



Aligning Incentives in Medicaid

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How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs

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Abstract: Colorado, Minnesota, and Vermont are pioneering innovative health care payment and delivery system reforms. While the states are pursuing different models, all three are working to align incentives between health care payers and providers to better coordinate care, enhance prevention and disease management, reduce avoidable utilization and total costs, and improve health outcomes. Colorado and Minnesota are implementing accountable care models for Medicaid beneficiaries, while Vermont is pursuing multipayer approaches and moving toward a unified health care budget. This synthesis describes the common drivers of reform across the states, lessons learned, and opportunities for federal administrators to help shape, support, and promote expansion of promising state initiatives. It also synthesizes strategies and lessons for other states considering payment and delivery reforms. The accompanying case studies describe the states' efforts in greater detail.



OVERVIEW

State fiscal pressures, which are predicted to continue, can be attributed in large part to rising health care costs. Growth in Medicaid enrollment in recent years, and an expected increase in enrollment in states that comply with the Affordable Care Act's 2014 Medicaid expansion,¹ have intensified interest among state policymakers to limit states' financial risk and to contain the overall growth in health care spending. At the same time, clear evidence of a fragmented health care system, avoidable utilization of high-cost services, lack of access to primary and preventive care, and health outcomes that lag behind those in other developed nations have sparked efforts to improve health care quality by redesigning the way care is delivered.

After decades of focusing largely either on improving care delivery or reducing costs—and often experiencing conflicts between the two—many policymakers now recognize that the two strategies must be integrated. That is, pay-

ment and delivery system initiatives must be aligned in order to enhance quality and reduce waste, thereby improving the value of care. Some emerging models go further by linking health outcomes for both individuals and communities to payment and delivery system reforms in seeking to achieve the Triple Aim of improving care experiences, improving population health, and reducing the per capita costs of health care.²

There is also growing recognition among policymakers and other health care stakeholders that achieving fundamental changes in health care practice requires broad-based involvement from payers. Incentives or requirements on providers to change behavior or achieve certain outcomes from only Medicaid, Medicare, or a commercial health plan will not be nearly as effective as common incentives from multiple payers that together cover a large portion of a physician practice's or a hospital's patients. Further, when all payers are aligned, it is more difficult for providers to shift costs to others when one payer reduces reimbursement.

A few states are pioneering comprehensive payment and delivery system reforms for their Medicaid populations or more broadly, either in response to federal opportunities or as early innovators of models that the federal government is now looking to test, replicate, and support.³ The Affordable Care Act provides numerous opportunities for state governments to obtain federal funding and technical support to develop and test new patient care models. The health reform law established a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) charged with testing innovative payment and service delivery models in both public programs.⁴

Though still in the early stages, experiences from these innovator states can provide critical lessons to other states that are considering or implementing payment and delivery system reforms. Information about pioneering state strategies, challenges, and successes also offers valuable insights to federal administrators and policymakers.

This issue brief synthesizes findings from case studies of three states that are pioneering health care payment and delivery system reforms: [Colorado](#), [Minnesota](#), and [Vermont](#). The case studies are based on literature reviews and in-depth interviews with Medicaid officials and other state-level planners, administrators of regional health networks, leaders of hospitals and insurers, and others. While the states' approaches differ, each provides examples of promising strategies and lessons. Though the sample is too small to permit generalization, we hope that this information will help federal and state policymakers and administrators understand how reform is unfolding on the ground and contribute toward the further design and implementation of comprehensive health care reform.

To inform our case study research, we interviewed 10 officials at CMS and the U.S. Department of Health and Human Services to ascertain what kinds of information about payment and delivery system reforms in pioneering states would be helpful in shaping federal programs and supports. Their responses suggested that greater insights into the following issues would be valuable:

- What drives state governments and other public and private entities to engage in comprehensive health care reform?
- How are natural competitive inclinations among health plans/payers overcome to engage them in common strategies and sharing of best practices?
- How can a state bring health care providers, health plans, and other stakeholders with varied and possibly conflicting perspectives and agendas to collaborate toward achievement of common goals?
- What specific payment and delivery system reforms show greatest promise or positive results?
- What challenges are states and communities facing, and how can the federal government help address or mitigate those challenges?
- What early lessons can be learned from these experiences that can help the federal government design or modify programs and supports to encourage, replicate, and expand comprehensive health care reform?

