less, and by making comprehensive reforms, the Medicaid program could be made to operate more efficiently while improving quality for all New Yorkers.<sup>81</sup> The end result represents the shared sacrifice of all stakeholders involved, as well as their commitment to enact much needed reforms to make the New York Medicaid program more efficient and improve care.

## Implementation Process

Implementation of the global cap was straightforward. According to key informants, the main concerns around implementation have been the limited amount and type of information in the monthly global cap reports and the desire to understand what industry led efforts were designed to generate savings. While the DOH included additional elements to their reports over time, these reports are limited to state fiscal information. Quality and access measures are collected and reported through other efforts by the State, but are not included in the global cap reports.

## Metrics and Outcomes

There is clear evidence that the global cap is generating cost savings. In its first year (SFY 2011-12), total NY Medicaid spending dropped by \$4 billion (\$2 billion state savings) and finished \$14 million under the cap without reducing benefits. In year two (SFY 2012-13), the program finished \$200 million under the cap. During this two year period, Medicaid enrollment grew by more than 390,000 enrollees, from 4.89 million enrollees in April 2011 (start of the program) to 5.28 million at the end of March 2013.<sup>82</sup> During this time, the State also absorbed a \$1.1 billion shortfall due to a change in Medicaid financing for developmental disability services with minimal reduction to provider reimbursement.<sup>83</sup> According to the DOH, cost savings were generated during this period by:

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<sup>80</sup> Affordable Housing Work Group Final Recommendations, A Plan to Transform the Empire State's Medicaid Program. *MRT Final Report and Action Plan*, page 362.

<sup>81</sup> Ibid.

<sup>82</sup> Ibid.

<sup>83</sup> Ibid

- Shifting less severe patients from the hospital and emergency room to more appropriate ambulatory/primary care settings;
- Controlling home care and personal care spending;<sup>84</sup>
- Shifting Medicaid recipients from FFS to Medicaid Managed Care; and
- Voluntary repayment of outstanding liabilities owed by providers.

A contributing factor to the program's success has been savings generated from MRT initiatives. There are currently 70 pilot and demonstration programs in place under the MRT plan.<sup>85</sup> According to the DOH, these MRT initiatives have significantly contributed to lower utilization of services (resulting in a savings of \$130 million in SFY 2012-13). In 2009, before implementation of the global cap, the cost to serve each Medicaid enrollee was \$8,493, compared to \$7,864 in 2012 (post-global cap).<sup>86</sup>

## Lessons Learned

According to key informants, the success of the MRT efforts and New York's ability to stay under the global cap is grounded in transparency, collaboration among stakeholders, and the shared belief such a measure is needed to ensure the long term fiscal viability of the Medicaid program. While advocates had concerns about limiting certain services,<sup>87</sup> the recommendations were developed by stakeholders including advocates, instead of coming from the Administration or the legislature, which streamlined the budget process and led to limited opposition.

The continued engagement of stakeholders also supported ongoing collaboration and alignment of incentives across providers. Stakeholders worked together to set budget goals, make compromises, and hold each other accountable. The need for savings realized in certain sectors to offset losses in other sectors required an open dialogue among parties who previously had little incentive to participate in exchanges in the past or to consider their role in the total cost of care.

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<sup>84</sup> In New York, Medicaid pays for personal care spending such as housekeeping, meal preparation, bathing, toileting, and grooming.

<sup>85</sup> A. Brino. January 31, 2013. *NY outlines Medicaid spending cap plans*. Government Health IT. Online at: <http://www.govhealthit.com/news/ny-outlines-medicaid-spending-cap-plans>

<sup>86</sup> Ibid.

<sup>87</sup> Interviewees shared concerns about some service limitations, such as utilization limits established for physical therapy, occupational therapy, and speech therapy/pathology.

## Oregon: Taking a Risk on Local Control

### Description of Cost Containment Strategy: Coordinated Care Organizations in Medicaid

The Oregon Health Authority (OHA) developed a Coordinated Care Model (CCM), a variation of the ACO model established under the ACA,<sup>88</sup> under their Medicaid program as a way to cut costs by reducing delivery system fragmentation and simultaneously improve health outcomes by increasing care coordination for their beneficiaries. Under this model, OHA contracts with Coordinated Care Organizations (CCOs), which are local, risk-bearing organizations paid under a global budget to provide a full range of services including medical, behavioral, mental health, dental (beginning 2014), and vision for the populations they serve.<sup>89</sup> Long-term care is excluded.

