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

Government leadership in reforming Minnesota’s health care delivery system is facilitated by a long history of bipartisan collaboration across many private stakeholders. To paraphrase one participant, Minnesota is the “land of 10,000 collaborations.” In the mid-1990s, at least a dozen large self-insured Minnesota-based companies formed the Buyer’s Health Care Action Group (now the Minnesota Health Action Group) and began contracting directly with provider systems, steering patients to low-cost providers through tiered cost sharing. These arrangements did not stick, and in the 2000s Minnesota’s large self-insured employers turned to employee cost-sharing to limit their spending. Today, employers are less directly engaged in broader health reform activities occurring in Minnesota. But their cost concerns have fueled insurer and provider initiatives to slow commercial health care cost growth through total cost of care (TCOC) contracts (arrangements similar to accountable care organizations) and related quality measurement activities. Until recently, insurers have restricted their reform
activities to the commercial side of their business, and the state government for the most part has not taken part in these efforts.

With passage of Minnesota’s 2008 health care reform law, the Republican governor and the legislature collaborated across party lines to assert state leadership in payment and delivery reform, focusing on primary care. In 2010, moved by fiscal concerns, the new Democratic governor advanced Medicaid’s role in the reform process, incorporating delivery initiatives into payment contracts that resemble, but have greater provider accountability than, arrangements emerging in the private sector. Private- and public-sector health reform is moving in a similar direction, but with its Medicaid contracts and other authorities, state government is now seeking to align payment policy across payers in the state. These initiatives, alongside the state’s active use of its authority on quality reporting, have generated some controversy among stakeholders.

State initiatives began in 2007 with legislation establishing patient-centered medical homes, referred to as health care homes (HCHs), for medically complex patients enrolled in Medicaid. In 2008, the state legislature built upon these efforts by passing landmark legislation requiring that Medicaid, the state employee health plan, and private insurers participate in the HCH initiative; it also required the development of certification standards for HCHs. The legislation also gave state government the authority to create a minimum of seven “baskets of care,” or bundles of services provided to treat specific health care conditions or episodes of care. Further still, the 2008 legislation called for the creation of a statewide quality reporting program and an all-payer claims database (APCD). However, the APCD’s use was limited to the provider peer grouping (PPG) initiative, the purpose of which was to measure health care value by comparing quality metrics and TCOC to identify the state’s most effective providers. State resources and authority regarding baskets of care were limited, and providers showed little interest in using them. State government had some difficulty, and providers actively opposed, implementing the PPG initiative. In response, the legislature suspended the initiative in 2014 and authorized the state to use the APCD’s data for other purposes, specifically to evaluate other initiatives.

In 2010, driven by fiscal concerns, the state legislature enacted more aggressive payment reform in Medicaid, authorizing the Department of Human Services (DHS) to establish TCOC contracts in alignment with similar contracts in the private sector. State Medicaid contracts actually went beyond commercial contracts with regard to the types and size of participating providers, the scope of services and quality metrics, and the degree of financial risk. With those contracts, state government not only aimed at alignment but also sought to (1) improve primary care and care coordination consistent with the HCH model, (2) integrate acute and long-term care and social service supports, and (3) give providers financial incentives to reduce cost growth. In addition, the state government pressured the managed-care plans with a one-time cap of 1 percent on their Medicaid margins (thereafter targeted at 2 percent) and instituted a competitive bidding process with its Medicaid managed care contracts.

State officials are using several tools to shape not only Medicaid but also commercial insurance and the overall health care system in the state. The state government (DHS and Minnesota Department of Health [MDH]) is using a Center for Medicare and Medicaid Innovation State Innovation Model (SIM) testing grant to achieve goals related to payment and care delivery reform with the intent of integrating
medical care, behavioral health, long-term care, and social services to improve the health of individuals and communities.

Although private- and public-sector health reform initiatives have similar goals, stakeholders express concern about both the Medicaid agency’s pressure on managed care plans and providers and the MDH assertion that it has authority to use data that providers are required to submit pursuant to the state’s quality rule for public health purposes.

Political and Policy Context

Minnesota is led by Democratic Governor Mark Dayton, who was elected in 2011 after a four-year hiatus following his service as a US Senator for Minnesota from 2001 to 2007. Governor Dayton’s election marked a shift in the partisan control of Minnesota’s executive branch, which was under the leadership of Republican Tim Pawlenty from 2003 to 2011. For the first two years of Governor Dayton’s term (2011 and 2012) the state legislature was led by Republicans in both houses. In 2013, Democrats gained majority control of both houses and created the first unified state government in over two decades—an arrangement that ended when Republicans gained control of the House of Representatives in 2015.

Also in 2013, Governor Dayton signed legislation approving the creation of MNSure, the state’s insurance Marketplace. The state’s health insurance exchange rolled out in 2013 and was plagued with major technical flaws and management problems. These failures have undermined the state government’s credibility and contributed to the perception that the state government lacks the technical capacity to manage and analyze health care data.

