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Aligning Federal and State Efforts on Payment Reform

Michael Stanek

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Executive Summary

A growing body of evidence is demonstrating that inefficient payment policies play an important role in driving up total health care spending and in reinforcing inefficiencies in health care delivery. In particular, the prevalent fee-for-service payment system, in which each discrete service is reimbursed separately, encourages unnecessary service volume and fails to vary payment based on factors like quality or outcomes. As a result, the current payment system pays for inefficient and poor service delivery no differently than effective, parsimonious care delivery.

The federal government and states are exploring new strategies for rewarding value in order to achieve better outcomes at a lower cost. States are designing or implementing innovative Medicaid managed care payment structures, new reimbursement models to support advanced models of primary care, and broader payment reforms like episode-based or global payments. The federal government is beginning to shift Medicare reimbursement toward holding providers accountable for costs and quality.

In July 2013, the National Academy for State Health Policy (NASHP) convened and facilitated a discussion among high-level state and federal leaders. The meeting gave state participants the opportunity to learn about and discuss new opportunities and promising practices for payment reform, including new federal opportunities, with their peers. Federal participants had the opportunity to learn about state approaches to payment reform and identify potential federal policy changes that can support state activities or better align federal strategies with state approaches. NASHP narrowed the focus of the meeting and paper to three broad categories, selecting examples of reforms that fit into them: primary care-based initiatives, payment reforms to foster integration of providers across care settings, and broader accountable care initiatives.

Key themes that emerged from the discussion include:

- Federal and state partners bring distinct and complementary capacities to engaging stakeholders. States can take the lead in forging local consensus, while the federal government has significant influence over the national conversation.
- Federal and state levels of government must develop and share a long-term vision and a defined transition process for payment reform strategies.
- Federal and state funders should view demonstration projects and existing initiatives as learning opportunities for future iterations of payment reform.
- Strategies for ensuring provider access to meaningful information are critical for implementing payment reform. States and the federal government must work to provide data analytics support and feedback to providers.
- Federal/state alignment can take many forms. There is a need for a mix of models that have different amounts of federal and state leadership, as well as different scopes and scales

Meeting participants generally agreed that both the federal government and the states must align around a shared vision of delivery system change and the payment structures needed to support it, leaving room for state-level tailoring and innovation.

The Case for Payment Reform

A growing body of evidence is demonstrating that inefficient payment policies play an important role in driving up total health care spending and in reinforcing inefficiencies in health care delivery.[1] In particular, the prevalent fee-for-service payment system, in which each discrete service is reimbursed separately, encourages unnecessary service volume and fails to vary payment based on factors like quality or outcomes. As a result, the current payment system pays for inefficient and poor service delivery no differently than effective, parsimonious care delivery.[2] The Institute of Medicine estimates that payment for unnecessary health services and inefficiently delivered services together cost the U.S. health care system $340 billion annually.[3]

The federal government and states are exploring new strategies for rewarding value in order to achieve better outcomes at a lower cost. States are designing or implementing innovative Medicaid managed care payment structures, new reimbursement models to support advanced models of primary care, and broader payment reforms, like episode-based or global payments. The federal government is beginning to shift Medicare reimbursement toward holding providers accountable for costs and quality. These efforts are designed to begin correcting the shortcomings of current payment strategies described below.

Fee-for-service payment encourages service volume. Compensating providers for each service delivered creates financial incentives to deliver high volumes of high margin services; alternative reimbursement models seek to correct these incentives.[4] In 2009, Blue Cross Blue Shield of Massachusetts launched the Alternative Quality Contract, a payment structure based on global budgets and performance incentives. Providers who entered the contract from fee-for-service arrangements experienced savings of 8.2 percent in the first year of the contract and savings of 9.9 percent in the second, with half of the savings attributable to lower service volume.[5]

Payment is often disconnected from the value of care provided. Traditionally, fee-for-service reimbursement has paid a set fee for each service provided, independent of quality indicators or outcomes. Misaligned financial incentives under fee-for-service arrangements can actually lead to disincentives for improvement or higher-value service delivery: one prominent integrated delivery system saw greater efficiency result in falling payments from external payers (including Medicare) leading to net losses despite achieving improvements in clinical outcomes.[6]

Current payment policy encourages fragmentation and duplication of services. Paying a separate fee for each service provided offers no incentive for teamwork or coordination across providers or care settings, leading to fragmentation in the health care delivery system.[7] New payment models, ranging from patient-centered medical home payments to bundled payment to shared savings, aim to incent care coordination between providers and across care settings.

Federal And State Policy Levers that Can Promote Payment Reform

As payers and as regulators, federal and state agencies have substantial leverage to implement payment reforms and push state markets towards reform. Pay-for-performance initiatives in many managed care and fee-for-service Medicaid programs have been in place for several years.[8] In recent years, particularly since the passage of the Affordable Care Act (ACA) in 2010, states have begun to build on these strategies, taking new approaches and utilizing new tools to support payment reform.

The Federal Government's Role

The Centers for Medicare & Medicaid Services (CMS) has experimented with payment reform in the past. A 2012 Congressional Budget Office analysis of four Medicare payment reform pilots begun between 1991 and 2008 found mixed results, suggesting the need for "additional experimentation, evaluation, and refinement over a period of years." [9] The federal government is asserting itself further as a leader and a key partner in payment reform with a flurry of reform activity, including within Medicare, since the passage of the ACA in 2010.

