Alaska Healthcare Transformation Project A Roadmap for Reform: A New Journey for Alaska Health Care Delivery

DATE: OCTOBER 28, 2019

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Executive summary

During the fall of 2018 and the spring of 2019, NORC at the University of Chicago (NORC) and its partners at the University of Alaska Anchorage (UAA), referred to as the NORC team, worked with the Alaska Healthcare Transformation Project (AHTP) and its Project Management Committee (the PMC) to support the state's vision of improving "the health of Alaskans while also enhancing patients' and health professionals' experience of care and lowering the per-capita healthcare growth rate."¹ NORC's charge consisted of four separate scopes of work (SOW), as follows:

- Alaska Historical Project Scan. Identify and assess selected delivery system reform experiments in Alaska over the past decade (2008 to the present), with priority to characterizing regional innovation within the state.
- Alaska Studies—Meta-Analysis. Identify and assess a group of Alaska-focused reports and studies issued over the past decade (2008 to the present) that concern health reform.
- **National Scan.** Develop case studies for selected states where delivery system reform relevant to Alaska's five key topics of interest offers lessons for prospective innovation.
- Drivers of Health Care Costs and Spend in Alaska. Review health care spending in the state and provide an assessment of the data available to support a fine-grained analysis of cost drivers. Propose recommendations of options for reforms that would likely reduce costs; in discussion with the PMC, work towards short-term and long-term steps towards implementation of one or more reform options.

This report focuses on the fourth item; the scope of work intended to acknowledge the historical analyses, draw on the state case studies, assess the current status of healthcare spending, and examine new approaches to cost-reductions as evidenced by the experiences of other states nationwide. This report provides options for reform in order to help Alaska make decisions on implementing health care transformation. While the details of the options require further refinement, our findings suggest some recommended starting points to lower Alaska's very high health care costs. The research team recognizes the unique aspects to and influences on health care delivery in Alaska, as well as the current economic situation. Costs continue to increase, while both public service and household budgets have become tighter, so there are revitalized efforts to bring innovations in care delivery and value-based payment (VBP) reforms to the state. In addition, consistent with evidence on the impact of social determinants of health (SDOH) on health care use and costs, there is growing recognition for addressing these factors.

Preliminary findings of this report were presented to the Alaska Healthcare Transformation Project Convening Group and Project Management Committee on July 10 and 11, 2019. The AHTP Convening Group represents a diverse body of stakeholders, including multiple payer, provider, academic, and patient representatives from different industries and disciplines. The NORC team presented recommendations and the stakeholders in the room discussed their overall level of agreement with each recommendation, pros and cons, and strengths and limitations. While the key recommendations in this final report remain consistent with the research team's key suggestions, the order and emphasis consider the actionable next steps and implementation strategies discussed by the PMC and AHTP Convening Group. As the NORC team recommendations are presented in the following pages, we make note of the insights gathered from the Convening Group and PMC. In particular, we note the AHTP recommendations as adopted by the PMC and conveyed in a letter of July 19, 2019 to the State and Foundation Funders of the project as well as subsequent Work Group Charges.

Many states have implemented reforms with the intent to improve the efficiency of payment, promote high-quality care delivery, and build analytic capacity for data driven decision-making. While this report draws on insights and lessons learned from other states, we fully recognize the unique nature of Alaska and the necessity to draw on the depth of knowledge of its stakeholder community to determine shared goals and the most appropriate short-term and long-term steps towards implementation. This report is limited to using publicly available data for studying health care prices and utilization, as there is no readily available, accurate and current data source within the state for studying costs across all payers. We believe that improving the quality and detail of data available to policymakers and stakeholders is a critical step towards reforming the healthcare landscape in Alaska.

The report lays out a variety of specific policy and payment tools available to shape reform. Lessons from other states suggest that adoption and implementation of reform requires commitment to an iterative, long-term process, with a willingness to make pragmatic course adjustment as necessary. In this report, we emphasize the value of governing structures, data analytics, and multi-stakeholder approaches. We also provide an explanation of the key factors that will enable transformation; more granular cost-savings estimates of the options discussed are needed. First, we review levels of spending, followed by some regulatory and regional considerations in Alaska. We then briefly discuss some tools for cost containment, followed by structures that are necessary for these tools to be operationalized in an effective manner. We then provide a close look at some of the options the PMC has highlighted of greater interest, and close with our recommendations. We also provide seven technical appendices on 1) outreach efforts to obtain data; 2) a summary of publicly available data; 3) details on all-payer claims databases (APCD); 4) screening tools and examples of state efforts around SDOH; 5) a synthesis of workforce recommendations from prior consultants; and 6) an example of a health care transformation readiness assessment.

Healthcare Spending in Alaska:

In 2014, Alaska had the highest per-person health care spending at \$11,064 (almost 38% above the U.S. average of \$8,045).² Alaska's growth in health care spending has consistently been higher than the national growth in health care spending and has increased significantly faster than the national rate. Between 1991 and 2014, Alaska's health care spending grew at a rate of almost 8%, almost two percentage points above the average U.S. growth rate (7.8% in 2014, compared to 6.0% nationally).²

Using Anchorage as a specific point of comparison and more recent commercial and Medicare claims data from the Health Care Cost Institute (HCCI), we compared Anchorage health care prices and utilization rates with three different comparison groups comprised of states with similar annual GDP per capita, real income per capita, and population density. Anchorage's healthcare price for all services were 165% of the national average, with the highest at inpatient services at 196% of the national average. Between 2013 and 2016, Anchorage experienced an 18% growth rate in prices. Cities with similar gross domestic product (GDP) saw increases between 10% and 17%. Anchorage's usage rates were below the

national average across all services except outpatient where they were on par with the national average. Between 2013 and 2016, usage rates declined in Anchorage by 5%. The decline in usage was less pronounced than in the other three comparison units with similar GDP levels.

About 63% of Alaskans have private coverage, either employer-based, direct purchase, or TRICARE.ⁱ As of 2016, commercial provider payment levels in Alaska were 76% higher than levels nationwide; physician payment levels were 148% higher and hospital payment levels were 56% higher.³ Employer sponsored coverage, or insurance purchased directly from a commercial insurer, is 358% of the nationwide base Medicare payment levels, or about 1.8 times the national commercial average. Premiums are also higher than the national average.

About 23% of Alaskans are covered by Medicaid. Medicaid fee-for-service (FFS) physician reimbursements rates in Alaska are about 2.3 times that of the national average Medicaid reimbursement in 2016.⁴ While Alaska's overall health care spending per capita is high, it's spending on Medicaid dollars as a share of the budget ranked near the bottom for all states. Alaska was ranked 46th lowest on Medicaid spending as a share of total state expenditures in FY2016. There is also considerable heterogeneity in spending across regions, due to population need, and based on regional economic conditions,

About 12% of Alaskans are covered by Medicare. Medicare reimbursement levels in Alaska exceed the rates for the lower 48 states. An analysis from 2011 showed that Medicare physician rates in Alaska were about 127% higher than the average Medicare reimbursement in select comparison states.⁵ One of the factors used to determine Medicare reimbursement for Alaska, the Physicians Work Geographic Practice Cost Index (PW GPCI), was set by statute at 1.5, which is approximately 50% higher than elsewhere.

Hospital margins increased from 8.8% to 16.1% between 2008 and 2014; low occupancy rates in some areas accounts for high operating costs, but rates in Anchorage are higher than the nationwide average. Hospital payment levels in Alaska are 373% of nationwide Medicare base, and 1.7 times the nationwide commercial average.³ Prices for medical items in Alaska have also increased, unparalleled to other consumer goods. For example, the total Anchorage consumer price index (CPI) was up 77% from 1991 through 2017 but the medical care part of the index was up 210%. Thus, prices for medical items increased nearly three times faster than prices in the overall CPI.

Health care professionals' annual salaries in Alaska are about 27% above the national average and the third highest in the nation; among physicians and surgeons, salaries are 21% higher than the national average and the third highest in the nation. High compensation levels may partly be due to difficulties in recruiting and retaining health care professionals in Alaska. Alaska attracts most of its physicians from outside the state. Nevertheless, despite annual salaries that are higher across all health care professionals, there still exists shortages in the state, with 85 primary care areas in Alaska designated as Health Professional Shortage Areas (HPSA) by the Federal government.ⁱⁱ Data from the Kaiser Family Foundation shows that only 26.3% of the need for primary health care professionals in Alaska is met, nearly 20 percentage points lower than national rate of met needs (43.9%)

ⁱ TRICARE provides health insurance to military service members, their families, and retirees.

ⁱⁱ To have a shortage, an area must meet the following population-to-provider ratios; for primary medical care it is 3,500 people to

¹ practitioner; for dental care it is 5,000 to 1; and for Mental Health Care professionals it is 30,000 to 1.

The high health care costs place strain on public personnel budgets in both public and private sector, and can create further challenges for Alaska to attract and retain employees and grow business. Public employee health costs are about 1.6 times the U.S. average and individual premiums are 1.5 times the U.S. average.^{iii,6} A recent study examined the effect of excessive health plan cost growth and found Alaskan employees have foregone around \$2.74 billion in wage increases over the past decade.^{iv} Elevated levels of spending have not bought better health in Alaska and there is no clear relationship between price variation and quality of care. And cost is still a significant barrier to care for many.⁷ In considering value-based reforms, we examine some factors unique to Alaska.

Alaska-Specific Context:

Alaska deals with many of the same health care cost drivers as other states but also faces unique problems such as a small population, large land mass, and many isolated communities. The distribution of the Alaska population makes it difficult to administer and access care, causing stark differences between the circumstances and costs faced by residents of different communities of the state. Alaska is a highly rural state: 86% of its municipalities are not connected to the road system, and 79% of municipalities are rural, with populations less than 1,500 residents and 13% have less than 100 residents.⁸ A recent study showed that costs for hospitals in Alaska are 38% above the average operating costs in comparison states; among rural facilities, costs are 86% higher.¹ Rural facilities incur high costs due to low occupancy rates. With fewer admissions, fixed operating costs for hospitals must be allocated to fewer patients, which contributes to the high prices.

Native Alaskans are the largest minority and are geographically spread out across the state with many living in rural communities. Alaska's Tribal health system serves about 20% of the Alaska population. Unlike the federally-run Indian Health Service (IHS) facilities in the lower 48 states, Tribal health authorities operate health care facilities under compacts with IHS.^v The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of all the Tribal health authorities in Alaska. ANTHC and Southcentral Foundation, the Anchorage area Tribal health authority, jointly own and manage the Alaska Native Medical Center (ANMC), a tertiary care facility. Tribal health clinics are the only providers in some rural areas, and they serve non-Native population in those areas.

Alaska's economy is driven by oil prices, unlike the rest of the U.S. When the U.S. economy experienced the extended slowdown that began with the Great Recession in 2007, Alaska experienced only about 18 months of moderate job losses in 2009-10. On the other hand, plunging oil prices put Alaska into a recession, albeit a relatively mild recession, from 2015 through 2018. On the price side, everything is more expensive in Alaska.

ⁱⁱⁱ The actuarial value is the ratio of expenses paid by the health plan to the total expenses eligible under the plan. An actuarial value of 80% indicates that 80% of health care expenses eligible under a health plan will be covered by the plan and 20% of the expenses will be covered by the employee.

^{iv} Mark A. Foster & Associates: Estimate based on CMS private health insurance cost per enrollee from 2007-2014, with MAFA projections through 2017 for Alaska adjusted to reflect "excess cost premium" and "excessive cost growth premium" in Alaska compared to U.S. applied across Alaska employment wage base.

^v For details on compacting and contracting under IHS Tribal Self-Governance Program, see <u>https://www.ihs.gov/selfgovernance/aboutus/</u>

The state health care policy environment

Each state has its own unique care delivery and policy context and history, based on the individual needs of the state and the set of historical legislative decisions and marketplace configurations that have influenced the cost of care. Alaska is no different. We worked to identify factors in the policy realm that could potentially play a role in influencing health care cost in Alaska. It is important to note that no single policy factor drives health care spending, but rather there are multiple factors that may have an influence on cost growth. Alaska has higher health care costs in part because health care policy has emphasized increasing access and has placed less emphasis on constraining costs. The goal of improved access has included increasing the number of specialists and primary care physicians and improving access to primary care in rural areas. Alaska also has unique laws to ensure patient choice and access, but these may also ultimately contribute to higher costs.

Going forward, Alaska may need to consider whether greater concern for health care costs may require modifications in the established policies that emphasize independence for patients and providers. Controlling cost will involve hard decisions about short-term and long-term challenges that will require difficult discussions with many stakeholders and policy makers to make the necessary changes. Greater price transparency and careful consideration of existing state policies that may have an impact on prices, along with better purchasing strategies, can likely also impact the rise in prices. It is important to note that, just as there is no single cause for the higher health care costs in Alaska; there is no single "silver bullet" to temper their increase moving forward. Many states are using multiple pathways to improve the value of the health care spending, and Alaska will likely decide to do the same.

