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Chickens, Eggs, and Institutions

Minnesota Launches Health Care Homes

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In mid- 2009, health care reform again stands high on the national agenda and so policymakers confront anew a dilemma: Can universal coverage and containment of the rate of growth of health care costs be achieved simultaneously? If not, which comes first, the chicken or the egg? Some think it irresponsible, not to say unsustainable, to inject new coverage for 45 to 50 million uninsured Americans into a system that already spends 16 percent of its GDP (about $7,000 per capita) on health care. Others find it indefensible, not to say immoral, that the uninsured should be held hostage year in and year out to society's collective unwillingness to temper the rise of its health costs.

The Obama administration has promised to address both coverage and costs. But the unhappy fate of the Clinton plan of 1993-94, which comprehensively conjoined employer mandates, regional alliances, and managed competition, suggests the risks of trying to do both universal coverage and cost containment in one policy package. Whether the Obama team and the Congress will attempt something similarly systematic by means of new and different tools (for example, individual mandates, expansion of public programs, analyses of comparative effectiveness, and revised methods for paying providers) remains to be seen.

While the feds face the chicken-and-egg dilemma afresh, some states have been wrestling with it intensively — and, perhaps, instructively for policy analysts, other states, and today's cadre of national reformers. The best known case is of course Massachusetts, which in 2006 passed legislation designed in essence to "just do it" — enact an individual mandate and other measures that would bring the state close to universal coverage — and address costs later (Appleby 2008). The state had its reasons: The Bush administration conditioned renewal of its Medicaid waiver on a shift

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of funds from institutional support to broader coverage, and an impressively large and solid coalition of groups supportive of universal coverage would surely crumble if cost controls on physicians, hospitals, academic medical centers, insurers, and other stakeholders were stirred into the strategic mix. Today almost 98 percent of Massachusetts' population has health coverage, and "later" has arrived: Costs, which run substantially above early estimates, are a source of growing political and governmental strain.

Meanwhile, Minnesota, as progressive a state on health policy as the U.S. federal system has to offer, is striking a different balance between coverage and cost controls. Having achieved 93 percent coverage of its residents (highest in the nation until Massachusetts surpassed it), Minnesota passed in 2008 a law that seeks to fix "the system" and slow the growth of costs as a presumed prelude to resuming its longstanding quest to reduce the number of uninsured. Among the law's many facets are provisions to encourage the spread of "health care homes" (also called "medical homes") first within Medicaid and thence to employees in state government and the private sector.

This report focuses on the logic underpinning, and the implementation challenges facing, health care homes in hopes of illuminating issues we consider central in cost containment. These are the institutional, political, bureaucratic, and federalism challenges that take center stage once the ink has dried on the theoretical model and some very tough policy tasks surface. Whether reformers (national, state, or both) commit themselves to system repairs on the back end of coverage expansions (Massachusetts) or on the front end (Minnesota), institutional considerations will be critical to success.

What Happens When Policy Prescription Is Put Into Practice?

Analytic models (often grounded in economics, health services research, and/or clinical studies) that tell policymakers how "optimally" to expand coverage, control costs, and trade off between these two goals seldom take account of the political and institutional dynamics that diverse policy strategies call into play. These dynamics, which invariably interpose between prescription and practice, include factors such as how proposals enter and ascend the policy agenda; the nature of effective political championship of proposals; legislative-executive and public-private bargaining and coalition building; the attunement of political leaders to bureaucratic arrangements and their consequences; managerial capacities in the public and private sectors; administrative improvisations in translating statutory into regulatory terms; relations between implementing agencies and trade associations and professional groups; negotiations among levels of government; and more. The prescriptive strain has its merits and uses, but its dominance,

Examining the institutional terrain for health care reform can be the key to promoting policy transfer from one state to another.

indeed near hegemony, in health policy analysis persistently obscures political and institutional considerations.