REFORM MODELS

Colorado, Minnesota, and Vermont have implemented or are piloting new methods of delivering and paying for Medicaid beneficiaries' care that aim to coordinate a broad range of health and social services—and shift some financial risk for the costs and quality of care to providers (Exhibit 1). Colorado and Minnesota are implementing accountable care models for Medicaid beneficiaries, while Vermont is pursuing multipayer approaches combining medical homes and community health teams as well as payment reforms. Vermont is also moving toward a unified health care budget. Their approaches differ, based on each state's health care market, reform history, size and demographics, economy, and political environment. State planners expect to expand their reforms if early experiences show success. Minnesota, for example, hopes to expand its Medicaid ACO demonstration to a larger Medicaid population in the future, as well as to state employees and potentially other payers.

Colorado

Colorado's Accountable Care Collaborative Program has begun to provide care for Medicaid beneficiaries through an accountable care organization (ACO) delivery model. Medicaid contracts with one Regional Care Collaborative Organization (RCCO) in each of seven regions to create a network of Primary Care Medical Providers (PCMPs). Medicaid provides the regional organizations with medical management and administrative support, while they in turn seek to ensure care coordination to Medicaid enrollees and better integrate care with hospitals, specialists, and social services. RCCOs and Medicaid contract with the PCMPs to provide comprehensive primary care and coordinate clients' health needs across specialties. Medicaid also contracts with a Statewide Data and Analytics Contractor to analyze performance data for the program. Enrollment began in May 2011, and by December 2012 about 30 percent of Medicaid enrollees were participating, with further growth expected. The state hoped to see 5 percent reductions in emergency department utilization, hospital readmissions,

and high-cost imaging and to achieve overall savings to offset the \$20 per member per month it is investing.

The program's first annual report⁵ indicated reduced utilization of emergency room services, hospital readmissions, and high-cost imaging; lower rates of aggravated chronic health conditions; and lower total costs of care for ACO participants, exceeding the cost of the program and their savings goal. Incentive payments to the PCMPs and RCCOs will begin in early 2013, and the state plans to slowly increase the portion of payment at risk, as well as pilot payment alternatives to fee-for-service contracts. Under a State Innovation Models Initiative grant from CMS in early 2013, Colorado will refine a plan to integrate behavioral and clinical health care through incentives to providers.

Minnesota

Six ACOs in Minnesota entered into risk arrangements with Medicaid beginning January 1, 2013, to achieve better health outcomes while being held accountable for the total costs of providing care to their patient populations. Another three will become operational later in the year, serving a total population of approximately 100,000 Medicaid beneficiaries. State Medicaid officials believe ACOs have greater potential than do traditional managed care organizations to encourage providers to change health care delivery, keep people healthy, and integrate care across settings. Although Minnesota has several integrated systems that meet ACO requirements, others will have to supplement their services, performance measurement and improvement activities, or cost-management efforts to meet the program standards.

Minnesota Medicaid launched its first accountable care program with an organization of safety-net providers in Hennepin County, which began enrolling low-income, childless adults in January 2012. A heavy emphasis on care coordination and improved access to appropriate services has succeeded in decreasing unnecessary utilization of higher-cost services. Under a new State Innovation Models Initiative grant, Minnesota will test an accountable care model that is

Exhibit 1. Medicaid Payment and Delivery System Reform in Colorado, Minnesota, and Vermont