Critical to the path forward is timely and detailed health care cost data. The lack of the availability of such data restricts Alaska's ability to identify, characterize, and address important questions. Alaska has not created an institutionalized capacity to conduct health care policy research. There is a considerable data gap for research and for monitoring and evaluating current trends and reforms. Alaska is beginning to look at VBP models and, with the right institutional structures, leadership, and stakeholder engagement, there are opportunities to apply new VBP tools in Alaska. Next, we summarize some VBP approaches for Alaska to consider, with examples from other states that have adopted those approaches.

Tools for Cost Containment

Value-based payment (VBP) refers to methods of paying providers that incentivize an efficient use of health care resources to constrain cost growth, in contrast to paying providers for each service, regardless of its effectiveness. This shift has been referred to as moving from "volume to value". There are many forms of VBP and all seek to create mechanisms that encourage providers to assume some or all of the financial risk. Federal legislation enacted in 2015 aimed to increase provider participation in VBP by requiring providers who accept Medicare payment to participate in one of two quality payment programs. One program includes several types of VBP arrangements known as Alternative Payment Models (APMs). The second is the Merit-based Inceptive Payment System (MIPS), which requires physicians to

report measures across four objectives.^{vi} Providers that participate in an APM avoid the reporting requirements of MIPS.

The Centers for Medicare & Medicaid (CMS) designed these models with an understanding that physicians will first participate in MIPS, and then move into an APM as they become more available. CMS had a goal of achieving 90% participation in APMs by 2018.⁹ VBP models include per-member permonth care coordination fees, bundled payments, shared savings and shared losses, incentive payments, and partial and full-risk managed care. Payment reforms can spur innovation in care delivery, as providers can use financial incentives to invest in improvements to the care delivery environment, tools such as physician telemedicine, and remote tele-diagnostics. To achieve that end, the U.S. Department of Health and Human Services (HHS) established the Health Care Payment Learning and Action Network Alternative Payment Model Framework (HCP LAN) to help organizations develop the capacity to implement successfully alternative payment models.

All of the case study states included in our National Scan incorporate VBP into their health reform efforts. For example, a number of states have used the HCP LAN in their MCO contracts. As Alaska considers options of VBP approaches, there are a number of tools and lessons that can be borrowed from other states. States can adapt these reforms to different settings and involve one or more payer, as well as vary their level of involvement. Many of these payment approaches can be implemented contemporaneously and complement each other. For example, there may be synergies and momentum from multi-stakeholder collaboratives that find consensus on designing provider reimbursement and incentives. In addition, states have come to understand that they can improve the health of their populations and potentially lower health care costs by focusing on factors outside the care delivery system that impact on health costs outcomes, and SDOH.

Governance structures, data infrastructure, and analytic capacity

Implementation of value-based models of care require both the availability of data and information to inform and guide efforts, as well as a coordinating entity with sufficient authority and capacity to ensure effective and collaborative policy development and implementation. Having a trusted entity that can both conduct the analyses necessary to guide policy development, as well as recommend health policy options to legislators, is a key to sustainable reform. Such entities can work across stakeholder groups and government agencies and maintain neutrality so that their work maintains broad buy-in.

Our analysis shows that these entities can be structured in a variety of ways. As the saying goes, form follows function: some are independent executive agencies, charged with carrying out legislated actions and policy goals, and are situated inside state government. Others exist outside government, in a non-profit or quasi-governmental capacity, and coordinate with the state but conduct independent data and policy analyses, and may also serve to convene other stakeholders. Other models are situated at stand-alone centers at universities, providing analysis and the ability to tap the expertise of both professional staff and university faculty. However Alaska may structure it, this entity would both facilitate and

^{vi} These are e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. The MIPS is one source suggested at the AHTP stakeholder meeting as one set of measures on which to align payers.

coordinate the activities required for successful transformation, as well as conduct or direct the analyses of data in order to understand opportunities for improving healthcare quality and value.

Any transformation effort will require data to identify opportunities for reducing spending and improving quality. Just as data helps providers make decisions about treatment, collecting data on outcomes across all payers would improve the capacity of policy makers to monitor and control costs. In addition, annual reports from all payers would help mitigate cost shifting among payers and provide price transparency to consumers.

The data available to researchers and policy makers in Alaska currently are insufficient for timely and accurate analyses required for understanding the levels, trends, and variation in health care cost and use. A centralized database with claims from all payers that includes five-digit ZIP codes to assess geographic variation and information on plan characteristics would be valuable to understanding price variation. For reasons we detail in this report and the Appendix, while Alaska may have sufficient Medicaid data, health data for state and local employee and retirees may not be representative to address many of the research questions on health care costs in Alaska.¹⁰

In addition, the state lacks access to data from the commercial sector. Purchasing data from firms that collect claims from commercial insurers is problematic for several reasons. The data would lack geographic or facility level identifiers, and be available for a limited set of procedures. In addition, the data would reflect a limited number of covered lives and likely preclude the ability to conduct regional analysis. Thus, it would not allow for detailed analyses of cost drivers and be of limited value in helping the state compare quality and costs among payees in the state. In addition, given that the cost of purchasing data from these vendors ranges from approximately \$35,000 to \$100,000 per year, we do not find much value in purchasing these data as a strategy.

Rather, investing in a centralized data source, namely an All-Payer Claims Databases (APCDs) would be valuable to understanding price variations and health care marketplace dynamics. APCDs are a tool to overcome the challenge of trying to collect pricing and spending information from a diverse set of providers. The primary effect of an APCD is to add data from private commercial insurance and from any voluntary provision by self-insured private sector employers. APCDs are intended to provide comprehensive information about health and healthcare across all settings and providers of care. Providing data to consumers on pricing may help consumers pick the best value, while it may help pressure high-priced hospitals and medical groups to limit their prices. The combination of claims data from all payers in the state provides the state with rich information on consumers of healthcare and the ability to examine longitudinal, person-level experiences of care. The establishment of an APCD was a recommendation made by the Health Care Commission, and APCDs were used in five of the seven states in our National Scan.

Alaska has a substantial opportunity to improve its data landscape as it continues its journey towards improving its health care system. Data analytics are not only foundational to VBP reforms, but also necessary to monitor the impact of different reform to inform policy. We next discuss some promising design options for VBP arrangements that step forward from the current FFS arrangement. We reiterate that the road to implementing any VBP model entails identifying opportunities for saving, clearing

barriers to change, designing reforms acceptable to all stakeholders, and accepting modest reductions from current spending levels.

Multi-payer Alignment

Multi-payer approaches are collaborative efforts between federal and/or state payers and commercial payers to reach shared goals by agreeing on strategic investments for care delivery transformation, such as shared investments in primary care, enhanced payment for practice transformation and embedded care management, quality performance-based incentives, population-based payments for investments in population health and coordination, and consistent performance metrics.¹¹ Multi-payer alignment can help ensure that purchasers and payers are coordinated in their efforts to transition to VBP, by aligning payment incentives and quality reporting measures. When payers agree on common performance measures and VBP principles and methodologies, and share investments in infrastructure to providers, they send "common signals" to providers about expectations while also reducing "noise" and provider reporting burden.¹² Conceptually, alignment of payment reform efforts across payers will result in synergies and efficiencies. It is also critical that providers be engaged early and thorough out the design of the approach and data collection; by doing so, providers may be more willing to engage in the investment of the payer efforts. For example, one study found all 17 of the home health models had physician leaders who supported the model implementation through provider outreach, education, and advocacy efforts.¹² A coordinated strategy across multiple payers designed with the input of providers has the following benefits:

- Consistent messaging and incentives to primary care practices;
- Reducing the administrative burden on providers who would otherwise have different merit-based incentive payments under different quality and payment methodologies; and
- Reducing cost shifting and the "free rider" problem and sharing investment responsibilities.¹³

Evidence from other states demonstrates that regulation of providers' prices and the use of global budgets, implemented in the public sector or in multi-payer models, and the use of delivery models such as coordinated managed care and accountable care organizations, have achieved savings. These models use collaborative approaches to engage providers to be part of solutions. These achievements were brought about largely through state legislation developed with the goal of cost reduction and health transformation. In Alaska, multi-payer coordination could be pursued by a working group under a lead entity that could bring together stakeholders to discuss and agree on principles such as rate setting or spending targets for services.

One option within a multi-payer approach is a global budget. These are fixed payments to providers for a specified population, or set of services, over a specific period, rather than fixed rates for each unit of service. They may be implemented at certain facilities (i.e., hospital global budgets) or as per member per month (PMPM) capitated arrangements. The theory is that this will encourage efficient use of both the intensity of services per an event (e.g., a joint replacement), as well as the number of events (total number of joint replacements). All-payer budgets have to date been most widely used in hospital settings, wherein a payer limits the amount of revenue a facility can receive in a year, regardless of the number of patients treated or the number of services provided. In multi-payer arrangements, each payer determines its

allocation to a hospital, usually set prospectively to cover its beneficiary population. In Alaska, multipayer arrangements for global budgets could be a long-term goal, pursued by working group.

There is also flexibility in global budgets; the fixed budget could actually be applied to specific settings, and through partial capitation or partial global payments. In the latter, providers receive a fixed (global) fee for specific services for each patient, but other services would be provided in a FFS manner with incentives for reductions. Specific services from specific providers could also be excluded from partial global payments. Similarly condition-specific capitation could be employed, which would be a global fee for all care received in treatment for the designated condition.¹⁴ A key advantage of this model is the potential to enable hospitals and providers to invest in clinical care improvements and population health initiatives. However, there are also potential unintended and adverse problems that could arise, though these may be mitigated by attention to design options and monitoring implementation with course corrections.

Later in this report, we provide details of two very recent innovative global budget models: 1) **Maryland's All-payer Total Cost of Care (TCOC)** model and 2) **Pennsylvania Rural Health Model**, a global budget model for rural hospitals that Pennsylvania recently adopted. In both of these models, participating providers are paid a fixed amount that is set in advance for the agreed upon services by all payers.

Decision Points in Implementation: There are a number of decision points in formulating these global budget models, and there are lessons learned from other states that Alaska can apply should it pursue this approach. An initial decision would be the level or setting of the global payments. To date, many initiatives have started with target limits on hospital spending, while others have limited growth in TCOC, through either voluntary participation of payers or mandatory participation through legislation. For example, a statewide implementation, with regional adjustments, may be efficient to reduce cost shifting to geographic areas that are not participating in the model. Other decision points include:

- the methodology to determine the specific budgets for each payer, such as based on historical claims data or capitation based target population served, or a combination;
- the use of any reference rates or spending growth limits;
- the methodology to determine the population attributed to each payer (the reference population);
- the methodology to adjustment for inflation and regional factors;
- the methodology to adjustment for demographics and health status changes in the reference population as well as catastrophic events;
- any shared savings or penalties and savings and loss-sharing limits;
- rewards for performance on quality measures and beneficiary outcomes; and
- the handling of outliers or unusually high cost cases.

Other implementation aspects, which are relevant to any approach, relate to specific interests in Alaska include stakeholder engagement and administration: engagement with Tribal health organizations, regionally-based care coordination, and using an administrative services organization (ASO) as a coordinating entity. The latter is examined in light of Alaska's Medicaid reforms, and that fully-capitated managed care has not been recommended nor pursued in Alaska. In the ASO arrangement, the state would retain the liability for all of the financial (claims and related expenses) and legal aspects of

employee benefits, and contract to a third party to coordinate services and provide technical and analytic support.

As Alaska implements value-based reforms and experiments with innovations in care delivery, it will need to cultivate a system of professionals with the appropriate level of different skills needed to address patients across the continuum-of-care settings and communities. Alaska has undertaken a series of workforce initiatives; we summarize recommendations on workforce issues from these projects in the Appendix 6. Telehealth can also expand interactions between patients and practitioners, and the technology is advancing rapidly. Programs piloting the provision of medical services via telehealth in Alaska have found that telemedicine can spur improvement in patient outcomes and satisfaction. However, the state would need to address the barriers to a broader adoption of telehealth programs (including limited telecommunications infrastructure, a lack of interoperability between systems, and provider reimbursement for telehealth) and adequately and sustainably support these investments.^{15,16}

The landscape of evidence assessed thus far highlights principles:

- Multi-payer approaches to payment reform can align incentives across the market, send common purchaser signals, and can reduce provider burden; independent evaluations show savings.
- Global budgets or all-payer rate setting are one point of multi-payer alignment that can provide predictable health care budgets and has shown to result in spending reductions.
- Addressing SDOH in VBP designs is important, particularly for Medicaid beneficiaries, because of their impact on outcomes.
- Given the unique needs and differences that exist across Alaska, reforms that allow for regional input in their design may help contribute towards successful implementation.

Below we provide policy and operational recommendations on key next steps for Alaska as it charts its course. The implementation decisions would part of the scope of the multi-stakeholder convened body to address.

Key Operational and Policy Recommendations

The recommendations below can be pursued by the state with varying levels of input and involvement from stakeholders across the health care community. However, because value-based arrangements may function best when all stakeholders collaborate, and payers are aligned on provider performance measurement and incentives, recommendations should be viewed as moving towards the longer-term goal of developing consensus. In the short term, the state can set up a value-based health care council, tasked with identifying goals for the VBP reforms. This council can then work on payment reform, and address issues such as data collection and reporting among payers and providers, with a goal of moving towards a global budget approach. Alongside this effort, another near-term goal for the state is to identify which social determinants of health are of highest priority and most feasible to address.