Enrollment in Minnesota’s Medicaid and CHIP programs has grown 19 percent since the passage of the Affordable Care Act (ACA) and now includes 19 percent of the state’s residents. Minnesota chose to expand Medicaid under the ACA and is the ninth-highest Medicaid spender in the country per enrollee. Cost growth decreased from an annual average of 7.0 percent per year over fiscal years 2007–10 to an annual average of 5.5 percent over fiscal years 2010–13.

State Goals

Minnesota’s adoption of HCHs predated the ACA’s promotion of medical homes. Fiscal pressure and new political leadership led state government to assert greater responsibility over statewide delivery and payment reform (guided by the “triple aim,” according to officials and most stakeholders), improving the care experience and health of the population while reducing per capita health care costs. Of particular concern to state public health officials are health disparities across the state, which they aim to address by extending TCOC contracts, SIM initiatives, and other measures. The state government’s goals are driven by both cost and quality. Cost containment goals are accompanied by clinical guidelines, protecting consumers to the extent possible given the available quality metrics.
View of State’s Role

Stakeholders perceive the Dayton administration as having moved state government from collaboration to health system reform. Private actors are pushing back on state initiatives in both payment arrangements and public health. The state government, payers, and other stakeholders want to align their payment and delivery system reform activities more closely, but they disagree over whether the public or private sector should lead those efforts. With regard to public health, one participant summarized, “The state health department sees its authority as broad and strong and very clear. Stakeholders feel that may be true but there hasn’t been a collaborative spirit, and there’s a feeling that they want to recreate the same things that have already been put in place in a different way." Opponents have had some success in fighting these initiatives.

Leadership

The reforms passed in 2008 and 2010 in response to growing fiscal concerns represent a commitment shared across party lines and administrations. Republicans supported both the 2008 and 2010 legislation as a way to save the state money; Democrats supported the legislation to address the perception that the plans’ Medicaid managed care margins were too high.

Governor Dayton wasted no time implementing the coverage components of the ACA, despite significant Republican opposition. However, partisan conflict has largely focused on the state’s failed implementation of the Marketplace. The bipartisan commitment to overall payment and delivery reform seems to be intact, with the exception of some controversy over the state’s intentions and capacity to collect and use data to manage the overall system. It remains to be seen whether stakeholders, unhappy with the administration’s assertiveness, generate further pushback from the legislature.

Authority and Leverage

The state government’s ability to implement payment and delivery reforms mandated in the 2008 and 2010 legislation is significantly enhanced by long-standing rules governing plans and providers. Minnesota law requires that all health plans operating fully insured products in the state be nonprofit and accept Medicaid-covered lives. As a condition for participation in the state employee health plan, workers’ compensation and local government programs, providers must accept Medicaid patients. Those requirements give state government extraordinary leverage over the health care system. The state government’s capacity to influence the system is further facilitated by the consolidation of providers into integrated delivery systems or multispecialty group practices. In addition, the ACA’s Medicaid expansion has strengthened the state government’s leverage over the health care system by increasing the number of Minnesota residents with Medicaid coverage.
Federal Role

As an early participant in multipayer primary care reform, Minnesota welcomed Medicare's participation in its HCH initiative. Drawing lessons from commercial payers, however, the states’ attention has broadened to TCOC as essential to affecting care delivery.

In 2013, the federal government awarded Minnesota's state government a Center for Medicare and Medicaid Innovation SIM testing grant to test new ways to deliver and pay for health care using the TCOC framework. State agencies are aiming to expand Medicaid’s payment reforms to Minnesota residents covered by commercial and self-insured plans through implementation of its SIM testing grant. The state government intends to use its SIM testing grant to align Medicaid’s reforms and the commercial and self-insured activities related to TCOC currently under way across the state.

Role of Medicaid

Before the passage of legislation in 2010, the Medicaid program lagged behind other payers in the aggressive use of payment reforms. Officials observed that "Medicaid wasn’t the driver in 2009. The commercial market was leading. When [the state government] observed that nothing was happening in Medicaid, [the state government] took the initiative to put something in place." Since 2010, Medicaid and other payers have moved on parallel tracks, with Medicaid out front in terms of scope and financial incentives. The state government believes that its Medicaid policies can influence the whole delivery system, in part because providers find it challenging to deal with differences across payers. "Providers are looking for alignment of incentives across payers to know what they are shooting for," said one interviewee. Underlying regulatory requirements for payers and providers to accept Medicaid patients give some credence to the state government’s hope. State officials are particularly proud of the Medicaid safety-net ACO operating in Hennepin County (Sandberg et al. 2014); they perceive it as an example of delivery reform’s potential to promote public health in the long run.