Key features of Oregon's CCM include:

- Development of broad networks of previously unrelated health entities (physician groups, hospitals, mental health organizations, dentists, vision providers, etc.) who agree to work together to collectively coordinate care and contain costs for a specific Medicaid population;<sup>90</sup>
- Broad flexibility to create the array of services necessary to improve care delivery and population health, including the flexibility to use Medicaid funds for non-traditional health care workers;<sup>91</sup>
- Demonstration of financial solvency, but with significant flexibility to establish provider contracts and rates based on local market dynamics;<sup>92</sup> and
- Responsiveness to community needs, including community advisory councils (CACs), the chair of which also sits on the local CCO board, and responsibility for conducting community health needs assessments.

Global budgets for CCOs include: 1) a capitated component including payments for physical and mental health; 2) payment for optional services including residential alcohol and drug treatment services, dental coverage, and selected case management programs offered in a few counties; and 3) transformation incentive payments (such as infrastructure payments for metrics reporting, delivery system transformation efforts in the first year, and incentives for meeting cost and health outcomes in later years).<sup>93</sup> CCO budgets grow at a fixed amount per year, 4.4 percent in

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<sup>88</sup> E. Stecker. March 14, 2013. *The Oregon ACO Experiment- Bold Design, Challenging Execution*. New England Journal of Medicine 368, 982-985.

<sup>89</sup> Ibid.

<sup>90</sup> J. Rojas-Burke. September 7, 2013. *Inside Oregon's Medicaid Lab*. Modern Healthcare. Online at: <http://www.modernhealthcare.com/article/20130907/MAGAZINE/309079891>

<sup>91</sup> CCO payments account for flexible services and reflect assumptions for use of these services. Memorandum. July 6, 2012. Oregon Health Authority. Online at: [www.oregon.gov/oha/OHPB/Documents/cms-waiver-brief.pdf](http://www.oregon.gov/oha/OHPB/Documents/cms-waiver-brief.pdf)

<sup>92</sup> Ibid.

<sup>93</sup> J. Smith. March 2013. *Transforming Healthcare in Oregon: Coordinated Care Organizations*. Oregon Health Authority Powerpoint presentation.



2013 and 3.4 percent in 2014, less than the expected 5.4 percent per capita increase among Medicaid patients nationally.<sup>94</sup> If a CCO exceeds its global budget, it is responsible for the excess costs.

Oregon is at risk of losing hundreds of millions of dollars under their waiver if this model fails. In exchange for \$1.9 billion in federal investment, Oregon must show a two percent reduction in the Medicaid per capita growth rate and generate \$330 million in savings over five years, all while ensuring that quality of care and population health both improve.<sup>95</sup> Penalties for failure are significant, ranging from \$145 million in Year 2, to \$183 million in Years 4 and 5.<sup>96</sup>

## Legislative History and Process

With a faltering economy, state budgetary problems, and an 11.5 percent Medicaid provider rate cut,<sup>97</sup> Oregon faced three possibilities to contain costs in its Medicaid program in 2011: cut services, cut reimbursement rates, or cut eligibility. Led by Governor Kitzhaber, a former ER physician who strongly believes in community driven change, Oregonians decided none of these were palatable options and instead developed the CCM.

In 2009, legislation was approved to develop the CCM. Through an extensive stakeholder engagement process, including 75 public meetings in one year, the State solicited widespread input from the public and the health care industry. OHA did not rush the stakeholder process and worked to ensure all interested parties had a seat at the table. According to key informants, while various industry groups raised specific concerns about the proposal's impact, few could argue against the need for fundamental system redesign. The exception was long term care, which OHA ultimately agreed to exclude from the model at the urging of advocates in the long term care community. The final details of the plan were adopted legislatively in 2011 and submitted to CMS through an 1115 waiver.<sup>98</sup> The waiver was granted on July 5, 2012.<sup>99</sup>

## Implementation Process

Oregon's 16 state-certified CCOs<sup>100</sup> are sparking innovation in health delivery across the state. CCOs are required to develop transformation plans that are responsive to community needs and demonstrate how the CCO will improve

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<sup>94</sup> S. Abramsky. March 2013. *John Kitzhaber's Oregon Dream*. The Nation. Online at: <http://www.virginiajagarcia.org/media/documents/TheNationArticle.pdf>

<sup>95</sup> Ibid.