As the state identifies what goals it seeks to achieve, and what APMs it may wish to implement, it can look to existing organizations, within both Alaska and other states, to identify models of organizational entities that could carry out these functions. The entity would have the independence, accountability, funding, operational flexibility, and management structure sufficient to effectively operationalize the APM, perform the overarching goals of controlling health care spending while ensuring quality. 1. Develop a Governing Body to Oversee Implementation of VBP Goals. Our national scan showed that the designation of a lead entity to oversee the development of health care policy was a key to ensuring the sustainability and trust in ongoing health reforms. Having a trusted entity that can both research and recommend health policy options and conduct the analyses necessary to bring data, information, and thoughtful study to health care marketplace issues is a key to sustainable reform. Such entities can work across stakeholder groups and government, maintain neutrality but understand perspectives, so that their work is understood, trusted, and maintains broad buy-in.

Depending on state goals, there are a variety of ways such an entity can be structured and chartered: as part of state government; as an independent non-profit; as a quasi-governmental governing board; in partnership with an academic organization; or some combination. There are strengths and weaknesses associated with each approach, but importantly such governance must be consistent with the political, social, and historical context of Alaska. The state can establish workgroup processes to:

- identify the key responsibilities of the entity;
- ensure key stakeholder input pathways and representation;
- consider the best organization structure and placement; and
- identify key initial organizational charges.

In Chapter 4, we describe approaches states have used to leadership and governance of health care reform goals. Below are specific short and long-term activities for this leading entity.

Address key legal and regulatory barriers that may create obstacles toward meeting the goals of reform. As discussed throughout this report, changes to care delivery models require examination and changes to existing legal frameworks. As Alaska moves down the pathway to reform, we recommend that it conduct a review of state laws and regulations that may hamper competition or act as barriers to implementation and success of preferred reform models. This review would then identify what actions could be taken to remove these barriers, and the potential consequences of these actions. For example, Alaska's Choice of Health Provider statute may need adjustments to foster competitive provider networks, should Alaska choose to move towards using more organized provider networks and incentivizing consumers to use high quality efficient providers.

- a. **Develop paths to multi-payer VBP alignment**. This could begin with identifying opportunities in service delivery, and working reciprocally with the identification of barriers to reforms. The work of the entity would also be to develop processes to measure and monitor the impact of VBP alignment on the quality of patient care. Aligning payers on quality reporting and incentive is discussed in more detail in Recommendation #3,
- b. Identify key social determinants of health focus areas and develop incentives for health care providers to address them. This report provides a variety of ways that states are examining and beginning to address SDOH systematically. SDOH drive costs and spending in Alaska, and getting upstream to address them is a key to controlling spending moving forward. Alaska can establish a workgroup under the leading entity that will develop a process to identify key SDOH priorities, and evidence-based interventions

around these priorities. The workgroup could then conduct data analyses to understand the potentially avoidable costs associated with SDOH, and the costs of interventions to address them, and work with providers and community-based organizations to determine the level and type of investments and payment strategies for interventions. For example, the workgroup could develop a standardized community health needs assessment, and findings could then be the basis for requirements for state health related contracts with providers.

The workgroup can also collaborate with hospital and health-related foundations to fund the development and implementation of SDOH work in partnership with the state. The workgroup would also seek funding from federal and other resources, such a provider tax to help fund the work of SDOH for local communities to address these under an overall statewide framework.

> AHTP PMC Recommendation on a Governing Body to lead reform:

The AHTP will seek to establish a group of stakeholders to provide leadership and would work with the state to be a focal point for controlling healthcare costs by developing sound policy based on evidence. This entity would have authority and resources to analyze data, and provide policy direction based on the analysis of data, and make course corrections was viewed as needed and necessary. The Project Management Committee will convene a work group to identify the scope and key responsibilities, stakeholder representation, and organizational structure and rules of engagement. Further, it is requested the Governor assign a top member of his Administration to participate in the design work of the leadership governance entity. After establishing the organizational charges and processes, the leading entity would determine long-term path to incorporate the data function, payment alignment group, including approaches to incentivize addressing the social determinants of health.

2. Initiate discussion and action plans to establish a statewide APCD and ensure sufficient analytic capacity. The establishment of an APCD will be key in providing an ongoing and detailed source of information on Alaska's health care marketplace. Current, detailed, and complete data about Alaska's health care marketplace will be critical to developing and comprehensively monitoring policy changes to improve the cost, quality, and access to care in Alaska. Establishing an APCD will facilitate Alaska's ongoing efforts to improve affordability and many resources are available to guide the state. Twenty states now have APCDs; our report summarizes the authority and uses of APCDs in 10 states, and more resources can be found on the APCD Council website.^{vii}

vii For example, brief case studies of the success and challenges of five states can be found in such as "Realizing the Potential of All-Payer Claims Databases" by Freedman HealthCare. http://www.statecoverage.org/files/RWJF Realizing Potential of APCDs.pdf

However, APCDs can take several years to be fully operational. Until an APCD is operational, the state can take incremental steps towards data aggregation. The state could start by discussing with stakeholders the barriers and concerns they face towards participation. With sufficient buyin attained, stakeholders can begin to establish the details of data structure, principles, and requirements for reporting that support the core purpose of the APCD. This includes agreement on measurement strategies, data submission, oversight and access to the data, as well as the timeline for implementation. The state could also require all commercial insurers to submit claims data to a centralized claims database, and encourage interested private self-insured employers to contribute to the same database. While this data aggregation is pursued, the state can also conduct analyses of the initial and reoccurring costs of an APCD, and identify funding options.

It will also be essential that the development and oversight of the APCD be within a trusted entity with sufficient analytic capacity to effectively analyze and use the data. This entity would oversee the administration, analytics, and staffing to ensure effective use an APCD. Administration could be under the Value-Based Healthcare Council described above, or as a separate entity that would help maintain and update data submission and governance.

> AHTP PMC Recommendation on Data and APCD development:

The Project Management Committee will convene a work group to identify options available to the State of Alaska to develop an APCD system to gather cost and quality healthcare data and ensure sufficient analytic capacity to effectively analyze and use the data for understanding cost outliers, to better understand the relationships between cost and quality at the provider level, to information meaningful reforms that actually save money, and improve access and quality. The workgroup will discuss feasibility and options for incremental approach to an APCD or whether some other structure such as data warehousing is most appropriate for Alaska. If an APCD is pursued, it will:

- Identify possible out-sourcing opportunities for an APCD;
- Establish a realistic timeline for implementation that details what activities and stakeholders will be required across the pases of start-up and maintenance of the APCD or other data structure, including legislative actions and plans for sustainability;
- Identify the necessary statistical, systems, and analytics staffing to be able to effectively use the data, and best practices around data submission.

The PMC further recommended the Governor instruct the Commissioners of all Departments work in concert in any and all systems development for storage and analyses of state healthcare expenditure information.

3. Set multi-payer goals for VBP reforms using the HCP LAN framework or similar framework. Many states are now beginning to use such frameworks to develop strategic plans for moving towards VBP within their states. For example, in some states, Medicaid programs are surveying health plans and providers to gain a baseline understanding of the proportion of payments that are made under the various HCP LAN categories. They then can set goals on

moving the proportion of payments made that are value-based or that carry higher degrees of provider responsibility for cost and quality outcomes. Importantly, the state must be able to identify areas for savings and reform approaches that incentivize quality and changes in care delivery, and identify any barriers to achieving these goals.

a. Develop a multi-stakeholder working group that includes providers and patients in VBP design discussions. In coordination with or under the guidance of the governing body, this group would bring together payers, providers, and patients to find agreement on how to assess and implement payment and delivery reforms.^{viii} Cooperation and negotiation are critical and instrumental to successful implementation of VBP.^{ix} This workgroup would include an even mix of providers and payers (large insurers in the state, Medicaid, state employee groups, other governmental purchases), Tribal health representatives, non-traditional providers such as pharmacists, as well patient representatives. It would convene regularly to discuss policy goals and gain feedback around specific VBP options, including quality metrics and reporting requirements, goals for addressing SDOH and aligning incentives to help providers make infrastructure or human resources changes necessary for care transformation.

This workgroup would establish other work groups where necessary to examine some of the additional issues raised in this report. A recent report from the Milbank Fund and Pacific Business Group on Health (PBGH) synthesized lessons learned for policy makers interested in gaining buy-in from the commercial insurers, with detailed case studies of individual states.¹⁷ Recommendations from peer states, such as in the aforementioned study, and resources at the Network for Regional Healthcare Improvement, can help the participating workgroup members communicate state VBP goals to constituents.

There are also initiatives in the private sector, such as Robert Wood Johnson Health System and Barnabas Health, Northwestern Medicine in Illinois (Northwestern Memorial HealthCare and Cadence Health), and the partnership between AtlanticCare and Geisinger. As the business model for care delivery changes, new resources are available to help hospital and health system management understand how to design population health management and partnership processes for decision making.¹⁸

b. Move towards a regionalized multi-payer global budget approach by building on existing care coordination efforts. The state has had some experience with VBP initiatives, mostly with Alaska Medicaid and Medicare, such as the Alaska Medicaid Coordinated Care Initiative (AMCCI) and Bundled Payment for Care Improvement (BPCI) model implemented by the Alaska Hospitalists Group approaches. Alaska can build on this key initial work and engage other payers through the multi-stakeholder workgroup, for example, to align incentives for care coordination. For example,

viii At the AHTP stakeholder meeting, it was suggested the workgroup be a "Value-Based Healthcare Council".

^{ix} For example, Miller describes a number of approaches that will encourage participation by payers and providers. See Miller, H. D. (2018). Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services.

stakeholders can work together to consider how to incrementally expand target populations of interest, e.g. persons with high behavioral needs and/or social risk factors. These aligned payment incentives, through infrastructure and/or population-based payments, can help providers make infrastructure or human resources changes necessary for care transformation and management across the delivery spectrum. For example, they can design incentives for communities and providers, health departments and social services to groups to address behavioral health and social risks, such as housing and transportation.

While from Alaska, the experiences of Maryland, Vermont, Pennsylvania, and other states described in this report provide some excellent potential starting points for designing global budgets. These examples demonstrate the feasibility in rural environments. By providing predictability of budgets in rural areas, they allow for structured resource allocation discussions at the local level, and can provide an over-arching budgetary goal in non-rural areas. And, as multi-payer approaches hold maximum value for savings across the health care system by aligning incentives and reducing provider burden, the state should pursue a multi-payer approach recognizing that it is a longer-term goal. There are many design details important in global approaches, such as the service mix, how the budget should be set and enforced. We provide some details in Chapter 5, but we envision that the governing entity and work group described above would lead discussions around operationalization and possibly oversee implementation as well.

AHTP PMC Recommendation on Value Based Payment Goals:

The Project Management Committee will convene a work group to chart a path to move Alaska payers and populations from the fee-for-service arena to more VBP models identified in the HCP-LAN. In the short-term (over the next year), it will identify quality metrics that are consistent across all payers as a means to reduce administrative burden on providers, examine and discuss payment for preventive services, transition services, and identify new billing codes or ways to pay providers that align across payer goals. These steps will create an atmosphere conducive to conducting healthcare business as a first step towards aligning value with payment.

Also, in the short term, the PMC recommended that the Commissioner of the Department of Health and Social Services consider including three specific items in the contract for the Administrative Services Organization (Optum) to include: (1) a requirement of standardized Social Determinants of Health (SDOH) screening for all recipients served; (2) Value Based Payment development and design to include training and support of providers; and (3) a requirement for a formal linkage between Optum and the Aging and Disability Resource Centers to provide referral information for participating practitioners once a social need is identified through the SDOH screening for those individuals with a qualifying disability.

Chapter 1: Introduction

Report overview

In September 2018, NORC at the University of Chicago (NORC) and its partners at the University of Alaska Anchorage (UAA) commenced work with the Alaska Healthcare Transformation Project (AHTP) and its Project Management Committee (PMC) to support the state's vision of improving "the health of Alaskans while also enhancing patients' and health professionals' experience of care and lowering the per-capita healthcare growth rate."¹⁹ NORC's charge consisted of four separate scopes of work (SOW), as follows:

- Alaska Historical Project Scan. Identify and assess selected delivery system reform experiments in Alaska over the past decade (2008 to the present), with priority to characterizing regional innovation within the state.
- Alaska Studies—Meta-Analysis. Identify and assess a group of Alaska-focused reports and studies issued over the past decade (2008 to the present) that concern health reform.
- **National Scan.** Develop case studies for selected states where delivery system reform relevant to Alaska's five key topics of interest offers lessons for prospective innovation.
- **Drivers of Health Care Costs and Spend in Alaska.** Review health care spending in the state and the prospects and limitations of available data sources that would support a fine-grained analysis of cost drivers relevant to these reforms. Propose recommendations of options for reforms that would likely reduce costs; in discussion with the PMC, discuss short-term and long-term steps towards implementation of one or more reform options.