	Colorado	Minnesota	Vermont
State Population (2010–11)	4,986,300	5,246,400	620,000
Medicaid Enrollment (#, % of pop.), June 2011	588,900, 12%	831,100, 16%	139,900, 23%
Medicaid Population in MCOs, July 2010	43,786, 7%	468,437, 64%	0, 0%
Payment/Delivery System Reform	Accountable Care Collaborative	ACO Demonstration	Hennepin Health Program
Payers Participating	Medicaid only	Medicaid only	Medicaid, Medicare, three commercial insurers, two large self-insured employers
Key Components	<p>Medicaid contracts with seven Regional Care Collaborative Organizations to create and support network of primary care medical providers; coordinate care with enrollees; integrate care with hospitals, specialists, and social services; and take some risk for cost/quality. Medicaid also contracts with a Statewide Data and Analytics Contractor to analyze performance data for incentive payments.</p>	<p>Three-year program: Medicaid contracts with delivery systems as voluntary demonstration sites testing shared savings/alternative payment models that increase provider accountability for cost and quality; enhances primary care and improves care coordination.</p>	<p>Advanced Primary Care Practices are paid fee-for-service plus per member per month fees tied to National Committee for Quality Assurance medical home scores. Multidisciplinary Community Health Teams, financed by all payers in region, provide care coordination, population health services, and address gaps in care. "Extenders" offer additional care management for Medicaid and Medicare beneficiaries with complex needs.</p>
#, % Medicaid Population Participating	Approx. 210,000, 30% (Dec. 2012)	Began Jan. 1, 2013	65,249, 29% (Sept. 30, 2012)
Medicaid Participation Goal	Dedicated to expand monthly; ultimate participation level not yet determined	150,000 (17% Medicaid pop.) year 1, grow toward 100%	Nearly 100% expected by October 2013
			<p>Planned: Medicaid, Medicare, and commercial payers</p> <p>State payment reform board working with hospitals and payers to pilot bundled payments, physician-hospital global budget, and population-based model with shared savings. State is exploring ways to use a "unified health care budget" to constrain the total costs with ACOs/payment pilots, other strategies.</p> <p>OneCare Vermont ACO began January 2013 for Medicare members; plan includes Medicaid and commercial payers in 2014–2015; multipayer payment pilots in development.</p> <p>Long-term goal to move to unified health care budget for all Vermonters</p>

Sources for state population, Medicaid enrollment, MCO enrollment: Kaiser State Health Facts, accessed December 2012, and Kaiser Commission on Medicaid and the Uninsured, Medicaid Enrollment: June 2011 Data Snapshot (exception: Vermont Medicaid MCO enrollment based on interviews with state leaders).

integrated across payers and a broad range of health and social services.

Vermont

Vermont is rapidly expanding its multipayer Blueprint for Health, which blends Advanced Primary Care Practices (APCPs) that offer medical home services and community health teams that provide multidisciplinary care coordination and support. Medicaid, expecting nearly all of its members to be served by APCPs in 2013, provides supplemental care management for its enrollees with the most complex conditions. Medicare also participates and Support and Services at Home (SASH) teams provide on-site assistance to help high-risk Medicare enrollees remain in the community.⁶

A bundled payment pilot and ACO shared savings program are expected to begin in early 2013, with Medicaid to participate in a shared savings ACO in 2014. Population and global budget payment models are under development and are intended to better align incentives to achieve high-quality care and to contain spending. The state is developing and plans to implement in early 2013 a Unified Health Care Expenditure Budget that would provide a framework for establishing growth trends for the state's entire health system, evaluating hospital/physician budgets, and modeling opportunities to reduce expenditures through multipayer payment/delivery system reforms. A 2013 State Innovation Models Initiative grant from CMS will support payment pilots and enhancements in health system infrastructure.

DRIVERS OF REFORM

Despite different circumstances, the three states share common drivers of health care reform. These include:

History and culture of reform: Health care reform efforts in these three states predated the passage of the Affordable Care Act; in each, the latest payment and delivery reforms were built on many rounds of legislation and other state-level efforts to address cost and quality concerns. Therefore, the latest reforms were viewed by stakeholders as an evolution rather than an upheaval, and stakeholders were already accustomed to communicating with one another.

