



# All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform

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## Introduction

Arkansas, Minnesota, Oregon, and Vermont are at the forefront of state efforts to coordinate value-based payment approaches across multiple public and private payers. Each is deploying some combination of payment and delivery system redesign that includes episode-based payment, patient-centered medical homes (PCMHs), and total cost of care arrangements among its Medicaid, Medicare, and commercially insured populations.

The Pacific Business Group on Health (PBGH) has partnered with the Milbank Memorial Fund to assess the development of these state-level, multi-payer delivery system and provider payment reform projects. The resulting report, after describing multi-payer activity generally, examines the extent to which self-insured employers are participating in the kind of delivery system transformation envisioned by the Centers for Medicare & Medicaid Services (CMS) State Innovation Models (SIM) program. The SIM program is an initiative of the CMS Innovation Center that provides states with up to \$100 million to develop and test models for multi-payer payment and health care delivery system transformation over a three- to four-year period.<sup>1</sup>

The report, which draws on a series of structured interviews conducted with state officials, insurance executives, and business leaders between June and October 2014, provides a summary of current recruitment efforts in each state and synthesizes lessons learned for public officials interested in further outreach to the employer community. More detailed case studies of individual states are included at the end.

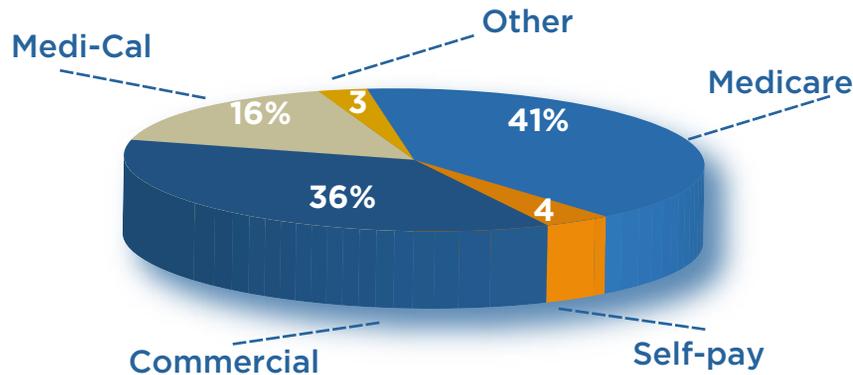
While each state has had success in moving toward more coordinated action across payers, particularly for primary care services, recruitment of employers with self-insured plans remains an ongoing challenge. Despite this, a key conclusion is that recruiting self-insured employers is both a worthwhile and attainable goal. The findings and recommendations of this report can be used by stakeholders looking to address employer recruitment challenges in future multi-payer work. Further outreach and ongoing dialog with employers can help officials coordinate payment and delivery system changes across the vast majority of the publicly and privately insured populations.

## Background

### The Need for Multi-Payer Collaboration

A typical provider in the United States must collect and coordinate revenue from multiple public and private payers. See Figure 1 for an example from a major health system in California. Each of these dozens of sources of funds has its own rules for payment and separately negotiated contractual standards. Coordination among payers is discouraged or illegal. The cumulative effect is to emphasize the economic and administrative status quo and reduce the ability of providers to innovate with improvements that benefit patients and populations.

Figure 1. Payer mix for large California Health System



Source. *Sutter Health 2013 Annual Report*

Analysts have pointed out that while this fragmented set of multiple public and private payer entities facilitates experimentation with a variety of payment structures and quality measurements, it also introduces several potential drawbacks.<sup>2</sup> Principal among these is that often any individual health plan represents only a fraction of a provider's total revenue, and thus the overall impact of a specific reform initiative can be small and the leverage of any given payer to drive performance improvement can be limited. From the provider's perspective, myriad payment programs have the potential to conflict with one another or fail to provide large enough incentives to undertake certain activities or invest in the infrastructure needed for improvements.

A variety of payers can also introduce a multitude of quality reporting requirements that can be difficult for a provider to manage. This often produces a significant reporting burden that contributes to the comparatively large administrative costs that characterize the US health system.<sup>3,4</sup> In addition, fragmented quality measures collected by various payers can be of limited value when they reflect performance on only a subset of a provider's patients. While aggregating and aligning data from multiple payers can allow for more meaningful and accurate performance measurement, it is tremendously difficult to do if each payer is engaged in unique payment initiatives that produce different quality indicators.

Multi-payer initiatives involve collaboration among public (e.g., Medicaid) and private (e.g., commercial insurance) payers participating in value-based payment and delivery system reforms such as episode-based payment and PCMHs. Successful multi-payer alignment can amplify the impact of payment and delivery system reforms by sending consistent incentives to health care providers and aligning performance measurement.

Several recent federal initiatives are explicitly premised on multi-payer principles and goals: the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration from 2010, a federal partnership with a state's Medicaid program and private insurers that provides advanced primary care practices with a monthly care management fee to improve coordination, access, and support for chronically ill patients; the Comprehensive Primary Care (CPC) initiative of 2012, which fosters collaboration between public and private payers to provide primary care practices with resources to better coordinate primary care for their patients;<sup>5</sup> and the SIM program, mentioned above.

### Barriers to Multi-Payer Activity

While the logic for multi-payer activity is relatively straightforward, the challenges in successfully deploying it are equally clear. From a legal standpoint, there are numerous anti-trust prohibitions against collaboration among payers—particularly collaboration that involves setting specific payment levels. This likely reflects not only a legal principle that payers should be competing rather than cooperating, but also a more nebulous belief in a spirit of competition that encourages differentiation among products. Across many industries, companies have incentives to make their products more—rather than less—unique. The same can hold true for insurers. Payment methodologies and quality measurements are often treated as proprietary and part of an individual firm's value proposition.

