In 2015, Urban conducted case studies examining health care stewardship in five states: Colorado, Minnesota, Ohio, Oregon, and Vermont. Stewardship demands active pursuit by governments of systemwide improvements, beyond typical public health and purchasing roles. This means developing a strategic framework for a health policy that reaches all citizens, building support among stakeholders, regulating and monitoring health care systems, and using data to improve. Through a series of on-the-ground interviews, we examined the unique ways states have leveraged their authority to improve the quality and efficiency of health care systems. To learn more or read the other case studies, visit http://www.urban.org/policy-centers/health-policy-center/projects/health-care-stewardship-case-studies.

Overview

Colorado Governor John Hickenlooper has stated his goal that Colorado be the healthiest state in the nation. His approach consists of four elements: improving prevention and wellness, expanding coverage access and capacity, improving health system integration and quality, and enhancing value and strengthening sustainability (Office of Governor John Hickenlooper 2013). The state’s initiatives to pursue this goal are aligned with, and in many respects supported by, a group of state-based health foundations. Key among them is the Colorado Health Foundation—the third-largest health foundation in the country—which embraces Governor Hickenlooper’s goal. Study participants made frequent reference to the “healthiest state” goal as well as the Triple Aim.1

This case study focuses on health system improvement. Colorado State government leaders were quick to point out their significant efforts and achievements regarding prevention and wellness. They
also note that strong leadership was required to secure gains in insurance coverage given the state’s “purple” politics. Accordingly, this report describes only a slice of the state’s overall approach, but it is a slice critical to achieving the state’s goal and one that enables direct comparison to the approaches other states are taking.

Two of the state’s many initiatives stand out as central to the health system improvement agenda. These two initiatives build upon changes to the state’s Medicaid program, but leaders within Colorado state government view these initiatives as the foundation for health system improvements that will ultimately affect the entire population’s health.

In 2011, Colorado launched the Accountable Care Collaborative (ACC), which created seven Regional Care Collaborative Organizations (RCCOs) responsible for supporting primary care providers in their network, assisting with beneficiary care coordination, and connecting beneficiaries to social services. RCCOs receive a capitation payment for care coordination and community integration, and they assume financial risk on a small portion of those payments based on certain health outcomes of all Medicaid enrollees within a geographic area. The RCCOs are viewed by state government as the platform for system integration.

In 2013, Colorado was awarded a Model Design grant under the State Innovation Models (SIM) program of the Center for Medicare and Medicaid Innovation (CMMI). The SIM plan focuses on the integration of behavioral health and primary care and builds off of a patient-centered medical home model, with a goal of 80 percent of Coloradans having integrated primary care and behavioral health services. To this end, the state plans to leverage the Medicaid program as a payer and use some private carrier participation to spread the integrated model. In December 2014, Colorado received a model testing award in the second round of SIM grants, providing the state with $65 million to support the initiative. Governor Hickenlooper also recently announced the creation of the Office of the State Innovation Model to coordinate the funds and the initiative.

Although the state has a clearly articulated goal of improving the health of all citizens of the state (as is consistent with the concept of stewardship), as of the date of interviews the steps needed to achieve the stated goals are somewhat unclear. Although the aspirational concepts are broadly agreed upon, the mechanism for spreading the improvements incubating in the Medicaid system to the state’s larger health care system is undecided. The approach the state uses to achieve consensus among stakeholders—a focus on broad goals but not the necessary implementation steps—can create the impression of more progress than has actually been made. Although the Medicaid program is moving forward with its initiatives, the need for harmony among diverse private actors may hinder the model’s extension to the broader population.

Political and Policy Context

Colorado’s electoral composition places it firmly in the category of a “purple” state. Governor John Hickenlooper is a Democrat, and the state has had a Democratic governor for more than 30 of the past
40 years. For most of that period, Republicans have controlled both houses of the legislature. Republicans now hold a majority in the senate, and Democrats have the majority in the house, but the margins are narrow and party control has shifted several times in the past decade.

