THE MILBANK QUARTERLY

Milbank Memorial Fund

May 2019

States Tackling Health Care System Transformation with Federal Support

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Executive Summary

Rising health care costs are a pressing concern for governments, payers, employers, and patients. States have a vested interest in improving health care and controlling health care expenditures as payers (for Medicaid), purchasers (for state employees), regulators, and sponsors or funders of key infrastructure like health information exchanges or medical education. But is state government an effective agent for transforming health care systems within the United States?

That is the question addressed in three recently published *Milbank Quarterly* articles evaluating Round 1 of the Center for Medicare and Medicaid Innovation's State Innovation Models (SIM) Initiative. These studies tackle the challenge of evaluation from different angles. Kissam and colleagues provide an overview of SIM activities in the six participating states, with a focus on where the initiative succeeded and where it failed in meeting initial goals for multi-payer engagement; Beil and colleagues assess efforts to integrate behavioral health and primary care; and Rutledge and colleagues measure the impact of accountable care organizations established with SIM support in the Medicaid programs of four of the states.

Three key themes emerged across these evaluation studies:

- States can transform Medicaid payment models, but they may have a greater impact when aligned with other payers.

- States were able to leverage federal funds to make targeted investments in health information technology to enhance communication across provider types, including behavioral health care providers.
- States face more work in overcoming challenges such as behavioral health provider shortages and patient dissatisfaction with some changes in care delivery.

This is the first in a new Milbank Memorial Fund series, *Research Into Practice*, that aims to make the research findings from *Milbank Quarterly* studies and their policy implications more accessible to policymakers and practitioners.

Introduction

Rising health care costs are a pressing concern for governments, payers, employers, and patients. States have a vested interest in improving health care and controlling health care expenditures as payers (for Medicaid), purchasers (for state employees), regulators, and sponsors or funders of key infrastructure like health information exchanges or medical education. But is state government an effective agent for transforming health care systems within the United States?

The Center for Medicare and Medicaid Innovation (Innovation Center) tested this question under the State Innovation Models (SIM) Initiative, which provided technical and financial assistance to six states in the Round 1 Model Test, awarding more than $250 million ($33 million to $45 million per state) in 2013 to Arkansas,[1] Maine,[2] Massachusetts,[3] Minnesota,[4] Oregon,[5] and Vermont.[6] Three recently published articles in *The Milbank Quarterly* offer an in-depth look at some of the impacts of this state-based approach. Among other results, the research found that states achieved limited multipayer alignment around value-based payment models like accountable care organizations (ACOs);[7] Medicaid ACOs in Maine, Minnesota, and Vermont were associated with some improvements in service use and quality, including statistically significant reductions in the number of emergency department (ED) visits, but only Vermont was able to slow the growth in total Medicaid expenditures;[8] and those states (Minnesota and Vermont) that addressed behavioral health integration with primary care slowed the rate of growth in Medicaid expenditures and reduced the number of ED visits by patients with behavioral health conditions in ACO models, but did not change the quality of care.[9]