Purchasing higher-value care. The federal government is a major purchaser of health care services through Medicare; total Medicare benefit payments in 2012 reached $536 billion.[10] At the same time, the federal government's policy-setting role in Medicaid programs makes it a key facilitator of state-level reforms. In addition to its role as a direct purchaser of services, the federal government also manages the largest employer-sponsored group health insurance program in the country; under the Federal Employee Health Benefits (FEHB) Program, the Office of Personnel Management contracts with private insurers to offer health benefits for more than 8 million federal employees and their families.[11] In 2012, the FEBH Program oversaw $45 billion in health care benefits.

Under the ACA, Medicare is beginning to pay for value through a Hospital Value-Based Purchasing (HVBP) Initiative that applies to all hospitals receiving Medicare reimbursement. Beginning in FY2013, hospitals receive a value-based incentive payment adjustment to all Medicare Diagnosis-Related Group payments tied to achievement and improvement on 13 clinical process of care and patient experience of care measures. By 2015, CMS will begin applying a value modifier to reimbursements under the Medicare Physician Fee Schedule based on cost and quality data.

Facilitating innovation at the federal level. In addition to the launch of Medicare-wide value-based payment reforms and the creation of voluntary programs that utilize alternative payment approaches, the ACA authorized the creation of a Center for Medicare and Medicaid Innovation (CMMI) within CMS. CMMI is charged with testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" and was empowered to rapidly test and bring to scale—including at a national level—payment innovations within the public insurance programs.[12] CMMI has launched a multitude of payment reform pilot programs (see Appendix A), including Pioneer Accountable Care Organization (ACO) models described in more detail below.

Supporting state innovations. Beyond affecting payment policy directly in its role as a purchaser of health care services, the federal government has a role to play in facilitating state-level payment reforms using waiver and demonstration authority. State reforms rooted in the Medicaid program—such as Oregon's Coordinated Care Organizations or Minnesota's Health Care Delivery Systems Demonstration (both described below)—often require federal approval of a Medicaid waiver or Medicaid State Plan Amendment. CMS can assist states in designing and implementing reforms by clarifying what is possible

for states under Medicaid State Plans and waiver authorities, as well as identifying or highlighting options available to states under managed care. CMS can help states navigate the approval process for waivers and amendments. It can also provide technical assistance to help states implement new state-level payment models and work to make Medicare data more readily available to state all-payer data initiatives. Federal grants to states can also have an impact; for instance, the State Innovation Models (SIMs) initiative funded by CMMI to support state-level multi-payer payment reform is helping states to pursue new strategies for rewarding value.

State Roles

State Medicaid authorities, purchasing agencies, and independent policy commissions have a range of tools at their disposal to support delivery system transformation using payment levers, often with legislative support or in partnership with private stakeholders.

Paying for high-value care. States have the financial leverage to pioneer new and innovative payment arrangements in Medicaid. In 2012, states are estimated to have spent a total of $432 billion–more than half in the form of federal matching funds—on their Medicaid programs.[13] States can also consider using state employee plan purchasing and benefit design to drive payment reform.

Convening key public and private stakeholders. Enabling providers to redesign care delivery in a sustainable way requires public and private payers to send coherent payment signals to the provider community. States can spearhead multi-payer reform initiatives by serving as a key convener of private sector partners. They can create a safe space for planning multi-payer reform, in part by passing legislation to provide antitrust protection for their private sector partners as they collaborate to align payment signals to health care providers.[14] Similarly, they can take steps to join with existing initiatives, both those initiated by the private sector and those being driven by Medicare. A number of private-sector payment reform initiatives, such as the Alternative Quality Contract mentioned above, offer new opportunities for states to build upon and expand the reach of existing successes.

Using regulatory levers. As regulators, state agencies, and particularly insurance departments, can also encourage commercial payers to participate in or pursue payment reform initiatives to support delivery system redesign. For instance, Rhode Island's Office of the Health Insurance Commissioner enforces a set of affordability standards that directs large health insurers to support the patient-centered medical home model and to work toward comprehensive payment reform across the delivery system.[15] States that are operating their own health insurance exchanges or performing plan management activities in a partnership exchange under the ACA can consider an active purchasing approach to the certification of Qualified Health Plans to encourage payment reform.[16] This strategy involves negotiating or including additional contracting standards for Qualified Health Plans in exchanges.[17] [18]

Facilitating payment reform. States can also provide critical support for the infrastructure needed to facilitate payment reform and changes to care delivery. They can support the information technology needed to aggregate data across systems to measure quality and costs.[19] Like the federal government, states can also work to provide technical assistance to private sector partners.

Project Methodology

In July 2013, NASHP convened and facilitated a discussion among high-level state and federal leaders. The meeting had multiple objectives: 1) state participants had the opportunity to learn about and discuss new opportunities and promising practices for payment reform with their peers, 2) states were able to learn

about new federal opportunities they can leverage to support payment reform, and 3) federal participants had the opportunity to learn about state approaches to payment reform and identify potential federal policy changes that can support state activities or better align federal strategies with state approaches.

NASHP conducted an environmental scan and synthesized background information about state and federal policy levers and initiatives to align federal and state efforts on payment reform and augmented those findings with the meeting discussion to produce this report. We narrowed the focus of the meeting and paper to three broad categories, selecting examples of reforms that fit into them: primary care-based initiatives, payment reforms to foster integration of providers across care settings, and broader accountable care initiatives.

The meeting and this report are the second in a series exploring opportunities for aligning federal and state policies to achieve shared goals related to achieving better quality, better health, and reduced costs. The first meeting explored potential for federal-state policy alignment to support delivery models that are emerging to link primary care providers not only to other medical service providers but also to resources in the community. [20] This report builds on the first report by considering payment reforms that support improved delivery of primary care, integration of care among primary care and other service providers, and transforming systems more broadly to achieve these goals.