<sup>96</sup> Centers for Medicare & Medicaid Services Amended Waiver List and Expenditure Authority. Online at: <http://www.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf>

<sup>97</sup> T. Abdollah. May 26, 2011. *Oregon Lawmakers Announce Medicaid Payment Cuts*. KATU News. Online at: <http://www.katu.com/news/122644439.html>

<sup>98</sup> *CMS Waiver – Request for Amended Waiver*. March 2, 2012. Oregon Health Authority. Online at: <https://cco.health.oregon.gov/DraftDocuments/Pages/CMS-Waiver.aspx>

<sup>99</sup> N. Budnick. July 9, 2012. *Oregon awarded \$1.9 billion federal funding pact, new flexibility for health care reforms*. The Oregonian. Online at: [http://www.oregonlive.com/news/index.ssf/2012/07/oregon\\_awarded\\_19\\_billion\\_fede.html](http://www.oregonlive.com/news/index.ssf/2012/07/oregon_awarded_19_billion_fede.html)

<sup>100</sup> Coordinated Care Organizations. Oregon Health Authority. Online at: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>

health outcomes, increase member satisfaction, and reduce overall costs. For example, some CCOs are increasingly using community health workers to help people navigate the health care system, reduce unneeded emergency room visits, and help patients manage chronic conditions.<sup>101</sup> Additional examples of local innovation include models of improved integration of behavioral and physical health care, movement toward patient-centered primary care homes, and targeted approaches to address complex medical conditions for focused groups of patients.<sup>102</sup>

While the state is seeing local innovation, CCOs still face many challenges transforming the local delivery systems. In response, the OHA developed a Transformation Center and assigned dedicated staff to each CCO to provide technical assistance and support. The Transformation Center manages statewide learning collaboratives and is a conduit for sharing best practices among CCOs.

According to advocates, ensuring consumer representation at the local CCO level has been challenging. Despite the initial extensive stakeholder engagement process, CCOs are only required to have one consumer representative on their board. And while CCOs must also have a Consumer Advisory Committee (CAC) to provide consumer input, it is not clear what impact the CACs have on the CCO's decisions. There is no requirement for CCO board or CAC meetings to be open to the public. It remains to be seen how influential these advisory committees will be to the CCOs' ongoing implementation.

## Metrics and Outcomes

The CCOs are in their infancy and it is too early to assess the success of the CCM. However, robust metrics have been put in place to help gauge impacts to consumers. To ensure cost is contained while maintaining quality and access, CCOs are required to monitor and report performance data on 33 metrics, 17 of which allow the CCO to earn quality based incentive payments. OHA publishes quarterly reports showing this quality and access data, financial data, and progress towards reaching benchmarks. These performance metrics evaluate access to care, member satisfaction with care, and quality of care in these specific areas:<sup>103</sup>

1. Improved coordination between behavioral and physical health care;
2. Improved maternity and perinatal care;
3. Reduced preventable hospitalizations;
4. Appropriateness of care settings;
5. Improved primary care;

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<sup>101</sup> B. Goldberg. October 18, 2013. Telephone Interview.

<sup>102</sup> Ibid.

<sup>103</sup> *Oregon's 1115 Medicaid Demonstration Accountability Plan and Expenditure Trend Review*. Oregon Health Authority

6. Reduced unnecessary and costly utilization by super-utilizers; and
7. Improved population health.

## Lessons Learned

According to key informants, Oregon was able to successfully enact legislation and implement the CCM due to three major factors: strong leadership by the Governor and Administration, shared vision across stakeholders, and open communication and transparency through the stakeholder engagement process.

Governor Kitzhaber's vision and leadership brought stakeholders together and created a shared understanding that the old fragmented system was unacceptable. This was done by defining the status quo, establishing a shared understanding of its inefficiencies, achieving alignment around a common set of principles, and having broad agreement by all parties to work towards the same unified goals.

Under this model, everyone has "some skin in the game." Required to live within a global budget, local providers are accepting a lot more risk. This spurs collaboration and creates incentives to address system fragmentation. The state is at huge financial risk if this model fails, and consumers ultimately bear the brunt should the CCOs fail.

If all goes well, Oregon may expand the CCOs to be an option for state, university, and school district employees. This would include up to 850,000 people who receive their health coverage through the state public employee's purchasing pool. CCOs could also potentially become an option for small businesses in the state's Health Benefit Exchange.<sup>104</sup>

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<sup>104</sup> T. Coughlin, and S. Corlette. February 8, 2012. *ACA Implementation in Oregon- Monitoring and Tracking Site Visit Report*. Robert Wood Johnson Foundation and the Urban Institute.

## Rhode Island: Rate Review with a Twist

### Description of Cost Containment Strategy: Rate Review

Created in 2004, Rhode Island's cabinet-level Office of the Health Insurance Commissioner (OHIC) is responsible for overseeing private health insurers, including the review of health insurance premium rates for 575,000 commercially insured individuals (roughly 55% of the population). OHIC has the authority to approve, reject, or request modifications to proposed rates. It is also responsible for "improving the health care system's quality, accessibility, and affordability."<sup>105</sup> To that end, OHIC moved to the forefront of cost containment and quality improvement efforts by developing Affordability Standards (Standards) for health plans in 2010.<sup>106</sup> The Standards were finalized after almost a year of work with stakeholders.