This institutional terrain has recently come into view in Minnesota's health care home initiative. We are well aware that a snapshot of one innovation, poised between legislation and implementation, in one state at one point in time is not conspicuously rich in "lessons for reform." Our aim, however, is not to supply "lessons." In health affairs, as in other policy domains, the 50 states differ markedly from one another at any give time, and reform regimes may vary within states — and of course between federal administrations. Such variations among states and administration all inhibit policy "transfer." Policy learning is less a matter of "how to do it" — contriving to transport interchangeable strategic parts among governmental venues — than one of "how to think about it" — insights from given cases that may strike sparks for other reformers at work in other contexts. We offer this mini-case as a kind of commentary on the stakes of premising expanded coverage on the promise of newfound system efficiencies.

The Minnesota Setting

Minnesota's impressively high rate of insurance coverage results from both extensive employer-based coverage and the state's willingness to supplement generous Medicaid and State Children's Health Insurance Program (SCHIP) eligibility levels with additional state-funded programs, including a high-risk pool, that the state has steadily but unflamboyantly assembled to impressive effect (Chollet and Achman 2003). In 2007 the state legislature's most formidable advocate for broader coverage, Democratic-Farmer-Labor Senator Linda Berglin (elected to the Minnesota House in 1972, the Senate in 1982, and current chair of its Health Human Services and Corrections "Budget Division") promoted and secured passage of a bill that would have brought new coverage to residents who fell through the cracks of the state's noteworthy portfolio of programs. The measure met opposition on cost grounds from leaders in the state's business community, some legislators, and Republican Governor Tim Pawlenty, a fiscal conservative, who vetoed the bill.

Pawlenty's veto set interested parties scrambling for common ground on which to compromise. Leaders of the Minnesota Medical Association (MMA) worried that accustomed payment and delivery arrangements were in the process of collapsing — but how quickly, and into what, was uncertain. The physician leaders recognized, as a spokesperson put it, that "no one wants to put more money into the health care system," but that calls for a shift towards hard-nosed capitation payments to physicians in Medicaid and other programs would thrust the society into "warfare" with policymakers. Under pressure from proponents of consumer-driven health plans on the right and from single-payer advocates on the left, the association had since 2004 been working to forge a

pragmatic, positive, and "proactive" agenda somewhere in the middle. In 2006 the MMA released a report that endorsed a range of reforms, including a mandate that all Minnesotans buy health coverage, enhanced public health investment, and better coordination of chronic care. It also convened a 26-member committee with broad representation across the health sector to develop legislation. Meanwhile the legislature and governor established task forces of their own, which met throughout the summer of 2007.

Early in 2008 the legislature passed and the governor signed legislation that jettisoned the individual mandate but gave new financial support to public health and promotion programs, launched a pay-for-performance initiative in Medicaid, authorized studies on capitation methods of payment and the definition of baskets of services in Medicaid and other systems of coverage. In a key innovation that sets Minnesota apart from other states, the legislators also set a timetable not only for moving chronic care beneficiaries in Medicaid from the fee-for service setting into "health care homes" equipped with "care coordinators," but also for making such homes available to the privately insured and state employees. As one legislative leader explained, "All this time we'd been very concerned about the uninsured seven percent, and it finally dawned on us that before going farther we first had to fix the system for the other 93 percent."

Same Old?

Forging a "system" from the institutional bits and pieces that fund and deliver care is of course an ancient theme in U.S. health policy deliberations. No one disagrees that coordinated, integrated, coherent patterns of care are preferable to the fragmented, unsystemic status quo. Variations on this theme have long addressed (for example) the virtues of access to generalists in preference to specialists; the merits of integrated systems such as prepaid group practices (a.k.a. managed care); the need for alternatives to emergency rooms as ports of first call; and, not least important, the benefits of the medical (or, in Minnesota's parlance, health care) "home." And the beat goes decidedly on: In its 2008 Report to the Congress, "Reforming the Delivery System," for example, the Medicare Payment Advisory Commission (2008, 39-48) urges a "Medical Home" initiative in the program and waxes eloquently for ten pages on how such homes can help beneficiaries to sustain relations with their primary care clinicians, support continuing and comprehensive care, and more.

