Politics and Policy of Health Reform

Statewide Payment and Delivery Reform: Do States Have What It Takes?

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Abstract States' role in payment as well as coverage will be subject to debate as the administration and the Congress decide how to address the Affordable Care Act (ACA) and otherwise reshape the nation's health policies. Acting as stewards of health care for the entire state population and stimulated by concern about rising costs and federal support under the ACA, the elected and administrative leaders of some states have been using their political influence and authority to improve their state's overall systems of care regardless of who pays the bill. In early 2015 we conducted on-site interviews with key stakeholders in five states to explore their strategies for payment and delivery reform. We found that despite these states' similar goals, differences in their statutory authority and purchasing power, along with their leaders' willingness to use them, significantly influence a state's ability to achieve reform objectives. We caution federal and state policy makers to recognize the reality that state leaders' political desire to exercise stewardship may not be enough to achieve it.

Keywords stewardship, payment reform, delivery reform, health reform, state health reform

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Health care payment and delivery reforms have been high on the nation's policy and political agenda since the passage of the Affordable Care Act (ACA) in 2010. Although public attention has focused primarily on the nature and impact of federal action—led by Medicare—to promote better quality care at equal or lower costs across the nation's health care system, states have also been active—with some explicitly aiming to reform payment and delivery for all payers in the state. Acting as stewards of health care for an entire state population, elected and administrative leaders have been using their influence and authority to improve states' overall systems of care, regardless of who is paying the bill.

States' role in payment as well as coverage will be subject to debate as the administration and the Congress decide how to address the ACA and otherwise reshape the nation's health policies. This article aims to inform these deliberations with an assessment of five states' recent experiences as health care stewards.

The World Health Organization defines stewardship as "the careful and responsible management of the well-being of the population" by the government (WHO 2000: viii). Stewardship functions include "defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information" (WHO 2000: xiv). Stewardship requires leadership and governance that ensures "that strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system design, and accountability" (WHO 2007: vi).

In some areas of health policy—public health might top the list, as in some states would access to coverage—state government stewardship is commonly accepted, even though its assertiveness and scope vary from state to state. When it comes to payment and delivery for medical services, however, the exercise of stewardship is more challenging. Because of the high degree of fragmentation of the American health care system and America's federalist structure, by international standards even the most ambitious state faces limits in exercising stewardship over health care payment and delivery (Brown, Isett, and Hogan 2010; Morgan and Campbell 2012). State authority over Medicaid or state employees' health insurance is relatively straightforward, but sources of authority over other payers may be amorphous, levers of influence will vary, and success will require getting actors outside of state government control to pursue a state leadership's goals.

Other studies of payment and delivery reform have focused on state governments' choice of policy tools (Hanlon 2012; Hinkle 2012; Silow-

Carroll, Edwards, and Rodin 2013; VanLandeghem and Schor 2012). We report here on states' political strategies for using these tools—that is, the political and policy actions state leaders have undertaken to engage a wide range of stakeholders to pursue a common goal. In five states we identified as taking different paths to delivery reform, we examined the factors encouraging state leadership, the sources of authority states possess, the specific approaches they have taken, and the strengths and limitations of their efforts as they pursue payment and delivery reforms.

Based on prior knowledge, a review of the literature, and State Innovation Model (SIM) proposals submitted to the Centers for Medicare and Medicaid Services (CMS), we identified numerous states in which the political leadership's clear expressions and the state government's concrete actions reveal a goal of system-wide payment and delivery improvement. We took improvement to mean greater system efficiency, not simply reducing public or private health care spending. We selected five geographically dispersed states with different health care cultures and stewardship strategies. We acknowledge that, because interest in stewardship is correlated with more liberal politics, the political diversity reflected in the selected states is not the same as if we had chosen from among all states. However, we sought a mix of states with decidedly different approaches to stewarding health payment and delivery reform: Colorado, Minnesota, Ohio, Oregon, and Vermont.