The geographic nature of a particular plan may also influence its decision to participate in state-based or regional multi-payer initiatives. Regional plans may have difficulty collaborating with national plans—national plans may simply be uninterested in smaller state-based initiatives as they cover a relatively small share of their total covered lives. Ultimately, the reach of each payer in any given market can be strongly predictive of its participation. Those with a larger market share stand to gain more from delivery system improvements in a particular area, and thus have more incentive to participate in a multi-payer initiative there.

Finally, it can be quite difficult to recruit the self-insured population into multi-payer projects given that commercial insurers function as administrative intermediaries rather than ultimate decision makers under self-insured arrangements. The power to decide rests with the sponsoring employer. As such, commercial issuers require permission from plan sponsors to participate in payment initiatives, and contacting each sponsor can be a significant and burdensome undertaking. This is by no means inconsequential—the self-insured population represents more than half of all workers with health insurance nationally and constitutes a growing share of the privately insured market.<sup>6</sup>

## Current Multi-Payer Efforts in Arkansas, Minnesota, Oregon, and Vermont

Despite these and other challenges, several states have made significant strides in coordinating value-based payment approaches among public and private programs, particularly in the area of primary care. Summaries of their current efforts and outreach to self-insured employers are included in this section. Further details are available in the case studies at the end of this report.

Arkansas is at the forefront of state efforts to coordinate multi-payer reform across multiple public and private payers. The state has had notable success rolling out an episode-based payment system among its Medicaid program and two largest commercial carriers, and its PCMH initiative now includes the majority of its providers and patients. It will soon roll out a “health home” program for patients with complex or special needs (e.g., developmental disabilities), which will work with their medical homes to coordinate medical, community, and social support services. Arkansas is a participant in the federal CPC initiative and the SIM program.

Minnesota’s multi-payer payment and delivery system reform strategy is primarily tied to spreading an accountable care organization (ACO) concept (the Minnesota Accountable Health Model framework) across Medicare, Medicaid, commercial payers, and self-funded populations in the state. Minnesota’s Accountable Health Model includes the development of common measurement tools across payers, improved clinical data exchange at the provider level, and alignment of payment and risk-adjustment methods for complex populations. Minnesota participates in the MAPCP demonstration and the SIM program.

Oregon’s recent multi-payer efforts center on spreading the coordinated care organization (CCO) model introduced into the state Medicaid program in 2012. CCOs are risk-bearing, community-based entities governed by a partnership among providers of care, community members, and others taking financial risk for the cost of physical, behavioral, and oral health care of a defined population. Several alternative payment methodologies underpin the CCO model now being spread under Oregon’s SIM initiative, including pay-for-performance incentives, shared savings payments, episode-based payments, and enhanced primary care fees. Oregon participates in the CPC initiative, the SIM program, and a state-based health care quality initiative that coordinates payment and measurement across multiple payers.

Vermont is a leader among states reforming payment and delivery systems, and continues to actively test value-based payment approaches across multiple public and private payers. This includes multi-payer medical home payment through the MAPCP demonstration and the Blueprint for Health. Vermont has also recently begun testing payment approaches under a SIM grant, including a shared savings ACO model that involves integration of payment and services across an entire delivery system, a bundled payment model that involves

integration of payment and services across multiple independent providers, and a pay-for-performance (P4P) model aimed at improving the quality, performance, and efficiency of individual providers.

Independent evaluations of each of these efforts released by CMS in January 2015 indicate that they indeed work, slowing cost growth for the populations they treat. Self-evaluations in many of the participating states also note improved care coordination and quality indicators.<sup>7</sup>

## Findings

### **1. Multi-payer reform is successful, but self-insured employer participation is limited**

States officials and insurance executives in Arkansas, Minnesota, Oregon, and Vermont unanimously agree that recruiting the self-insured population into multi-payer arrangements is crucial for achieving the goal of comprehensive payment and delivery system reform. Self-insured employers often sponsor a significant portion of the commercially insured lives in each state: according to the Medical Expenditure Panel Survey, more than 58 percent of those with private sector health insurance are enrolled in self-insured plans. Recruitment efforts for this population in SIM programs vary, but often include some combination of outreach by state officials, insurance executives, and “employer advisory councils” composed of representatives from the business community.

All four of the states in this study have had success engaging at least some self-insured employers into multi-payer efforts. This includes public employees and (in several cases) public school teachers, who are unique targets given that they can often be recruited through executive fiat. Study participants uniformly noted that strong leadership from the governor in each state either through indirect influence or direct executive action was conducive to public employer participation.

Successful recruitment of self-insured lives in the privately insured population was much more limited. In Arkansas, the nonpartisan Center for Health Improvement has brought the state’s largest privately self-insured employer into the fold. Overtures to other self-insured firms are ongoing. State officials and insurance executives in Minnesota and Oregon have generated some interest in multi-payer reform among select employers, yet traction remains limited among several others. Similarly, while Vermont has identified recruiting self-insured employers into the state’s PCMH initiative as a top priority, the position and interest of several large companies in the state are not clear.

### **2. Self-insured employer participation is limited for several reasons**

Participation of self-insured employers in multi-payer payment and delivery system reform efforts is limited for several reasons. First, while state officials make clear that recruitment of the self-insured population is a priority in each state, it is often one of several competing priorities. As a result, many employers and potential participants have not heard from state officials. Moreover, while insurance carriers are often taking part in multi-payer reforms

with their fully insured lives, they remain reluctant to ask their self-insured lines of business to participate. As a result, many employers are not familiar with—or are confused about—multi-payer activity in their state.

