

State-Driven Initiatives to Support Moving to Value-Based Care in the Era of COVID-19

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AUTHORS

National Governors Association Center for Best Practices

Caroline Picher
Lauren Block*

Duke-Margolis Center for Health Policy

Mark Japinga
Hemi Tewarson

*Lauren Block's contributions to this publication were made during her tenure at NGA

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Introduction

Over the last several decades, health care costs in the United States have increased significantly without corresponding improvements in outcomes. States have increasingly looked to move away from volume-based fee-for-service (FFS) payments for health care, a system where a provider is paid a fee for each service, as a mechanism to combat this trajectory, and COVID-19 pandemic has strengthened the rationale for these efforts. Providers receiving value-based prospective payments have demonstrated greater financial resiliency than providers relying solely on FFS payments.¹ In addition, value-based payment (VBP) models, where providers are rewarded for providing cost-effective and quality care, can offer states greater flexibility in care delivery, which may facilitate tailored approaches to addressing equity, disparities and social determinants of health through innovative workforce models, telehealth adoption and care coordination strategies.

The confluence of rising health expenditures and the pandemic's disruption to the health care system may catalyze greater interest in VBP arrangements. However, the path forward is challenging and complex. In 2018, only 30% of Medicaid payments were made through value-based arrangements, a sign that providers were hesitant to transition to new models.² Multiple factors influence this reluctance. High start-up costs to build data infrastructure and implement care transformation make the transition to VBP a multi-year process—especially to show significant savings—compounding provider uncertainty about making the leap. Also, because payers each have their own VBP models, payment methodologies and performance metrics, it can be challenging for providers to make targeted, confident investments. States can play a critical role in helping overcoming barriers to VBP participation with a unified vision by using their central role as regulator, convener, and administrator.

On October 27, 2020, the National Governors Association Center for Best Practices, in partnership with the Duke-Margolis Center for Health Policy, hosted an expert roundtable for senior state officials, national experts, and industry participants to discuss the state role in accelerating the transition to value post-COVID-19. This issue brief summarizes four key areas where state-driven strategies can standardize and streamline broader adoption of VBP, supplemented by case examples and priority areas where additional federal support could amplify efforts. The four key areas are:

- ▶ **LONG-TERM VISION:** Laying out a multi-year process that includes both strategic vision and substantial investment to secure buy-in and build the necessary infrastructure and care teams needed for success.
- ▶ **PAYER ALIGNMENT:** Standardizing quality metrics, reporting, and expectations that can simplify participation in VBP models.
- ▶ **STAKEHOLDER CONVENING:** Bringing together public and private stakeholders to develop a coordinated vision.
- ▶ **DATA COLLECTION:** Ensuring states, plans, and providers have access to timely and accurate information to monitor quality and make improvements.



Long-Term Vision

Adoption of large-scale delivery system reforms is a multi-year process that requires executive leadership, vision, and investment of time and resources. Because of the number of parties engaged and coordinated infrastructure required, states should anticipate the time it takes to secure buy-in and build infrastructure. In many instances, overcoming adverse events can serve as the impetus for transformation. For example, **Oregon's** Coordinated Care Model, which has been adopted by coordinated care organizations (CCOs) for Medicaid members, was spearheaded in 2012 by former Governor John Kitzhaber in response to high unemployment, low tax revenues, and a budget shortfall in Medicaid stemming from the Great Recession, as an alternative to large provider rate cuts.³ The CCO Model relies on community-based organizations to provide integrated physical, behavioral, and dental health care to Medicaid recipients. CCOs receive a capitated payment in exchange for providing care, and total Medicaid spending can grow by no more than 3.4% per year.⁴ Oregon also added a cost growth target as part of these reforms, which expanded over eight years into a multi-payer effort, including the public employee and educators benefit programs in 2013 and all payers in 2021.⁵ Further, the state is facilitating widespread adoption and alignment of VBPs to support achievement of the state's spending target. The resulting Oregon VBP Compact—a voluntary commitment by payers and providers across the state to achieve a series of VBP targets—has been signed by the largest health systems and commercial insurers, accounting for nearly two-thirds of the state's covered lives.⁶

As another example of an incremental implementation, in 2013, **Tennessee** established its Health Care Innovation Initiative as part of a State Innovation Model grant. The effort, driven by former Governor Bill Haslam, was comprised of three strategies, (1) primary care transformation through a patient-centered medical home model; (2) improving quality for long term services and supports; and (3) improving care delivery through retrospective episodes of care.⁷ The goal of the initiative was to improve health care quality and outcomes by moving 80% of the state's population into value-based payment models within five years.⁸ The state's rollout of the initiative was gradual, with Tennessee implementing the first three episodes of care in 2014 increasing to 48 by 2019.⁹ Phasing in approaches allows states, plans, and providers to evaluate outcomes to determine what works and where changes are necessary and allows for a smoother transition for providers to take on increased risk over time.

