

As Washington has sought to bring Medicaid spending under control, Utah has been charting its own path for the future of Medicaid, the federal-state health insurance program for Utahns living in or near poverty. That path is called accountable care, and the state took its first steps in that direction in January 2013 when its new *capitated care* (plans are paid a lump sum to care for a group of patients) contracts with Medicaid health plans took effect.

Accountable care changes the way we pay providers. Right now, we pay for each test or procedure—whether patients benefit or not. That gives the provider a perverse incentive to order more tests or procedures than may be necessary. Accountable care pays the provider to make patients well and keep them healthy. This is better for patients—and for taxpayers. The decisions made by the state and Medicaid health plans in the coming months will determine how successful Utah's Medicaid transformation will be in achieving the goals of better health outcomes and slower cost growth in Medicaid.



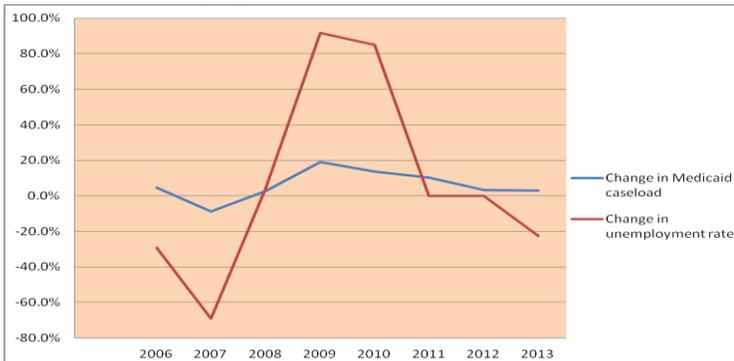
Jason Cooke moderates panel of Medicaid plans at the Better Care Conference: Collette Heaps (HealthChoice Utah), Russ Elbel (SelectHealth), Chad Westover (Molina Healthcare), Vicki Wilson (Univ. of Utah Healthy U)

### In the Beginning, There Was Senate Bill 180

When the Utah Legislature met in 2011, the state's revenue outlook was grim due to the lingering recession. Medicaid enrollment grew as thousands of Utahns lost their jobs, along with whatever employer-sponsored insurance they may have had. This was Medicaid doing its job, mitigating the worst effects of the Great Recession. Though growth in Medicaid enrollment was not exceptional, policymakers grew frustrated with the

Affordable Care Act's Medicaid "maintenance of effort" requirements. Utah Medicaid was already trimmed to the bone, and now Obamacare was telling them they could *never* cut back eligibility or eligibility standards. In the legislative session, a consensus emerged around a proposal by Senator Dan Liljenquist. [SB180](#) directed the Department of Health to apply for a waiver from certain federal Medicaid requirements. Embedded in the bill was direction to transform Utah Medicaid by moving to accountable care.

Utah Unemployment Rate & Medicaid Enrollment 2006-12



### The Specifics

While SB180 did not provide a lot of details on what Utah's transformed Medicaid program should look like, it did offer a few general directions.

**Provider Payment Reform:** Restructure payments to give providers incentives to deliver the most appropriate care at the lowest cost while maintaining or improving the health status of patients.

- Payments are *bundled* to cover the range of services delivered over entire episodes of illness instead of for individual services delivered at each encounter with the patient.
- Payments can also be used to reward providers for making a measurable contribution to the patient's health.



Andrew Riggle ([Disability Law Center](#)) speaks with René Markus Hodin ([Community Catalyst](#)) at Better Care Conference

*Patient Engagement:* Restructure incentives to reward patients for their efforts to maintain or improve their health. In the waiver request ordered by SB180, the state asked for flexibility on Medicaid cost sharing limits. Patients seeking care in the wrong settings were to be penalized and asked to pay more for services, despite all the research indicating that such measures reduce access to cost-effective care.<sup>i</sup> CMS (Centers for Medicare and Medicaid Services) rejected these and other harmful provisions of Utah's waiver. They did, however, approve the core focus on accountable care. As important as SB180 was in providing the impetus for the transformation of Utah Medicaid, SB180 left it to health department officials and stakeholders to build the right ACO model for Utah.