In several cases, outreach from state officials or insurance executives to employers has not been well targeted. While human resources (HR) administrators are often intimately familiar with the health care benefits offered to their company's employees, they may lack the necessary authority to make a change like signing up for a PCMH initiative that requires an upfront PMPM investment. Visionary leadership within an organization is helpful when the return on a particular payment or delivery system initiative is not entirely clear—an intuitive “sell” requires a forward-thinking commitment to improvement and value.

Several features unique among private sector employers also make recruiting them into multi-payer initiatives challenging. These include the inherently conservative nature that characterizes many employers' decisions regarding health care benefits. Several large businesses noted their reluctance to tinker with their employees' coverage, especially for payment programs that were seen as experimental or transitory. A “wait and see” attitude is also prevalent in the recent era of moderate health care cost growth. Also, while these initiatives are organized and led at a state or regional level, authority for health insurance benefits for national employers often rests in a single central office, creating significant difficulties for communication, let alone alignment of policies.

Finally, several large employers noted their desire to drive—rather than follow—decisions regarding health care payment and delivery. Many self-insured businesses have experimented with value-based payment approaches in recent years. While they are willing to share their experiences and are open to the general idea of collaboration, several expressed reluctance at being told what to do by the state or a collaborative in which they have limited control.

## Recommendations for Recruiting Self-Insured Employers into Multi-Payer Efforts

State officials, insurance executives, and business leaders in Arkansas, Minnesota, Oregon, and Vermont provided several recommendations for stakeholders interested in recruiting self-insured employers into future multi-payer efforts.

### **1. More outreach is needed**

It is clear that more outreach is needed to communicate the general principle of multi-payer initiatives, the potential benefits of reform to employers, and the specific steps being taken by state officials and insurance companies. Several business leaders involved in this study were simply unaware their state was attempting to deploy multi-payer payment and delivery system initiatives; virtually all expressed preliminary interest in learning more.

## **2. State executive branch leadership is crucial**

Many current participants noted that executive leadership is crucial for launching and sustaining multi-payer activity. Support from the governor and other state leaders can create an echo chamber that communicates not only the presence of multi-payer collaboration but also the benefit all stakeholders gain by participating. This sense of a collective effort and the limits of “going it alone” must be communicated to individual participants.

Executive support is also conducive to the inclusion of state employees and teachers, a substantial proportion of employees insured by self-insured employers in many states. Several stakeholders noted that recruitment of state employee and teacher groups can be done through indirect influence or direct executive action.

## **3. Insurance carriers are important partners**

Insurance carriers themselves remain important participants in and advocates for multi-payer payment and delivery system reform. While a few of the large employers taking part in this study report skepticism regarding the benefits of any one payment initiative, virtually all are receptive to strategies insurance companies have deployed in their fully at-risk population. Moreover, insurance markets are often dominated by a few large carriers; while they have been reluctant to use their leverage to encourage participation in the past, the potential exists. Self-insured employers purchasing coverage in markets characterized by a dominant domestic insurer have limited alternatives.

## **4. Outreach needs to be targeted**

Outreach and education—whether conducted by insurance carriers, state officials, federal agencies, or business organizations—need to be better targeted going forward. The experiences of the four states in this study suggest awareness regarding the need for and benefits of multi-payer coordination must be raised. Also the specific contact in any given company must have both the vision and the clout to make benefit changes that could require upfront investments with a nonstandard return on investment in some places. Conversations with senior executives—rather than HR administrators—are often more fruitful. In addition, certain employers merit consideration when prioritizing among the privately self-insured population: those with a sizable portion of their workforce or a well-defined legacy in a specific state make natural allies in state-specific payment improvement efforts.

## **5. A neutral convener is helpful**

Many participants in this study noted that having a neutral convener—inside or outside of state government—was helpful in recruiting self-insured stakeholders. For instance, the Arkansas Center for Health Improvement and Vermont’s Green Mountain Care Board both share the broad charge of improving the health and well-being of their respective states. These entities served as natural conveners for recruiting all stakeholders in an inclusive process. Ultimately, officials found that very few of those invited to take part did not. Some have since created employer advisory councils tasked specifically with increasing awareness and recruiting the business community.

## 6. Federal support is an essential component

Finally, federal support has been an essential component of the success of multi-payer payment reform initiatives in all of the states in this study. The CPC initiative and the MAPCP demonstration kick-started multi-payer medical home programs in several states, and SIM funding has fueled multi-payer collaboration on an expanded set of multi-payer payment and quality measurement initiatives. Several state officials noted a desire to continue to collaborate with the federal government, ultimately more fully integrating Medicare payment models in state-based initiatives.

## Conclusion

Successful recruitment of self-insured employers into multi-payer efforts is both a worthwhile and an attainable goal. While numerous challenges and barriers to further collaboration exist, the experiences of Arkansas, Minnesota, Oregon, and Vermont demonstrate that it is possible. Indeed, while some business leaders in this study had not known their state was attempting to execute multi-payer payment and delivery system initiatives, most expressed preliminary interest in learning more. It is clear that continued outreach is needed.

Stakeholders must communicate the general premise of multi-payer initiatives, their outcomes, the possible gains of reform to employers, the specific steps being taken by state officials and insurance companies, and the ways self-insured employers can collaborate in these efforts. There is an audience receptive to this message—employers, like all payers, are continually searching for ways to lower costs and improve outcomes in health care. Multi-payer payment and delivery system reform is a key step in the health system transformation desired by all.