More specifically, OHIC's Standards require the three major Rhode Island insurers to:<sup>107</sup>

- *Support stronger primary care infrastructure.* Insurers are required to increase the share of the total medical payments made for primary care by one percentage point per year from 2010 to 2014.<sup>108</sup> Insurers are prohibited from building this into premium increases, which they achieve by decreasing spending on non-primary care services.
- *Promote patient-centered medical homes.* While the original requirement was for health plans to hire a certain number of care coordinators, this Standard evolved by 2012 to require health plans to financially support the Rhode Island Chronic Care Sustainability Initiative (CSI), an all-payer medical home/practice redesign effort.<sup>109</sup> Plans are allowed to have their own specific medical home initiative; however, that program must still be consistent with the CSI. For the first time, this Standard created a unified, statewide medical home model.
- *Offer support to CurrentCare.* While the original requirement was to support adoption of electronic medical records (EMRs) in physician offices,<sup>110</sup> this Standard evolved by 2012 to require health plans to financially support CurrentCare, Rhode Island's health information exchange.<sup>111</sup>

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<sup>105</sup> OHIC, "Primary Care Spending in Rhode Island," September 2012. Please See:

[http://www.ohic.ri.gov/documents/Insurers/Reports/2012%20Primary%20Care%20Spend/Primary%20Care%20Report\\_FINAL.pdf](http://www.ohic.ri.gov/documents/Insurers/Reports/2012%20Primary%20Care%20Spend/Primary%20Care%20Report_FINAL.pdf)

<sup>106</sup> S. Corlette, K. Lucia and K. Keith. September 2012. *Cross-Cutting Issues: Monitoring State Implementation of the Affordable Care Act in 10 States: Rate Review*, Urban Institute. Available at: <http://www.urban.org/UploadedPDF/412649-Monitoring-State-Implementation-of-the-Affordable-Care-Act-in-10-States.pdf>

<sup>107</sup> The three largest health plans in Rhode Island are subject to the Standards: Blue Cross Blue Shield of Rhode Island (BCBSRI), Tufts Health Plan (Tufts), and United Healthcare (United).

<sup>108</sup> Because Tufts is a new plan in Rhode Island, it was not given a spending target. Ibid.

<sup>109</sup> Health Insurance Advisory Council, *System, Affordability Priorities for Health Insurers in Rhode Island*. Rhode Island Health Insurance Commissioner. April 17, 2009. Online at:

[http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%205\\_HIAC%20Report%20-%20System%20Affordability%20Stds%20&%20Priorities%20for%20Insurers.pdf](http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%205_HIAC%20Report%20-%20System%20Affordability%20Stds%20&%20Priorities%20for%20Insurers.pdf)

<sup>110</sup> Ibid.

- *Move toward hospital payment reform.* While the original requirement focused on comprehensive payment reform,<sup>112</sup> this Standard evolved to focus on adding six new contract provisions for hospitals, including: limits on the growth of hospital payments, administrative simplifications, quality payment incentives, and care coordination requirements.<sup>113</sup>

Rhode Island's rate review process is regarded as one of the most effective and innovative rate review processes prior to the passing of the Affordable Care Act. The Standards require plans to take proactive steps to bring down costs or face penalties, and this is a unique approach under consideration by other states.

## Legislative History and Process

The swift and surprise closure of the Harvard Pilgrim Health Care's Rhode Island affiliate in December 1999 prompted statewide debate on insurer solvency. This created a window of opportunity to pass legislation authorizing rate regulation. According to a key informant, it was hard to argue against rate regulation given Harvard Pilgrim's demise caused significant disruptions in provider-patient relationships and gaps in continuity of care for many enrollees.<sup>114</sup> There was a strong community coalition that supported rate regulation, including organized labor. An integral part of the advocacy strategy was to centrally feature the depth of the impact of the closure on enrollees, particularly through story banking and enrollee testimonies.

Rhode Island is the only state that has a dedicated Health Insurance Commissioner, distinct and separate from the Insurance Commissioner.<sup>115</sup> The 2004 authorizing legislation charged OHIC to:

- Protect consumers;
- Ensure fair treatment of providers;
- Ensure solvency of health insurers; and
- Improve quality, access and affordability.

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<sup>111</sup> Bailit Health Purchasing, *Assessment of the Rhode Island Office of the Health Insurance Commissioner's Affordability Standards, Final Report*. August 2013

<sup>112</sup> Ibid.