From these centrist politics health reform initiatives have emerged that reflect the state’s emphasis on practical, nonideological solutions. In the 1980s, Colorado was one of many states to adopt small group health insurance reforms, such as guaranteed issue, guaranteed renewal, and limitations on pre-existing condition exclusion, as mechanisms to expand access to coverage. In 1992, the Republican-controlled legislature passed a bill, signed into law by Democratic Governor Roy Romer, to study a statewide universal health insurance proposal known as ColoradoCare (Colorado Health Institute 2007, 6). The Colorado Department of Health Care Policy and Financing (HCPF) was created in 1994, emphasizing the state as purchaser and institutionalizing a policy capacity within the executive agency.

Most observers mark the start of the state’s current health reform initiatives with the creation of the 208 Commission, a blue ribbon commission that was signed into law by Republican Governor Bill Owens in 2006 but that met and made its recommendations during the tenure of Owens’ successor, Democratic Governor Bill Ritter.

The Commission’s charge was “studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents.” It examined five comprehensive reform proposals and issued 32 recommendations in January 2008. The recommendations were adopted by 24 of the 27 commissioners, making it a broad consensus statement regarding what was needed to improve Colorado’s health care system. A comment frequently heard in our interviews was that the Affordable Care Act (ACA) included many of the provisions the state had embraced from the 208 Commission. The state worked to implement several of the Commission’s recommendations to increase coverage, access, value and transparency for consumers, many of which were accelerated by opportunities in the ACA, as described below.

In 2011 Colorado passed legislation to have the state create its own health insurance exchange (called Connect for Health Colorado), and in 2013 legislation expanded Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level. These bills passed despite some Republican opposition and were signed by Governor Hickenlooper, who supported them (Hill et al. 2012).

These events occurred during a period of tremendous growth in the Medicaid program. Average monthly enrollment in Medicaid has increased 61 percent since the enactment of the ACA, the fifth-largest increase across all states and a rate that has exceeded initial estimates for the Medicaid expansion (Colorado Health Institute 2013b). Colorado ranks near the national average of per capita Medicaid costs, but the average annual cost growth since 2007 ranks among the highest.

Three additional elements of Colorado’s political and policy environment arose in our conversations as particularly relevant to the current policy discussion: the state’s experience with Medicaid managed care, the existence of a competitive commercial health insurance market, and spending constraints imposed by the electorate.
Medicaid Managed Care

Like most states, Colorado moved the vast majority of adults and children into Medicaid managed care plans in the 1990s. That system unraveled, in part because of a lawsuit brought by the health plans challenging how the state set its capitation rates. By 2011, fewer than 10 percent of Colorado’s Medicaid enrollees were in comprehensive managed care plans, making the state an outlier compared to the rest of the country. Many stakeholders in Colorado think that Medicaid’s experience contracting with managed care has failed and that the state must find a different approach to cost control and health system integration in that program. Mental health is a notable exception to the state’s use of direct contracting in the Medicaid program. In 1995 the state moved to capitated regional behavioral health organizations, and that structure remains in place.

Commercial Health Insurance Market

Colorado has an unusually competitive private insurance market. The largest insurance carrier only has a 33 percent market share, one of the lowest in the country. Colorado has seven commercial carriers with at least 5 percent market share. Twenty carriers participated in the state’s marketplace for the 2014–15 plan year, up from 18 in 2013–14, and insurance rates statewide increased less than 2 percent (Colorado Health Institute 2014).

The Taxpayer Bill of Rights

In 1992, Colorado voters adopted the Taxpayer Bill of Rights (TABOR), which caps state spending growth at inflation plus population growth and tightly constrains new revenue sources. A unique feature of TABOR is the requirement that excess revenues be rebated to taxpayers, meaning that even when revenue grows because of economic growth, the new revenue cannot be spent if it exceeds the TABOR spending formula. TABOR creates a zero-sum environment for state budgeting, which places tremendous pressure on the Medicaid budget and dramatically increases the barriers to adopting any state initiatives that require state spending. In 2009, the legislature passed a bill authorizing HCPF to assess a hospital provider fee to generate matching funds in Medicaid that would increase access or improve quality. That bill allowed HCPF some latitude to circumnavigate strict TABOR restrictions and made an expansion in Medicaid eligibility possible, but the Medicaid program still faces strong pressure to minimize cost growth.