## Case Study: Arkansas

### Overview

Arkansas is at the forefront of state efforts to coordinate value-based payment approaches across multiple public and private payers. The state has had notable success rolling out an episode-based payment system among its Medicaid program and two largest commercial carriers, and its PCMH initiative now includes the majority of its providers and patients. Arkansas is unique among states in that it has successfully recruited a substantial portion of its self-insured population into its multi-payer reforms. Several factors have contributed to this success, including strong executive leadership at the state level, the vision and guidance of the Arkansas Center for Health Improvement (ACHI), an inclusive effort to convene and engage interested parties, the presentation of payment reform initiatives as permanent changes rather than temporary pilots, and a broad base of public and private funding support.

## Current Multi-Payer Efforts

Arkansas's current multi-payer work is coordinated by the ACHI, a nonprofit, nonpartisan policy center created in 1998 with the broad charge to lower costs and improve care for all Arkansans.<sup>8</sup> In 2011, the state Medicaid agency and two private health plans formed the Arkansas Health Care Payment Improvement Initiative (APII), a collaboration overseen by ACHI that utilizes episode-based payment, PCMH fees, and accountable care shared savings arrangements to lower costs and improve quality for various populations of patients across the state. These strategies are summarized in Table 1.

Arkansas's multi-payer efforts also build on partnerships originating in 2012 with the federal CPC initiative. Currently five payers—Medicare, Arkansas Medicaid, Arkansas Blue Cross and Blue Shield, Humana, and QualChoice—participate in Arkansas's CPC initiative by providing 69 primary care practices with additional PMPM fees along with shared savings.

These CPC arrangements dovetail with the goals of APII's PCMH initiative, which aims to provide the majority of Arkansans access to a PCMH by 2016.<sup>9</sup> Persons with complex or special needs (e.g., developmental disabilities) will also have access to health homes, which will work with their medical homes to coordinate medical, community, and social support services. Payments will include performance-based care coordination fees, as well as shared savings for medical homes based on their ability to reduce total cost of care while also achieving quality goals.

Finally, Arkansas will continue to institute and expand its system of episode-based care delivery for acute, procedural, or ongoing specialty care conditions, using a retrospective payment approach that rewards providers who deliver high-quality, cost-effective, and team-based care across an entire episode of care. Services for special needs populations will be further enhanced by payments reflecting each client's assessed level of need. Participating payers currently utilize episode-based payment for 15 conditions; officials hope to expand this list to 40 to 50 conditions by 2016.<sup>10</sup>

Table 1. Summary of Arkansas Multi-Payer Payment Improvement Initiative

Component	Summary	Payment Model	Populations Served	Payers Participating	Type of Self-Insured Employers
Episode-Based Payments	Health care provider accountable for the cost and quality of services for a particular diagnosis (e.g., hip/knee replacement) over a defined period (30 days prior to and 90 days after).	Retrospective, episode-based payment for outpatient services. Upside and downside risk. Quality requirements.	Patients receiving care for 15 conditions as of Q4 2014. Episodes rolled out based on clinical condition rather than patient population. 2016 target is 40–50 conditions.	Medicaid, Arkansas Blue Cross and Blue Shield, QualChoice	State employees, public school employees, Walmart
PCMH	Team of health care providers takes responsibility for overall health of patients. Designated primary care doctor coordinates care across clinical settings.	Primary care practices receive PMPM payments and shared savings (min. 5,000 patients). Upside only. Quality requirements.	79% of eligible Medicaid beneficiaries (289K lives) with 600 Medicaid-accepting providers as of Q4 2014. 2016 target is 80% of Medicaid population.	Medicare (CPC only), Medicaid, Arkansas Blue Cross and Blue Shield, QualChoice, Humana	State employees, public school employees, Walmart
Health Homes	Team of health care providers takes responsibility for overall health of complex, chronically ill patients. Includes care for behavioral health and long-term services and support (LTSS).	Practices receive a risk-adjusted PMPM fee assessed every 2 years. Upside only. Quality requirements.	Three waves rolling out in 2015: adults with developmental disabilities; individuals requiring LTSS; individuals with serious mental illness. 2016 target is 30% of LTSS patients in health homes.	Medicaid, Arkansas Blue Cross and Blue Shield, QualChoice	State employees, public school employees

## Lessons Learned

### Success Factors

State officials and private insurance executives are generally pleased with Arkansas's progress toward its goal of moving the majority of public and private health care spending to value-based payment arrangements by 2016. Arkansas's episode-based payment scheme and PCMH initiatives have been particularly successful, covering a substantial portion of Medicare patients (PCMH through CPC), the state Medicaid program, the fully insured populations of the state's large health plans, and three large self-insured employers (state employees, state teachers, and Walmart).<sup>11</sup> Health homes for adults with complex needs—the third major component of Arkansas's multi-payer payment reform initiative—will roll out in three waves beginning in 2015.

Individuals taking part in this study identified a number of factors contributing to the success of multi-payer efforts in the state, including:

- Strong executive leadership at the state level, including an early commitment from outgoing Arkansas Governor Mike Beebe. Executive support encouraged numerous public and private stakeholders to come together to discuss the challenges facing the state's health care system and ultimately facilitated the participation of state employees and teachers in payment reform initiatives.
- The vision and leadership of the ACHI. Having this nonprofit organization communicating cross-cutting public health goals and a payment reform strategy for improving care across populations helped unite multiple stakeholders.
- An inclusive effort to convene and engage interested parties—including hospitals, doctors, health plans, and the general public—on an ongoing basis. Officials held numerous meetings to provide information and solicit feedback during the planning, roll-out, and evaluation phases of various initiatives.
- Presenting payment reform initiatives to hospitals and doctors as permanent changes rather than temporary pilots. Providers were more willing to take part in and commit to initiatives that were seen as enduring shifts rather than passing experiments.
- A broad base of public and private funding support for health reform activities. A diversified funding stream helped state officials provide technical expertise and facilitation among major stakeholders in a stable and neutral forum.