<sup>113</sup> A complete discussion of the contract provisions are available at: Rhode Island Office of the Health Insurance Commissioner, "The Affordability Standards: A Summary," undated. Online at: <http://www.ohic.ri.gov/2011%20Affordability%20Standards%20Assessment.php>

<sup>114</sup> M. McComas. May 2003. *Measuring the Fallout from Shutdown of a Rhode Island Health Organization*. Robert Wood Johnson Foundation. Online at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2003/05/measuring-the-fallout-from-shutdown-of-a-rhode-island-health-org.html>

<sup>115</sup> J. Buntin. January 31, 2011. *The Nation's Only Health Insurance Commissioner Takes on the Health-Care System*. Governing Magazine. Online at: <http://www.governing.com/topics/health-human-services/Nations-Only-Health-Insurance-Commissioner-Takes-Health-Care-System.html>

## Implementation Process

OHIC sets and enforces standards for insurers to meet the four charges above. Under the leadership of the Health Insurance Commissioner, OHIC used an extensive stakeholder process to create the Standards in 2009 and 2010. At the center of this process was the statutorily created Health Insurance Advisory Council (HIAC). Comprised of a range of stakeholders,<sup>116</sup> HIAC gave input on the development and prioritization of the Standards. Through 2011 and 2012, the planning effort continued to develop specific metrics for the selected priorities, and drove public support for CurrentCare and hospital payment reform. Specific steps taken by HIAC included:<sup>117</sup>

- Releasing key documents for public comment that were previously unavailable for consumer and payer input;
- Working with health plans, especially medical directors, to help ensure feasibility (health plans were otherwise excluded from HIAC membership);
- Working with policy experts to ensure Standards were evidence based; and
- Making recommendations on the Standards to be used.<sup>118</sup>

Generally, stakeholders reported that their voices were heard during the process,<sup>119</sup> with specific policies having been changed in response to input. For example, obstetricians and gynecologists believed some of the spending for the care they provided should count towards primary care, where it had originally been excluded. In response, OHIC allowed for such spending to be counted, if that spending could be traced specifically to a primary care activity.<sup>120</sup>

## Metrics and Outcomes

Most Rhode Island stakeholders believe the impact of the changes will take several years to realize fully. Nonetheless, there have been several evaluations that assess progress to date. The results include:

- *Promoting primary care spending.* The three health plans met this Standard from 2010 to 2012, and as a result, the total spending on primary care increased.<sup>121</sup> For 2013, one health plan appears to be relying on falling total costs in order to show that the share of primary care spending has grown sufficiently.<sup>122</sup>
- *Supporting CSI.* This Standard was called a “game changer” by stakeholders during interviews in terms of moving medical homes forward.<sup>123</sup> By requiring support of a single medical home model, OHIC was able to

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<sup>116</sup> OHIC Health Insurance Advisory Council Charter. Online at: [http://www.ohic.ri.gov/Committees\\_HealthInsuranceAdvisoryCouncil\\_About.php](http://www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_About.php)

<sup>117</sup> A. Sherwin. May 2009. *Using Health Insurance Regulation to Achieve Health Care Cost Containment and Health Reform: The Rhode Island Experience*. Master's Thesis for Brown University

<sup>118</sup> Ibid.

<sup>119</sup> Ibid.

<sup>120</sup> Ibid.

<sup>121</sup> Ibid.

<sup>122</sup> Ibid.

<sup>123</sup> Ibid.

simplify and focus growth efforts. While the work is in process and almost \$27 million has been spent since 2009 on medical homes under this program, researchers concluded that it is too early to know if access to medical homes has increased.<sup>124</sup>

- *Promoting CurrentCare.* Given the complexity in creating health information exchanges, it is believed to be “too early to know” the impact of this standard.<sup>125</sup>
- *Requiring hospital payment reform.* Given that there are six different contract provisions, it is difficult to make a broad statement about the impact of the changes. Overall, the results from the different provisions are mixed, with most provisions requiring more time to fully assess.<sup>126</sup> Stakeholder interviews found that administrative simplifications requiring plans and hospitals to work together to improve operations, such as improvements in claims and eligibility verification processes, have been value-added and “successful” at promoting communication.<sup>127</sup> In contrast, hospitals have been slow to adopt the care coordination standards.<sup>128</sup>

## Lessons Learned

Strong leadership in the OHIC and flexibility during implementation were noted in stakeholder interviews as being essential to the success of health insurance rate review in Rhode Island. Also essential were community and health plan buy-in, and engagement of stakeholders including the sizeable small business community in the state. Small business owners were increasingly frustrated with health insurance rate increases, so OHIC helped establish a small employer taskforce to engage and educate this community. Through the support of this taskforce, small business owners became increasingly vocal in making public comments about the need for cost containment during OHIC information gathering sessions.

Interviewees noted that relationships matter, and that in their state, it is possible to convene all of the relevant stakeholders at a single meeting. Even though that might not be possible in larger states, it was suggested that regional meetings could be held first, with results fed into a state-level meeting. Interviewees also recommended that states build coalitions and invest in education around key issues, which is perceived to be critical but requiring perseverance over time.

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<sup>124</sup> Ibid.