State Goals

The overarching goal for Colorado’s health system improvement is to make Colorado the healthiest state in the nation. That goal is embedded within the governor’s broader goal of economic development, with good health and an efficient health care system as necessary inputs to a successful economy. The vision outlined in the governor’s State of Health proposal focuses strongly on public health, integrated care and prevention, and payment and delivery reform (Office of Governor John Hickenlooper 2013). The SIM initiative has specific goals, and Governor Hickenlooper’s plan includes a range of explicit
numeric goals, such as ensuring 7,500 Colorado children visit the dentist before age one and recruiting 148 additional primary care providers (Colorado Health Institute 2013a). But those goals were rarely mentioned in interviews, suggesting that they serve as internal benchmarks rather than as sources of public accountability.

**View of the State’s Role**

As described by study participants, the state government has a legitimate and important role in improving the health care system. This perspective was always qualified by the statement that the state only acts once stakeholders have reached a consensus. The state acts as a convener and a consensus builder, but it does not strongly wield its authority. There is a strong bias in Colorado against regulation and public spending. To overcome this bias, stakeholders must clear the path for public action. As one participant noted, “When I first came [to Colorado] I asked which legislator was sponsoring [legislation], and now I ask which advocacy organization is sponsoring through the legislator.”

**Leadership**

Over the years, leadership on health policy has emerged mostly from the governor’s office, although each governor has treated health policy with different importance. Each governor did not seem to have fundamentally different health care goals, but rather the amount of leadership exercised on the topic varied. Views of the current administration are mixed: Governor Hickenlooper is generally seen as supportive of health system improvement, but he is not making health a particularly high priority. When he has focused on health, it has often been on elements outside the scope of our inquiry (such as prevention and coverage).

Over time, different handfuls of legislators have taken the lead on health care issues. Most members of both political parties have given deference to the views and perspectives of those leaders, but term limits and the shifting majority control of the legislature have limited those leaders’ power.

A group of health-oriented foundations led by the Colorado Health Foundation are considered critical to developing, promoting, and sustaining the health agenda. Those foundations provide both continuity that the political sector lacks and resources, particularly for research and analysis, that are almost impossible to secure in public budgets. The foundations also support stakeholder convenings, an approach that mirrors the consensus-building approach of the public sector. The Colorado Health Foundation has committed to 10 years of delivery reform funding and is convening a work group of stakeholders throughout the state, consisting of private and governmental entities, to help organize a “collective impact” grantmaking agenda.\(^{15}\)
Authority

As do all states, Colorado has direct authority over Medicaid program administration. The ACC initiative, the SIM program, and other activities (such as expanding patient centered medical homes) all emerge from the state’s executive branch authority.

One important outgrowth of the 208 Commission was the recommendation to create an all payer claims database (APCD); the APCD’s creation was authorized by the state legislature in 2010. Responsibility (but not funding) for creating the APCD was given to HCPF. HCPF selected the Center for Improving Value in Health Care (CIVHC) as administrator of the APCD, and it was implemented in 2011.

Colorado has used other sources of authority little to promote broad health system improvement for all Coloradans. With few exceptions, efforts by the Division of Insurance or the Department of Public Health and Environment do not appear to reach beyond their traditional functions into support for broad health system improvements. Interviewees made little mention of the purchasing power of state employees as a lever for health system improvement.

Colorado has taken advantage of new authorities created by the ACA. In addition to expanding Medicaid and creating its own health insurance exchange, Colorado is a statewide site in the CMMI-initiated Comprehensive Primary Care Initiative and a participant in the SIM initiative. In an environment with limited state funding, these CMMI initiatives attract significant private sector attention, in part because of the federal resources they bring.