### Challenges

While officials have had success recruiting Arkansas's largest private sector employer—Walmart—and public sector groups including state employees and teachers into the state's multi-payer initiatives, incorporating the remainder of the state's self-insured employers remains an ongoing challenge. Insurance carriers are an important advocate for employer engagement; however, while the state's largest health plans are committed to APII's

methods and do participate with their fully insured groups, neither they nor the state can compel self-insured employer participation. To address this issue, officials have created an employer advisory council and continue to make overtures to large employers in concert with the state's large carriers. In addition, the state's largest business trade group—the Arkansas State Chamber of Commerce—has officially signaled its approval and continues to participate in recruitment efforts.

### Advice and Insights

Arkansas officials, insurance executives, and those business executives participating in multi-payer payment reforms offer several pointed recommendations for states trying to recruit self-insured employers. Principal among these is the need for concerted and consistent outreach over a sustained period of time, particularly from a diverse set of interested parties including the governor's office, state agency leadership, and insurance companies. While large employers in Arkansas and elsewhere are generally conservative with health care benefits and can be somewhat hesitant when approached to participate in multi-payer reforms, they are eager for health care savings and receptive to strategies their carriers have bought into with their fully insured population.

State officials in Arkansas deliberately launched episode-based payment as the first payment improvement initiative given employers' tepid reaction. In some ways, episodes are an easier "sell," given that they require no upfront investment or initial PMPM fee from employers. Lowering the financial commitment required to participate eased the way for the incorporation of PCMH initiatives at later stages.

### Conclusion

With its multi-payer initiatives—including episode-based payments, PCMHs, and health homes—Arkansas has experienced measurable success. Recruitment of self-insured employers to participate in these initiatives has also been fairly successful. The state's largest private employer, Walmart, participates in both the episode-based payment and PCMH initiatives; state employees and teachers are committed to all three. Arkansas officials and insurance executives continue to engage other self-insured employers through an employer advisory council.

## Case Study: Minnesota

### Overview

Minnesota's multi-payer payment and delivery system reform strategy is primarily tied to spreading an ACO concept (the Minnesota Accountable Health Model framework) across Medicare, Medicaid, commercial payers, and self-funded populations in the state. Minnesota's Accountable Health Model includes the development of common measurement tools across payers, improved clinical data exchange at the provider level, and alignment payment and risk-adjustment methods for complex populations. Several factors are conducive to the success of Minnesota's program, including a legacy of payment and delivery system reform, a history of collaboration among the state's private carriers, executive leadership from the governor, and a strong backing from the legislature. While large employers have not yet joined state-led multi-payer initiatives in any significant way, they are actively experimenting with alternative payment arrangements and are receptive to strategies being tested by Medicare, Medicaid, and the state's commercial carriers.

### Current Multi-Payer Efforts

Minnesota's current multi-payer work is coordinated by the Minnesota Department of Health and the Minnesota Department of Human Services, state agencies jointly charged with carrying out Minnesota's State Health Care Innovation Plan under the federal SIM program. As noted above, Minnesota has based its multi-payer initiatives on its Accountable Health Model framework, spread across Medicare, Medicaid, commercial payers, and self-funded populations in the state. In 2012, more than two million of the state's 5.4 million residents were covered in self-insured plans.<sup>12</sup> The state's multi-payer strategies are summarized in Table 2.

Minnesota's multi-payer reforms build on the state's comprehensive 2008 reform law that resulted in the introduction of a medical home (the Health Care Home) program, an all-payer claims database, and a statewide quality reporting and measurement initiative. The Minnesota medical home initiative provides extra payments to doctors for partnering with patients to coordinate care. The state also participates in the MAPCP demonstration. Minnesota's Accountable Health Model framework is based on the Integrated Health Partnerships (IHP) demonstration program that began operating in January 2013. Under the IHP, Medicaid providers enter into accountable care arrangements that include sharing both upside and downside risk for costs and meeting quality targets for a defined population of patients. Minnesota's Accountable Health Model includes the development of common measurement tools across payers, improved clinical data exchange at the provider level, and alignment of payment and risk-adjustment methods for complex populations.

Minnesota is using SIM funding to increase the kinds of care offered through ACOs, including long-term social services and behavioral health services. It is also in the initial stages of supporting community organizations called "Accountable Communities for Health" that integrate medical care with behavioral health services, public health care, long-term care,

social services, and other forms of care. Accountable Communities for Health also share accountability for population health and provide care centered on the needs of individuals and families.

Like other SIM initiatives, Minnesota’s transformation plan includes significant investments in health care infrastructure. Over the next two years, the state will continue to implement a comprehensive, statewide program to close gaps in health information, create a quality improvement infrastructure, and enhance the workforce capacity needed for team-based, coordinated care. The program includes support to primary care physicians who wish to transform their practices into PCMHs.