A Look at Select Federal and State Initiatives

NASHP identified payment reform initiatives launched by the federal government and states in recent years to begin curbing unnecessary volume incentives, rewarding value, and reducing fragmentation of the delivery system. These examples were chosen to illustrate a framework of payment reform that builds outward from primary care-based strategies toward increasingly ambitious and expansive models. We examine: 1) reforms centered on primary care, 2) reforms radiating outward from primary care settings to facilitate links with other services, and finally 3) strategies for building on the first two approaches to create new, large-scale accountable care structures across settings and systems of care.

States are experimenting with a variety of approaches to payment reform, both within Medicaid programs and more broadly (see Appendix B for a table summarizing several state initiatives). Most federal activity in pursuit of payment reform is centered in CMS due to its importance as a payer and policymaking organization. Appendix A contains a sampling of current federal initiatives for payment reform, particularly within the Medicare program. The CMMI established under the Affordable Care Act has launched a number of payment reform pilots and initiatives, ranging from payment models to support enhanced primary care models to bundled payment approaches.

Payment Reform to Support Primary Care

Primary care is a popular starting place for federal and state payment reform initiatives due to its importance as the core of the "medical neighborhood" that encompasses the entirety of medical, community, and social services accessed by individuals.[21] Enhanced models of primary care like the patient-centered medical home seek to create financial incentives for care coordination, as well as prevention and early detection of health issues, in order to realize savings outside of primary care in the future and can serve as precursors to broader system reforms. These models establish a foundation upon which larger accountable and integrated payment models can build. The federal government and states are both fostering new payment approaches to reward performance and support patient-centered medical homes through direct payment and by leveraging contracting or convening strategies to engage others to support primary care payment reform.

Federal Initiatives. The federal government is experimenting with reforms to Medicare payments to primary care practices, in some instances in partnership with existing state and private reform initiatives. Through the Medicare Advanced Primary Care Practice (MAPCP) Demonstration, Medicare is participating in multi-payer patient-centered medical home initiatives in eight states, adopting the primary care payment model used in each state initiative.[22] Under CMMI's Comprehensive Primary Care Initiative, primary care practices are receiving monthly care management fees to help them better coordinate care for fee-for-service Medicare beneficiaries. [23] The federal government has also expressed support for these models for its own employees. The Office of Personnel Management issued a letter to FEHBP-participating insurers in early 2013 reiterating support for implementation of the patient-centered medical home model in health plans available to federal employees.[24]

State Initiatives. State strategies for payment reform vary, but they all seek to begin moving away from simple fee-for-service reimbursement strategies that promote provider silos and fail to reward quality. As of the spring of 2013, 29 states have adopted policies and are making payments to support the patient-centered medical home delivery model.[25] These payment models often layer additional per member per month or lump sum payments and requirements on top of traditional fee-for-service reimbursement to primary care providers to encourage greater care coordination and accountability.[26]

For instance, **Colorado** and **Maryland** are supporting patient-centered medical home models that rely on per member per month payments but allow for performance-based shared savings. **Rhode Island's** Office of the Health Insurance Commissioner has engaged Medicaid (both fee-for-service and managed care) and commercial payers in a multi-payer medical home program called the Chronic Care Sustainability Initiative (CSI-RI). Under the initiative, primary care practices receive per member per month payments whose value depends on achievement of performance targets related to utilization, quality, member satisfaction, and process improvement.[27] Medicare participates in CSI-RI through the MAPCP Demonstration.

Oklahoma's Medicaid program operates a patient-centered medical home primary care delivery system and offers performance-based incentive payments to primary care physicians who meet or exceed quality targets around factors like rate of screenings for children and cervical cancer screenings.[28]

Payment Reform to Support Integration Across Care Settings

Federal and state policy alike are building upon and moving beyond the platform of primary care-based payment strategies to promote integration with a broader array of providers and care settings. These efforts are taking various approaches, such as leveraging managed care contracts, using regulatory authority to revamp hospital payment or pricing, and supporting integration of a range of providers across settings (e.g. by reimbursing for episodes of care). The first paper in this series examined federal and state efforts to build linkages, often using new payment strategies, between primary care providers and community-based behavioral health care, public health, long-term services and supports, and socio-economic supports.[29] This section briefly explores payment strategies to support integration of providers inside and outside of primary care settings, including between hospitals and community-based providers.

Federal Initiatives. The federal government is supporting initiatives to encourage integration using Medicare payment policies that reward outcomes that can best be achieved via more integrated service delivery. As early as 2007, the Medicare Payment Advisory Commission (MedPAC), the body charged with advising Congress on Medicare payment policy, was exploring options for discouraging excess hospital readmissions for Medicare beneficiaries. This effort was in recognition of the fact that hospital actions, including "improved communication with community physicians and post-acute care providers," can lower readmission rates.[30] A Hospital Readmissions Reduction Program that institutes financial penalties to hospitals with excess readmissions around select conditions was authorized by the ACA and effective for hospital discharges beginning in the fall of 2012.[31]

The federal government is also leveraging its policymaking authority over Medicaid programs to provide new opportunities to states. Under the Money Follows the Person demonstration, states are reorienting payment incentives to encourage community-based long-term services and supports instead of care provided in institutional settings. The ACA created a new Medicaid state plan option that provides eight quarters of enhanced federal funding to support Health Homes for Enrollees with Chronic Conditions, a delivery model that seeks to integrate physical health care, behavioral health care, and community-based social services and supports for Medicaid beneficiaries with multiple chronic conditions. States may support health homes using per member per month payments or they may propose alternative payment methodologies.[32]

State Initiatives. More ambitious alternate payment models, like bundled or episode-based reimbursements, are promoting team-based care that bridges primary care and more specialized services. These models pay a fixed amount for a set of services associated with a particular episode of care or in a particular period of time.[33] For instance, **Arkansas**'s Medicaid program, in partnership with private payers in the state, has implemented a Health Care Payment Improvement Initiative under which providers are

eligible for risk- and gain-sharing around select episodes of care (e.g., care administered in the 30 days following a hospitalization for congestive heart failure).