Economic necessity: Unprecedented growth in the Medicaid caseload because of the recession, combined with rising health care prices and constrained revenues, reinforced the need for Medicaid agencies and state legislatures to seek new ways to contain cost growth.

Multistakeholder and/or bipartisan agreement on priorities: Though stakeholders' preferred strategies often differed, there was agreement across multiple stakeholders and often across the political aisle on priorities and goals for health system reform. Shared goals included improved health outcomes, reduced costs, better coordination of care, and improved patient and provider experiences. Participants also realized that providers' incentives need to be better aligned across payers to achieve these goals.

Strong health care leadership: Leaders and champions for reform among governors, state legislatures, Medicaid agencies, and the health care industry were critical factors driving reform in all three states.

Exhibit 2 delineates the legislation and executive actions that paved the way for delivery/payment reforms in the three states.

LESSONS

Many cross-cutting lessons emerged from the three states' experiences. These may be useful to other states that are considering or are in the early stages of planning health care payment and delivery reforms. They also may inform federal policymakers as they shape health system regulations, grant programs, and technical assistance. Lessons include the following:

Allow regional or local flexibility: Policymakers must acknowledge regional and community differences and allow some flexibility in reform design, albeit within some general guidelines, to match local culture, needs, and circumstances. For example, the availability of and existing relationships among service providers shape the composition of community health teams in Vermont and the provider networks in Colorado. Minnesota allowed community-based entities to propose and develop their own ACO models. Vermont found that unique local circumstances—such

Exhibit 2. Key Legislative and Executive Activity for Payment/Delivery Reforms

Colorado

- Accountable Care Collaborative (ACC) Program was established as part of the Medicaid agency's budget request for FY 2009, which was enacted as SB 259.
- As of June 2012, the state legislature had also passed legislation (HB 1281) requiring global payment or other payment reform pilots within the ACC program.
- SB 127, creating long-term care health homes in the ACC.

Minnesota

- 2008 health care reform law created the health home program and the statewide quality reporting and measurement system.
- 2010 health care reform law enabled the development of accountable care organizations in Medicaid and the safety-net ACO in the Minneapolis–St. Paul area.
- A 2011 executive order facilitated ACO implementation and created workgroups with broad stakeholder representation tasked with developing key features of the demonstration program.

Vermont

- 2003 Governor's initiative launched Blueprint for Health.
- 2005 "global commitment to health" waiver placed the Medicaid program under a spending cap but offered greater flexibility to establish benefits and coverage levels.
- 2006 legislation codified the Blueprint for Health as part of sweeping reform (Act 191), emphasizing care coordination and delivery system improvements initially targeting chronic care patients.
- Vermont Act 128 of 2010 called for statewide Blueprint expansion.
- Vermont Act 48 of 2011 specified piloting new (non-fee-for-service) models of payment on a road toward a single-payer system.

as border communities where residents cross state lines to get care—warrant different payment models.

Standardize measures and invest in robust data collection: All three states have found that standardization of performance measures and state-level data collection and evaluation are critical to create effective incentives for providers, establish accountability, and assess the impact of the payment and delivery system changes. States typically do not have this expertise in house; Vermont contracts with a university, Colorado contracts with a data analysis vendor, and Minnesota has formed public–private workgroups to address data issues. All-payer claims databases are viewed as important tools.

Leverage resources across departments: Medicaid agencies can overcome historical barriers to partner with other departments and agencies to leverage resources. In Vermont, Medicaid and various state departments (e.g., those focusing on mental health and addiction, public health) are working together on multiple initiatives, using intergovernmental agreements to delegate responsibilities, share expertise, and pool resources to improve community health.

Identify, convene, and educate stakeholder leaders: Recruiting and keeping stakeholders involved and engaged are critical. All three states took on roles as conveners and educators, facilitating dialogue among providers, payers, and in some cases consumers. States could establish task forces and committees with goals and timetables.