Table 2. Summary of Minnesota Accountable Health Model Multi-Payer Activity

Component	Summary	Payment Model	Populations Served	Payers Participating	Type of Self-Insured Employers
ACO / Total Cost of Care Arrangements	Provider organizations accountable for the total care of patients, including population health outcomes, patient care experiences, and the cost per person.	Shared savings to sub-capitation arrangements with both upside and downside risk. Quality requirements.	2016 goal incorporates the majority of the state’s publicly and privately insured population, current ACO providers, and Hennepin Health.	Medicaid, Medicare (Pioneer and Shared Savings Programs), Blue Cross and Blue Shield of Minnesota, Medica	State employees
PCMH (Health Care Homes / MAPCP demonstration)	Advanced primary care practices work with multi-disciplinary community health teams to coordinate care for patients.	Primary care practices receive fee-for-services (FFS) payments plus PMPM fees tied to state certification standards and expectations.		Medicaid, Medicare (MAPCP), Blue Cross and Blue Shield of Minnesota, Medica	State employees
Accountable Communities for Health	Provider, plan, or other entity agrees to enter into risk-based contract for full range of medical, behavioral, and social services.	Currently testing some level of financial accountability for population health.	Integrates medical care, behavioral health services, social services, and LTSS for complex patients.	Medicaid, Blue Cross and Blue Shield of Minnesota, Medica	State employees

## Lessons Learned

### Success Factors

Minnesota has made significant progress toward the Triple Aim goal of improved population health, improved patient experience, and lower costs through multi-payer delivery system transformation.<sup>13</sup> Individuals taking part in this study identified a number of factors contributing to the success of multi-payer efforts in Minnesota, including:

- Active private carriers that eagerly sought to align commercial ACO payment arrangements with Medicaid and the Medicare Shared Savings and Pioneer Programs.
- A history of collaboration among the state's private carriers, typified by the Minnesota community measurement initiative in the early 2000s.
- A familiar community of stakeholders with a culture of cooperation and compromise.
- A sophisticated set of health care delivery systems in the state, including integrated delivery systems with experience coordinating care for defined patient populations.
- Executive leadership from the governor and strong backing from the state legislature that signal a widespread basis of support and enduring commitment to reform.

### Challenges

Recruitment of Minnesota's self-insured employer population into multi-payer payment reform initiatives remains an ongoing challenge. While the state's largest commercial carriers have consistently led multi-payer efforts in the state and have bought into coordinated strategies with their fully insured population, Minnesota's multi-payer initiatives are largely unknown within the business community. Despite this, conversations with large employers in the state indicate that businesses are active in pursuing value-based payment arrangements through their third-party administrators and are receptive to the strategies that carriers, the state Medicaid agency, and the federal Medicare program are pursuing in concert with one another.

### Advice and Insights

The lack of employer awareness of multi-payer efforts in Minnesota suggests that concerted and consistent outreach is the key element of any recruitment campaign. Minnesota enjoys strong support for its payment and delivery system transformation work among its governor, legislature, and private carriers. It has a legacy of collaboration among health plans that is conducive to multi-payer initiatives. It also possesses a strong history of support for health reform initiatives, including its comprehensive health reform law from 2008. Drawing on this shared experience and culture of collaboration has facilitated coordinated value-based payment and delivery system reforms. While its large employers have not yet joined multi-payer efforts, the state continues to actively reach out to the business community.

## Conclusion

Minnesota has a history of collaboration among its private payers and has done significant work to align accountable care payment methods among Medicaid, Medicare, and its commercial carriers. The state is using SIM funding to increase the kinds of care offered through ACOs, and, like other states, is beginning to experiment with even broader population health models through its Accountable Communities for Health initiative. While large employers remain active in value-based purchasing arrangements, they have not yet joined Minnesota's multi-payer activity in notable numbers although they are interested in strategies being pursued by the state's commercial carriers, Medicaid, and Medicare.

## Case Study: Oregon

### Overview

Oregon's recent multi-payer efforts center on spreading the coordinated care organization (CCO) model introduced into the state Medicaid program in 2012. CCOs are risk-bearing, community-based entities governed by a partnership among providers of care, community members, and others taking financial risk for the cost of physical, behavioral, and oral health care of a defined population. Several alternative payment methodologies underpin the CCO model now being spread under Oregon's SIM initiative, including pay-for-performance incentives, shared savings payments, episode-based payments, and enhanced primary care fees. While Oregon has not yet recruited a substantial portion of its private, self-insured population into its multi-payer SIM reforms, it is successfully incorporating public employees and teachers. Recruitment of large employers continues through a task force convening under the umbrella of the Oregon Health Authority.

### Current Multi-Payer Efforts

As noted above, Oregon's multi-payer strategies focus on the spread of risk-bearing, community-based CCOs. There are currently 16 CCOs operating in Oregon. While they have the flexibility, within model parameters, to institute their own payment and delivery reforms to achieve the best possible outcomes for their membership, they are accountable for the health and care of the population they serve and are rewarded for improving both quality of care and health care value. Over the next several years, CCOs will transition payment for care from a fully capitated model to payment that is increasingly based on health care outcomes.

Oregon also began participating in the CPC initiative in 2012. The CPC initiative fosters collaboration between public and private payers to provide primary care practices with resources to better coordinate primary care for their patients. Currently five payers—CareOregon, Oregon Health Authority, Providence Health Plan, Regence BlueCross BlueShield

of Oregon, and Tuality Health Alliance—participate alongside Medicare in Oregon’s CPC initiative by providing 67 primary care practices with additional PMPM fees along with shared savings for more than 400,000 patients, including 54,000 Medicare and Medicaid beneficiaries.