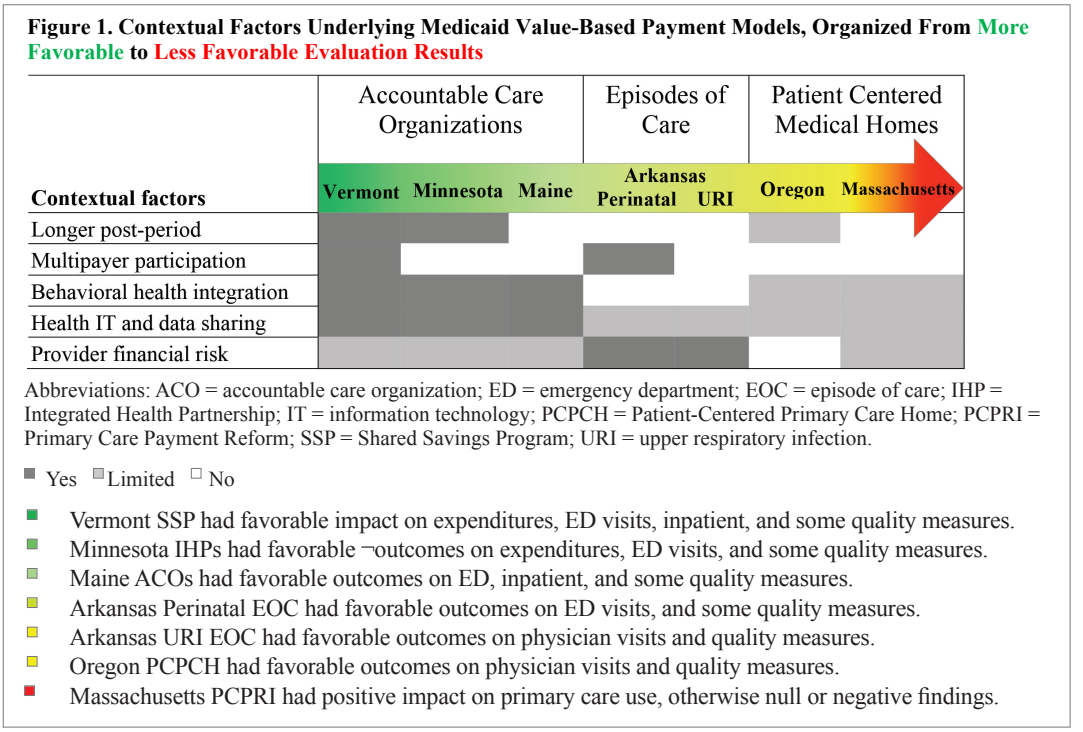
Three key themes emerged across these evaluation studies. First, states can transform Medicaid payment models, with some positive outcomes for the ACO-attributed population and behavioral health subgroups, but they may have a greater impact when aligned with other payers. Second, states were able to leverage federal funds to make targeted investments in health information technology to enhance communication across provider types, including behavioral health care providers. Third, states face more work to overcome such challenges as shortages of behavioral health providers and patient dissatisfaction with some changes in care delivery, both of which can influence the efficacy of payment models designed by states.

A Focus on Medicaid Payment Models to Drive Change

The SIM Round 1 evaluation demonstrated some key positive findings regarding Medicaid payment models. Vermont's ACO model yielded savings to Medicaid ($97 million, or an 8.4% relative reduction in costs) over three years—perhaps due to a greater alignment of incentives across payers or Vermont's strong history of multipayer primary care transformation over the past decade. Medicaid expenditures generally increased in other state models after the first implementation year. Minnesota's Medicaid ACO saw promising reductions

in total expenditures (-4.8%) by the third year. These findings suggest that models may need time to become established before they can achieve cost savings. Beyond expenditures, Medicaid ACO models in Maine, Vermont, and Minnesota reduced the number of ED visits by 3%, 4.5%, and 7%, respectively. Maine and Vermont also reduced the number of inpatient hospital admissions by 7% and 11%, respectively. Patient-centered medical homes (PCMH) in Massachusetts and Oregon improved physician access but generally did not improve other outcomes. Episode of care (EOC) models in Arkansas improved quality outcomes but did not reduce hospital-related utilization. Contextual factors underlying the Medicaid payment models may relate to whether the model demonstrated more or less favorable evaluation results (Figure 1). For example, while these analyses relied on at least two years of post-
period data, longer time spans may be needed, after the models become established, to observe the impact on outcomes.

Figure 1. Contextual Factors Underlying Medicaid Value-Based Payment Models, Organized From More Favorable to Less Favorable Evaluation Results



Multipayer Participation Was Not Always Achieved

"Payer engagement was a struggle. . . they don't want to engage. They are doing their own thing."
—Minnesota state official[10]

The Innovation Center expected that Medicaid and the commercial sector would work in concert toward health care transformation, based on the premise that payer alignment around common payment models creates

shared provider incentives. Only Vermont was able to align its ACO shared-savings payment model and quality incentives across Medicare, Medicaid, and commercial payers. By using clear state authorities, Oregon and Arkansas were able to align both Medicaid and a narrow set of commercial insurers. Through stakeholder engagement and a strong leader facilitating multipayer participation, Arkansas was able to persuade most of the other commercial insurers to voluntarily participate in a subset of EOC or to join the PCMH model in later years, representing larger segments of the commercial population. However, stakeholder engagement was not enough to create multipayer participation in Maine and Minnesota, where commercial payers (1) did not want to adopt a model specific to one state given their lines of business in multiple states; (2) did not want to share propriety payment design information with the state; and (3) were concerned about subsidizing care delivery for a practice's entire patient panel if not all payers were participating. Massachusetts chose to focus on developing value-based payment models in Medicaid only to bring Medicaid into better alignment with other existing initiatives in Medicare or among commercial payers.