Leverage

Colorado has leveraged funding and state programs to encourage system change. Public initiatives, particularly SIM, are intended to influence private markets and thereby generate system change. Although SIM is a recent program, it is backed by a sizeable federal grant and has already generated much stakeholder interest in pursuing new reforms. Despite such initiatives, nongovernmental stakeholders indicate that the state has yet to wield its leverage to the fullest extent. Moreover, much of the direct action taken in the Medicaid program appears to stem from the fear of failing at cost containment and moving "backwards" into Medicaid managed care. Colorado implemented Medicaid managed care in the 1990’s but the effort was, according to one state leader, “spectacularly unsuccessful.” The state subsequently lost a lawsuit over the capitation rate setting. Now, fewer than 10 percent of enrollees are in comprehensive managed care, and there is little interest in returning to traditional Medicaid managed care.16
Federal Role

Federal support has played an important role in furthering Colorado’s agenda. Opportunities through the ACA, such as the Medicaid expansion and premium tax credits, have allowed the state to achieve its goals of expanding coverage and reducing the number of uninsured residents. With these problems addressed if not resolved, the state’s focus has shifted to improving the organization and delivery of care. The SIM initiative provides both funding that allows the state to experiment with approaches to delivery system reform and an opportunity to concentrate efforts in the public and private sectors.

Role of Medicaid

The current era of health system improvement led by Medicaid began with the ACC initiative, launched in 2011. The ACC is a primary care program within Medicaid designed to improve health and reduce costs. The program provides care through patient-centered medical homes to Medicaid beneficiaries and employs RCCOs to coordinate among providers and connect beneficiaries to services. According to HCPF, the ACC program serves 58 percent of Medicaid enrollees and has generated net savings of about $30 million after administrative expenses (Accountable Care Collaborative 2014).

One of the SIM project’s goals is for 80 percent of Coloradans to have integrated primary care and behavioral health services. In Medicaid, the integration will build off the ACC model; private payers will design their own integration models. So far, six insurers have agreed to participate. Medicaid is also piloting a payment reform program, the Accountable Care Collaborative Payment Reform Initiative, also called Medicaid PRIME, in which Rocky Mountain Health Plan is implementing global budgeting, global payment, gain sharing, and behavioral health integration. The pilot, established in statute in 2012, was initially created to produce Medicaid savings, but the state views the pilot as the basis for expanding the model beyond Medicaid and into the larger health care market.

Structures and Processes

Colorado relies heavily upon nongovernmental commissions and organizations to define and guide the state’s health system improvement agenda. These entities generally use a consensus-based process that can be slow and iterative, but it helps sustain momentum regardless of political leadership.

The 208 Commission described earlier is considered the starting point for the Colorado’s current round of health system reforms. In 2014, bipartisan legislation created the Colorado Commission on Affordable Health Care. This commission was charged with analyzing health care costs and making policy recommendations to the governor and the legislature over the next three years to lower state health care costs. That commission’s charge overlaps somewhat with that of the 208 Commission, and the two commissions have similar stakeholder composition and several overlapping members.
In addition to those high-level commissions, state stakeholders convene several workgroups and meetings. Some stakeholders indicated that they feel spread thin by needing to be present and vocal at dozens of commissions, workgroups, and meetings throughout the state. Deference to consensus means that input to policymakers, particularly legislators, comes at least as much through consensus groups as through direct lobbying.

Colorado’s heavy reliance upon consensus has some significant benefits. Stakeholder input is inherent in the policy development and implementation process and many stakeholder viewpoints are solicited before action is taken. Further, the stakeholder process is real: participants feel that their voices matter and affect policy.