Tennessee, which has rewarded performance and improvement through financial incentives in its contracts with plans participating in its Medicaid managed care program (TennCare) since 2006, is now beginning to explore bundled payment strategies, as well.[34] **Minnesota**'s Department of Health was directed by the state's 2008 health reform law to establish uniform "baskets of care," sets of health care services associated with particular conditions or episodes of care.[35] Providers in the state may opt to use and receive a single payment for these service bundles.

Maryland's Health Services Cost Review Commission launched a voluntary bundled payment initiative for hospitals in the state in 2012. Thirty-one hospitals across the state are participating. This initiative, called the Admission/Readmission Revenue (ARR) strategy, bundles payments for initial hospital admission and readmissions within 30 days.[36] A goal of this payment strategy is to incent better coordination between hospitals, primary care, and the community to prevent unnecessary hospital readmissions.

Payment Reform to Facilitate Accountable Care Models

Federal and state policymakers are beginning to explore strategies for building on existing payment reform approaches designed to improve primary care and integration. Policymakers are taking the next step beyond these approaches, facilitating larger system redesigns with the goal of creating accountable, fully integrated health care systems. These kinds of large-scale changes include engaging ancillary services and public health, moving toward global budgeting or statewide health care cost growth targets, as well as scaling existing reforms that are limited in scope or geography. Shared savings approaches are currently a popular strategy for transitioning toward these re-designs.

Federal Initiatives. Medicare's status as a major payer has made reform of its fee-for-service reimbursement approach essential for broader system reform. Under the ACA, CMS is rewarding providers that voluntarily link with partners to create ACOs that can coordinate patient care across the spectrum of care settings.

Under the Medicare Shared Savings Program (MSSP), ACOs can share in any savings achieved, provided quality of care does not suffer. As of the spring of 2013, more than 200 ACOs have been recognized under the MSSP, nearly equally split between physician-led and hospital-led ACOs.[37] Medicare has also designated 32 health systems as Pioneer ACOs that will chart a path beyond shared savings arrangements to population-based payment models, building on previous experiments at CMS like the Physician Group Practice Demonstration.

State Initiatives. Many states are developing models that fall under the umbrella of accountable care. While definitions of these models vary, they generally share certain characteristics: organizations (e.g., provider-led ACOs) assume responsibility for a defined population of patients across a continuum of care, with payment linked to measurable cost and quality indicators. [38]

Minnesota's Health Care Delivery Systems Demonstration is rewarding provider groups and integrated delivery systems that achieve savings below a total cost of care target while meeting quality performance requirements.[39] **Maine** is developing an Accountable Care Communities initiative in its Medicaid program that resembles the Medicare Shared Savings Program.[40] Each initiative uses a shared savings payment model, as well as a shared risk model for more advanced provider groups.

The **California** Public Employees' Retirement System has collaborated with a payer (Blue Shield of California), a hospital system, and a physician group to create an ACO for some of its members. This

pilot relies on a hybrid of shared savings and global payment approaches; the pilot has a global spending target and offers shared risk and savings among the participating hospital and physician group. Blue Shield and the two provider organizations operate under a three-way per member per month budget; each shares in the savings achieved under the target, and each bears financial risk for spending in excess of the target.[41]

Opportunities for Policy Alignment

The proliferation in payment reform initiatives at the federal and state level in recent years has left substantial room for greater alignment and improvement of existing policies. Representatives of states and the federal government implementing many of the initiatives featured above gathered in July 2013 to discuss the future of payment reform strategies, particularly at the intersection of federal and state policy. The themes that emerged stressed the importance of envisioning and operationalizing a deliberate path from primary care payment reform through payment models promoting more integration to accountable care models and beyond. Together, the themes and lessons below offer direction for greater coherence between future federal and state strategies.

Federal and state partners bring distinct and complementary capacities to engage key stakeholders.

Stakeholders across the health care system are involved in efforts to reshape care delivery and devise payment strategies to support a re-envisioned delivery system. Participants at the July 2013 meeting hosted by NASHP identified the initiation of a process for bringing stakeholders together as a key first step toward a system-wide reform of payment structures. The challenge, as one participant noted, is that in order to build a better functioning system "everything has to change simultaneously." Achieving change on that scale will require active participation and buy-in from a range of stakeholders.

Given their proximity to and existing relationships with many key stakeholders, states can take the lead in forging this consensus. As one federal participant noted, "states are the experts in what the local delivery system is equipped for" and so should be at the forefront of tailoring payment and delivery models to local circumstances. States with successful payment reform initiatives have fostered relationships with and between key stakeholders. In developing its multi-payer patient-centered medical home model, CSI-RI, **Rhode Island** invested two years in building trust and listening to the concerns of participating stakeholders. **Oklahoma** built support for its medical home program through as series of 23 regional town hall meetings that engaged providers and staff in the design of the program.