That this integrative theme and these variations on it have been sounded so persistently for so long testifies to the challenge reformers face: Fragmentation is, among other things, a distribution of power and money among the system's stakeholders, a distribution fortified by a cultural legacy derived from the identification of less "managed" arrangements with good access to and quality of care. The sheer venerability (and impotence) of the refrain that broader coverage must and should presuppose or

propel changes in the production functions of the heavily specialized, technical, and service-intensive U.S. health care system tempts one to dismiss the widely surging enthusiasm for medical/health care homes as this year's winning entry in the sloganeering contest that passes for reform. (Because medical/health care homes differ in their definitions, elements, populations, outcomes, and other variables, no summary judgment as to whether "the" approach is "evidence-based" is possible. For an argument that "peer-reviewed literature documents improve quality, reduced errors … increased [patient] satisfaction," and other benefits of medical homes, see Rosenthal 2008.)

Uncertainties in the evidence base aside, both the rationale for the innovation and the sophistication of Minnesota's spadework in launching and nurturing it are compelling. Two-thirds of the state's Medicaid beneficiaries (mainly the "mothers and kids" population) are in managed care, while one-third (primarily the disabled and other chronically ill groups) remain in fee-for-service care. Within that one-third, however, are the 10 percent or so of all Medicaid beneficiaries who account for about 70 percent of the program's total spending. Health care homes and their care coordinators are expected to get diabetics, asthmatics, and other chronically ill beneficiaries primary and secondary preventive services and suitable access to care that is well coordinated across providers and settings, thus averting emergency room visits, hospital admissions, and other costly and unnecessary encounters. The state created the position of medical director within its department of human services and hired a physician who had run the federally funded Minnesota Pediatric Medical Home Learning Collaborative. This project, launched in 2004 (Schiff and Ricketts 2006), demonstrated that the approach could be implanted successfully, thus yielding both savings and — very important to the designers—hopes that the strategy will in time spread outward from Medicaid to state employees and the private sector, gaining sufficient market share and clout to slow the growth of health care spending in the state as a whole.

Minnesota policymakers have a long history of using payment practices and regulations to "move the market."

Health Care Homes: The Institutional Terrain

The prospects that the health care home can be made to "work" on some serviceable scale turn on institutional dynamics in three recurrent realms on which political analysts of the policy process have long sought to throw light:

- Political resolve among the state's public and private stakeholders.
- The degree of support from higher-ups in the federal government, especially payers in the Centers for Medicare and Medicaid Services (CMS).
- Adroit strategic and managerial improvisations within the implementing agencies.

Stakeholders

As political veterans routinely observe, Minnesota is "unusual." Policymakers have a long history of unapologetically "moving the market" by means of payment practices and regulations. Clinics (as in "Mayo Clinic") and group practice have long predominated among physicians, for example, so the "team" approach, including the use of nurses and nurse practitioners, investments in information technology, and a focus on the health of populations finds smoother sledding than it does in states dominated by physicians in solo practice and very small groups with a strong entrepreneurial (profit-maximizing) ethos. State programs derive some of their revenue from a tax on providers that the state's physicians and hospitals did not welcome but have grudgingly tolerated. As noted above, the Minnesota Medical Association, convinced that change is in the air and that outright resistance did no good, was proudly proactive as a voice for the reforms enacted in 2008. Although not indifferent to their economic interests, physicians in Minnesota, a medical association staffer observed, "look at the social and community dimensions of issues."

Minnesota's insurance industry is similarly exceptional. The state allows only nonprofit plans to operate within its borders, and requires plans that want to market to state employees to do so to Medicaid beneficiaries too. Moreover, single-payer sentiment is strong enough within the state to give insurers pause over practices that might hasten their industry's demise.

The state is headquarters for some large firms (General Mills, for instance) that have long worked individually and collectively (most recently in a Buyers' Alliance and Minnesota's strong Chamber of Commerce) to slow the growth of health costs. The business community (including many firms that are self-insured and thus exempted by federal law from state mandates) was a leading voice for conditioning further extension of publicly funded coverage on cost-containing measures, and strongly supported the 2008 reforms.