Rhode Island's Office of the Health Insurance Commissioner (OHIC) began implementing the state's affordability standards beginning in 2010. The office was established by legislation to guard the solvency of health insurers, protect the interests of consumers, and improve the quality and efficiency of health care service delivery and outcomes across the system.¹⁰ This mission gives the office unique authority to pursue systemwide health care transformation through policies that impact both insurer and provider behavior.¹¹ OHIC built upon these efforts over the course of the following ten years.¹² For more information about Rhode Island's Affordability Standards, see [Rhode Island's Affordability Standards Improve Value of Health Care in the Commercial Market](#).



Payer Alignment

Aligning payment incentives and performance measures across multiple payers, or “payer alignment,” can simplify participation in multiple VBP models through standardized quality metrics, reporting, and expectations.¹³ Several states have taken steps towards greater alignment across payers. **Massachusetts**¹⁴ and **Minnesota**¹⁵ used legislative measures to require commercial plans to align on quality measures, while **Rhode Island**'s¹⁶ OHIC requires use of aligned measures through regulation. **Washington**¹⁷ and **Connecticut**¹⁸ both encourage payers to adopt a set of aligned quality measures voluntarily. Many of these efforts required a substantial amount of time and stake holder engagement on the part of the state in order to coalesce around aligned measure sets.¹⁹

Some states are pursuing larger scale reforms such as multi-payer, global budget models that include commercial payers and Medicare. These models provide an opportunity for a system-wide transition to VBP. **Maryland**'s Total Cost of Care Model expands on the state's All-Payer Model by bringing global budgets to some primary and specialty care providers in addition to hospitals.²⁰ **Vermont**'s all-payer Accountable Care Organization (ACO) leverages the state's small market and population to move public and private payers to value-based reimbursement at the same time.²¹ **Pennsylvania**'s Rural Health Model specifically targets rural hospitals, which have consistently struggled in recent years under FFS reimbursement.²²

HOW VERMONT'S ACCOUNTABLE CARE ORGANIZATION MODEL SUPPORTS MULTI-PAYER ALIGNMENT AND VBP



In 2016, **Vermont** signed an all payer ACO Model Agreement with the Centers for Medicare and Medicaid State Innovation (CMMI). Under the model, Medicaid, Medicare, Blue Cross and Blue Shield of Vermont and MVP Health Care contract with ACO that assumes the risk for meeting financial targets and performance benchmarks. OneCare Vermont is the only ACO operating in the state and contracts with the above-named payers to coordinate care for high-risk individuals. As a condition of the contract, OneCare Vermont participates in a downside financial risk arrangement for the ACO and participating hospitals.²³

The state level agreement with CMMI encourages Medicare, Medicaid and commercial payers to align on overarching goals and performance measures and gives the state tools to customize Medicare's participation. In its evaluation of the first three years of the model, the Department of Vermont Health Access (DVHA), which holds the Medicaid contract with OneCare and offers the most advanced two-sided risk sharing arrangement among the payers, found that the model provided Medicaid and the providers within OneCare's network more budgetary predictability, therefore providing more stability to the health care system. DVHA also found that providers receiving prospective payments under the ACO model spent less than expected over the three years, whereas providers in FFS arrangements spent more than expected.²⁴ DVHA also found that Vermont providers in alternative revenue models who received prospective payments for some portion of their business were better positioned to weather the loss of FFS revenues during the COVID-19 pandemic.²⁵



Stakeholder Buy-In

Successful reform efforts also require a wide range of stakeholder buy-in. A state's legislative and regulatory power gives it a unique agenda-setting role, allowing leaders to identify priorities, build a vision, and bring key players to the table. For example, a statewide alignment effort requires, at a minimum, buy-in from state regulatory agencies, state employee benefits administrators, commercial insurers, providers, hospital systems, large employers, and the federal government (when including Medicare).