For each state we conducted background research on the political environment, the history of health reform efforts, and the current initiatives designed to improve health system performance. With the assistance of a key informant for each state, we identified leaders in the public and private sectors across a range of stakeholder interests who have been the most involved with these improvement efforts. Using semistructured interview protocols, we explored their perceptions of state government objectives, actions, and interactions with stakeholders in pursuing payment and delivery reform. We used these interviews (with a range of thirteen to twenty policy participants per state), conducted in early 2015, to prepare case studies that describe each state's stewardship process. The state reports were shared in draft form with all interviewees, who were given the opportunity to suggest edits. They are available at the Urban Institute's website.

This commentary is based upon the authors' knowledge of the field combined with information garnered through site visits. The authors shared notes and observations and readily acknowledge that our conclusions draw upon our experience as much as they draw upon the case studies and other data.

Common Forces Shaping Stewardship

To begin with, all five states' policy objectives have a lot in common—as do the policy problems, political pressures, and policy opportunities they face.

Leaders in our five states have consistently embraced better care, better health, and lower costs—some form of the Triple Aim—as the overarching goal of their payment and delivery reforms. Further, they have zeroed in on enhanced primary care as fundamental to achieving their goals.

That states share common objectives is not surprising, given their exposure to a common set of health policy challenges and proposed solutions, as well as to tools the federal government may provide to address them. The Triple Aim, framed by Don Berwick and colleagues from the Institute for Healthcare Improvement in 2008, is the simultaneous pursuit of "improving the individual experience of care; improving the health of populations; and reducing per capita costs of health care for populations" (Berwick, Nolan, and Whittington 2008: 760). Public and private sector leaders in all five states view this as a useful framework and one that guides their thinking and their strategy for delivery system reform.

Leadership in the five states similarly emphasizes enhanced primary care as essential to building the type of health care system that can achieve the Triple Aim. The *medical home* idea—of which each state has its own version—emerged at about the same time as the Triple Aim. It was promoted by four physician societies in 2007 and subsequently endorsed by many more medical organizations (Berenson, Devers, and Burton 2011). Strengthening primary care to facilitate and coordinate patients' access to social and medical services appeared at the earliest stages and remains at the core of all five states' reform initiatives.

Why so much enthusiasm for these delivery reform ideas? Concern about public spending on health care makes state political leaders hungry for policy solutions. The 2008 recession heightened that concern, creating a dramatic and lasting effect on state budgets. Even as the economy—and along with it, state tax revenues—has recovered, these states find their resources tightly constrained. Medicaid spending has been and remains carefully scrutinized, and generally, curbing that spending is viewed as imperative. In Vermont and Minnesota, concerns about private health spending have a long history of shaping the health policy agenda.

The five states' enthusiasm for new forms of action also reflects the frustration with—or the recognition of limits to—actions already taken to limit public or private spending. To state leaders concerned with public

spending, Medicaid leadership of system-wide payment and delivery reform offers an alternative to reducing the program's provider payment rates or covered benefits—measures seen as simply shifting costs either to providers or to enrollees. Some states' leaders explicitly stated, while others showed by their actions, that they also found traditional Medicaid managed care insufficient to achieve desired results. Colorado long ago abandoned comprehensive Medicaid managed care, and its health community views homegrown efficiency as the state's last chance before returning to what many viewed as a failed model. Whether within managed care or through new delivery models, leaders in all five states sought new tools to influence providers and patterns of care.

The federal government has also played a substantial role in promoting state action. Oregon's governor used the prospect of federal fiscal help through a Section 1115 waiver to gain political support and resources for transforming its Medicaid and public employees' delivery system. In Colorado and Oregon, policy makers welcomed the ACA's coverage expansion as addressing a problem state leadership had long tried but failed to address on its own, using up fiscal resources and limited political capital in the process. As someone in Colorado explained it, the ACA brought a sense of mission accomplished on coverage, thereby allowing the policy community to turn its attention to a new problem: the efficiency of the delivery system. Minnesota's failed implementation of the state's ACA marketplace indirectly benefited leaders' pursuit of reform. With public attention focused on challenges in the marketplace, state officials have been able to pursue payment and delivery reforms under the radar screen.