Structure and Processes

Responsibility for implementing the state’s health care reform activities is divided within the state government. MDH houses the APCD and the state’s quality reporting functions. MDH also has administrative oversight of several health information technology activities, including the state's health information exchange and electronic health record mandate. DHS, the agency charged with operating the state’s Medicaid program and MinnesotaCare (the state’s basic health plan), is taking the lead on restructuring Medicaid’s contractual arrangements and interacting with the Medicaid managed care plans. MDH and DHS both play a role in implementing the HCH initiative and administering the SIM grant. MNSure, a quasi-independent agency, is responsible for implementing the state’s health insurance exchange under the ACA.
Over the past decade, MDH and a nonprofit organization created by plans and the Minnesota Medical Association, called Minnesota Community Measurement (MNCM), have had a hand in collecting and measuring comparable health care performance data across all payers. MNCM’s board of directors collects provider data both independently and under contract with MDH; includes physicians, plans, hospital and state government representatives, employers, and consumers; and measures provider performance data on quality, cost, and patient experience. Historically, MDH has contracted with MNCM to collect provider data on quality, cost, and patient experience. More recently, MDH has asserted its authority to access data MNCM collects under contract, a move that has stirred controversy within the state.

Strategy for System Change

DHS, the agency charged with operating the state’s Medicaid program, is using a two-fold strategy to pressure both insurers and providers into more efficient care delivery. First, DHS has adopted an aggressive stance in its dealings with its Medicaid managed care plans. In addition to caps on plans’ Medicaid margins, DHS has instituted a competitive bidding process with its Medicaid managed care contracts. Simultaneously, DHS has begun to bypass the plans entirely and deal directly with providers through TCOC Medicaid contracts.

Alongside the payment and delivery system reforms led by DHS, MDH is moving ahead with data analysis aimed at more broadly improving public health for all residents. However, the state government may lack sufficient leverage to fully achieve that goal. MDH faced significant political headwinds from providers and payers as they tried to implement the PPG initiative using the APCD. Both providers and payers expressed concern about the accuracy of the PPG initiative’s results, the technical challenges associated with developing appropriate and accurate measures for the initiative, and what the results would say about individual providers. MDH was unable to overcome these challenges. Legislation in 2014 suspended the PPG initiative and repurposed the APCD to evaluate the HCH program and the SIM grant; study hospital readmission rates; analyze variation in costs, quality, utilization, and illness burden (based on geography or populations); assess Minnesota’s ability to develop a state-based risk adjustment system; and perform additional studies directly authorized by the legislature.

More recently, MDH’s approach to implementing the statewide quality reporting program, under which providers are required to submit quality measures to be publicly reported,\(^\text{10}\) has triggered resistance from a range of stakeholders. MDH contracts with MNCM to develop the measures and collect the relevant data from providers for the statewide quality reporting program. A statewide quality rule, updated annually, describes the data elements that providers are required to submit to MDH or to its designee (MNCM). The plans initially objected to using state-selected quality measures, preferring the flexibility to design their own quality measures as they had done in the past. Though providers supported the use of one set of quality measures, some providers had concerns that the state government was ignoring other perspectives during the development of the quality measures.
There is currently disagreement over who has authority to access and use the data that underlie MNCM’s quality measures. MDH views its access to data as inherent in its contracts and legislative responsibilities. Some stakeholders have raised concerns that MDH’s data role has given the state government too much control over data analysis and reporting. One stakeholder noted, “There is general concern that the state can use information as a shaming approach instead of improvement approach.”

### Progress to Date

DHS is pushing forward with more aggressive management of Medicaid, in particular paralleling existing private sector TCOC arrangements. The state government, payers, and other stakeholders want to align these efforts more closely. As one stakeholder described it, "Providers are looking for alignment of incentives across payers to know what they are shooting for...be able to measure what they are doing and know if they are moving the dial, and...develop and restructure themselves under the new payment incentives." Alignment across payers is a work in progress.

Regarding data access, stakeholders are resisting what they perceive as state government encroachment on activities that have historically been the responsibility of MNCM. The state government hopes to ensure that data submitted pursuant to state law and rule are available to providers and to communities for health improvement efforts and that such data are effectively used to assess Minnesota’s health reform activities.

### Sustainability

Controversy over the ACA’s exchanges has given the state government political cover to focus on other kinds of health reforms, and a commitment shared across party lines and administrations to slow cost growth has led to a focus on payment and delivery system reform, including assertive reshaping of Medicaid, which the state hopes will lead to alignment of all payers and provide a foundation for broader population-based health.

Assertion of the state government’s authority has triggered pushback from other stakeholders. As has occurred in the past, some stakeholders argue that the state government does not have the technical expertise and capacity to analyze patient data.

On payment reform, it remains to be seen whether Medicaid’s new TCOC contracting arrangements will become a permanent feature of the Medicaid program and whether the state government will be able to foster greater alignment across payers.
Conclusions

Minnesota’s journey began largely as collaborations among the private sector. Medicaid became a significant lever with which the state government advanced delivery system reform, and such reform was made possible by underlying statutory authority, consolidation of the state’s health care delivery system, and requirements that all providers and payers accept Medicaid beneficiaries. The federal government’s award of a SIM testing grant to the state government has also encouraged more aggressive state action, and the state government hopes to align delivery system reform across payers. However, many private stakeholders still resist the notion that the state government is in charge of delivery system reform and have had some success in fighting state government control over health care data.

Notes


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