This report focuses on the fourth SOW, an examination of health care spending in Alaska, reform strategies, and the data required to inform these strategies. The SOW intends to build on the knowledge provided in the prior three reports, assess the current status of healthcare spending and challenges to cost-reductions, evaluate the experience of other states nationwide to date, and provide options for reform to help Alaska make decisions with regard to implementing health care transformation. A main goal of the final report was to provide a "Roadmap" of short- and long-term actions that Alaska could take to develop and implement health care transformation that achieves the following three goals of the AHTP:

- **Healthy Alaskans:** Increase the percentage of Alaskan residents with a usual source of primary care by 15% within five years
- **Healthy Economy:** Reduce the overall per-capita health care growth rate to the greater of 2.25% or CPI within five years
- Everybody's Business: Align all payers—public and private—toward value-based alternative payment models with streamlined administrative requirements within five years.

In addition, the PMC also defined five priority topics as building blocks of health care transformation in the state, as follows:

Increase Primary Care Utilization

- Coordinate Patient Care
- Implement Payment Reform
- Increase Data Analytics Capacity
- Address Social Determinants of Health (SDOH)

In the spring 2019, during the production of this "Roadmap" report, the NORC team presented the draft findings from the third SOW, the National Scan to the PMC. Based on the information presented, the PMC provided feedback and initial direction on focus areas for the Roadmap. The PMC asked NORC to consider specifically the following elements:

- Establishing a lead organization to oversee policy development, data analysis, and direct the ongoing work related to transformation efforts in Alaska;
- The development and implementation of an All-Payer Claims Database (APCD) and related necessary analytic capacity to be used as a key tool for understanding and addressing cost drivers in Alaska's health care system;
- The construction and implementation of global health expenditure budgets, implemented in a multi-payer environment;
- Examination of various multi-payer approaches that the state could take to better align incentives in the health care market and reduce provider burden;
- In a multi-payer environment, consider models of care coordination;
- Include the concept of regionalization to recognize the heterogeneity and key differences that exist in various regions of Alaska;
- Examination of approaches to addressing underlying Social Determinant of Health (SDOH), including the adoption of screening tools and options for more widespread interventions.

This report is intended to be a document for the PMC and AHTP to consider and provide reaction and direction. Therefore, in the Executive Summary and final chapter, we present the convergence of NORC's findings with local stakeholder insights and decisions by the AHTP Board and PMC. In **Chapter 2**, we discuss health care costs and expenditures in Alaska, drawing on the most recently available information. Chapter 2 also highlights data challenges and gaps in Alaska and includes a review of Alaska's statutory and health policy environment. This background and context leads to a discussion in **Chapter 3** of efforts and frameworks that other states have adopted to introduce increased value in their health care systems, including a discussion of how various states are examining SDOH in the context of payment and value reform, and tools they are using to screen for SDOH.

Chapter 4 presents some suggested first steps down the road, including establishing leadership governance and developing robust and broad data infrastructure and analytic capacity. In **Chapter 5**, we discuss multi-payer approaches, global budgets, and regionalization, and provide some options for decisions and discussion. In addition, we touch on some elements that Alaska may wish to consider, such as consumer engagement and rural considerations. We conclude in **Chapter 6** with a discussion of the path forward and make recommendations around next steps for Alaska in the focus areas of the Roadmap.

There is a variety of roads that Alaska can consider, and this report lays out some of the paths and suggested goals, both short and long term, that can be followed as Alaska continues to work to ensure an affordable and sustainable health care system.

We start the road in Chapter 2, where we examine the starting point for the journey.

Chapter 2. Where is Alaska at on health care spending?

The first step in the journey to health care reform for Alaska is to understand where Alaska starts that journey. Health care delivery in Alaska is by a variety of providers who receive fee-for-service (FFS) payments from third-party payers. This chapter provides a brief description of what is known about healthcare spending, costs, and drivers in Alaska using publicly available data sets. We first provide a brief overview of the national healthcare cost drivers, and then focus on the available data for Alaska, how Alaskans pay for healthcare, and healthcare prices and utilization relative to other geographic areas with similar characteristics. This is followed by a brief description of price variation for state employee health plans, private employer-sponsored coverage, Medicaid and marketplace spending, and Medicare spending. We then describe some factors unique to Alaska (population and demographics, physician salaries and supply), and identify some of the factors that may have led Alaska down a path that has resulted in uniquely high costs of health care delivery. Chapter 3 follows with an exploration of how different approaches being undertaken by states with regard to incorporating value-based payment (VBP), cost containment measures, and SDOH considerations into their health transformation strategies.

We note that much of the comparative total health care expenditure data in this chapter are presented through 2014, the most recently available data comparing Alaska to the United States. Further, in this chapter, we discuss more recent data available from the Health Care Cost Institute (HCCI), comparing the Anchorage area to other geographic areas. As we discuss throughout this report, gaining access to more timely and detailed health care cost and utilization information will be critical to continuing to reform Alaska's health care delivery system. The lack of current information has been frustrating to policymakers and stakeholders, and gaining access to detailed, up-to-date, and granular information with the accompanying analytic capacity will form a key recommendation in the report.

This report is limited to using publically available data for studying health care prices and utilization, as there are no readily available, accurate and current data sources within the state for studying costs across all payers. We believe that improving the quality of the data used in research is an important step towards reforming the healthcare landscape.

National Drivers of Health Care Costs

In 2017, the United States spent approximately \$3.5 trillion on health care.²⁰ In 2017, the U.S. had the highest health consumption expenditures in the world at \$10,224 per capita. This is twice the average (\$5,280) of countries comparable to the U.S. and \$2,000 more than Switzerland, which has the second highest health consumption expenditures per capita at \$8,009.²⁰ Nationally, technology, administrative expenses, pharmaceutical costs, unhealthy lifestyles, chronic diseases, aging, wasteful spending, and labor are frequently cited as the primary drivers of growth in health care costs.^{21,22} For example, about half of real health expenditure growth is due to advances in medical technology.^{23,24}

While chronic diseases are common and costly, they are also preventable.²⁵ According to the Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion,

there have been increases in tobacco use, poor eating habits, excessive alcohol use and decreases in physical activity leading to increased rates of chronic diseases and health care costs. Treatment for chronic diseases cost the nation \$1.1 trillion in annual health care expenditures in 2016.²⁶ The most common chronic conditions include hypertension, cholesterol imbalance, osteoarthritis, diabetes, and chronic obstructive pulmonary disease. Much of this spending is concentrated in a small share of the population. Those with five or more chronic conditions make up 12% of the population but account for 41% of total health care spending.²⁵ These individuals also spend twice as much on average as those with three or four conditions. This spending was also found to vary by insurance type with Medicare and other public insurance spending considerably more than private insurance.

Administrative costs are enormous in the U.S. due to the complex private health insurance system, as compared to other Organisation for Economic Co-operation and Development (OECD) countries.²⁷ In 2015, spending on health insurance administration per capita in the U.S. was \$787 compared to the OECD median of approximately \$89. Switzerland spent the next highest amount at \$286 with France following at \$272 per capita. Administration costs make up as much as 31% of health care expenditures in the U.S.²⁸ Wasteful spending, in the form of failures in care delivery, administrative complexity, overtreatment and other sources, is estimated to cost the U.S. between \$558 billion per year or 21% of health care expenditures to \$910 billion per year or 34% of health care expenditures.²⁹ Exhibit 2.1 shows the costs of wasteful spending in 2016. Looking only at the mid-level estimate, administrative complexity costs the most at \$248 million.

| | Annual Cost to US Health Care System | | |
|-------------------------------|--------------------------------------|-----|------|
| | Low | Mid | High |
| Failures of care delivery | 102 | 128 | 154 |
| Failures of care coordination | 25 | 35 | 45 |
| Overtreatment | 158 | 192 | 226 |
| Administrative complexity | 107 | 248 | 389 |
| Pricing failures | 84 | 131 | 178 |
| Fraud and abuse | 82 | 177 | 272 |
| Total | 558 | 910 | 1263 |
| % of Total Spending | 21 | 34 | 47 |

Exhibit 2.1: Annual Costs of Wasteful Spending, 2016

Source: Berwick & Hackbarth, 2012. Data shown are based on extrapolated of National Health Expenditure data from 2011 to estimate 2016.

What does the data tell us about Alaska's Healthcare landscape and costs?

Most expensive health care in the country and still growing rapidly

In 2014, Alaska spent more per capita than the U.S. overall in five out of nine personal health care categories. Alaska spent nearly 1.4 times more per capita on personal health care and 1.8 times more on

physician and clinical services than the U.S. overall. Alaska had the highest health care spending among all states, at \$11,064 per capita in 2014, compared with around \$8,000 nationwide (Exhibit 2.2). Similar to the national average until 2000, Alaska's growth in health care spending has consistently been higher than the national average (Exhibit 2.3). Since then, Alaska's growth in health care spending has increased significantly faster than the U.S. (Exhibit 2.4). Prices for medical items in Alaska have increased unparalleled to other consumer goods. For example, the total Anchorage consumer price index (CPI) was up 77% from 1991 through 2017 but the medical care part of the index was up 210%. Thus, prices for medical items increased nearly three times faster than prices in the overall CPI.



Exhibit 2.2: Alaska Health Care Spending Compared to the U.S. Average

Source: CMS, Office of the Actuary, National Health Statistics Group, 2017.



Exhibit 2.3: Growth in Per Capita Health Expenditures, U.S. v. Alaska, 1991-2014

Source: CMS, Office of the Actuary, National Health Statistics Group, 2017.

While growth in Alaska's health care spending has steadily increased since 1997, its gross state product has declined in recent years.² From 2009-2014, Alaska's personal per capita income grew 1.4% slower than its health care spending. Between 2009 and 2014, Alaska had larger average annual increases in all categories of personal health care spending than the United States except prescription drugs, which decreased by 1.1%. Hospital care constitutes the largest share of the health care dollar, in both Alaska and nationwide, at about 43% in Alaska (Exhibit 2.5).





Source: CMS, 2017



Exhibit 2.5: Health Care Spending by Type of Service, Alaska 2014 (Total, All Payers)

Sources: U.S. Census Bureau; and CMS, Office of the Actuary, National Health Statistics Group. Excludes spending on personal health care.

How does Anchorage compare to similar metropolitans and rest of the country?

To understand how Alaska compares to other areas of the country, this section looks at healthcare spending and utilization data from 2012-2016 for commercially insured individuals and Medicare beneficiaries across metropolitan areas that are comparable to Anchorage, and relative to the national average. We used HCCI Healthy Marketplace Index as there is no timely and inexpensive data source within Alaska for studying growth and variation of health care prices in the commercial sector. The data combine both commercial and Medicare spending, and we are able to provide accurate comparisons of health care spending and utilization rates for Anchorage with different comparison metropolitan areas with similar annual GDP per capita, real income per capita, and population density, along with the national average.^{x,xi}

We begin with the results for Anchorage's health care spending and utilization compared to three comparison metropolitan areas with similar GDP per capita. Exhibit 2.6 shows that in 2016 Anchorage's healthcare prices for all services were higher across all services by significant margins compared with the comparison cities and the national average. While the real GDP per capita is similar for the Minneapolis-

^x Data on population factors were taken from 2017 economic data from the Bureau of Economic Analysis.

xi The Anchorage Metropolitan Area is defined by the US Census Bureau to include the Matanuska-Susitna Borough.

St. Paul-Bloomington area and Anchorage, Anchorage's health care spending for all services was 165% of the national average compared to Minneapolis' 132%. Of note, spending for professional services in Anchorage was 196% that of the national average.^{xii} Growth rates were relatively similar across all services except for inpatient services. Between 2013 and 2016, Anchorage experienced an 18% growth rate in spending, while the comparison cities with similar GDP saw increases between 10 and 17%.

Exhibit 2.6: 2016 Health Care Spending in Alaska Relative to National Average Compared to Areas with Similar GDP Per Capita is Much Higher



Source: Health Care Cost Institute, 2018.

Anchorage's usage rates (inpatient, outpatient, and all services) were below the national average across all services except for outpatient services, which were on par with the national average (Exhibit 2.7). Between 2013 and 2016, usage rates for all services declined in Anchorage by 5%. The decline in usage was less pronounced than in the other three comparison cities with similar GDP levels. Anchorage was also the only metropolitan area in this group to observe an increase in outpatient and professional services. In general, there does not appear to be evidence suggesting that excess usage is the driving force behind Alaska's high health care spending.

^{xii} Anchorage's 2016 annual GDP per capita in 2017 was \$62,125. The metro areas with the most similar counties were Minneapolis-St. Paul-Bloomington, MN-WI (\$62,206); Columbus, OH(\$61,778); and Portland-Vancouver-Hillsbro, OR-WA (\$52,175).



Exhibit 2.7: 2016 Usage Rates in Alaska Relative to the National Average Compared to Areas with Similar GDP Per Capita Are Not Much Higher

We also examined a comparison group of metropolitan areas with similar per capita income.^{xiii} Similar to the previous comparison group, Anchorage's price levels were significantly higher. While Anchorage had prices 196% above the national average, the closest comparison city by income per capita (Manchester-Nashua) had prices only 120% higher. The greatest disparity was with Baltimore, where there was nearly a 100 percentage point difference in the relative prices paid for services (Baltimore prices were 67% of the national average whereas Anchorage prices were 165% of the national average). There is also a larger difference between Anchorage's growth rate and that of the other three areas. In contrast, usage rates in Anchorage were significantly lower than the other comparison cities with similar income per capita.