The ACA's direct support for payment and delivery reform has provided an even more powerful motivation for state reform efforts. All five states have benefited concretely from the dollars and purchasing power provided by its coverage expansions and from its delivery reform initiatives that support the Triple Aim, enhanced primary care, and other delivery system improvement efforts at the state and federal levels (CMS 2016a; CMS 2016b).

Of greatest significance to our states has been CMS' SIM initiative, which distributed two rounds of funds totaling over $950 million to thirty-four states and Washington, DC. Our five states, among twelve others, received SIM model testing grants. In the first round, Minnesota, Oregon, and Vermont were each awarded $45 million, for use over a forty-two-month period. In the second round, Colorado and Ohio were awarded $65 million and $75 million, respectively, for use over a forty-eight-month period. These grants directly support stewardship of delivery

reform—funding states to develop and implement state health care innovation plans that engage a broad range of stakeholders in a statewide system delivery reform agenda (CMS 2016c; CMS 2016d).

Finally, the ACA's Medicare payment and delivery reforms provide a substantial catalyst to state-based reform agendas, attracting providers' attention and creating opportunities that state governments can emulate or build upon. The initiatives range from performance-based payments to reduce hospital readmissions through support for Medicare's primary care demonstrations to payment and delivery reform initiatives such as accountable care organizations (ACOs). Vermont stands out among our five states as having most aggressively hitched its reform wagon to Medicare's—tying Medicaid and marketplace plans into Medicare ACOs to build a statewide multipayer payment/delivery structure.

The Varied Paths Stewardship Takes

Although states face common problems and a shared policy and political environment, their strategies for achieving similar goals reflect significant differences in both legal authority and the capacity and willingness to use political and purchasing power to influence actors that state government cannot completely control. Details on policies tools and more importantly, strategies to promote them, follow. But in summary: Vermont has the broadest authority and leverage and is actively engaged in multipayer reform. Minnesota's Medicaid-focused initiatives intentionally parallel private sector activity, and the state has both the authority and the market leverage to pursue multipayer policy alignment. Oregon lacks statutory authority but aims to leverage its consolidated public purchasing power—for Medicaid, public employees, and marketplace enrollees—to promote system-wide change. Colorado and Ohio see Medicaid as leading by example—supplemented in Ohio by the current governor's pressure on private actors to participate and in Colorado by a longstanding consensus-building process across the public and private sectors.

Political leaders in Vermont have focused on building a unified universal health care system in statewide ACOs (the largest initiated by all hospitals in the state). These ACOs serve Medicare, Medicaid, and Marketplace health plans and are incorporating the state's commitment to enhanced primary care that integrates health and social services. At the time of writing, the state and CMS had agreed to an all-payer ACO model that will apply "the same payment structure for the majority of providers throughout

the state's care delivery system and transform health care for the entire state and its population" (CMS 2016e: n.p.; Zemel and Riley 2016).

Vermont's government has extensive statutory authority and leverage to promote this vision of health system stewardship, along with the political willingness to use it. Legislation aimed at moving the state toward a single-payer system simultaneously created the legal authority and the administrative structure (the Green Mountain Care Board) to regulate virtually all critical aspects of its health care system. Regulation is facilitated—some observers say necessitated—by the state's highly concentrated health insurance and health care industry. Vermont has one dominant Blue Cross insurer, only two major hospitals (counting New Hampshire's Dartmouth-Hitchcock along with the University of Vermont Medical Center), and a limited number of self-insured employers outside the state's control.

With the governor's decision not to pursue a single-payer system, stewardship focused on using the state's authority and leverage to mobilize all payers—including Medicare—to adopt a common payment and delivery approach. Under state government leadership and the threat of unilateral state government action, a "coalition of the willing" that includes nearly all providers and payers in the state has collaborated to achieve these goals.