But relying on consensus has some costs as well. Consensus is slow to develop and is often achieved by watering down proposals, limiting their likely effects. Reliance upon the same stakeholders keeps the public out of many discussions. Public processes, such as legislative hearings, give way to less accessible forums, such as commission meetings. The mechanisms by which committees and commissions come to agreement can be more opaque than such traditional public processes as debates over legislation. One telling comment made by a participant was that the consensus-based process employed in Colorado makes it very easy for all of the system actors to agree at a high level because they know it is unlikely they will ever be compelled to act against their interests. Despite the rhetoric supporting greater efficiency, none of the stakeholders has been asked to give up anything important, including revenue. These limited expectations have made it possible to sustain consensus but have also decreased the odds that real system change will occur. According to one interviewee, “On one level the goal is shared, but how you get there and move forward is another story.”

It is not surprising that the informants we spoke to were generally supportive of the consensus processes, because many of them are designated participants in those processes. Some did raise concerns about the exclusion of the public and the problem that legislators, who serve part time and face term limits, are less exposed to policy issues than they would be if they were more closely involved in substantive discussions.

In some respects, Colorado’s reliance upon consensus is unavoidable. The politics of the state do not lend themselves to strong policy pronouncements, much less formal initiatives, far from the political center. Tax and spending limitations mean action can only occur when consensus exists. And the absence of a single dominant payer, health system, or employer means that change only occurs through collective action. As one interviewee said, “If we don’t fix this, no one will.”

Colorado also relies upon public-private partnerships that operate outside of state government to carry out important tasks. Three such institutions are CIVHC, the Colorado Regional Health Information Organization, and Connect for Health Colorado (the state’s health insurance exchange or marketplace). Each of those organizations was chartered by the state, given a modest amount of money to begin operations, and was then expected to become financially self-sustaining.

Colorado’s culture of relying upon these nongovernmental entities for critical functions creates opportunities for success that would not exist if those entities were part of state government.
Independence provides continuity across political transitions and creates multiple loci of leadership and creativity. Another interesting benefit that emerged from our discussions is that a lack of public support forces these entities to succeed in the marketplace, making them more responsive to their customers’ needs than they might be if they received public funding. According to one participant, “[These organization’s] separateness...helps [them] do it for all Colorado, not just Medicaid and not just CHIP.”

But this proliferation of organizations also creates barriers. A common theme from our interviews was the lack of coordination across entities and the lack of a coherent vision to guide their work. As with the commission processes described above, the spreading of responsibility across organizations creates fatigue among stakeholders who have to participate in many meetings and discussions to assure that their voices are heard. Further, many functions depend upon ongoing support from philanthropy, which is not guaranteed.

**Strategy for System Change**

Despite the clearly articulated goal of improving health for all Coloradans, and despite the view of those in state government that health system improvements initiated by Medicaid would spread to systems that serve all residents, interviewees saw little clarity in how this spread would happen. As noted, Medicaid has created new institutions (such as RCCOs) and is working with private actors (such as Rocky Mountain Health Plan and Kaiser), and the state has organizations with broad system improvement goals (such as CIVHC). Private-sector actors are aware of the goals and have embraced at a high level the need for greater efficiency and integration. But the actual mechanism for spreading improvements through the health care system is unclear.

In some respects, the anticipated pathway for spreading Medicaid delivery system improvements to the private sector is rooted in circumstances particular to Colorado. With the failure of capitated managed care, the Medicaid program reverted to its fee-for-service roots. Without comprehensive managed care contracts, each Medicaid initiative (RCCOs, behavioral health integration, and the like) creates an opportunity to negotiate health system changes with indigenous private actors, such as health plans and health systems. The stakes in these negotiations are high. There is a shared perspective that “unless we do something we will go back to traditional managed care in Medicaid.” If health system changes take root, they occur in partnership with private actors, and it is the state’s expectation that health systems changes initiated by Medicaid will then spread to the rest of the health care system.

Ample activity throughout the private sector aligns with the state’s goals. Health systems are participating in Medicare’s accountable care organization programs and similar models in the private sector. Rocky Mountain Health Plan is a nationally recognized leader in organizing and delivering low-cost, high-quality care. Kaiser Health Plan, an integrated system, has a significant presence in the state. Denver Health is often cited as a leader in care integration among public systems.