Participants noted the importance of initial stakeholder meetings as "group therapy sessions" in which stakeholders could discuss issues, express concerns, and build relationships. States may need to overcome sentiments like "the only way you can pay a primary care provider more is to pay a specialist less," which can pit providers against each other. As one participant noted, slowing health spending growth will not mean a reduction in total health spending from current levels: providers need not lose revenue under reform. One participant also observed that these meetings could be valuable for policymakers, advising that officials should look to innovative provider systems in their states to find reform ideas that are most likely to be effective.

Regardless of the process used by states to build consensus among stakeholders, federal messaging and policy must support state efforts. The federal government, as a major payer and regulator, has significant influence over the national conversation. Coherent signals from both the federal government and states can lend credibility to stakeholder engagement processes. More than just investing in and fostering new payment models, the federal government must promote these models to providers and patients alike. One participant noted that "we *alert* people about Medicare ACOs, we don't encourage them," suggesting that the positive attributes of new payment and delivery models are not being adequately conveyed at the federal level.

Federal and state levels of government must develop and share a long-term vision and defined transition process for payment reform strategies.
Ultimately, a key goal of any process with stakeholders must be to build consensus on a shared vision of a redesigned delivery system and the payment structures needed to sustain it, including a shared understanding of what it means to pay for value. Federal and state payment strategies that seek to support goals like keeping patients healthy, reducing hospitalizations, and encouraging successful outcomes ultimately aim to support care redesigns that facilitate the delivery of higher-value care. Payment reforms play an important role in enabling the emergence of new patterns of care delivery and making possible their sustainability.

Meeting participants agreed that investments in change must be supported by reforms to payment structures if they are to succeed. For instance, the Health Resources and Services Administration provided Federally Qualified Health Centers with tens of thousands of dollars to support practice transformation. While the funds were useful, they revealed the limits of what can be achieved with one-time investments in new care processes. Ultimately, the ongoing funding streams available to providers must support and reinforce the care delivery patterns that payers wish to see.

Participants stressed the importance of developing payment reform initiatives as part of a broader long-term vision of system change. While many projects are driven by the immediacy of short-term considerations, ultimately the viability of system change rests on the federal government and states having long-term strategies and visions in place. Meeting participants emphasized the tension between short-term and long-term considerations. Some participants noted that stakeholders in their states have been reluctant to join payment reform demonstrations in the past because demonstrations are by definition temporary, while others expressed concern about the stability of reform visions across changes in gubernatorial administrations.

Providers in **Rhode Island** have become more willing to take on greater challenges in payment and delivery reform because of the state's demonstrated commitment to sustaining its approach. The endorsement of the medical home model in standards adopted by Rhode Island's Office of the Health Insurance Commissioner helped to instill confidence in providers that the state was dedicated to a vision and not just short-term results.

Participants acknowledged that short periods of time are often not enough to show results from reforms, reinforcing the importance of commitment to a long-term vision. Practices may be able to build up their capacity to function as patient-centered medical homes over a few years, but the cost savings of new delivery models may not materialize over such short periods. In fact, participants suggested that attempting to accelerate that timetable or force immediate savings could be a deterrent to providers considering participation in reform initiatives. Providers are more likely to join initiatives if they are not pressured to find immediate savings but rather have the space and time to pursue sustainable changes to care delivery.

Participants suggested that providers will also be more comfortable in participating if the federal government and states specify and commit to a path the payment reform will take, identifying what the next model (e.g., global capitation) will be. Beyond understanding the federal and state vision for reform, stakeholders will benefit from understanding the transition pathway, including intermediate steps like shared savings that are an important way to pave the way to lasting payment reform.

Understanding how to "graduate" from medical home payments to accountable care payments is a key concern for state officials. However, some state leaders indicated that the patient-centered medical

home model remains a foundation of accountable care strategies. For instance, **Minnesota**'s Health Care Delivery Systems Demonstration exists alongside and in conjunction with the state's enhanced primary care initiative, health care homes; many participating delivery systems' clinics are certified as health care homes.

There can be a middle ground between models like medical homes and more comprehensive payment reforms that put providers at risk for the total cost of care associated with patients. Payers can think of payment approaches along a continuum with more transition steps. Providers can gradually become accountable for more facets of patient care without initially being held accountable for all care needed by a patient. They can gradually build more and more relationships with peers across the continuum of care.

Federal and state funders should view demonstration projects and existing initiatives as learning opportunities for future iterations of payment reform.
Current federal and state initiatives run the gamut from redesigning primary care, facilitating integration of different provider types, and facilitating more accountable delivery structures, yet there was a sense at the meeting that current approaches are often too haphazard. As implemented, these models may not be perceived as an intentional process toward achieving a broader vision. There was recognition at the July 2013 meeting that even if the federal government and states develop and agree upon the outline of a long-term vision of care delivery and the payment structures to sustain it, there will necessarily be a number of course corrections and revisions as each moves to implement it. Payment and delivery designs must evolve along with our understanding of what works and what does not.

Participants at the meeting felt having learning systems in place will be an important component in long-term success. Some participants worried demonstration projects are too often understood only as successes or failures, instead of being recognized as opportunities to improve program designs. Some expressed concern about what happens to state programs when federal demonstrations end. However, some participants pointed out that the Medicare Shared Savings Program grew out of a demonstration project, the Physician Group Practice Demonstration, lending credence to the idea that demonstrations can have sustainable and long-term outcomes.