Finally, we examined metropolitan areas with similar population density to Anchorage.^{xiv} In this group, Anchorage again has the highest price levels among the comparison metropolitan areas, although two comparison cities (Albuquerque and Colorado Springs) had a growth rate on outpatient services 1% higher than Anchorage.

Source: Health Care Cost Institute, 2018.

^{xiii} Anchorage's real per capita income in 2016 was \$57,481. The metro areas with the closest real per capita income were Fayetteville, Springdale-Rogers, AR-MO ^{xiii}(\$57,724); Manchester-Nashua, NH ^{xiii}(\$57,388); and Baltimore-Columbia-Townson, MD ^{xiii}(\$57,754).

^{xiv} Of the metropolitan areas, Anchorage had the lowest at 14.5 people per square mile. Boise, ID has the closest population density to Anchorage at 52.4 people per square mile followed by Albuquerque, NM (95.6), and Provo, UT (97.6).

How does Alaska Pay for its Health Care?

Exhibit 2.8 below shows the different types of coverage Alaskans had in 2017. Similar to the U.S. population in general, more than half of Alaskans were covered by employer-sponsored insurance (ESI). Medicaid was the second highest coverage type at about 23%.³⁰



Source: United States Census Bureau, American Community Survey 2017. The Indian Health Services provides care to all eligible Native Americans but is not a health care plan. Being eligible for IHS services alone does not meet the minimum essential coverage requirement. Individuals who only have access to Indian Health Service care are considered uninsured in the American Community Survey. IHS is not an entitlement program and provides only those services not available through other sources.

Employer Sponsored Insurance:

ESI includes commercial insurance bought by firms in the private sector, by the State of Alaska for employees, and plans purchased directly by individuals. People between the ages of 19-64 are most likely to be covered by ESI. In 2017, 188,000 employees worked in establishments that offered coverage; 148,000 of these persons were eligible for it, and about 72% of those eligible for coverage enrolled in coverage. Similar to overall state health care trends, average annual deductibles for family coverage in Alaska have increased while median household income has fluctuated.

Family health insurance costs increased at a yearly average of 6.3% for private employer-sponsored plans, although employers are paying for most of the increases. Between 2003 and 2015, deductibles have increased by nearly 2.7 times, and more than doubled as a percentage of median household income.³¹ In

2017, the average deductibles for single and family coverage were \$1,856 and \$3,252 respectively. 43.2% of employees were enrolled in high deductible plans.³²

Alaska's average annual family health insurance premiums for private employer-sponsored coverage have also grown steadily since 2003 and remained consistently higher than the national average. At \$7,964, Alaska had the highest average annual premium for single coverage in 2017. Average annual premiums in Alaska have consistently increased since 2014 but have recently seen decreasing rates of growth yearly.³² Currently, employees pay about 28% of the premium cost for family coverage (19% of premium costs for individuals). Prior reports have estimated that commercial health care premiums in Alaska were approximately 30% above the average relative to comparable states.

Commercial provider payments have been estimated at 76% higher than other areas similar to Alaska nationwide, with physician payment levels 148% higher and hospital payment levels 56% higher.^{xvf,33} In an analysis prepared for the Alaska Division of Insurance, Oliver Wyman (2018) compared the commercial insurance reimbursement rates for physicians in Alaska to three states (Montana, North Dakota, and Idaho) and Seattle and reimbursement rates of commercial insurance to Medicare reimbursement in all five areas.³⁴ The study found that overall Alaska commercial insurance reimbursement rates were about 45% to 85% above the four comparison regions.

State Employee Health Plans:

Previous analyses in 2016 estimated that public employer plans cover at a minimum 40% of the state, 86,614 households of public employees or retirees, and 162,750 Medicaid recipients.^{xvi} The aggregate cost of public employee plans in 2016 was \$1.475 million. Spending by category is shown in Exhibit 2.9.

| Public Employee Health Care Spending in Millions (\$M) | | | |
|--------------------------------------------------------|-------|--|--|
| State Medicaid | 1.695 | | |
| Alaska Retirees | 504 | | |
| State of Alaska Employees | 383 | | |
| School Districts | 372 | | |
| Political Subdivisions | 216 | | |

Exhibit 2.9: Public Employee Health Care Spending in Millions (\$M), 2016

Source: PRM Consulting Group, 2017

^{xv} Areas selected for being high-cost, and/or mainly rural, sparsely populated, or having some geographic proximity in the Pacific Northwest. See source for methodology.

^{xvi} Data on public employees from PRM: Phase I - Consolidated Purchasing Strategies, Table 1: 86,614 households with public employer health plans. The study stated that sources included summaries compiled by the Anchorage Economic Development Council; PRM estimated that the aggregate number of covered lives in 2016 was more than 40 percent of the State's population which they estimated at 740,000.

Previous analyses have found that plans for public employees are highly fragmented, with 100 different plans covering 44,000 benefit eligible employees (excludes retirees).³⁵ This is due to school districts and local governments developing and negotiating their own plans, leading to large variation in public health care plan costs across different groups and employers. For employers with 200-500 employees, monthly plan costs ranged from \$1,400 to \$3,000 per month.³⁶ Larger groups with 800+ employees saw less variation with 60% of monthly costs of those in large groups at approximately \$2,000. Deductibles also varied across plans ranging from \$50 to \$5,950. Pharmacy plans exhibited less variance with co-pays between \$10 and \$13 and \$20 and \$30 for formulary brand drugs.

These prior analysis also found that two insurance companies (Premera and Aetna) and their networks provided coverage to more than 90% of employer plans, showing a lack of competition between insurers and lack of competition between providers. Alaska also had a larger proportion of care delivered by non-preferred providers compared to the lower 48 which is likely due to the lack of competition among providers.³⁶

Medicaid

Medicaid is the second highest coverage type at around 23%. Medicaid provides coverage for eligible low-income people, families, children, pregnant women, the elderly and people with disabilities. Currently, 15% of seniors in Alaska and just over half of all children in Alaska are enrolled in Medicaid. In recent years, Alaska has seen an increased number of enrollees and spending on Medicaid services due to the Medicaid expansion in 2016 and a recession beginning in 2015.

Enrollment in Alaska increased by 81% from 131,136 enrollees between FY2005 to 237,494 in FY2018; about 22% of the increase is attributable to the Medicaid expansion (Exhibit 2.10).³⁷ Between FY05 and FY18, overall spending on Medicaid in Alaska increased from \$1.19 billion dollars to \$2.35 billion dollars- an average yearly increase of \$116 million dollars. Seventy percent of the increase is federally funded while about 28% is state funded. This growth in Medicaid spending is largely attributed to the Medicaid expansion, which brought about an increase in both newly eligible and currently eligible persons enrolling in coverage, and a recession that began in 2015. Under current trends, by 2039, the proportion of seniors in Alaska enrolled in Medicaid will grow to 22% and the proportion of children in Alaska enrolled in Medicaid will grow to 60%.³⁷

While Alaska's overall health care spending per capita is high, it's spending on Medicaid as a share of the state budget was ranked near the bottom (46th lowest) of all states in FY2016. Many reasons may contribute to this relatively low share, including higher state spending for other programs, lower Medicaid spending on skilled nursing care (because of the state's relatively younger population), and a higher federal share due to 100% reimbursement for care at Tribal organizations. There is also considerable heterogeneity in spending across regions, due to population need, and based on regional economic conditions, with the highest spending per beneficiary in the northern southeast region and the lowest in the northern and interior regions of the state. State spending has remained relatively flat due to reforms passed by the state legislature in 2016 through Senate Bill (SB) 74, as shown in Exhibit 2.11. In FY18, SB 74 saved the state approximately \$140 million in state general fund savings and lowered the rate of the forecasted increase per-enrollee cost for future spending.





Medicaid Enrollment & Spending in Alaska 2012 – 2018 Date-of-Service Actuals

Source: Evergreen Economics, 2018







Source: Evergreen Economics, 2018

Cost-savings to the state from reforms in SB 74 include recovery of more than \$40 million in overpayment paid to providers and enforcement of the Surveillance and Utilization Review System (SURS); new state waivers to support people with developmental disabilities (Home and Community Based Services waiver); active management of the Medicaid pharmacy benefit, as well as other cost-savings initiatives.^{xvii}

^{xvii} Savings are to the state's budget; some of the costs are shifting federal sources.

Spending is still predicted to increase on average by 4.6% per year between FY19 and FY39, reaching \$5.7 billion in FY39. Prior to SB 74, spending on Medicaid services was predicted to grow on average annually by 7.8% and reach \$4.7 billion by CY2025. Federal spending on Medicaid in Alaska is expected to grow at 4.7% year. The largest contributor to growth in Medicaid spending will be health care price inflation at nearly 45% of total spending and 70% of additional spending.

The most frequently used Medicaid services are physician and practitioner professional services, followed by outpatient services, pharmacy and dental. The growth rate is lowest for dentists at 1.0% annually, with the highest in pharmacy at 1.6%. Although the most frequently used services were physician and outpatient services, nearly 20% of Medicaid spending was on hospital expenditures.

Medicare

Medicare covers a majority of those 65 and older, and in 2018, covered about 13% of Alaska's population.³⁸ The average Medicare enrollee statewide was 70, two years lower than the national average. Because Medicare is paid for by the Federal government, and in light of the many Medicare payment delivery reforms in Medicare, we do not focus attention to spending and utilization among Medicare beneficiaries in this report. We do, however, use Medicare reimbursements rates as a point of comparison between Alaska and other states later in this report.

The Tribal health system.

Alaska's Tribal health system serves about 20% of the Alaska population. Unlike the federally-run Indian Health Service (IHS) facilities in the lower 48, Tribal health authorities operate health care facilities under compacts with IHS.^{xviii} The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of all the Tribal health authorities in Alaska. ANTHC and Southcentral Foundation, the Anchorage area Tribal health authority, jointly own and manage the Alaska Native Medical Center (ANMC), a tertiary care facility. Tribal health clinics are the only providers in some rural areas, and they serve non-Native population in those areas.

Financing of the Tribal health system is a unique combination of funds received under IHS compacts and FFS payments from third party payers which include Medicaid, Medicare, the Veterans Administration, and employer-based health coverage. Unlike providers who depend almost entirely on FFS funding, the Tribal health system has some discretion in the use of compacted funds to pay for services not covered by FFS payers. For example, the Tribal system has more flexibility in addressing social factors that may be affecting a member's health status.

The Tribal system has used that flexibility to undertake a wide variety of steps to improve the health of Alaska Natives. Most notably, Southcentral Foundation's NUKA model has attracted wide attention as a Patient Centered Medical Home (PCMH) model that incorporates management of SDOH into its primary health care delivery. ANTHC has developed a wide array of programs to address the specific health care challenges of rural Alaska. ANTHC has been active in addressing environmental factors that contributed

^{xviii} For details on compacting and contracting under IHS Tribal Self-Governance Program, see <u>https://www.ihs.gov/selfgovernance/aboutus/</u>

to the incidence of diseases like tuberculosis and has provided communities with support to develop funding for inadequate sewer and water infrastructure. In addition, ANTHC has created training programs for Alaska Natives to provide front-line medical services in positions such as dental health aides and community health aides.

The federal government reimburses the State of Alaska for 100% of the costs of Medicaid services provided to Alaska Natives at Tribal health facilities. Alaska Natives represent about 40% of Medicaid patients. For most Medicaid expenses incurred by non-Alaska Natives, the federal government covers 50% of the cost and the state covers 50%. Overall, the Medicaid funding pattern in Alaska is approximately one-third state funds that reimburse providers outside the Tribal system, one-third federal funds that reimburse providers outside the Tribal system.

Importantly, optional programs (such as adult dental) are federally funded at Tribal facilities if and only if they are available to all enrollees. This Medicaid funding for Tribal facilities is a significant benefit to Alaska, but it has the negative effect of multiplying any state Medicaid reductions. For example, ending adult dental benefits under Medicaid would reduce state costs for the program by about \$25 million, but would also reduce the federal match for those costs by \$25 million and in addition reduce federal payments for adult dental care at Tribal facilities by about another \$25 million.

A recent change in federal policy expanded the Medicaid services that are subject to the 100% federal funding for American Indians and Alaska Natives. In 2016, CMS announced that care delivered by non-Tribal providers under care coordination arrangements (CCAs) with Tribal health systems would receive 100% federal funding. Since 2016, 18 Tribal health organizations have developed 1450 CCAs with 137 non-Tribal providers. Under those CCAs, Alaska shifted \$44 million of Medicaid costs in FY 2018 to the federal government. Of that \$44 million, \$28 million was for transportation costs. Expanding the use of CCAs has been a goal of the Alaska Department of Health and Social Services (DHSS) under both the Walker and Dunleavy administrations.

The Tribal health care system is not a form of insurance; the system directly provides care to Alaska Natives. Any interpretation of data on health care insurance coverage in Alaska must recognize this. Depending upon how insurance coverage data are collected, some members of the Tribal health system could be reported as uninsured, even though they receive regular care through the Tribal system.