Build on what exists: States must begin health care reform from where they are. Colorado and Vermont's Medicaid programs have primarily fee-for-service contracts, so their reform efforts build on that model. Minnesota is building its ACO program on the managed care organizations and integrated care networks that already exist in the state. The states have benefited from the fruits of past health care reform efforts, including multipayer databases, community health teams, and others.

Broaden service integration: Delivery system reform requires true integration of services. This may begin by coordinating primary and specialty care, but then expand by aligning incentives and extending networks to integrate behavioral health, community-based services, long-term care, and eventually the full continuum of care. Colorado found locally tailored

care management helped break down traditionally separated services, particularly for treating patients with complex needs.

Acknowledge long-term nature of savings:

States and other stakeholders with needs for immediate savings must accept that most reforms require time to achieve savings (as well as improved health outcomes). This poses challenges for private payers, providers, and state and federal governments that want evidence of improved quality and reduced costs in the short term.

Integrate reforms across state programs as well as with Medicare and commercial insurers:

Aligning goals, measures, and incentives across Medicaid initiatives, multiple state programs, and with Medicare and commercial insurers reduces cost-shifting and strengthens the potential for delivery system transformation. For example, Minnesota's multipayer health homes program certifies health homes that are a required component of the new Medicaid ACOs but may also serve other patient populations. Vermont incorporated Medicaid reform into its multipayer, community-based Blueprint for Health and is continuing its systemwide focus through payment reform pilots and a unified health care budget.

OPPORTUNITIES FOR FEDERAL ACTION TO SUPPORT STATE EFFORTS

Interviewees in all three states acknowledged the assistance they have received from CMS in planning and implementing their reforms. Based on the challenges faced, however, it appears CMS could further support state pioneers and replication of reforms in other states in several ways:

Flexibility: CMS is supporting innovation in the three states profiled as well as numerous others through State Innovation Models Initiative grants and other Center for Medicare and Medicaid Innovation programs. While providing structure and direction, CMS may consider giving states further flexibility to test strategies for funding health care and for integrating care, particularly by applying models on a small scale, in different circumstances, and in early years.

For example, this may mean allowing care managers to provide services that fall outside the traditional purview of Medicaid, or allowing providers to take on higher levels of risk.

Better access to data: Timely access to data is essential for states to calculate payment rates, attribute patients to providers, and assess health outcomes, utilization, and costs. CMS can facilitate data exchange by:

- providing technical assistance and best practices for establishing all-payer claims databases that capture quality, utilization, and cost information from all public and private payers in a state;
- making “clean” (validated, complete) Medicare data more readily and quickly available to states, payers, and providers; and
- exploring with states ways to reduce barriers to information-sharing related to state and federal privacy laws such as HIPAA.

Medicare participation: With Medicare a dominant health care payer, it should be ready to participate in multipayer programs and system redesign so that all payers are aligned and offer meaningful incentives to change provider behavior. These can build on initiatives already under way that target those dually eligible for Medicare and Medicaid.

Grant simplification: Current expenses related to federal grant application appear to impede many organizations and states from pursuing innovative proposals. CMS could consider ways to simplify the application process.

Clinical process change: Few providers have experience with practice-level transformation, and states lack resources to assist providers in meaningful ways. CMS could provide or support more technical assistance for identifying effective strategies and training staff in outpatient clinical settings.

Additional financial support: Given states' continued fiscal challenges, CMS could consider additional ways to help states bear their share of health costs such as faster payment of grant funds, greater financial support for administrative costs, and slower

phasing out of federal matching funds than had been planned.

Quality standards: There is support among states for creation of a small set of standard, well-validated, and actionable quality metrics to enable performance comparisons across regions and states. The recent CMS funding opportunity for Adult Medicaid Quality Grants is an important step in this direction.