Some state officials expressed frustration at the proliferation of federal grant opportunities, suggesting that the short timelines involved in designing them at both the federal and state level left little time to learn from previous efforts. There was a sense that an important opportunity to use demonstrations and grants as learning opportunities was being lost. Participants returned to the theme of the importance of advancing an overarching vision, suggesting federal grant opportunities and programs aimed at states should be part of a learning pathway for system change. Disconnected experiments and insufficient time for reflection and learning will not produce a coherent path forward. Accordingly, the real promise of the new Innovation Center at CMS is not in supporting isolated projects but rather in piecing together a better system and better way to construct health care payment and delivery.

Federal agencies must "look beyond the Medicare lens" to explore system-wide reform opportunities, including state-level issues. One participant noted one challenge to achieving alignment around integration of primary care with behavioral health services and long-term services and supports is that this goal has not generally been a multi-payer effort; Medicaid is a much more prominent purchaser of such services than either Medicare or commercial payers. Federal officials will need to appreciate issues facing states that may fall outside of the federal government's normal purview.

Strategies for ensuring provider access to meaningful information are critical for implementing payment reform and require federal and state assistance.
The success of payment reforms and delivery system redesigns hinges on the ability of providers and payers to operationalize them. Providers need information on their performance and on the populations they serve if they are to improve care delivery; payers need data if they are to reward performance and financially support higher-value care delivery. Meeting participants identified the collection and effective use of data and information as a critical component of any payment reform strategy. For instance, **Minnesota** is providing feedback on performance to providers as part of its Health Care Delivery Systems Demonstration, while **Tennessee** plans to provide actionable information through practice reports as part of its episode-based payment reforms.

Data analytics capacity is as important as having access to needed data itself. If the federal government and states share a goal of fostering more physician-led accountable care organizations, both levels of government will need to provide additional support in offering them access to meaningful information and showing them how to use it effectively. In order for physician-led groups and other provider systems with limited data analytics capacity to use data, understand attribution, and manage their populations as well as larger systems, federal and state technical assistance may be needed. One participant suggested that states or the federal government could support more learning collaboratives for providers on how to use the data. Building up data analytics capacity can help provider groups to restructure how care is delivered and develop a business case based on their own unique opportunities for improvement.

An important policy step that federal and state partners can take to support payment reform is to build a community resource to provide meaningful feedback to providers. In some states, this process will be complicated by competing efforts in the public and private sectors to develop information collection capacity. Regardless of how data is obtained and shared, participants stressed that providers need data upfront to understand the population for which they are responsible. Payment models that rely on retrospective attribution and data analysis may have unintended consequences, penalizing providers who keep patients well and depriving them of information they need upfront to improve outcomes for others.

Federal and state efforts to ensure the sustainability of health information exchanges (HIE) need to be linked. Just as information-sharing capacity can support payment and delivery system reforms, participants suggested that reformed payment approaches can support HIEs. In particular, support for HIE infrastructure needs to be built into reformed payment structures.

Recognize that federal/state alignment can take many forms.
Participants spent considerable time exploring the best ways to understand and approach alignment. As reflected in the findings above, discussion focused more on the opportunities for the federal government and states to align on a broader set of goals rather than aligning on particular payment reform models. There was general agreement among participants that there is no "silver bullet" to achieving the goals that payment reform aims to achieve. In line with the observation that local delivery systems differ in design and capacity, this approach to alignment stresses the need for a mix of models with different amounts of federal and state leadership, as well as different scopes and scales.

CMS has taken multiple approaches to aligning payment reform initiatives with other stakeholders in states. In the MAPCP Demonstration, Medicare joined with existing multi-payer medical home payment reform initiatives in eight states. The Comprehensive Primary Care Initiative, on the other hand, has taken the opposite approach, seeking to collaborate with commercial and state insurance plans around a new payment model. Participants suggested that having Medicare join more state-based payment reform

initiatives would be a major step forward. One participant suggested that in the long-term, the success of such initiatives will depend on Medicare's willingness to "put its weight as a payer" behind them.

Given constraints like the design of the Medicare Shared Savings Program imposed by federal statutory requirements, alignment may need to take on a broad definition. CMS is limited in its ability to alter certain aspects of the program to meet individual state needs or goals, but progress can still be made if states and commercial payers align parts of their initiatives where possible. States can also take a leading role in setting up learning networks to support providers, including those states taking part in federal reform initiatives. These networks can help providers align around a shared understanding of care coordination and integration.

Beyond strategies for alignment, the group considered existing federal mechanisms for promoting alignment. The 1115 Demonstration Waiver mechanism can be a powerful tool for implementing payment reforms, particularly for Medicaid populations that have complex needs, including medical, functional, and behavioral. Supporting more integrated service delivery may ultimately prove to be best done by states, but the federal government can facilitate state action and strategies through mechanisms like the waiver approval process.

Pulling it together: compiling next steps for the federal government and states

The themes and lessons described above offer concrete steps for federal and state partners as they seek to align efforts and push reform beyond primary care settings toward more integrated, accountable models. Experts at the meeting suggested:

- The federal government and states need to align on a broad set of payment reform goals.
- Federal and state payment reform models alike need to create more opportunities for limited accountability, allowing providers to transition from primary care-based payment to broader accountable care models by gradually taking on more risk and responsibility.
- Federal and state support for HIE must be built into reformed payment structures because greater access to data and information are essential to making payment reform and delivery redesign work.
- States would benefit by having Medicare join more reform initiatives at the state level to ensure they are sustainable and they are not undermined by the absence of such a significant payer.
- A streamlined Medicaid waiver process that allows for expedited approval of proposals when their provisions fall within parameters specified by CMS would not only help the federal government to support alignment of successful approaches across states, it would prevent "all of the energy getting sucked out of the project during the Medicaid waiver process," as one state official put it.
- There must be more coherence and "connectedness" between federal grant opportunities and programs for states. Different opportunities should be part of a purposeful framework and should reinforce a pathway forward.
- Reform needs to promote value in service delivery for more than physical health care. Services like behavioral health and long-term services and supports should be incorporated as payment reform models expand beyond primary care settings.
- States, with the implicit or explicit backing of the federal government, can host learning collaboratives to help providers align on and expand their understanding of care coordination, value-based purchasing, and data use.