One might ask if it is possible for the traditional health care system to adopt more of the innovative approaches seen in the Tribal system. In examining this possibility, it is important to remember the unique characteristics of the Tribal system. The Alaska Natives served by the Tribal health system are "members", rather than "patients" or "clients." Representatives of those members manage the system; the providers within the system are employees. While third-party payers are billed, members are guaranteed access to care regardless of third-party coverage. The system has emphasized culturally-appropriate standards of care, which also helps connect members to the Tribal health system. In sum, the Tribal health

system is a unique institutional development that responded to the unique history and health challenges of Alaska Natives.

Alaska Specific Health Care Cost Drivers

What are Alaska's Challenges?

Alaska deals with many of the same health care cost drivers as the other states but also faces unique problems such as a small population, large land mass, and many isolated communities. This distribution of the Alaska population makes it difficult to administer and access care, causing stark differences between the circumstances and costs faced by residents of different communities of the state. Alaska is a highly rural state with 86% of its municipalities not connected to the road system. A report completed by Milliman, Inc. in 2011 for the State of Alaska compared Alaska to Washington, Oregon, Idaho, Wyoming, and North Dakota and found operating costs for hospitals in Alaska were approximately 38% above the average operating costs in comparison states.³⁹ If only rural facilities were counted, that number jumps to 86% above the average. One reason for this is that occupancy rates in rural areas were lower in Alaska. With fewer admissions, fixed operating costs for hospitals must be allocated to fewer patients, which contributes to the high prices. This is possibly driven by the lack of primary care physicians and other health care resources in rural areas. Alaska facilities also had higher profit margins in each year of Milliman's analysis—this was primarily driven by two urban facilities with higher margins than anywhere else in Alaska or the comparison states.

Characteristics of Alaska residents

Alaska has 737,438 residents, with the majority living in the urban hubs. Native Alaskans are the largest minority (Exhibit 2.14) and are geographically spread out across the state with many living in rural communities. Communities are unequally distributed across eight Alaska regions including northern (2%), northwest (8%), western (15%), Southwest (13%), interior (21%), Southcentral (10%), gulf coast (20%), and Southeast (11%) regions.⁸
Exhibit 2.14: Alaska Demographics by Race, 2017



Source: United States Census Bureau, 2017.

According to the State of Alaska's Department of Commerce, Community, and Economic Development (DCCED), about 79% of municipalities in Alaska are considered rural, with populations less than 1,500 residents. Over half (55%) of municipalities are extremely small with populations less than 500 residents; 13% have less than 100 residents. In contrast, only six municipalities (4%) have 30,000 residents or more. Alaska also has a large military population with three major bases in two of its urban areas with each base averaging around 6,000 military personnel. The Veteran population represents about 9% of the population.

Alaska's median household income is \$73,181 but living costs are nearly 30% higher than the national average. In 2018, Alaska on average had 327,700 persons (all ages) employed throughout the year. Government, trade, transportation, utilities, educational, and health services were the largest industry employers.⁴⁰ As of March 2019, unemployment was 6.5% in Alaska, about 1.8 times the U.S. average rate of 3.9%.⁴¹

Provider Adequacy Issues. Recruiting and retaining health care professionals in Alaska has been difficult, likely due to the high living costs, isolation, and harsh climate. Alaska must attract most of its physicians from outside the state. About 14% of currently active physicians graduated from the University of Washington's Regional Medical Education Program at the University of Alaska Anchorage, the only program in Alaska that provides physician degrees.⁴² One result has been high rates of compensation for physicians.

Despite annual salaries in Alaska that are 21% above the national average for physicians and surgeons, and 27% higher across all health care professionals (Exhibit 2.15), there still exists shortages in the state, with 85 primary care areas in Alaska designated as a Health Professional Shortage Area (HPSA) by the

Federal government.^{xix} Data from the Kaiser Family Foundation shows that only 26% of the need for primary health care professionals in Alaska is met while nationally 44% of need is met. For mental health care practitioners, only 23% of need is met in Alaska compared with 26% nationally. Dental care professionals are slightly more prevalent but the percent of need meet in Alaska is still lower than the national average (27% in Alaska versus 33% nationally). Similar to the shortage of providers, Alaska has a lower than the national average rate of hospital beds available per 1,000 people, whereas by comparison, North Dakota and Wyoming, which similar resource-based economies with low-populations, meet the average or are above it.





Source: United States Bureau of Labor Statistics, 2017

Cost of Chronic Disease in Alaska:

Alaska residents have similar health problems as those in the lower 48 states, with heart disease, tobaccorelated health problems, and diabetes among the most prevalent chronic diseases. About 30% of adults in Alaska have high blood pressure and 34% of adults have high-cholesterol levels. Similar to national trends, cancer, heart disease, and stroke were the leading causes of death in Alaska. Diabetes was the eighth leading cause of death with 8% of Alaskans diagnosed with non-pregnancy related diabetes

xix To have a shortage, an area must meet the following population-to-provider ratios; for primary medical care it is 3,500 people to 1 practition are for double care it is 5,000 to 1, and for Martel Haelth Care professionals it is 20,000 to 1

to 1 practitioner; for dental care it is 5,000 to 1; and for Mental Health Care professionals it is 30,000 to 1.

While only 18% of adult Medicaid beneficiaries were treated for a chronic disease, this population accounts for 47% of Medicaid spending on adults or \$565 million of \$1.2 billion. On average, an adult beneficiary diagnosed with a chronic condition incurred \$30,000 in Medicaid services; a Medicaid beneficiary not diagnosed with a chronic condition incurred \$7,700 in Medicaid services. The most expensive chronic conditions were strokes at \$60,487 per Medicaid beneficiary and injuries from falls with \$81,009 per Medicaid beneficiary.⁴³ Obesity is also a significant cost, at \$459 million annually with state and federal governments paying for more than 25% of these costs through Medicare and Medicaid. About 67% of Alaska adults and 31% of Alaska youth were overweight or obese. Tobacco use is also high: about 20% of adults in Alaska smoking cigarettes compared to 17% nationally, while 11% of high school students in Alaska currently smoke, on par with the national average.

Health of Rural Alaska and Alaska Natives:

Rural residents, Alaska Natives, and those with low socioeconomic status were at higher risk for chronic diseases. Alaskan Natives health was also most similar to those in the least healthy quartiles of counties nationally.⁴⁴ Alaska Natives as a whole saw lower levels of health compared to white and non-Native Alaskans, according to ANTHC.⁴⁵ Alaska Natives life expectancy is 70.7 years compared to the national average of 78.6 and Alaska's 75.9 years. There has been no improvement in cancer and suicide mortality rates while Chronic Obstructive Pulmonary Disease (COPD) mortality rates increased in the past 35 years.

The Alaska economic context

Alaska's economy is driven by oil prices, making it different from the rest of the U.S. Since 2015, the decline in oil prices have put Alaska into a recession, albeit a relatively mild recession, from 2015 through 2018. Compared to the lower 48 states, the cost of living in Alaska cities is 28% to 37% above the national average.⁴⁶ To date, Alaskans have been largely insulated from the costs of higher state government spending on health care. Income from oil royalties and oil taxes and from withdrawals from the Constitutional Budget Reserve and/or the Earnings Reserve have paid for about 80% of General Fund expenses in recent years. Only about 20% of state general fund revenues in Alaska come from non-oil taxes or fees. The stronger economic conditions and the advantages of large oil revenues to fund state government may have caused Alaska to feel less threatened by higher health costs than other states. The current state budget challenges and weaker economy, driven by lower oil prices, may be changing that.

Higher reimbursement rates for both Medicare and Medicaid

Medicare reimbursement rates vary across states to reflect differences in the costs of providing care and Alaska's Medicare reimbursement levels exceeds the rates for other states by about 25% to 30%. This is due the Medicare Improvements for Patients and Providers Act of 2008, which sets the Physicians Work Geographic Practice Cost Index (PW GPCI) for Alaska at 1.5, instead of being estimated the way other states' PW GPCI's are estimated. The effect is that the PW GPCI for Alaska is nearly 50% higher than elsewhere. (The next highest PW GPCI for 2019 was 1.083 for San Jose, California.) The PW GPCI is

combined with other factors to determine the compensation for a particular service. The 2019 Alaska Geographic Adjustment Factor (GAF), which CMS calls an approximate tool for comparing Medicare physician reimbursement levels across localities, was equal to 1.294.⁴⁷

Federal contributions to Medicaid are higher in Alaska for three reasons. As discussed above, 100% of the cost of care for Alaska Natives provided within the Tribal health system or under coordinated care agreements with Tribal health providers is covered by the federal government. In addition, Medicaid reimbursement rates to providers are relatively high in Alaska. For the U.S., Medicaid rates for physicians average only 72% of Medicare. Alaska is one of only two states (the other is Montana) where Medicaid rates are higher than Medicare rates. A Kaiser Family Foundation study estimated that Medicaid physician rates in Alaska were 126% of Medicare levels in 2016.⁴⁸ In October 2017, Alaska implemented an across-the-board 10.3% reduction in reimbursement rates for professional services provided to Medicaid patients. During FY 2019, rates were further reduced, and the overall budget for Medicaid and Mental Health services was cut by around 21%.^{49,50} The ratio of Medicaid to Medicare rates has therefore declined, but Alaska still has the highest ratio in the country.

The state health care policy environment

Each state has its own unique care delivery and policy context and history based on the individual needs of the state and the set of historical legislative decisions and marketplace configurations that have influenced the cost of care. Alaska is no different. This section of the report describes the state health policy environment. In this section, we identify factors in the policy realm that could potentially play a role on influencing health care cost in Alaska. It is important to note that no single policy factor drives health care spending, but rather there a set of factors that may have an influence.

Alaska has higher health care costs in part because health care policy has emphasized increasing access and has placed less emphasis on constraining costs. The goal of improved access has included both expanding the scope of specialty care available in Alaska's cities and improving access to primary care in rural areas.

Alaska statutory framework

Historically, as third-party payment for health care services became the predominant form of payment, a FFS payment system developed in the U.S. As this system developed, there was a consistent focus to ensure that patients and providers made medical decisions. Third-party insurers paid the bills, but they were relatively uninvolved in the decisions about care. This third-party, FFS finance structure lacked incentives to restrain increases in the cost of health care. The sustained increases in the real cost of health care in the rest of the U.S. has led to much greater involvement of third-party payers, both government and private, in health care decisions. Over the past few decades, more states and employers have shifted to managed care arrangements that encourage greater control over provider choice, utilization of services, and cost. However, currently there is no managed care in the state.

One way that third-party payers such as managed care organizations can manage costs is by negotiating lower rates from a network of providers and providing incentives for enrollees to use those "in-network" or "preferred" providers. Restricting the choices available to patients has been unpopular with both patients, who greatly value the historic ability to see any provider, and with providers, who negotiate terms for joining a network.

Choice of Health Care Provider statute and the 80th Percentile Rule. In response to the development of restricted networks, Alaska enacted a Choice of Health Care Provider (COHCP) statute (AS 21.07.30) which requires that insurers that use networks of preferred providers to offer patients the option of going to any out-of-network provider. Insurers can charge enrollees who use out-of-network services higher premiums, co-pays, and deductibles, but those additional charges to enrollees must be based upon additional costs incurred by the insurer.

A number of other states also enacted "freedom of choice" or "any willing provider" statutes. However, Alaska was unique in implementing a state-determined minimum payment to out-of-network providers. That was achieved when the Director of Insurance promulgated the 80th percentile rule in 2004 (3 AAC 26.110), which requires that payments based upon charges by out-of-network providers must be no less than the 80th percentile of all charges for that service in the relevant geographic area. The rule was intended to provide transparency and reduce out-of-network balance billing for consumers, as well as possibly attract physicians to work in Alaska. There are wide-ranging perspectives and views on the 80th percentile rule. In recent years, insurers and other payers in Alaska have raised concerns about the 80th percentile rule, and argued it may have contributed to escalating payments.^{xx} While empirical evidence on the impact of the 80th percentile rule on health care cost and consumer protection is limited, analysis by Guettabi (2018) found that health care reimbursements, and particularly physician reimbursements, have grown more rapidly in Alaska since the rule's implementation in 2004 than in the rest of the U.S.⁵¹

There is an analogous statute (AS 21.86.078) for health maintenance organizations (HMOs) that requires all HMOs to offer a point-of-service option that allows enrollees to go to an out-of-network provider without a referral or prior authorization. Alaska has no HMOs. The small market in Alaska probably makes it more difficult to achieve the necessary scale (in terms of covered lives) required for most HMO models. However, the requirement to allow enrollees to opt out of network may possibly have had an impact on the lack of development of HMOS in the state.