Minnesota's government is focusing on alignment rather than uniformity among payers, using the state's purchasing power to emulate and expand commercial insurers' total cost of care or ACO-like contracts with health systems in the Medicaid program. By facilitating service integration across a broad array of health and social services, the goal is to promote public health as well as more efficient delivery of medical services.

Minnesota also has considerable statutory authority and market leverage, though it is less comprehensive and more contested than Vermont's. Minnesota law requires all fully insured health plans as well as providers to accept Medicaid beneficiaries, the state's large self-insured employers are putting budget pressure on the health systems that dominate delivery in the state through ACO-like payment mechanisms they refer to as total cost of care contracts, and health systems are seeking consistency and predictability across payers. Minnesota law also imposes a number of specific requirements: (1) private insurers subject to state law must make payments to practices certified under the state's *health care home* initiative, and their payment methodology must be consistent with the one used by Medicaid; and (2) providers must participate in the state government's statewide quality reporting program to promote public health and to evaluate reforms.

The state's Medicaid contracts go beyond commercial practices in the types and the size of participating providers, the scope of services and quality metrics, and the degree of financial risk providers are expected to bear. State government is exercising greater influence over the reporting of quality metrics previously left largely to the private sector. These actions are generating pushback from stakeholders not fully on board with what some see as putting state government in charge of delivery reform, rather than pursuing the collaborative effort they have come to expect.

In Oregon, Colorado, and Ohio, government authority and leverage are far more limited. Although differences exist among these states, none has statutory authorities that facilitate the extension of reform initiatives beyond public programs. System-wide reform, accordingly, rests heavily on the persuasive power of political leadership.

State government in Oregon has established Medicaid-based coordinated care organizations (CCOs) and is extending them first to public employees/retirees and next to the ACA marketplace, with the ultimate aim to have all insurers and residents in the state adopt the coordinated care model. CCOs—relying on patient-centered, team-based care—are locally governed organizations accountable for the delivery of services (except long-term care) to a defined population within a global budget that consolidates funding streams for medical, dental, and behavioral health.

CCOs have quickly become an integral part of the state's Medicaid program and have met initial cost-containment and improvement benchmarks (OHA 2015). Although the expansion of CCOs to other publicly financed consumers proceeds, state leaders' ability to drive private purchasers to join their efforts remains in doubt. Especially enticed by the substantial funding enhancement provided under the Section 1115 waiver, stakeholders may have been willing to accept collaboration in a single delivery system under a global budget for Medicaid and other public beneficiaries. But the CCO's reliance on collaborations across competitors and partnerships between insurers and providers conflicts with the competitive forces that dominate the more lucrative private insurance market. As an Oregon observer explained, "I think people are willing to cooperate on Medicaid because no one was making money on it. But everyone is still thinking about making money on the commercial side" (Berenson, Hayes, and Lallemand 2016).

The state government in Ohio has sought to motivate reform by example—coordinating among its state agencies to focus its own payment and delivery initiatives and engage the private sector to follow suit. Most importantly,

the governor actively pressed private payers to collaborate with Medicaid in adopting patient-centered medical homes and bundled episode payments—a direction in which many private purchasers and providers were already moving. The episode-based bundle approach, developed and promoted by McKinsey and Company, relies on fee-for-service payment but rewards or penalizes "accountable providers" for costs relative to targets for a long list of care episodes, such as knee replacement or coronary artery bypass graft (Garrett et al. 2015).

The governor has used his charisma and the power of his office to get private actors to endorse his concepts, but the process moves slowly. The governor created the Office of Health Transformation (OHT) to coordinate the activities of the various state agencies involved in health system improvement and to provide a focal point for engagement with the private sector on related initiatives. The later receipt of two rounds of SIM grants solidified this role for the OHT.

Despite clear authority and action to change its own approach to purchasing, the state has no formal authority to effect the private sector's move from volume to value. Many purchasers and providers were already moving in this direction, and the governor offered them strong encouragement. Still, the state lacks any stable structure to assure coherence between the approaches taken by the public and the private sectors or the continuation of these efforts after the current governor leaves office.