Multi-payer work is also being undertaken by the independent, nonprofit Oregon Health Care Quality Corporation (Q Corp), a large partnership of consumers, providers, employers, policymakers, and health insurers founded in 2000. Q Corp, a participant in the Robert Wood Johnson Foundation Aligning Forces for Quality program, is, among other things, coordinating payment models among five health plans and 14 physician practices working together to improve care management for complex patients in the state. Q Corp also encourages alignment of quality measurement and reporting across payers, and leads a patient-centered primary care institute for practices looking to qualify under the Oregon Health Authority’s PCMH program.

Several alternative payment methodologies underpin the CCO model now being spread under Oregon’s SIM initiative, including pay-for-performance incentives, shared savings payments, episode-based payments, and enhanced primary care fees. Officials are targeting all Medicaid patients (including those eligible for both Medicaid and Medicare, called “dual eligibles”), state employees through the Public Employees’ Benefit Board (PEBB), and those purchasing qualified health plans on Oregon’s health insurance exchange. Participation of the Oregon Educators Benefit Board (OEBB) is imminent. These strategies are summarized in Table 3.

Table 3. Summary of Oregon Multi-Payer Payment Activity

Component	Summary	Payment Model	Populations Served	Payers Participating	Type of Self-Insured Employers
PCMH (Patient-Centered Primary Care Home Program and CPC initiative)	Advanced primary care practices work with multi-disciplinary community health teams to coordinate care for patients.	Primary care practices receive FFS payments plus PMPM fees tied to state standards.	Medicaid and dual eligibles are required to be a member of a CCO; CPC clinics now serving more than 400,000 patients.	Medicare (CPC), CareOregon, Oregon Health Authority, Providence Health Plan, Regence BlueCross BlueShield of Oregon, and Tuality Health Alliance	State employees (through PEBB), OEBB

CCOs	Team of health care providers takes responsibility for overall cost and quality of health care for a specific group of patients over a defined period of time.	CCOs are accountable for the health and care of the population they serve and are rewarded for improving both quality of care and health care value. CCOs are transitioning from a fully capitated model to payment based on health care outcomes.	Medicaid, dual eligibles, state employees, health insurance exchange customers.	Medicaid, qualified private health plans on health insurance exchange	State employees (through PEBS), OEBS
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## Lessons Learned

### Success Factors

Oregon officials are pleased with the state’s progress implementing multi-payer payment and delivery system reform in support of the Triple Aim: better care, better health, and lower costs. Oregon met a SIM goal of reducing per capita Medicaid spending by one percentage point through July 2013 and two percentage points by July 2014 through the multi-payer CCO model. It is now targeting two percentage point reductions in per capita cost trend for state employees and dual eligibles. Individuals taking part in this study identified a number of factors contributing to the success of the multi-payer efforts in Oregon, including:

- Strong executive leadership, including consistent support for Oregon Governor John Kitzhaber and state agencies that facilitated the participation of the PEBS and the OEBS.
- A strong history of health reform, including legislation fueling primary care redesign in 2009 and the use of CCOs in 2011.
- An inclusive process with extensive public outreach, including 76 public meetings leading up to the initial introduction of CCOs.
- An independent group (the Oregon Health Authority) tasked with improving health system quality while lowering costs for all Oregonians.
- The constructive relationships driven by the Oregon Health Care Quality Corporation, which has brought payers together from across the state to coordinate payment for complex patients under the Robert Wood Johnson Foundation Aligning Forces for Quality program.

## Challenges

Oregon officials believe recruitment of the state's self-insured population into multi-payer efforts is crucial to the long-term success of its ambitious payment and delivery system transformation. More than 16 percent of the state's four million residents were estimated to be covered under a self-funded arrangement in 2011.<sup>14</sup> While state leaders have had success bringing in public sector groups like state employees and public school teachers, large private employers have not yet joined the SIM initiative. As in other SIM states, officials continue to make overtures to self-insured employers in concert with the state's large carriers. Fortunately, several businesses—particularly those that strongly identify themselves as “Oregon-based”—are receptive to value-based payment redesign and open to collaboration with other payers.

## Advice and Insights

As in Arkansas, Minnesota, and Vermont, strong executive leadership from the governor's office has been a boon to multi-payer efforts in Oregon. This consistent base of support has facilitated the participation of the two largest public sector self-insured populations, the PEBB and the OEBC. Similarly, the state's domestic insurers have embraced multi-payer value-based models. Currently, the task of “selling” multi-payer CCO and PCMH initiatives is being carried out by several groups, including an employer advisory group organized by the Oregon Health Authority.

## Conclusion

Oregon is at the forefront of state efforts to coordinate value-based payment approaches across multiple public and private payers. The state has made considerable progress implementing its CCO model with strong medical home components—this initiative now includes Oregon's Medicaid program, private health plans sold on the health insurance exchange, the PEBB, and the OEBC. Recruitment of the self-insured population remains an ongoing challenge, though state officials continue to engage self-insured employers through the state's employer advisory group organized by the Oregon Health Authority.

## Case Study: Vermont

### Overview

Vermont is at the forefront of state efforts to reform its health insurance payment and delivery system, and continues to actively test value-based payment approaches across multiple public and private payers. This includes multi-payer medical home payment through the MAPCP demonstration and the Blueprint for Health. Vermont has also recently begun testing payment approaches under a SIM grant, including a shared savings ACO model that involves integration of payment and services across an entire delivery system, a bundled payment model that involves integration of payment and services across multiple independent providers, and a pay-for-performance (P4P) model aimed at improving the quality, performance, and efficiency of individual providers. While Vermont has had mixed success recruiting its self-insured population into multi-payer reforms, it remains committed to bringing its entire population into its payment and delivery system redesign efforts.