Retiree Benefits. The ability to revise health care coverage for state and local government retirees in Alaska is restricted by the protections afforded government retiree benefits in the Alaska Constitution. In 2003, the Supreme Court of Alaska decided in *Duncan v. Retired Employees of Alaska* (S-10377) that this constitutional provision does cover the health benefit components of retiree benefits. The court found that the details of the health care package could change, but that the disadvantages of the changes had to be offset by at least equal advantages. The test of benefits versus losses is applied at the level of the covered

^{xx} For example, the Alaskans for Sustainable Healthcare Costs, a group of employers and payers who lobby for changes to reduce healthcare costs has made changing the 80th percentile one of its three legislative priorities. See <u>https://sustainablehealthcareforalaska.com/</u>

group, rather than at an individual retiree level. This constitutional protection places some limits on the ability of the state to change the plan structure for retirees, although the exact bounds of those limits have not been fully tested.

Recent Alaska health care policy initiatives

All states face the challenges of high health costs. However, state policy responses have varied widely across states. Those differences in responses are themselves informative about how political, economic, and social differences have shaped American state health care policy. This section looks at recent Alaska health care policy initiatives not simply as a historical exercise but also as a lens through which to understand the landscape for future policy development.

Alaska Health Care Commission

The Alaska Health Care Commission (HCC), which operated from 2009 to 2015, arguably made the most comprehensive effort to date to understand the drivers of high health costs in Alaska. While the HCC did not have any authority to take action, it commissioned four critical studies on the drivers of health care costs in Alaska. Prepared by Milliman, Inc., the studies provided an empirical foundation for the widely-held view that high provider compensation rates, particularly physician compensation rates, are a major driver of Alaska's health care costs. But the HCC also recognized the limits of the available data and of the available analytical capacity to support thoughtful policy development. With respect to data, it recommended that participation in the Health Facility Data Reporting system be mandatory, a step that has since been implemented. It also made a recommendation to create an APCD.

The HCC made recommendations in four policy areas that have been important in Alaska health care since:

- Specific legislative and administrative changes to address waste, fraud and abuse in Medicaid. A number of those recommendations were reflected in SB 74.
- That the 80th percentile regulation be revisited (although it did not make specific recommendations for change.)
- Steps to develop common purchasing strategies by different state agencies, which presaged the interest in a Health Care Authority.
- Price transparency legislation, which was passed in 2018.

The HCC made a broad recommendation to "pay for value." A recurring theme was that changes to improve the quality of health care delivery must be coordinated with reimbursement reform. The importance of payment reform to adopt advanced primary care models was emphasized. Among the other issues identified were: expanded emphasis on evidence-based practice; better integration of behavioral health services with primary care; a strong endorsement for continued integration of health information technology into health care delivery, and new reimbursement approaches for end-of-life services. The Commission did not endorse specific payments models for general adoption. Instead, it tended to endorse experimentation and pilot projects. The view of the Commission was that "payment reform is not the

magic bullet for health care reform, but it is one essential element in transforming Alaska's health care system..."52

Despite making headway on understanding the cost drivers in Alaska, identifying areas for further study, and considerations for actions to reduce cost, the HCC did not have any authority to implement or pursue policy reforms, thus limiting its ability to introduce or change laws. The HCC was defunded in 2015, when the State of Alaska implemented broad budget cuts in response to large reductions in oil receipts. One might ask what lessons the HCC presents for the current point in health care reform in Alaska. The HCC certainly identified many of the themes of policy development since introduced, including Medicaid reform and price transparency. Some initiatives identified by the HCC, such as its recommendations to create an APCD and stronger analytic capacity for health care policy, are strongly echoed in our findings around opportunities for Alaska moving forward. The dissolution of the HCC also points to the need for a long-term commitment by an independent entity that can link research and policy analysis to legislative action. While the HCC did not move the "pay for value" agenda beyond broad principles and pilot experiments, our findings point to opportunities to move toward more VBP while maintaining a FFS environment.

The Patient Protection and Affordable Care Act and Medicaid expansion

The federal Patient Protection and Affordable Care Act (ACA) was enacted in 2010, and several of its major provisions came into effect in 2014. A broad purpose of the ACA was to expand access to affordable health care. Two major steps in that direction were Medicaid expansion and the advance premium tax credit (APTC). Medicaid expansion increased the upper income eligibility limit for adults from 100% of the federal poverty level to 138%. The APTC provided subsidies for families with income between 100% and 400% of the federal poverty level to buy health insurance in the Health Insurance Marketplaces created by the ACA. Although we are unaware of any comprehensive research on the effects of expanded coverage in Alaska, there was a reduction in uncompensated care by 7.6% in 2014, and an additional 24.5% in 2015.⁵³

In 2017, Alaska implemented the Alaska Reinsurance Program to stabilize the Health Insurance Marketplace (HIM). It agreed to provide \$55 million to reimburse insurers for 33 of the most expensive treatments for individuals insured through the Alaska HIM. That reimbursement had the desired effect: premiums in the HIM rose only 7% in 2017 and fell 22% in 2018. Because many enrollees in the HIM receive APTC subsidies, the reinsurance program substantially reduced the federal subsidies paid to those enrollees. Since the federal subsidies were lower, Alaska had applied for and received a Section 1332 State Innovation Waiver, which sought reimbursement from the Federal government for those federal savings. The 1332 waiver was granted in July 2017, with a January 1, 2018 effective data. CMS estimated that the reimbursement to the state would be \$58 million in 2018 and \$69 million in 2019. Six other states (Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin) have since received CMS approval for waivers for state reinsurance programs.

Payment reform under Medicaid reform initiatives (SB 74)

In 2016, the Alaska Legislature passed SB 74, which addressed a wide set of issues in Medicaid design and delivery. The mandate under SB 74 was to study and implement a set of changes specified by the statute. This was very different from the general mandate assigned to the HCC to study health care costs and make recommendations. SB 74 directed DHSS to implement several administrative steps to better monitor Medicaid spending, to manage fraud and abuse, and to improve management of specific categories of expenses. SB 74 also directed DHSS to examine and pilot alternative payment regimes for Medicaid.

SB 74 directed DHSS to consider and to contract for one or more of the following alternative payment systems: premium payments for Centers of Excellence; penalties for hospital acquired infections, readmissions, and outcome failures; bundled payments for specific episodes of care; and/or global payments for contracted payers, primary care managers or case managers. In June 2018, DHSS announced its intent to award contracts for two demonstration projects under the "global payments" option. As of this writing, the Medicaid managed care will not be implemented, while Providence Family Medicine Center will demonstrate a PCMH model in the Anchorage area.

In addition to these contracts for demonstration projects, DHSS also contracted with Milliman, Inc., to develop specifics in the areas of bundled payments and health homes.⁵⁴ Milliman was asked to identify parameters that might define a small number of "episodes of care" to implement a test of bundled payments in Juneau or Fairbanks. Their report identified three bundles for potential demonstration projects: maternity and newborn; behavioral health; and septicemia and infections. The Milliman "Health Home" report discussed the experiences in other states with health homes and assembled data on which patient diagnoses generate the high level of system usage that would warrant investing in coordinated care for Medicaid enrollees with chronic conditions. Milliman identified nine chronic conditions that are associated with 92% of Medicaid costs. The 28% of patients who have two or more of these chronic conditions account for 75% of Medicaid costs. Investments in coordinated care for this population offers the greatest opportunity for success in a health home model.

Health Care Authority Studies

SB 74 also directed the Alaska Department of Administration to assess the feasibility of creating a single Health Care Authority (HCA) to provide health care coverage to a large pool comprised of Medicaid and state and local employees and retirees. The Department commissioned four reports from three consultants.

• The Health Care Authority Feasibility Study Phase I – Consolidated Purchasing Strategies ("PRM-I") by the PRM Consulting Group analyzed the possible impact of consolidated purchasing strategies for public insurers. PRM-I concluded that the potential gains from a joint purchasing strategy were generally small and argued that a competitive insurer and provider environment would be necessary if a joint purchasing strategy were to have a large impact. The report concluded that Alaska's health care markets lacked the necessary competition. PRM-I did identify three strategies that could generate modest savings, with or without an HCA.

• The Health Care Authority Feasibility Study Phase II – Analysis of Coordinated Health Plan Administration ("PRM-II") also by the PRM Consulting Group examined various administrative savings from a consolidated HCA. PRM-II provided an estimate of savings from pooled purchasing of 1.2% (\$14.5 million) by year 5 and that an HCA could achieve modest annual administrative savings of 1.3% (\$17.4 million) by year 5. Most of those savings would accrue to the smaller plans that are merged into a larger pool. The single biggest savings would be on reinsurance costs that small, self-insured employers incur to manage risk.

PRM-II did identify one area for potentially large gains: the possibility that a multi-employer pool could avoid ACA "Cadillac taxes" on high premium plans, if those are actually implemented in 2022. The report argued that many public employee plans in Alaska could reduce expenses by creating "tiers" of coverage. Under a tiered plan, an employee pays a different premium for coverage for self-only, self-and-partner, self-and-family, or self-and-partner-and-family. Particularly for families with two employed adults, the extra premiums create a disincentive for including family members in two insurance plans. The disincentives under tiered premiums result in fewer coverage lives by public employer health insurance programs and fewer individuals with dual coverage.

- *"Estimate of the Potential Value of Consolidating Alaska State, Local, and School District Public Employee Health Plans* by Mark A. Foster and Associates (MAFA) was generally more optimistic about the potential for administrative and joint purchasing savings under an HCA. Unlike PRM, MAFA believed that a single large purchaser would be able to leverage its purchasing power into larger provider discounts. MAFA projected that an HCA for public employees and retirees would achieve administrative and pooled purchasing savings of 8.8% by 2025, which was well above the estimates provided by PRM.
- The *Health Care Authority Feasibility Study* by the Pacific Health Policy Group (PHPG) assessed what would be necessary to incorporate Medicaid into an HCA. PHPG concluded that it would be preferable to launch an HCA without Medicaid and then add Medicaid after the HCA was well established. Two types of factors drove this cautionary advice. First, because Alaska Natives are 40% of Medicaid enrollees and are subject to 100% federal funding, there are unique issues to consider when Medicaid changes involve Alaska Natives. Second, Medicaid administration involves different administrative processes than traditional insurance administration, which limits the scope for efficiencies. Moreover, an HCA does not alter how Medicaid rates are set since the state already sets Medicaid provider payments, which are much lower than the reimbursement paid on behalf of government employees.

Health care pricing transparency

In 2018, the Alaska Legislature enacted health care price transparency requirements as part of Senate Bill 105. The provisions required each provider to post the undiscounted price for their ten most frequently performed procedures. That list must be provided to DHSS, which is directed to compile and post the information on its website. The legislation also required providers to provide good faith estimates of the

expected full cost of any treatment within ten days, if requested by the patient. The estimate must also provide information to the patient about the insurer networks, if any, to which the provider belongs. SB 105 was preceded by the similar Anchorage Health Care Transparency Ordinance (AO 2017-26), enacted in 2017.

Price transparency has been a relatively common and popular state legislative initiative. While there may not be definitive empirical analysis of price transparency, the limited available evidence is skeptical about benefits. For example, a recent working paper by Christensen, *et al.* (2018)⁵⁵ used a national sample from the IBM Watson MarketScan data for hospital charges for five common procedures to examine price transparency. They found that price transparency did not affect payments or consumer search but that it caused hospitals to reduce average posted charges by 5%. That is, price transparency seemed to lower both posted charges and the discounts to those charges. They attributed the reduction in posted prices to "reputation effects."

The arguments for price transparency may not rest only upon immediate cost reductions due to consumer search for less expensive providers. Transparently posted prices may provide information that supports the evolution of new healthcare pricing institutions.

Relatively more limited experience with earlier cost containment models.

It is worth noting that Alaska has had relatively limited engagement with the cost containment models than other states. For instance, there are no HMOs in Alaska and Alaska is the only state without any Part C Medicare Advantage plans available. Because of Alaska's COHCP statute, Alaskans have less experience with requirements for pre-approval. Preferred provider networks in Alaska have covered a much smaller share of providers (and especially some specialists) than in other states. Moreover, while VBP models are beginning to be explored in Alaska, their implementation is not, at present, widespread.

The less prevalent nature of cost containment approaches in Alaska may help explain part of the disproportionate growth in health care costs in Alaska. In addition, it might be tempting to suggest that adopting some of these cost containment models would be one approach to addressing the high costs. As discussed above, however, there are undoubtedly many different contributors to Alaska's health care cost growth and models of restraining health care cost must be appropriate to each state's cultural and political environment. A research program and appropriate data collection tools, such as an APCD, that can help sort out the contributions of these different factors would be very valuable in informing future policy choices.

Finally, VBP models often try to incorporate incentives for cost control along with new features to incentivize quality of care. Alaska is beginning to look at VBP models and, with the right institutional structures, leadership, and stakeholder engagement, there are opportunities to apply new VBP tools in Alaska.

Summary

Alaska faces similar challenges as many other states, but to an exacerbated degree, with high spending in the private sector driven largely by higher prices. There is a multitude of factors that likely influence higher prices in Alaska, including the costs associated with physician recruitment and a somewhat unique set of state laws intended to ensure patient choice and access but that may also ultimately contribute to higher costs. Among state and local employees, dispersed purchasing may put some limits on bargaining power. Two factors have been important in Alaska health policy: expanding access by increasing the number of specialists and primary care physicians, and protecting the ability of patients and their providers to make independent decisions. The combination of a strong economy, substantial oil revenues to fund state government, and relatively generous federal funding for health care costs has allowed Alaska to, historically, worry less about health care cost containment. Lower oil prices and declining oil production have negatively affected both the private economy and the state government budget, giving health care cost containment perhaps greater policy emphasis. To date, that shift is reflected in significant policy steps for reforming Medicaid payment and delivery and in analysis of a possible HCA.