NOTES

- ¹ Although the federal government will pick up most of the additional costs of covering these new populations in early years, state policymakers are concerned about increased state costs in later years and covering new enrollment by individuals who are currently eligible but not enrolled.
- ² Developed by the Institute for Healthcare Improvement, the Triple Aim framework is an approach to optimizing health system performance. See <http://www.ihl.org/offers/Initiatives/TripleAim/Pages/default.aspx>.
- ³ For example the medical home concept, developed “in the field,” is being expanded through CMS’ Multi-Payer Advanced Primary Care Practice demonstration. Medicare is joining Medicaid and private insurers in eight state-based medical home efforts (Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont).
- ⁴ The Innovation Center created the State Innovation Models initiative to help support states in health system transformation. This initiative has made \$275 million available to states, through competitive bidding, to design and test multipayer payment and delivery models that deliver high-quality health care and improve health system performance. Other Affordable Care Act opportunities for states include the Medicare Shared Savings program (Section 3022); a payment bundling pilot (Section 3023); Medicaid health homes (Section 2703); extension of a gain-sharing demonstration (Section 3027); and integration of care for the Medicare/Medicaid dual-eligible population (Section 2602). For more information on the health reform legislation’s payment and delivery provisions and opportunities, see: CMS Innovations Center, <http://www.innovations.cms.gov/>; Health Care Delivery System Reform and The Patient Protection and Affordable Care Act, <http://www.whitehouse.senate.gov/imo/media/doc/Health%20Care%20Delivery%20System%20Reform%20and%20The%20Affordable%20Care%20Act%20FINAL2.pdf>; and Changing Delivery and Changing Care: Summary of the Delivery and Payment Reform Elements of the Patient Protection and Affordable Care Act of 2010, http://www.healthcareDisclosure.org/docs/files/Disclosure_PPACA_SummaryDeliveryPaymentReform.pdf.
- ⁵ See the Accountable Care Collaborative Annual Report at http://www.colorado.gov/cs/Satellite?c=Document_C&childpagename=HCPF%2FDocument_C%2FHCPFAddLink&cid=1251633513486&pagename=HCPFWrapper.
- ⁶ SASH is funded through CMMI’s Multi-Payer Advanced Primary Care Practice demonstration.

The case studies in the *Aligning Incentives in Medicaid* series look at Colorado’s Accountable Care Collaborative Program, Vermont’s multipayer Blueprint for Health program, and Minnesota’s introduction of accountable care organizations, which will enter into shared savings and risk agreements with Medicaid.

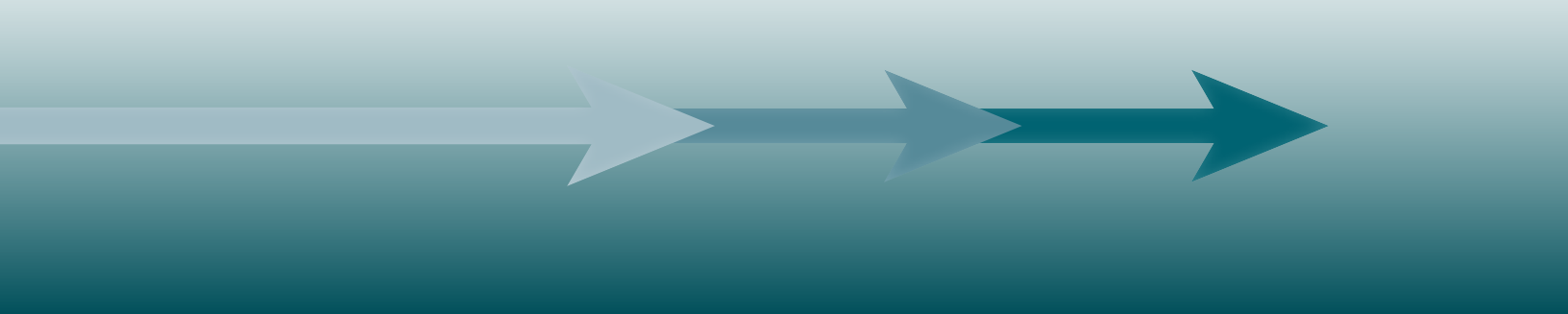
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