<sup>125</sup> C. Koller, September 10, 2013. *Rhode Island's Affordability Standards: Aligning for Transformation*, Milbank Memorial Fund

<sup>126</sup> C. Koller, September 20, 2013. *Using Payment System Reform to Stimulate Delivery System Change*, Milbank Memorial Fund

<sup>127</sup> Ibid.

<sup>128</sup> Ibid.

## Vermont: On the Road to Single Payer

### Description of Cost Containment Strategy: Single Payer

Vermont has a multi-faceted approach to health reform and is putting steps in place to request a federal Affordable Care Act (ACA) waiver<sup>129</sup> to implement the first single payer financing system in the country. Single payer systems typically have lower administrative costs, less expensive health care coverage, and equitable coverage for everyone.<sup>130</sup>

Vermont's single payer plan will be designed "to replace private insurance tied to employment with universal coverage that encourages efficiency, lowers overhead costs, and incentivizes health outcomes."<sup>131</sup> It will cover all Vermont residents and include primary, preventive, and chronic care; urgent care; and hospital care.<sup>132</sup> Like single payer systems in several other countries, Vermont intends to allow health plans to continue to offer coverage once the single payer plan is implemented.<sup>133</sup> If Vermont residents obtain coverage through a private health plan after single payer is implemented (e.g., an employer may wish to purchase coverage where the benefits exceed those included in the single payer plan), the private coverage would be their primary source of coverage and the state single payer plan would be secondary.<sup>134</sup>

### Legislative History and Process

Vermont has a tradition of progressive health legislation. In 2006, Vermont enacted their Blueprint for Health, the state's initiative that aims to "integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs by promoting health maintenance, prevention and care coordination, and management."<sup>135</sup> As part of the Blueprint, about two-thirds of residents, including those with private health insurance coverage, receive coordinated care in patient-centered medical homes accompanied by

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<sup>129</sup> Section 1332 of the Affordable Care Act allows states to request five-year waivers of certain key provisions of health reform, including the individual mandate and the requirement to set up an exchange. To be approved, a "waiver for state innovation" must cover at least as many people as under the ACA and provide coverage that is at least as comprehensive and affordable, at no greater cost to the federal government. The waiver provision in the ACA was included due in part to efforts by Vermont's Senator Bernie Sanders who supported the state's desire to implement a single payer financing plan.

<sup>130</sup> Peter I. Buerhaus. Is U.S. Health Care Evolving Toward a Single-Payer System? An Interview with Health Care Economist Paul Feldstein, PhD. *Nursing Economic\$,* May-June 2010, 28(3).

<http://medicineandpublichealth.vanderbilt.edu/Is%20U.S.%20Health%20Care%20Evolving%20Toward%20a%20Single-Payer%20System.%20An%20Interview%20with%20Health%20Care%20Economist%20Paul%20Feldstein,%20PhD.pdf>

<sup>131</sup> Vermont's Health Care Reform, Unified Green Mountain Care website: <http://hcr.vermont.gov/timeline/gmc>

<sup>132</sup> Ibid.

<sup>133</sup> Only three countries (Canada, Cuba, and North Korea) have a "true" single payer system. Peter I. Buerhaus. Is U.S. Health Care Evolving Toward a Single-Payer System? An Interview with Health Care Economist Paul Feldstein, PhD.

<sup>134</sup> *Vermont Health Care Reform Transition Chart*. Agency of Administration. Online at: <http://hcr.vermont.gov/sites/hcr/files/2013/coverage%20transition%20chart%282%29.pdf>

<sup>135</sup> *What is the Vermont Blueprint for Health?* 2011. Vermont Child Health Improvement Program. Online at: [http://www.uvm.edu/medicine/vchip/documents/2011VCHIPINSERT\\_BLUEPRINT.pdf](http://www.uvm.edu/medicine/vchip/documents/2011VCHIPINSERT_BLUEPRINT.pdf)



community health teams that support practices' care delivery and patients' self-management.<sup>136,137</sup> Medicaid beneficiaries with complex conditions receive additional support services and more intense care coordination.<sup>138</sup>

In the 2009 gubernatorial election, Governor-elect Peter Shumlin focused on single payer as a key campaign policy platform.<sup>139</sup> Vermont's Legislature passed S 88 in 2010 to establish a commission to study different health care delivery reforms. The commission drafted three reform options for the state, and single payer was ultimately adopted by the Legislature.

Act 48, the Vermont Health Reform Law of 2011, required the state to develop a detailed plan for universal coverage through a single payer system and create a five-member Green Mountain Care Board (GMCB) charged with changing the way Vermont pays for health care and controlling the growth in health care costs.