But interviewees said little ties these activities to the state’s overall goals. The absence of a dominant health plan, as well as the sense that larger employers are disengaged from the process
because of their defined contribution approach to health benefits, leaves a leadership vacuum. Investments in primary care and care integration may be occurring, and these actions are aligned with overall system goals, but the proliferation of initiatives does not equate to an overall strategy.

Many participants inside and outside of government expressed the view that the state’s pursuit of funding opportunities, particularly federal opportunities, leads to a “constellation of initiatives” that do not always connect. Although each initiative may play a role in improving the health care system, the relationships across those initiatives may not be clear. In particular, data collection initiatives, monitoring systems, and performance metrics proliferate. According to one participant, “We go wide but never deep.” Many informants hoped that the new SIM initiative would bring these various tracks together, but it is too early in the process to know if that will happen.

Progress to Date

When asked about progress to date, participants focused on processes such as the creation of RCCOs and the launch of the APCD. The absence of reported progress on outcomes (other than reported savings associated with the RCCOs) reflects the infancy of some of the initiatives, the lack of agreement on measures of success, and data limitations. According to the ACC 2014 annual report, the collaborative saved on net around $30 million dollars (Accountable Care Collaborative 2014). The report also indicates modest success at reducing emergency room visits, high-cost imaging, and hospital readmissions in some populations.

Data are a major component of the SIM initiative, and the state plans to build a data hub that draws upon multiple data sources, including clinical, claims, and public health. Such data will enable the creation of a baseline and robust monitoring of performance going forward. However, this system is not yet in place.

The consensus-based processes the state employs can also create an illusion of progress when little has actually occurred. Agreement on broad goals does little to further the actual steps necessary to achieve improvement. In particular, fundamental changes, such as imposing resource constraints or shrinking the size of some organizations, are unlikely to even be discussed in consensus processes. Meaningful progress towards system change will prove challenging if all parties must constantly be in agreement.

Sustainability

Colorado’s reform efforts seem to transcend gubernatorial administration because of the practice of gaining broad stakeholder consensus before the state takes action. The constant engagement of stakeholders in discussion provides important continuity. The periodic engagement of high-level commissions, such as the 208 Commission and the new Commission on Affordable Health Care, keeps the state focused on critical health system goals. There was some consensus among interviewees that the general course of health system change under way will continue into the future regardless of the
elected political leadership. There was also some concern that stakeholder agreement does not extend to the public and the electorate and that the changes to date remain fragile unless the public fully understands their importance.

Conclusion

Based upon our interviews, it appears that much of the Colorado health community embraces the concept of stewardship: the notion that the state has responsibility for improving the quality and controlling the costs of the health care system. This view was shared by those inside and outside government.

Colorado carries out this role primarily through building consensus rather than by exerting its legal authority. Under such a model, the state focuses on establishing high-level goals and relies heavily upon private actors to define and execute the course. The Medicaid program can be a source of innovation and action, but the extension of its own program administration to the broader health care system is thus far limited. Although interviewees largely agreed on the goal of improving the health of Coloradans and the health care delivery system, there is markedly less agreement on details of the mechanism for improvement and measures of success. The collaborative and consensus-driven culture identified by interviewees, along with leadership diffused throughout various stakeholder groups, has led to a wide range of initiatives and a sustained effort at reform spanning across administrations. However, this approach to reform can be slow and iterative and has created several programs focused on specific issues within the delivery system but that lack a cohesive vision. Although the state has succeeded at defining goals and a vision for system change, actual reform will require movement beyond aspirations.

Notes

1. As defined by the Institute for Healthcare Improvement, the Triple Aim is the pursuit of three dimensions: improving patient experience of care, including quality and satisfaction; improving the health of populations; and reducing per capita cost of health care. See “The IHI Triple Aim,” Institute for Healthcare Improvement, accessed November 18, 2015, http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx.


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