Conclusion

Payment reform is essential for supporting redesigned care delivery processes that provide more integrated, higher-value care without financial incentives for unnecessary volume. Providers that seek to provide higher quality care while reining in costs need revenue streams that reinforce and reward the new care delivery patterns. Traditional fee-for-service payment has become an impediment to these new models because it rewards volume over value and teamwork. The federal government and states, with support from the Affordable Care Act and numerous pieces of state-level legislation or regulation, have launched a variety of payment reform initiatives in recent years. These initiatives have often begun by reforming payments to primary care providers, with some models taking an additional step to support greater integration between primary care providers and other service providers (e.g., behavioral health or long-term service and support providers). Other models are even more expansive, seeking to build accountable care structures that support better service delivery across a spectrum of care settings.

Officials from the federal government and several states gathered in July 2013 to discuss opportunities for aligning payment reform strategies. The discussion emphasized areas where federal and state opportunities to promote alignment overlap, as well as areas where the two levels of government have different responsibilities in an aligned system. Both the federal government and the states must align around a shared vision of delivery system change and the payment structures needed to support it, leaving room for state-level tailoring and innovation. They can also collaborate on payment models that Medicare and Medicaid will both pursue, as they have in states where Medicare has joined state-level primary care payment reform initiatives under the MAPCP Demonstration.

In areas where federal and state responsibilities differ, the two levels of government can support each other. States can take the lead in convening stakeholders to tailor a state-level vision and transition pathway, but these efforts will have more weight if reinforced by federal signals. The federal government can leverage the Medicaid waiver approval process to promote both innovation and alignment in states, as well as more carefully connect federal grant opportunities to support a coherent vision. Both levels of government can do more to ensure that they are learning from demonstrations and initiatives to continually refine a vision of system change. Together the federal government and the states can support transition processes to promote payment models that facilitate better care delivery.

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APPENDICES

Appendix A: Select Federal Payment Reform Initiatives

Initiative	Description	Status
Money Follows the Person[42]	The "Money Follows the Person" Rebalancing Demonstration Program (MFP) helps states rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-two States and the District of Columbia have implemented MFP Programs. National contractors with subject matter expertise are available to support CMS, MFP grantees and others with technical assistance on program implementation, promote best practices and provide guidance on MFP quality improvement strategies to enhance system performance and individual consumer outcomes.	First grants awarded in 2007
Medicare Advanced Primary Care Practice Demonstration[43]	Under this demonstration program, Medicare participates in existing state multi-payer health reform initiatives that currently include participation from both Medicaid and private health plans. The demonstration program pays a monthly care management fee for beneficiaries receiving primary care from advanced primary care (APC) practices. The care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients. Additionally, each participating state has mechanisms to offer APC practices community support and linkages to state health promotion and disease prevention initiatives.	Implemented beginning in late 2010
Health Homes for Enrollees with Chronic Conditions[44]	Medicaid State Plan Option to create Health Homes for Enrollees with Chronic Conditions. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Health Homes are limited to Medicaid beneficiaries with multiple chronic conditions.	First State Plan Amendment approved in late 2011
Office of Personnel Management Support for Patient-Centered Medical Homes[45]	The Office of Personnel Management encourages carriers that contract with the Federal Employees Health Benefits Program to support the patient-centered medical home model. OPM allows carriers with experience-rated contracts to submit investments to support PCMH transformation for consideration outside their administrative expense limit if needed.	Model was initially encouraged by OPM in 2011

Initiative	Description	Status
Medicare Shared Savings Program[46]	The Shared Savings Program allows provider organizations that voluntarily enroll as ACOs to share in the savings if they lower the growth in their health care costs while meeting performance standards on quality of care.	First ACOs under the program were announced in 2012
Pioneer Accountable Care Organizations[47]	The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with—but separate from—the Medicare Shared Savings Program.	Performance period began in 2012
Comprehensive Primary Care Initiative[48]	Medicare is working with commercial and state health insurance plans to offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that chose to participate in this initiative are given resources to better coordinate primary care for their Medicare patients, and after two years are offered the chance to share in any savings they generate.	Participating primary care practices were announced in mid-2012
Medicare Hospital Readmissions Reduction Program[49]	Under the ACA, Medicare is reducing payments to hospitals with excess readmissions for three conditions: acute myocardial infarction, heart failure, and pneumonia. The program is effective for hospital discharges beginning October 1, 2012.	Effective for discharges beginning October 1, 2012
Medicare Value-based Purchasing (VBP) Program[50] **and Physician Value-Based Modifier**[51]	The ACA established the VBP Program, a pay-for-performance approach under which Medicare makes incentive payments to hospitals based on 1) how well they perform on select quality measures, and 2) how much they improve their performance on each measure during a baseline period. The ACA also mandated that by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule. Both cost and quality data are to be included in calculating payments for physicians. By 2017, the Value-based Payment Modifier is to be applied to all physicians who bill Medicare for services provided under the physician fee schedule.	VBP Program is effective beginning in FY2013; value-based modifier for physicians begins for some groups in FY2015

Initiative	Description	Status
State Innovation Models Initiative[52]	The Center for Medicare & Medicaid Innovation is providing states with grants to support the design and testing of state-based models for multi-payer payment and delivery system reform.	Initial awards were made in February 2013
Bundled Payments for Care Improvement Initiative[53]	Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. The initiative is using four models: 1. Retrospective acute care hospital stay only 2. Retrospective acute care hospital stay plus post-acute care 3. Retrospective post-acute care only 4. Prospective acute care hospital stay only	Participating organizations were selected in 2013

Appendix B: Select State Payment Reform Initiatives

This list is meant to be illustrative only and is not inclusive of all payment reform efforts within and across states.