## Critical Elements of Accountable Care: Lessons from States and Local Best Practices

The good news is Utah is not alone in seeking payment and delivery system reforms for Medicaid.<sup>ii</sup> The experience of other states and of some of Utah's own health care systems provides lessons for the next, decisive stage of Utah's Medicaid transformation. From early innovators we know these are the critical elements of accountable care:

### Community-Centered Approach

States leading the way in Medicaid accountable care show some variation in approaches. But the one feature Oregon, New Jersey, Massachusetts, North Carolina and other prominent ACO states have in common is their engagement of the entire community in support of ACO goals.<sup>iii</sup> Utah leaders want to transform Medicaid in ways that limit cost growth and improve health. Stakeholders want the same things—why not bring them together to learn from other states and build on Utah best practices? State leaders will often point out that Utah is home to deep expertise in making health systems more effective while controlling costs. And they're right. That's why Utah should bring local expertise to bear on our ACO model.

### Patient-Centered Care: Health Homes

Accountable care changes the way providers work together in addressing their patient's needs. Creating an effective 'health home' puts the patient at the center of his care and gives him an alternative to seeking routine care in expensive settings like the emergency room.<sup>iv</sup> Utah's healthcare systems already are national leaders on this front. Intermountain Healthcare, for example, reduced preventable hospitalizations from just under 5% to over 19% and emergency room utilization by 7.3%.<sup>v</sup> University of Utah Health Systems is also deeply involved in implementing the health home concept.

### Beyond the Medical Model

While the medical home is a fundamental building block for Utah's Medicaid transformation, it also relies on a range of social services to succeed. Knowing which services are available and recruiting them to support patient care and wellness can mean the difference between making it to a doctor's appointment or missing it and then needing more expensive care later on. The resource that makes that difference can be transportation, or it can be a person the patient trusts in the neighborhood who keeps track of a patient's appointments. The health home pools knowledge of the patient's medical needs across their medical team. It also ensures everyone engaged in the patient's care is familiar with the patient's social situation and any barriers to care.<sup>vi</sup> Utah has a leg up on one proven strategy to address such barriers: community health workers. The research literature points to cost savings and better health outcomes in populations served by CHWs.<sup>vii</sup>

### UHP's Better Care Conference

In December 2012 UHP brought together a diverse audience of 150 representatives of the health plan, provider, consumer, advocacy, and state agency communities. At this conference, they heard from leading practitioners from Utah and around the country. Copies of the presentations can be found at <http://www.healthpolicyproject.org/Media.html>. Also see UHP's reading list on accountable care: [http://www.healthpolicyproject.org/Publications\\_files/Medicaid/2012/Better%20Care%20Reading%20List.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/2012/Better%20Care%20Reading%20List.pdf)

### **Tools and Incentives for Patient Engagement That Work**

Placing the patient at the center of care means making her an active participant in her own care. In this model, health care is no longer something that providers do *for* or *to* the patient. *It is what providers and patient do together as a team.* The patient is able to focus on getting well and on the activities that help her stay well or manage her chronic conditions. This deeper level of engagement in health and health care requires two critical assets: 1) knowing the patient and aspects of her life that support or block her participation; 2) providing tools and incentives to help her take charge of her health.<sup>viii</sup>

### **Continuity of Care through Enrollee Retention**

Like its predecessor model, managed care, accountable care functions best when patients stay enrolled in Medicaid. This consistency develops stronger ties to providers, thus facilitating better access to preventive care. But this goal does not describe the reality for many Medicaid patients. Enrollees move on and off Medicaid, many because their income hovers just below the eligibility threshold. Even the smallest pay increase from a job that doesn't offer insurance could disqualify them from Medicaid in the next month. Other enrollees fall off the program because of the hassle of renewing applications. Some states guarantee coverage for 12 months at a time—but not Utah.<sup>ix</sup> This and other simplification measures can bring efficiencies to Medicaid by improving continuity of care. A [robust navigator program](#) can also help enrollees keep their coverage current.<sup>x</sup> One of the key reasons why federal health reform expands and simplifies Medicaid enrollment is for the sake of improved access to preventive care and population health. A robust approach to accountable care should make it easier to sustain such worthy investments as the Medicaid expansion.