This public-private institutional milieu is distinctive among the states. At the opposite end of the spectrum, Florida, for example, lacks an income tax; has executive and legislative leaders whose biggest reform idea is to authorize "bare bones" insurance policies, and meanwhile shifts the cost of caring for the more than 20 percent of Floridians without insurance to the counties and localities. Florida's health system is dominated by highly entrepreneurial solo and small group medical practices; houses an exclusively for-profit set of health insurance plans; and features many small firms, few large ones, and no prominent business leadership on health issues. If context and capacity to formulate progressive policies were all that mattered, Minnesota's reforms should be well along the high road to success.

Fiscal Federalism

Formulation, however, is but the beginning of a policy tale that unfolds in protracted and sometimes subterranean sagas of negotiation, implementation, and management. Although private insurers sometimes support health care home pilot projects, in Medicaid such innovations in delivery depend on supportive changes in payment policies, and thus on decisions made in Washington by CMS and, of course, Congress. Health care home demonstrations could save money on the chronic care of their participants, but sponsoring hospitals might nonetheless suffer a loss if the Medicaid payment system did not allow them to accrue the savings thus produced. Thence a slippery slope into what could become a reform abyss: Medicaid has long lived (as one interviewee for this study put it) "in the shadow" and as a stepchild of Medicare, the payment codes of which have heavily influence Medicaid payment practices. Coordinated care teams do not readily fit codes predicated on one-on-one provider-patient encounters, and some CMS officials are said to fear opening the floodgates to arrangements that may entail higher payments for "services" of indeterminate source, content, and value.

Congress has authorized the Centers for Medicare and Medicaid Services to run a dozen demonstrations of medical homes in Medicare, in eight states.

"We want more bundling of services for payment," lamented one supporter of health care homes, "while CMS wants more unbundling so they can see each dime." But CMS officials are, unsurprisingly, not all of one mind on these perplexing issues and how to resolve them; indeed, Congress has authorized the centers to run a dozen three-year demonstrations of medical homes in Medicare in eight states (Centers for Medicare and Medicaid Services 2009). As CMS sorts out internally what it expects from health care homes and how it plans to pay them and the organizations running the demonstration programs, the Minnesotans must feel their way among officials in its regional and central offices in search of strategic counsel— and/or consolation. State reform is not simply an state affair but also reaches, as it were, upward and outward, toward federal policy, and does so on many more issues than the notorious ERISA rule that preempt state regulation of many employer benefit plans (and thus employer mandates).

Agency Management and Implementation

The institutional concomitants of reform extend not only up and out but also down and in — into the murky precincts of the state agencies that must decide what they mean and require operationally and improvise practical solutions to conundrums that arise in the course of implementation.

The architects of the reforms of 2008 acknowledge that although no one actively opposes health care homes, their eventual success will depend on myriad refinements and details. For reasons of both quality and cost, a "health care home" cannot be any organizational concoction that declares itself one. The state departments of human services and health must jointly create "rules, standards, and measurements," in the words of one policymaker,

who added that rules must define clearly, among other matters, the specific roles of the care coordinators; that standards must be rigorous enough to permit the state to reject shaky applications; and that measurements cannot cover "just the easy stuff." These regulations will govern the certification, and annual recertification, of eligible health care homes, a task in which nongovernmental bodies also might pay a role (for instance, the National Committee for Quality Assurance, which has a Patient-Centered Medical Home program and issues standards and guidelines for medical homes).

This making, implementing, and refining of rules will be a tall order for the state agencies in question, and will acquire added complexity from the need to consult and satisfy beneficiaries, providers, and the groups that represent them politically. Health care homes, an official asserted, are to be "physician-headed and patient-centered" arrangements that redesign primary care in ways that deploy nurses and nurses practitioners so that physicians may (in a phrase we heard often in Minnesota) "practice at the top of their license." Other goals include reducing physician visits but increasing patient "touches"; giving patients what they want (the reform statute explicitly calls for "consumer engagement") and building trust; and all the while managing care better but avoiding gate keeping and the rougher irritating edges of "managed care."

Might It Work?