State	Initiative	Description	Status
Arkansas	Health Care Payment Improvement Initiative[54]	Providers serving Medicaid, Arkansas Blue Cross Blue Shield, and Arkansas QualChoice are eligible for risk- and gain-sharing for five episodes of care based on average cost of care per-episode, assessed yearly based on claims data. Gain-sharing and risk-sharing is dependent on achievement on "must pass" quality indicators which differ for each episode type.	Performance periods begin in 2013
California	CalPERs Accountable Care Organization[55]	California Public Employees' Retirement System (CalPERS)—an executive branch agency that is responsible for providing retirement and health benefits to public employees, retirees, and their families—launched an ACO pilot in partnership with Blue Shield of California and select providers in 2010.	Implemented in 2010
Colorado	Accountable Care Collaborative[56]	Seven Regional Care Coordination Organizations provide medical management, care coordination among providers and services, and support to providers, and are accountable for quality and cost through utilization-based incentive payments and a shared savings program. In the initial phase, incentive payments are available for performance. A shared savings component is expected in the future.	Implementation began in 2011

State	Initiative	Description	Status
Maine	Accountable Care Communities[57]	Under the MaineCare Accountable Communities initiative, Medicaid providers will enter into alternative contracts directly with the Maine Department of Health and Human Services. These contracts will use a shared savings model, with the amount of shared savings linked to provider attainment of quality benchmarks. The initiative's design is modeled after the Medicare Shared Savings Program.	Initiative under development as of mid-2013
Maryland	Hospital Admission/ Readmission Revenue Episode Payment Structure[58]	The Admission-Readmission Revenue arrangement is a voluntary revenue constraint program developed by the Maryland Health Services Cost Review Commission. It provides hospitals with a financial incentive to more effectively coordinate care and reduce unnecessary readmissions to their facility. The methodology results in the establishment of a Charge per Episode constraint. A Charge per Episode target for a facility applies to inpatient admissions and readmissions and subsequent readmissions up to a maximum of three readmissions.	Implementation began in 2012
Massachusetts	2012 Cost Containment Law[59]	Under its 2012 cost containment law, Massachusetts established a quasi-independent Health Policy Commission to establish and monitor a state health care cost growth benchmark, certify ACOs and patient-centered medical homes, and administer the state's Healthcare Payment Reform Fund. The state's exchange, state employee health plan, Medicaid, and private insurers are required to implement, to the maximum extent possible, alternative payment methodologies to fee-for-service. The reforms also contained new price and data transparency requirements for insurers.	As of mid-2013, not yet implemented

State	Initiative	Description	Status
Minnesota	2008 Payment Reforms[60]	Minnesota's 2008 reform law called for the creation of a standardized set of quality measures for providers across the state, as well as a provider peer grouping system to allow consumers and purchasers to compare providers on risk-adjusted cost and quality measures. "Baskets of care" were established for services usually delivered together, as was a statewide system of quality-based incentive payments to providers. The law also created certification standards for health care homes.	Initial baskets of care were identified in 2010
Oklahoma	SoonerExcel Patient-Centered Medical Home and Performance-Based Payments[61]	Oklahoma has implemented a patient-centered medical home primary care delivery system for most Medicaid beneficiaries through its primary care case management program, SoonerCare Choice. SoonerExcel is the performance-based reimbursement component that recognizes achievement of excellence in improving quality and providing effective care. The SoonerExcel "bonus" payments are made to qualifying providers that meet or exceed various quality-of-care targets within an area of clinical focus selected by Oklahoma Health Care Authority.	SoonerCare PCMH implemented in 2010
Oregon	Coordinated Care Organizations (CCOs)[62]	CCOs are responsible for integrating and coordinating physical, mental, behavioral and dental health care for Medicaid enrollees. They will operate under global budgets that include capitated per member per month (PMPM) payments, transformation incentive payments, and Medicare funding to blend with Medicaid funds for dual eligibles. CCOs are expected to move beyond fee-for-service payment mechanisms for compensating health care services providers.	Implementation began in 2012

State	Initiative	Description	Status
Rhode Island	Chronic Care Sustainability Initiative (CSI-RI) [63]	Under CSI-RI, nearly 100 percent of payers in Rhode Island are using a common approach to reimburse participating medical homes for providing enhanced services. Practices receive a base payment PMPM in the first year of the renewal contract; after the first year, PMPM payment can increase or decrease based on achievement of performance targets related to utilization, quality and member satisfaction, and process improvement. Utilization targets are aggregates which consider utilization across CSI practices.	First convened in 2006
Tennessee	TennCare Pay-for-Performance Quality Incentive Payments[64]	TennCare, Tennessee's Medicaid managed care program, offers quality incentive payments for six physical health Healthcare Effectiveness Data and Information Set (HEDIS) measures and for three behavioral health HEDIS measures to managed care organizations (MCOs). MCOs are eligible for incentive payment if they demonstrate significant improvement from baseline for the specified measures or meet a specified goal. As of 2013, TennCare is exploring episode-based payment options.	Pay-for-performance incentives first offered in 2006

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