*Policymakers, advocates, and providers fill the room at UHPP's Better Care Conference*

## **Promising Utah-Based Initiatives to Bring Utah Accountable Care to the Next Level**

Utah stakeholders are mobilizing around key elements of the accountable care model. For example:

- The [Medicaid Reform Leadership Team](#), a UHPP-hosted collaboration of providers, community groups and advocates, and health plans has been working since passage of SB180 to build consensus around priorities in Utah's ACO process. During the first year, we facilitated input on the state's waiver request; hosted conference calls and face-to-face meetings with CMS officials through the waiver process; made the case for the new quality measures group, held a statewide [Accountable Care Boot Camp](#) and [Health Equity Summit](#) (see notes for both).
- [Take Care Utah](#), a UHPP-based "no-wrong door" enrollment assistance partnership with [United Way of Salt Lake](#) and its "[Promise Neighborhoods](#)" in and around Title I schools, is building a network of community-based navigators around the state. This effort includes enrollee retention as well as beneficial linkages to health homes. It is based at UHPP because it seeks to leverage policy opportunities to maximize enrollment and patient engagement in health homes. For the 2013 session, we are crafting legislation with Sen. Luz Robles to extend the use of community health workers in Utah's ACOs, building on the success of strategies used in the Promise Neighborhoods. UHPP is also working to [amend emergency room diversion legislation](#) to include proven community and health home strategies.
- The Utah Partnership for Value-Driven Health Care, a community collaboration spearheaded by [HealthInsight](#), created a "health homes" working group charged with identifying health home models and adapting them for Utah.
- [UPIQ, the Utah Pediatric Partnership to Improve Health Care Quality](#) is coordinating a community collaboration around pediatric asthma.

## **Critical Activities for State and Community Leaders in 2013**

### **Strategic Planning**

Transforming Utah's Medicaid program will be a multi-year process. Health plans must put in place new technology and business processes to support coordination across all providers. The state's provider culture must gradually adapt to the changes in care delivery and payment methodologies. The Medicaid Division, for its part, should play a prominent role in monitoring these activities and measuring results. Utah still needs a multi-

year strategic plan that ensures that we take the necessary and proper steps toward fully realized accountable care (see [Oregon planning process materials](#)).<sup>xi</sup> That plan should be developed in a community-wide collaboration led by the Department of Health.

### **Evaluation that Engages Community Input**

The term “evaluation” is often viewed as a judgment on the performance of entities charged with implementing a project. But in this case, evaluation should be seen as a taking stock of progress and identifying any needed course corrections. The community’s role does not end with the planning process. Community stakeholders must be engaged in assessing progress every step of the way. The Leadership Team is the logical facilitator of community engagement in evaluation. With ears to the ground in communities with high Medicaid enrollment, Take Care Utah is well positioned to monitor the changes in care delivery as they unfold.

### **Conclusion: Guideposts on the Road to Accountable Care**

Attempting to change, let alone transform, a program as complex as Medicaid does not follow a straight line. Deviations from that line have to be dealt with within the framework of a set of basic principles. Utah is well-served to look to the experience of other states—as well as its own thought leaders—in assembling that framework. Many of those states, communities, and Utah thought leaders were brought together by UHPP at its Better Care conference on December 14, 2012. A series of guideposts emerged from that meeting which can serve as the starting point for a set of basic principles. They are:

- Just as it takes a coordinated team to care for the patient, it takes a community-wide team to make the ACO model work for patients who need it most and thus represent the greatest potential for savings to the Medicaid program.
- But accountable care is about more than saving money. It is about changing what the components of the Medicaid system do and how they interact with each other. It is about minimizing waste and over-use in that system to free up resources for worthy uses for Medicaid dollars: like the Medicaid expansion.
- Think beyond the medical model. Think in terms of a *health* model that marries the medical component with community resources that enable the patient to be an active participant in the maintenance of her own health.
- Maximize proven community resources, like community health workers, to extend the capacity of the ACOs.
- Gain sharing (that portion of savings that is used to reward providers for improving health outcomes) should be shared by the plans and providers; a portion of savings should be re-invested in proven areas of the program.
- Knowing the patient as a whole person – not just the condition that required him to seek care in the first place, but the totality of his health, is essential. That means understanding his life circumstances, many of which can positively or negatively affect their physical and mental health.
- Do what works in patient incentives. Follow what little science there is on the issue.<sup>xii</sup>
- Don't let other issues distract from the commitment to accountable care. Budget and policy debates will come and go. But when it comes to better health for Utahns enrolled in Medicaid and managing costs, this is where the action is.