Many states have used stakeholder committees or advisory boards to gather feedback and gain buy-in. For example, for cost growth target initiatives, **Massachusetts**, **Oregon**, **Delaware**, and **Rhode Island** have all convened advisory councils comprised of key health care stakeholders such as hospitals, health plans, consumer advocates, large employers, and policy leaders, to discuss implications of potential policy options on their respective organizations. Recently **New Jersey** and **Pennsylvania** have announced that they are creating similar advisory boards to guide the development and implementation of the states' health care transformation initiatives.^{26,27}

The aftermath of the COVID-19 pandemic may offer new opportunities for states to engage large employers regarding VBP, as the economic downturn puts new pressure on large employers to reduce rising employee health care expenses as commercial health care costs continue to rise steadily. A recent RAND study found private insurers paid hospitals an average of 247% of Medicare rates. These cost increases require employers to pay on average more than \$15,000 per employee in yearly premium contributions, an increase of \$5,000 in the past decade.²⁸ Because self-insured employers represent more than half the insurance market in some states and states are preempted from regulating insurance policies that private employers offer through self-insurance, Governors need self-insured employers to choose to participate in reforms to have widespread impact.



Data Collection

States, health plans, and providers need access to timely and accurate claims and encounter data to identify steps to measure performance, track patients, improve care and build an analytics infrastructure that can support these efforts. Financial incentives, especially for safety net or small providers who lack the tools, technology, staffing, and workflow can facilitate compliance or voluntary adoption of VBP models.²⁹ These payments may initially help support infrastructure development and later align with performance measures.³⁰ In addition, Centers for Medicare & Medicaid Services' study of 10 states using Medicaid Section 1115 waivers to accelerate adoption of VBP describes the non-financial supports offered to safety net providers to advance adoption including "technical assistance, data and analytics support, and VBP training and work groups" which may be offered by the state or managed care organizations, and may include practice supports or coaches.³¹

States are particularly well-suited to help collect, standardize and aggregate data on behalf of providers and across the state. Both **Massachusetts** and **Oregon** have had great success collecting standardized provider data through health plans as a part of large-scale cost and value reforms, requiring plans to report data for their cost growth target efforts.³² These states, as well many others, also have an all payers claims database (APCD), which can supplement reporting.³³ However, relying on an APCD in isolation could be complex as data would not be standardized and self-insured employers may choose not to participate, resulting in incomplete information.



The table below provides examples of cost control, transparency, and delivery system reform strategies states are using either in their Medicaid programs or through multi-payer approaches.

State Strategies to Promote Value and Lower Health Care Costs			
Strategy	Market	Intended Outcome	States Implementing Approach
Accountable Care Model	Medicaid, multi-payer	Requires providers to coordinate care to reduce unnecessary care and improve quality	Vermont*
			Oregon
			Colorado
			Massachusetts
Cost Growth Benchmark	Medicaid; multi-payer	Cap or target for spending growth in Medicaid and/or across payers to lower the growth rate of health care expenditures. Benchmark may also link to health care quality measures	Massachusetts
			Delaware
			Oregon
			Rhode Island
Episode-based Payments	Medicaid; multi-payer	Providers are paid based on all care delivered for a specific illness or condition, rather than by service	Arkansas
			Ohio
			Tennessee
Rural Health Model	Multi-payer	Global budgets for rural hospitals and providers to improve predictability of income and encourage community health interventions	Pennsylvania
Total Cost of Care Model	Multi-payer	Global budgets for spending for all hospitals in the state, encourage care redesign and focus on primary care	Maryland
Commercial Market Affordability Standards	Multi-payer	Set of standards controlling hospital costs, alternative payment model adoption, and other cost and value drivers	Rhode Island**

*See “How Vermont’s Accountable Care Organization Model Supports Multi-Payer Alignment and VBP” for more information about Vermont’s All Payer ACO

**See “Rhode Island Implements Affordability Standards to Improve Value of Health Care in the Commercial Market” for more information about affordability standards

RHODE ISLAND'S AFFORDABILITY STANDARDS IMPROVE VALUE OF HEALTH CARE IN THE COMMERCIAL MARKET



To address rising health costs and limited accountability for health outcomes, in 2010, the Rhode Island Office of the Health Insurance Commissioner (OHIC) instituted affordability standards for commercial health insurers to improve affordability of health plans, enhance consumer protections, and improve quality of care. As part of its affordability standards work, OHIC used its authority to convene key payor and provider stakeholders to achieve buy in and gather input on delivery system reform models and unified sets of performance measures.²³ OHIC built upon those standards in 2015 and 2020. Key reforms required under the standards include:

- ▶ Requiring increased insurer investment in primary care spending through a one percent per year increased from 2010 to 2014 and subsequently a mandatory primary care spending floor of 10.7 percent ;
- ▶ Establishing hospital spending price controls of the Medicare price index plus one percentage point for both inpatient and outpatient services from 2010 to 2014 and subsequently equal to the consumer price index plus one percent;
- ▶ Including a cap on annual price inflation and requiring the transition of hospital payments from per diem payments to payments based on diagnostic-related groups (DRGs);
- ▶ Expanding the adoption of the patient-centered medical home (“PCMH”) model by primary care practices;
- ▶ Implementing spending targets for alternative payment models (APMs) to encourage movement to downside risk; and
- ▶ Requiring insurers to provide funding for implementing electronic health records and a statewide health information exchange.³⁴

OHIC has seen significant results since the implementation of the affordability standards, both through an increase in primary care investment and a decrease in health care spending. Primary care spending as a percentage of total medical spending more than doubled between 2008 and 2019 increasing from 5.7 percent to 12.5 percent.³⁵ Because OHIC did not allow insurers to pass the increased cost of primary care investments on through premiums, spending did not impact premium costs for consumers. A recent study found that overall FFS medical spending decreased 8.1% relative to other states since 2009, which is largely attributed to Rhode Island’s hospital price controls.³⁶ Additionally, since 2015 (the year the APM targets were promulgated) the percentage of total medical spending under an APM increased from 20 percent to just over 40 percent in 2017.³⁷ Over the same period, there was also an increase in the utilization of downside risk models, where providers take on financial risk for patient outcomes. Between 2014 and 2017, medical spend in downside risk models increased from \$3 million to \$404 million.³⁸



Federal Actions to Support States Movement to Value

Value-based payment models offer the greatest flexibility and an optimal financial structure for lowering costs, improving outcomes, and addressing key priorities, but many states struggle to operationalize these complex models and could benefit from additional federal support. The Centers for Medicare & Medicaid Services (CMS) recently issued a roadmap to accelerate adoption of value-based payment models at the state level, focusing on similar key components like long-term vision, alignment, and data.³⁹ To help states narrow their viable options, CMS' Center for Medicare and Medicaid Innovation (CMMI) could consider outlining a more concrete strategic vision for the priorities and goals of the movement to value that aligns with broader efforts in the Medicare program. Key priority areas CMS could consider include enhancing support for primary care, data standards and recommendations for system improvement, aligning initiatives, improving maternity care, integrating behavioral health services, and doing more to address social determinants of health.

CMS may also consider new ways to help states achieve value-related goals beyond waivers and State Plan Amendments (SPAs) to help states get new payment initiatives off the ground. Since states may not have the bandwidth to independently develop and administer VBP models from scratch, more detailed sample templates could give a clearer baseline from which to work. In addition, model documents could include information on the following topics to assist states in adopting reforms:

- ▶ Key features of similar primary care and population health models to ensure alignment with existing Medicare and Medicaid models.
- ▶ Data sharing protocols and performance measures regarding quality of care, outcomes, and equity, with a specific focus on collecting data related to social determinants of health.
- ▶ Components of common specialized care episodes in areas like maternity, behavioral health, and substance use disorder.
- ▶ Opportunities for structuring rural health reform, including global budgets.

To encourage states to take on new initiatives, CMS could also provide additional financial and infrastructure support for standing up VBP models in exchange for a state's commitment to participate over a certain period of time. Initiatives such as the ACO Investment Model, which involved pre-payment of anticipated shared savings, helped encourage rural providers to participate in value-based payment approaches and gave them the capital needed to develop necessary infrastructure and capabilities. Similar funding programs specifically targeting states—not unlike the Delivery System Reform Incentive Payment Program (DSRIP)—could kickstart initial investment in readiness assessments, service integration, or building data sharing capabilities, all critical tools for organizations to succeed in implementing value-based payments.

CMS may consider making multi-payer collaboration a key component for federally supported Medicaid models to align these efforts with other public and private payers to ensure a long-term unified push towards a common goal. The extra push from CMS could help states gain extra leverage when convening stakeholders on these issues, allow for state- and national-level alignment, and ensure incentives are aligned to help organizations make sustainable investments that benefit their whole patient populations, not just those in Medicaid.

Conclusion

Health system transformation is complex, requiring extensive resources and time to implement successfully, but many states have already made great strides towards paying for better outcomes and stabilizing long-term cost growth. Executive leadership is critical for the vision and action needed to get these programs in motion, with a wide variety of complementary efforts needed to make them work well. Collaboration and convening helps states facilitate provider adoption of value-based care models through standardized approaches. An incremental approach allows states to evaluate progress and make adjustments as needed while expanding initiatives over time. Federal support can help states understand the components and infrastructure needed for effective implementation. With COVID-19 creating momentum for health system reform, state level efforts now can build the foundation needed for transformative change.

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