Whether Minnesota's ambitious agenda for health care homes is realistic remains to be seen. Advocates for the disabled, for example, have raised questions about "agency." Do the physicians in these teams "work" for the patient or the Medicaid program? Are health care homes sufficiently distinct from capitated primary care case management models that "who's the boss?" concerns need not arise? Advocates have also objected to proposed mandatory assessments of the needs of disabled beneficiaries and underscored the challenges of coordinating care for people who often combine multiple and heterogeneous conditions, including but not limited to usual suspects such as diabetes, asthma, hypertension, and congestive heart failure. Each such caveat complicates the definition of the home health care enterprise, the drafting of standards for certification, and their implementation over time. These caveats collectively compel continuing consultation not only among the pediatric, managed care, disability, and long-term care divisions within the key state agencies (which the governor's health cabinet is intended to coordinate) but also much patient collaboration between public regulators and private organizations.

Conclusions

Minnesota's commitment to health care homes is predicated on bottom-line performance that policymakers will scrutinize closely. Better coordinated care is expected to pay for itself in the

coin of reduced emergency rooms visits, hospital admissions, and other overused medical services; generate savings by slowing the growth of costs for that small chronically ill percentage of Medicaid beneficiaries who account for the lion's share of the program's spending; trigger further benign economies among state employees and within a not-insubstantial portion of the private sector; and enhance quality to boot.

Such a redesign, however, affronts payment and delivery patterns that endure despite trenchant criticism because they reflect a "medical-cultural nexus" (Brown 2008) that insists that "more is better," equates good quality with easy access to specialized (and expensive) medical care, resists enhancing the roles of generalist physicians and nonphysician personnel, and recoils at "real" management of care. This of course is why proponents of universal coverage "now" fear that conditioning it on the achievement of systematic changes in financing and delivery, however desirable, is a recipe for further political stalemate.

Minnesota has pushed the expansion of coverage doggedly for more than two decades and in the process achieved the lowest percentage of uninsured of any U.S. state save Massachusetts. Now the state is betting that it can introduce changes in health care production functions that will slow the growth of health spending in both Medicaid and the private sector and serve as a prelude to the next drive toward more nearly universal coverage. The strategies it has adopted — more emphasis on prevention and public health measures, linking physician payment to acceptable performance, and, our focus here, the health care/medical home — have been widely viewed as desirable. Their fate depends on the kind of institutional considerations highlighted here, which too often get short shrift.

The hurdles are high. Securing and sustaining cooperation between agencies with distinct cultures — the Department of Human Services is a purchaser whose clients are individual Medicaid beneficiaries; the Department of Health is a regulator whose clientele is "the population" of five million Minnesotans — will require leadership and innovation both atop and within the bureaucracy. Defining, designing, and developing health care homes that prove acceptable to public officials (elected and appointed), citizens in need of chronic care, providers, budget makers, and advocates on both left and right will require political and managerial skills. Such state reforms may offer insights not only within the states that launch them but also for other states and to federal payers for Medicaid, Medicare, and CHIP. Not least important, state-based innovations may prove enlightening for those crafting the new national health care policies now under discussion in Washington. Meanwhile, reformers in Minnesota have their work cut out for them. Getting the state's payment preferences embodied in, or at least not inconsistent with, federal rules may prove infeasible. Convincing current and future governors and legislative leaders to invest — and to persist in investing — political capital in

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complex reforms that deliver subtle and (at best) medium-term results may not be easy.

On the other hand, "it's hard to defend overuse," in the blunt phrase of an interviewee in a physicians' association. For more than 30 years, John Wennberg and other researchers have discomfited policymakers with details suggesting that in the medical realm more is not necessarily better, opening windows of opportunity for innovations proceeding on the premise that different service configurations (more of some things, fewer of others) can produce access to and quality of care no less good, and arguably better than, the status quo. Downsizing by means of managed care has hit fierce resistance; maybe incremental rightsizing via health care homes will fare better. State and national policymakers will not stop striving to slow the growth of Medicaid spending or worrying about what these rates of spending mean for their hopes to reduce the number of uninsured Americans. Minnesota's recent entries in the reform sweepstakes, which launch timely and promising innovations in an unusually propitious political and institutional milieu, merit close monitoring.

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