<sup>i</sup> L. Ku & V. Wachino, “The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities (July 7, 2005). <http://www.cbpp.org/files/5-31-05health2.pdf>.

<sup>ii</sup> Track state Medicaid accountable care initiatives here: <http://www.nashp.org/quality-cost-and-health-system-performance/aca-implementation-state-health-reform/acos>. Also see Kaiser Family Foundation, Emerging Medicaid Accountable Care Organizations: The Role of Managed Care, May, 2012. <http://www.kff.org/medicaid/upload/8319.pdf>

<sup>iii</sup> National Academy for State Health Policy, On the Road to Better Value: State Roles in Accountable Care, 2011. <http://www.nashp.org/publication/better-value-state-roles-promoting-aco>.

<sup>iv</sup> Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System, Hasselman, D. and Bachrach, D., Center for Health Care Strategies, June 2011 accessed January 30, 2013 at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261271](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261271)

<sup>v</sup> Fields D, Leshen E, and Patel K., “Driving quality gains and cost savings through adoption of medical homes,” Health Affairs, May 2010; 29(5): 819-826.

<sup>vi</sup> The Camden Model; An Integrated, Community-Led, Safety Net Accountable Care Organization, presentation by Joseph Fleming, UHPP Better Care Conference, December 2012, [http://www.healthpolicyproject.org/Publications\\_files/Media/2012/BC%20Conference/Fleming-The%20Camden%20Model.pdf](http://www.healthpolicyproject.org/Publications_files/Media/2012/BC%20Conference/Fleming-The%20Camden%20Model.pdf).

<sup>vii</sup> Center for Public Policy and Administration, Community Health Workers in Utah: An Assessment of the Role of CHWs in Utah and the National Health Care System, 2012. <http://www.health.utah.gov/disparities/data/CommunityHealthWorkersInUtah2012.pdf>

<sup>viii</sup> Patient Incentives in Medicaid, presentation by Lydia Mitts, Families USA, at the UHPP Better Care Conference, December 2012 accessed online January 30, 2013 at [http://www.healthpolicyproject.org/Publications\\_files/Media/2012/BC%20Conference/Mitts-Patient%20Incentives%20in%20Medicaid%20\[Compatibility%20Mode\].pdf](http://www.healthpolicyproject.org/Publications_files/Media/2012/BC%20Conference/Mitts-Patient%20Incentives%20in%20Medicaid%20[Compatibility%20Mode].pdf)

<sup>ix</sup> Kaiser Commission on Medicaid and the Uninsured, Coordinating Care and Coverage in Medicaid and the Exchanges, October, 2010. <http://www.kff.org/healthreform/upload/8118.pdf>.

<sup>x</sup> Using Data to Drive State Improvement in Enrollment and Retention Performance, Trenholm, C., Harrington, M., Snyder, A., and Weiss, A., Robert Wood Johnson Foundation, December 2011 accessed January 30, 2013 at [http://www.nashp.org/sites/default/files/data.drive\\_state\\_improvement.enrollment.retention.performance.pdf](http://www.nashp.org/sites/default/files/data.drive_state_improvement.enrollment.retention.performance.pdf)

<sup>xi</sup> Oregon Health Authority, *Oregon Health Care Innovation Plan Submitted to Centers for Medicare & Medicaid Innovation*, September 21, 2012, <http://cms.oregon.egov.com/oha/OHPB/healthreform/docs/or-health-care-innovation-plan.pdf>

<sup>xii</sup> Lydia Mitts/Families USA, *Patient Incentives in Medicaid* (PPT)

[http://www.healthpolicyproject.org/Publications\\_files/Media/2012/BC%20Conference/Mitts-Patient%20Incentives%20in%20Medicaid%20\[Compatibility%20Mode\].pdf](http://www.healthpolicyproject.org/Publications_files/Media/2012/BC%20Conference/Mitts-Patient%20Incentives%20in%20Medicaid%20[Compatibility%20Mode].pdf)