### Current Multi-Payer Efforts

Vermont's current multi-payer efforts originated in 2006 with the introduction of the Blueprint for Health, a care coordination initiative for the chronically ill that has since evolved into a PCMH and comprehensive community health undertaking. The state passed further reform legislation in 2011 that called for pilots of new payment models and a potential path toward a single-payer system. Vermont is one of eight participants in the MAPCP demonstration. Vermont continues to experiment with multi-payer medical home payment through the MAPCP demonstration and Blueprint for Health. As noted above, it has also recently begun testing payment approaches under a SIM grant, including a shared savings ACO model, a bundled payment model, and a P4P model. These strategies are summarized in Table 4.

The current Vermont model for health system transformation also includes federal investments in health system infrastructure that will support delivery system redesign and state evaluation activities. These include implementation of electronic systems that can improve clinical and claims data transmission, integration, analytics, and modeling; expanded measurement of patient experience of care; improved capacity to measure and address health care workforce needs; health system learning activities essential to spreading models and best practices; and enhanced telemedicine and home monitoring capabilities.

Various elements of Vermont's multi-payer initiatives now encompass Medicare and Medicaid, as well as the state's three major insurers, Blue Cross and Blue Shield of Vermont, MVP Health Care, and CIGNA. The state's self-insured population—estimated to be around 105,000 covered lives (or 17 percent of the state's total population) in 2009<sup>15</sup>—includes state employees, who participate in multi-payer initiatives, as well as a large private employer that has tentatively agreed to participate in the medical home-based Blueprint for Health.

Table 4. Summary of Vermont Multi-Payer Activity

Component	Summary	Payment Model	Populations Served	Payers Participating	Type of Self-Insured Employers
PCMH (Blueprint for Health / MAPCP demonstration)	Advanced primary care practices work with multi-disciplinary community health teams to coordinate care for patients.	Primary care practices receive FFS payments plus PMPM fees tied to NCQA PCMH scores.	121 practices serving 514,385 Vermonters (82% of total state population as of Q4 2013).	Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA	State employees, IBM
Shared Savings ACOs	Team of health care providers takes responsibility for overall cost and quality of health care for a specific group of patients over a defined period of time.	Practices receive a risk-adjusted PMPM fee. Upside and downside risk by 2016. Quality requirements.	Expands the Medicare shared savings ACO model to include Medicaid and commercial payers across the state's ACO systems (Fletcher Allen and Dartmouth-Hitchcock).	Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA	State employees
Bundled Payments	Volume-based incentives are replaced with episode-based payments, which encourage collaboration and efficiency across providers and systems.	Retrospective, episode-based payment for acute and post-acute care. Upside and downside risk. Quality requirements.	Approximately 300 oncology patients in a defined area receiving primary, specialty, and hospital care. Approximately 100 patients receiving detoxification and additional services and treatment in an inpatient setting.	Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA	
P4P	Volume-based incentives are replaced with incentives for improving quality and efficiency of care.		Medicare will use P4P programs for all providers, Medicaid will work to expand P4P programs to all participating providers, and commercial carriers are expected to participate in varying scope.	Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA	

## Lessons Learned

### Success Factors

Vermont has made significant progress toward its overarching transformation goal of moving to a high-performance health system. Coordinated multi-payer activity is a linchpin in its current strategy. Individuals taking part in this study identified a number of factors contributing to the success of multi-payer efforts in Vermont, including:

- A strong history of ambitious health reform in the state, including the Blueprint for Health care coordination initiative in 2006 and Act 48 reform legislation, which required a move away from FFS payment beginning in 2011.
- Wide-ranging support for health system transformation, including executive support from the governor, legislative backing from the state assembly, and industry support from the state's commercial carriers.
- Close ties among major stakeholders in the state, including frequent interaction and a legacy of collaboration on myriad health reform initiatives.
- The presence of an independent group—the Green Mountain Care Board (GMCB)—tasked with improving health system quality while lowering costs for all Vermonters. The GMCB has far-reaching power, including the regulation of insurance rates, approval of hospital budgets and major expenditures, and testing of payment and delivery system reforms.

### Challenges

While multi-payer activity is widespread in Vermont, it is not without ongoing challenges—state officials and insurance executives have had some success recruiting self-insured public sector groups like state employees into reform efforts, but have made more limited inroads with the state's self-insured employer population. To address this issue, the GMCB continues to make overtures to self-insured employers in concert with the state's large carriers. IBM has recently expressed support in principle for participation in the medical home-based Blueprint for Health.

### Advice and Insights

State officials, insurance executives, and business leaders offered a number of insights for states looking to recruit self-insured employers into their reform initiatives: It is vital to create an echo chamber that includes the governor, state leadership, and insurance companies all highlighting the importance of coordinated multi-payer activity. Utilizing an open and inclusive process for convening stakeholders can facilitate widespread support across interest groups. And finally, while insurance carriers remain crucial participants in and important advocates for multi-payer activity, effective recruitment of self-insured employers likely requires concerted and sustained outreach beyond that of third-party administrators.

## Conclusion

Vermont leads state efforts with its health insurance payment and delivery system reforms and continues to actively test value-based payment approaches across multiple public and private payers. The state has made significant progress executing a medical home initiative among its Medicaid program and three largest commercial carriers—this initiative now includes essentially 100 percent of Vermont’s providers and a substantial portion of its residents. Recruitment of the self-insured population remains an ongoing challenge, though one large employer recently indicated an interest in participating. The state continues to engage other self-insured employers through GMCB and is committed to recruiting its entire population into its payment and delivery system redesign efforts.

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