Medicaid Payment Models Integrated Behavioral Health

To drive integration of behavioral health and primary care, Maine and Minnesota implemented a behavioral health home model using a Medicaid State Plan Amendment (SPA) under the Medicaid Health Home State Plan Option authorized under the Affordable Care Act (ACA). The Medicaid ACO models in Maine, Minnesota, and Vermont, as well as Oregon's Coordinated Care Model, included behavioral health-related quality measures. ACOs in Maine, Massachusetts, and Minnesota included behavioral health providers, and behavioral health services were included in the total cost of care calculations (Vermont plans to include behavioral health costs by 2020).

"I have found it really helpful to have a behaviorist in my office, and also a pharmacist, and also one of our medical assistants is the official care coordinator. . . . So, care coordination, to me these days, really means a team approach."
—Oregon provider[10]

Medicaid beneficiaries with behavioral health conditions served by Medicaid ACOs had generally positive outcomes. Total expenditures in Vermont and Minnesota grew more slowly (-6.5% and -11.9%, respectively) for Medicaid ACO beneficiaries with behavioral health conditions relative to their comparison groups in the first three years of implementation. Likewise, the

"Yes, my care is coordinated. I know that when I go to one doctor, my paperwork is immediately at the other doctor. I have like a baseball team of nine and I am the manager. My doctor is up to date. I'll go to Acadia and they will say, 'Did you know that your [blank] are high.' They all communicate."
—Maine Health Home consumer

number of ED visit rates declined (-1.8%, -4.6%, -6.1%) more for these same beneficiaries in Maine, Minnesota, and Vermont, respectively, and the inpatient admission rate declined (-12.4%) more for Vermont ACO beneficiaries with behavioral health conditions, relative to their comparison groups.

Targeted Investments in Health Information Technology Made a Difference

> *"Those discussions have now pushed us . . . to purchase a unified EMR for our network, not part of [the] SIM Initiative but as a result of [it]. Pushed the entire delivery system to think about how do we work more efficiently . . . internally within our silos of care and then how do we look at how we work together at the state level and regionally."*
> —Maine provider

Maine, Minnesota, Oregon, and Vermont each invested more than 20% of the state's total SIM award in health IT infrastructure, and it was in these states that providers noted increased access to and use of electronic health information. SIM funds in Maine, Oregon, and Vermont facilitated third-party services to communicate electronic hospital admission, discharge, and transfer notifications. Vermont prioritized connecting the Medicaid ACOs to its health information exchange (HIE) so that its ACOs could use clinical data to manage care. These funds helped providers in Maine and Oregon connect to the statewide HIEs. Technical assistance was critical to helping behavioral health providers in Maine use the HIE. To facilitate behavioral health integration with primary care, Oregon and Massachusetts implemented telehealth or telephonic initiatives to increase access to mental health services.

Payment Models Under SIM Offered Opportunities for Providers to Gain Experience With Shared Risk

The experience of these six SIM Round 1 states suggests that Medicaid can structure opportunities to build providers' confidence in participating in alternative payment models. States eased providers' reluctance to take on population accountability for Medicaid patients by iterating and evolving the models over time. As a result of the SIM investments, a range of providers received training, resources, and experience in managing quality of care and costs for their populations. Although the resulting impact on outcomes was modest, these models served a diverse range of Medicaid populations and gave providers experience with taking on financial risk (e.g., one-sided risk only in which states paid shared savings earned by participating organizations without requiring organizations to pay penalties if they did not meet expected benchmarks for quality or savings). All the states are sustaining

the Medicaid payment models developed or broadened with support from the SIM Initiative, and some have moved providers into two-sided financial risk arrangements, as in Massachusetts's ACO model, Minnesota's "2.0" version of the Medicaid ACO, and Arkansas's, Oregon's, and Vermont's multipayer participation in Advanced Alternative Payment Models (APMs).