The Vermont legislature assigned the GMCB unprecedented responsibility for the following major factors influencing the cost of health care:

- Improving the health of Vermont's residents;
- Overseeing a new health system designed to improve quality while reducing the rate of growth in costs;
- Regulating hospital budgets and major capital expenditures as well as health insurance rates;
- Approving plans for health insurance benefits in Vermont's new "exchange" program as well as the plan to recruit and retain health professionals; and
- Approving plans for building and maintaining electronic health information systems.

The State has sought consumer involvement throughout its health reform discussions, including two rounds of public engagement in 2011 and 2012. As a precursor to single payer, the State's health reform initiatives required in Act 48 of 2011 include setting up a health insurance exchange (through which all individual and small group insurance must be purchased in Vermont—there is no option to purchase these products outside the exchange); insurance rate review in the individual and small group markets; and the launch of several pilot projects involving accountable care organizations (ACOs), bundled payment for episodes of care, and global hospital budgets.<sup>140</sup>

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<sup>136</sup> C. Bielaszka-DuVernay. 2011. *Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Cost*, Health Affairs, 30(3):383-386. Online at: <http://content.healthaffairs.org/content/30/3/383.full>

<sup>137</sup> *The Vermont Blueprint for Health*. National Academy for State Health Policy. Online at: <http://www.nashp.org/sqipt-states/1083>

<sup>138</sup> S Silow-Carroll. 2013. *Medicaid Is One of Multiple Payers in Vermont's Health Care Reforms*, The Commonwealth Fund. Online at: [http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1668\\_SilowCarroll\\_Medicaid\\_Vermont\\_case\\_study\\_FI\\_NAL\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Mar/1668_SilowCarroll_Medicaid_Vermont_case_study_FI_NAL_v2.pdf)

<sup>139</sup> *Single Payer System Takes Center Stage in Vermont*. November 9, 2012. Healthcare Technology News.

<http://www.pnhp.org/news/2010/november/single-payer-system-takes-center-stage-in-vermont>

<sup>140</sup> State of Vermont. *Act No. 48. An act relating to a universal and unified health system*. <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf>

Though the ACA waivers will not be available until 2017, Vermont plans to seek a waiver for a single payer financing system as early as 2015.

## Implementation Process

Vermont anticipated developing a financing plan for the single payer model in 2013; however, that has been delayed due to the need to focus on setting up the ACA health insurance exchange, which opened for enrollment on October 1, 2013. According to key informants, it was confusing for residents to simultaneously receive information about obtaining coverage in the state health insurance exchange (beginning January 1, 2014) and about single payer (potential future coverage). As a result, education efforts in recent months have focused on the exchange.

In the meantime, Vermont has many health reform efforts underway, including implementation and testing of its state health care innovation plan that is being supported by a \$45 million federal State Innovation Model (SIM) grant from CMS.<sup>141</sup> Under the SIM grant, Vermont's payers (commercial and Medicaid) will test three existing Medicare models, including shared savings ACOs, bundled payments, and pay-for-performance. These models are designed to improve quality, encourage collaboration and efficiency, and move toward value-based payment. There are three existing ACO pilots: 1) a statewide ACO that involves 13 of the state's 14 hospitals and about 2,000 physicians; 2) an ACO led by federally qualified health centers; and 3) an ACO led by independent physicians.

## Metrics and Outcomes

The GMCB will ultimately decide on which outcome measures are selected. Providers are seeking to limit the number of measures, and advocates are pushing for additional measures for different populations. According to its strategic plan, Vermont will collect and report data on a variety of access, population health, cost, and financing measures.<sup>142</sup> Potential measures include the percent of residents in a medical home, rates of obesity and smoking, the adequacy of provider supply, rate of growth in Vermont health care expenditures, and passage of legislation authorizing financing for and receiving a federal waiver for a single payer plan.

## Lessons Learned

According to stakeholders interviewed, strong leadership by the Governor (and his office) and legislators, along with early and sustained involvement of a wide array of health care providers (including mental health, long-term care, and home health) and consumers, were essential for helping to move reform efforts along more quickly and in a way

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<sup>141</sup> State of Vermont. July 31, 2013. *State Innovation Model Operational Plan for Health System Innovation*. [http://gmcboard.vermont.gov/sites/gmcboard/files/VT\\_SIM\\_Operational\\_Plan080213.pdf](http://gmcboard.vermont.gov/sites/gmcboard/files/VT_SIM_Operational_Plan080213.pdf)

<sup>142</sup> Ibid.

that is more accepted by those affected. It was noted that comprehensive health reform in Vermont is easier because it is a small state.

From the consumer perspective, there have been opportunities for involvement in the many workgroups related to implementing the various aspects of health reform in Vermont. One representative from a consumer organization noted that their resources were stretched thin while trying to actively participate in all of the relevant workgroups seeking consumer input.