Colorado policy makers face similar limitations in a very different context. Colorado's government adopted regional care collaborative organizations (RCCOs) in Medicaid as its platform for system integration and has piloted a program of behavioral health and primary care integration with the Rocky Mountain Health Plan and Kaiser Permanente. The state's RCCOs are a purely Medicaid program. Although the SIM goals of behavioral and physical health integration embrace 80 percent of Coloradans, the state's authority does not reach that far. State leaders' strategy is to use pilots to generate evidence of the health and financial gains associated with integration and thereby build strong stakeholder consensus for health system improvement to move reform beyond Medicaid to the broader system. Indeed, Colorado has a sizable infrastructure of commissions and independent agencies designed to promote consensus and health system improvement. If the pilots succeed and the consensus holds through the challenges of implementation, the state's goals can be met. But if any of those elements fail, the state has no legal authority to bring private payers along.

The Challenges Facing State Stewardship

The differences across these five states in legal authorities' and governments' willingness and abilities to exercise political and purchasing power are striking, if not surprising. After all, these differences reflect long-standing variation in political cultures and institutions. All five states view payment and delivery reform as dependent upon the coordinated efforts of public and private payers. But each state's statutory authority and purchasing power, along with leaders' willingness to use them, matter enormously in moving private actors. Although it is beyond our scope to assess the impact of the strategies we examined, our exploration reveals the challenges to effective stewardship that even a committed state will face.

States limited to using Medicaid or even broader state government purchasing power as their core source of leverage will be hard put to get all payers in sync. Approaches that stakeholders will accept for public beneficiaries are not so readily adopted when higher-paying commercially insured patients are involved. Strong and clear government authorities—which depend on political leadership, coalitions, and favorable circumstances to exist—are fundamental to a state's ultimate ability to put stewardship goals into policy practice. Without those authorities and supportive politics, neither a governor's charisma nor a statewide investment in consensus-building seems likely to push to resolution the inherent trade-offs involved in real delivery system reform.

Even states with broad authorities face a challenge in aligning payment policy across payers to send a consistent and sufficiently powerful signal to health care providers to change their behavior. Relatively broad state authority may stop short of bringing in self-insured plans and cannot by itself secure payment rates in alignment with Medicare. Furthermore, statutory authority by no means insulates state governments from political pushback when states actually seek to use that authority.

States also depend heavily on support from the federal government to pursue their goals for health system improvement. Federal Medicaid policies and the ACA affect states' flexibility to transform the programs for which they are directly responsible. Federal resources—most notably the SIM program—have supported much of each state's investment in payment and delivery reform that extends beyond Medicaid. Medicare payment policy, which only one of our five states (Vermont) has aimed to shape in a comprehensive way to align with its approach, is vital to all states' health care systems. In all five states, federal resources have provided the financial capital allowing states to engage stakeholders, enable

new connections among them (through organizational change, technical support, and information sharing), and more broadly, mobilize their engagement in pursuit of the state's payment and delivery reform goals.

It is unclear whether a new administration will continue efforts of this kind. Under the SIM program, the federal government supported states pursuing payment and delivery reform, reflecting a shared set of goals. But that investment focused only on a state's delivery system reform goals, not on the state's legal authority or political will to achieve them. If the administration wishes to continue support for states in a shared reform agenda, its actions should take into account the states' authorities and political leverage as well as the goals state governments espouse.

Overall, our exploration of five states' strategies for system-wide payment and delivery reform demonstrates that even when enthusiasm is high, state authority to achieve desired change may be lacking. Neither state nor federal leaders committed to reform can afford to ignore the importance of statutory authority—in addition to political will—to effective reform implementation. Although recognizing this reality may dampen some leaders' and stakeholders' beliefs that states can achieve payment and delivery reform, a realistic assessment is essential. Ultimately, state leaders' political desire to exercise stewardship may not be enough to achieve it.

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