States Face More Work to Overcome Emerging Challenges in Health Care Delivery

Even though states used SIM awards to provide resources to providers, such as workforce training, performance feedback reports, and access to event notification systems regarding hospitalized patients, countervailing trends of behavioral health professional shortages and provider burnout impeded their progress toward health system transformation. In addition, consumer engagement was not a large focus area for the states, and some providers were reluctant to assume the financial risk for patients' costs of care, especially those providers who viewed consumer behavior as unpredictable and difficult to influence. Those providers were concerned about being held accountable for patients' inefficient use of health care services (e.g., nonemergency ED use, resistance to receiving an evidence-based test) despite the providers' efforts to educate patients on appropriate care.

> *"When I call there, they be like, 'Well, we'll have the nurse to call you back,' I talk to the nurse or whatever, and it'll be like 2 weeks or maybe 3 'til she'll have an opening. . . . So, I go to the emergency room. I go to the emergency room a lot because I know I'm going to be taken care of once I go there. They read my chart and see what I'm going through."*
> *—Arkansas consumer*

How States Can Assist in Achieving Federal Goals

Health care expenditures are expected to represent close to 20% of the gross domestic product by 2027,[11] further impacting consumers as well as public and private insurers. States can help health systems, payers, and providers bend the cost curve by encouraging them to move away from fee-for-service toward population-based payment models tied to quality,[12] particularly in Advanced Alternative Payment Models.

The Innovation Center plans to continue to partner with states to improve the quality of care received among Medicaid beneficiaries. Lessons learned from SIM Round 1 have been incorporated into new Innovation Center Medicaid payment models, including the Integrated Care for Kids (InCK)[13] and the Maternal Opioid Misuse (MOM) Models.[14] These models test standardized payment and care delivery interventions and incorporate a longer time horizon (five to seven years) to allow states and providers time to become established and

to allow the Innovation Center time to observe and evaluate the effects of the interventions. The models require that states share accountability for cost and outcomes while allowing states flexibility in designing a payment strategy that meets the needs of their local context.

More broadly, the Centers for Medicare and Medicaid Services continues to offer opportunities[15] and resources for states to pursue Medicaid health reform with an increased focus on outcomes.[16] The Medicaid and CHIP Scorecard[17] was developed to increase public transparency in program administration as well as outcomes. States launching innovative payment models within Medicaid can aid in these efforts by submitting data on these measures, as well as improve the Scorecard rates, since many models are focusing on improving quality. While the first round of Scorecard data was released after the SIM Round 1 Initiative, it is clear that in some areas, even these highly innovative SIM states can make additional improvements in the quality of care Medicaid beneficiaries receive (Table 1).

Table 1. Medicaid Scorecard Rates (%), SIM Round 1 States, Survey Responses (2014)a, and Select Quality Measures (2016)b

State	Usually / Always Get Care Quickly (adults)[a]	Usually / Always Get Needed Care (adults)[a]	30-Day Follow-up After Hospitalization for Mental Illness (age ≥ 21)[b]	6 or More Well-Child Visits Within First 15 Months of Life[b]
Arkansas	77	79	56	35
Maine	72	81	not reported	70
Massachusetts	75	80	81	83
Minnesota	72	84	63	58
Oregon	72	72	88	63
Vermont	74	83	76	67

[a]2014 Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems[18]
[b]2016 Child and Adult Health Care Quality Measures[19]

The Innovation Center's final evaluation report[20] (with methods appendix[21]) provides greater details about each state's activities, achievements, challenges, and lessons learned from implementation. A summary is available in a two-page Findings at a Glance.[22] Future evaluation reports on the SIM Round 2 states[23] will further inform the ways in which states and federal partners can work together to tackle the complex issues involved with transforming the health care system to one that offers the greatest value.

Notes:

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***The Milbank Quarterly* Articles**

States Encouraging Value-Based Payment: Lessons From CMS's State Innovation Models Initiative
By Stephanie M. Kissam, Heather Beil, Christina Cousart, Leslie M. Greenwald, and Jennifer T. Lloyd.

Behavioral Health Integration With Primary Care: Implementation Experience and Impacts From the State Innovation Model Round 1 States
By Heather Beil, Rose K. Feinberg, Sheila V. Patel, and Melissa A. Romaire.

Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts
By Regina I. Rutledge, Melissa A. Romaire, Catherine L. Hersey, William J. Parish, Stephanie M. Kissam, and Jennifer T. Lloyd.

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The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.