## V. Conclusions

Even though growth in health care costs has recently slowed, cost containment continues to be a major focus nationally. Many states and health care stakeholders are increasingly turning their attention to payment and delivery system reforms as a means of addressing rising costs and improving care delivery. The ACA's impact on these cost containment measures and the changing health care landscape has yet to be determined. As more individuals obtain coverage, the approaches that states implement are likely to evolve.

Across the states, there is significant variability due to local political and market dynamics. These differences drive the form and focus of efforts, and approaches are typically designed to address local needs. Several commonalities emerged:

- Most states are employing multiple strategies simultaneously;
- Strong leadership at the state level is important to establish a shared vision;
- Ongoing, inclusive and broad stakeholder engagement is key to achieving agreement between competing constituencies; and
- Ongoing data collection and evaluation are needed to measure progress.

A common trend among the different approaches to containing costs is a shift in accountability to major players in the health care system. For example, by transferring financial risk to providers or provider organizations, states hold providers accountable for the cost of care they provide and for patients' health outcomes. When cost and quality information are made available, patients and payers are increasingly incentivized to choose high-quality, low-cost care options. Requiring insurers to meet affordability standards ensures that the plans are aligning provider payments and incentives with state goals and doing their part to support system changes emphasizing primary and preventive care. All of these strategies focus on aligning incentives among the different players and increasing transparency to achieve lower cost, higher quality, and better outcomes.

We observed differences among the states in regards to market dynamics such as practice patterns, makeup of provider groups, and their risk tolerances. While extensive stakeholder engagement may pave the way for interventions that alter market dynamics, provider payment methodology is an important factor in determining the type and scope of achievable reforms. Additional work exploring the cause and effect of local market dynamics and types of strategies used may be helpful for states and stakeholders in the planning process.

Several states commented that further work for the dually eligible Medicare-Medicaid recipients is an important area to address as this is a high-cost and medically vulnerable population. Fifteen states currently have a dual demonstration to address this population.<sup>143</sup> More initiatives in this area are likely as this population stands to benefit the most from intensive care coordination. Some states also cite that while their cost containment efforts focus on the Medicaid population, there is a desire to expand efforts to state employee purchasing pools, state health benefit exchanges, and other state programs, with an overall goal of building critical mass in several programs to spur adoption in the private sector.

Payment reform and cost containment efforts are evolving, and states are doing a lot of experimentation and employing many strategies at once. As a result, it may be challenging to tease out the impact of one strategy vs. another. While it is important to develop robust and clear metrics to assess outcomes that are specific to local needs, there are no cross-cutting measures across all states to allow evaluation of initiatives using similar methods. It is unclear how one would evaluate an ACO model in a managed FFS state like Minnesota and in a highly integrated, managed care state like California. Agreement on a small number of common metrics would allow for a more robust meta-evaluation and could be led by a cross-cutting entity such as CMS, the Agency for Healthcare Research and Quality (AHRQ), or the National Quality Forum. Because efforts in many states are still in their infancy and are being refined, it will be important to revisit these states in a few years to better assess effectiveness of the various strategies.

## VI. Methodology

General background research was conducted to identify states that have innovative strategies, are advanced in their approach, or are illustrative of how states can balance competing interests. States to include in the report were then selected in collaboration with project funders. Our goal was to feature a range of states that have distinctive approaches.

After selecting the states for inclusion in the case studies, the authors conducted background research on each state, including extensive document review (legislation, key workgroup reports, news articles, published and gray literature) of the states' initiatives. We then developed a structured interview guide that asked about the major cost containment initiatives in the state, the legislative history, implementation challenges, and lessons learned. We conducted two to three in-person or telephone interviews with high level state officials, think tank experts, evaluators, and consumer advocates per state. The interviews were typically 30 to 60 minutes in length. After completing the

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<sup>143</sup> State demonstrations to Integrate Care for Dual Eligible Individuals. Centers for Medicare & Medicaid Services. Online at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html>

background research and interviews, we analyzed the information to identify key themes, issues, and lessons learned and wrote case studies for each state. Finally, we analyzed the cross-cutting themes from all of the states.

## VII. Acknowledgements

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The authors of this report are Lisa Chan-Sawin and Peter Harbage of Harbage Consulting with Karen Shore, PhD, an independent consultant. All errors are those of the authors.

## VIII. About Harbage Consulting

Established in 2005, Harbage Consulting is an independent health policy research and consulting firm with expertise in public programs, delivery system reform, and health policy communications. With a focus on increasing value in health care delivery, we help our clients understand, navigate, and succeed in implementing a wide range of health policies and programs, including Medicare, Medicaid, the Children's Health Insurance Programs, and health reform implementation. Based in California, our services include policy analysis, implementation, and operations of government health care programs, as well as strategic guidance and support around health care politics, policy, and communications.