The high costs for health insurance borne by payers places a strain on personnel budgets in both the public and private sector, creates a challenge for Alaska to attract and retain employees by offering competitive wages and benefits – as health benefit costs replace wage growth, particularly among entry level positions. Public employee health costs are about 1.6 times the U.S. and the average individual, premium are 1.5 times.^{xxi, 6} A recent study examined the effect of excessive health plan cost growth and found Alaskan employees have foregone around \$2.74 billion in wage increases over the past decade.^{xxii}

State policy can impact the market dynamics that lead to higher health care spending and address some of the underlying health care market imperfections. For example, most states have used managed care for their Medicaid populations to standardize performance expectations and foster competition among insurers.⁵⁶ Greater price transparency and careful consideration of existing state policies and the adoption of better purchasing strategies can likely influence prices. It is important to note that, just as there is no single cause for the higher health care spending in Alaska, there is no single "silver bullet" to temper their increase moving forward. Many states are using multiple pathways to improve the value of the health care spending, and Alaska will likely want to do the same.

To summarize, the elevated levels of spending has not bought better health, price variations are not correlated to the quality of care, and cost is still a significant barrier to care. In a survey conducted in the Homer Area, 40% of respondents had experienced barriers to accessing healthcare in the previous year. Of those respondents who had experienced difficulty accessing care, 74% cited cost of care as a barrier.⁵⁷

Going forward, Alaska may need to consider whether greater concern for health care spending requires modifications in the established policies that emphasize independence for patients and providers. Alaska

^{xxi} The actuarial value is the ratio of expenses paid by the health plan to the total expenses eligible under the plan. An actuarial value of 80% indicates that 80% of health care expenses eligible under a health plan will be covered by the plan and 20% of the expenses will be covered by the employee.

^{xxii} MAFA: Estimate based on CMS private health insurance cost per enrollee from 2007-2014, with MAFA projections through 2017 for Alaska adjusted to reflect "excess cost premium" and "excessive cost growth premium" in Alaska compared to U.S. applied across Alaska employment wage base.

can control health care spending but controlling costs will involve hard decisions about short- and longterm challenges. This will require difficult discussions with many stakeholders and policy makers to make the necessary changes. Changes in spending will also reverberate to ensuring the health care workforce is sufficient and aligned with new directions. It requires working with providers on payment reform, collaboration by health plans on plan design, ensuring prices negotiated downward must be passed along to consumers, and improving data reporting among both groups.⁵⁸ Reforms will also require shaping how consumers seek high quality health care in a manner that enables greater spending on other priorities.

A central finding is that limitations on the availability of timely and detailed health care cost data continue to restrict Alaska's ability to address important questions. Alaska has not created an institutionalized capacity to conduct health care policy research, leaving a considerable data gap for research and for monitoring and evaluating current trends and reforms. This is particularly true in the commercial market, where the understanding of price heterogeneity, market structure, and consumer behavior is very limited and somewhat dated. An important step going forward is investing in both creating a data repository such as an APCD as well as in the analytical capacity to provide health outcome policy-focused and organizational research. While establishing an APCD is an important mission for the state over the next decade, it is equally important to obtain quality data sets in the meantime and conduct rigorous research.

While Alaska has more limited experience with some incentive-based models and VBP structures, it can learn quickly from the experience of others, and with its small population, is well positioned to undertake such reforms. In the next section of the report, we detail some VBP approaches for Alaska to consider, with examples from other states that have adopted those approaches.

Chapter 3: Understanding the new road system

Over the course of the past 20 years, health policy has increasingly shifted attention towards aligning the incentives in the health system away from a pure FFS payment environment and towards greater incentives to reward lower cost and higher quality care. Increasingly, private insurers and federal and state governments are turning toward models of VBP to better align these incentives. In this environment, states are turning to a variety of different approaches to introduce value and VBP into their delivery systems. In addition, states have increasingly come to understand that much of health care spending is driven by factors that are beyond the actual health care delivery sector. These "social determinants of health," or the conditions where people live and work, have a major impact on health care expenditures and states have begun examining systematic ways to better understand and address these determinant.

In this chapter, we discuss VBP in the context of a collaborative framework developed through CMS. We then introduce examples of how states are implementing value initiatives within their states, and close with examples of how states are examining and addressing SDOH. These examples are not intended to be an exhaustive list; rather, in each case, we are providing examples of lead states to inform Alaska's considerations moving forward.

Background to VBP reforms

VBP refers to methods of paying providers that incentivize an efficient use of health care resources to constrain cost growth, in contrast to paying providers for each service, regardless of its effectiveness. This shift has been referred to as moving from a system that rewards value rather than volume, or "volume to value." ^{xxiii}, ⁵⁹ There are many forms of VBP, but two critical components of many VBP approaches are the measurement of provider care delivery on desired patient outcomes and offering providers payment bonuses and/or penalties based on these patient outcomes.⁶⁰ Many models also seek to create mechanisms that encourage providers to assume some or all of the financial risk. These two VBP tools, measurement and pay-for-performance, are found across a number of VBP approaches, including PMPM care coordination fees, bundled payments, shared savings and shared losses, incentive payments, and partial and full-risk managed care. Payment reforms often can spur innovation in care delivery as providers are afforded with financial incentives to continuously improve the care delivery environment, and can better test approaches in physician messaging, telemedicine, and remote tele-diagnostics.⁶¹

As VBP has become more prevalent, efforts have emerged to characterize the varying nature of these payments. One such effort, and one that is commonly cited, is the Health Care Payment Learning & Action Network Framework, or the HCP-LAN framework. The HCP-LAN framework describes the collaborative effort, led by CMS, to work across public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community to move health care delivery from quantity to quality and increase person-centered

^{xxiii} One example of this phrase comes from a physician and former Republican Senator Bill Frist, who, "The most powerful way to reduce costs (and make room to expand coverage) is to shift away from volume-based reimbursement (the more you do, the more money you make) to value-based 'reimbursement." Source: Frist, B. —How the G.O.P. Can Fix Health Care, I New York Times, February 21, 2010, p. A16.

care.⁶² The framework focuses on 1) quality, as assessed through process, outcome, patient-recorded outcome and patient experience measures, in clinical and behavioral health; 2) efficiency in achieving the core outcome goals of patients, providers, payers, and purchasers in relation to their costs; and 3) collaborative patient engagement through improving appointments wait times and encouraging appropriate utilization, providing information on high-value providers and transparent price information, and provide ongoing feedback that providers can use to improve patient experience.

The HCP-LAN framework assigns payments to health care providers in a progressive path on four categories, as shown in Exhibit 1 below, from Category 1 to Category 4, with increasing provider accountability for both quality and total cost of care (TCOC), and a greater focus on population health management (as opposed to payment for specific services). The overarching goal is to move the U.S. health care system from FFS into payment and delivery options, which promote high-quality and effective care, through system wide efforts to invest in high-value health care services. The framework recognizes the need for data analytics to support tools such as risk stratification and monitoring patient outcomes, and to that end, many VBP reforms provide infrastructure payments for such investments. We introduce the HCP-LAN framework because many states, including states in our national scan, adopted the HCP-LAN framework as a way to monitor their progress toward adoption of VBP methods.

Exhibit 3.1: The HCP-LAN Framework



Source: Health Care Payment and Learning Action Network, 2017, Mitre Corporation

Options for value improvement: key tools

All of the case study states included in our National Scan incorporate VBP into their health reform efforts. For example, a number of states have used the HCP LAN framework in their MCO contracts. As Alaska considers options of VBP approaches, there are a number of tools and lessons it can borrow from other states. Exhibit 3.2 summarizes some of these tools.

States can pursue one or more initiatives and apply them in different settings. All of the examples can be done within a program or in a multi-payer arrangement, with each payer coming to agreement on spending and growth targets, level of involvement as well as a consistent set of quality measures and reimbursement strategies. Some states then focus on specific high risk populations, or focus on behavioral health integration, and may do so with through Medicaid waivers to improve care for particular populations. If target populations are identified, then the needs of these populations can inform provider participation and payment methodology, as well as provider networks, payments, such a requirement of certain provider types (i.e. inclusion of Federally Qualified Health Centers (FQHC)), or coverage

services. Some states go further to specify the development of coordinated care organizations, or require providers and/or MCOs to link health and social service needs, for example, through requirements for plans to address SDOH. The target population can inform the setting and strategies of implementation, such as hospital or primary care, or both. The target population will also inform which quality performance metrics the state and any other payers will use for performance based incentive payments.

Alaska can borrow concepts and strategies in VBP from other states but will consider its unique markets, provider networks, and the health needs of its population. Below we lay out some decision points in making determinations of payment models, both in design and implementation. These are illustrative of the types of decisions that will be necessary as value-based models become more prevalent.

Some payment strategy decision points for tying quality improvement to payment incentives:

- shared savings arrangements: upside only or shared risk/reward and risk corridors;
- retrospective versus prospective payment: either a bonus or withhold, wherein a fraction of the FFS payment is withheld but reimbursed based on positive performance on specific measures (such as clinical process-of-care measures);
- layer of approaches: paying providers through FFS + a fixed PMPM payment for infrastructure or coordinated coordinate care;
- methodology for setting benchmarks, whether hospital-specific global budgets or PMPM care coordination payments;
- use an episode or bundled base payment for certain services.

Some implementation decision points include:

- target population focus of reform: high-clinical risk, behavioral integration;
- care delivery settings, such as hospital inpatient, outpatient, total cost of care, etc.;
- level of regional adjustments and local flexibility;
- level of statewide harmonization and administration;
- risk stratification methodology, capping and outlier levels and risk thresholds;
- a consistent set of quality measures and incentives for quality (e.g., hospital readmission and emergency department visit rates, tobacco and substance abuse counseling and cessation; preventative care and screenings measures);
- coordination of reform in the context of other initiatives payments.

VBP approaches can be tailored to regional and local concerns. For example, some states are targeting specific alternative payment models for FQHC services, or testing coverage of alternative services —such as expanding reimbursement for home visits or telehealth, and covering new services in lieu of those already covered in the state Medicaid plan, such as certain clinical treatment services.⁶³

| Value Initiative | Example State | Implementation Feature | Select Policy Design Decision |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| All of these can be done | in a multi-payer a | I rrangement, with each payer deciding on spending and growth targets and lev agreement on a consistent set of quality measures and reimbursement strate | vel of involvement. Where multi- |
| Global budgets: a fixed budget for each hospital each year based on each projected expenditures | Maryland | All-payer, statewide implementation for hospital services State caps annual growth in per-person spending Voluntary participation for rural hospitals Multi-payer participation Mandatory redesign of care delivery systems for participating hospitals Prospectively set all-payer global budget for participating hospital which | - Methodology for setting hospital- specific global budgets - Settings: Hospital inpatient, outpatient, TCOC |
| Managed FFS Medicaid: ASOs | Colorado | includes inpatient and outpatient services Administered through regional accountable entities with independent structures and coordination Incremental design approach Behavioral health integration | - Incentives for PCMH and quality - PBPM infrastructure or |
| support service delivery and purchasing, customer service, care management | Connecticut | Program is self-insured No MCO contracts: four Administrative Services Organizations (ASOs) administer the plans statewide: medical, behavioral health, dental, non-emergency medical transportation ASO not responsible for provider network or claims ASOs conduct data analysis, utilization management, routine care coordination; intensive care management | supplemental care coordination payments - Level of health and social need integration -Agreement on quality measures |
| Managed Care Capitation: contracting facilitates budget predictability; can also increase value-based design features. | Oklahoma | OK Health Authority oversees Medicaid and State Employees Regional Care Organizations (RCOs) RCOs bear upside and downside risk Global budget for each RCO determined on PMPM basis PMPM growth rate capped by the state; also uses Episodes models for some conditions Contracts with Tribal Organizations | - MCO and provider reimbursement strategies -Agreement on quality measures |
| Bundled episode- payments: <i>a</i> | Arkansas | Multi-payer model Mandatory participation for AR providers Identification through claims data of a "Principal Accountable Provider" (PAP) for each episode of care. | - Types of episodes and episode definition; |
| comprehensive payment (bundle) for all services to treat a defined episode of care, such as a condition or procedure | Colorado | Reimbursement for hospital services Services provided 24-hours immediately prior to, and after, an inpatient hospitalization, including outpatient, clinical laboratory, and supply during the hospital stay, are included in an "episode." Enhanced Ambulatory Patient Grouping (EAPG) methodology used for outpatient services All Patients Redefined Diagnosis Related Groups (APR-DRG) methodology used for inpatient services. | - Types of bundles and bundle definition - Grouping software; - Bundle and/or episode coordinator - Risk stratification |
| Accountable Care: providers improve care coordination; can earn shared savings | Rhode Island | Accountable entities (AEs) contract with state MCOs AEs are required to address SDOH AEs required to enter into value-based alternative payment methodology with MCO partners Total cost of care methodology for Medicaid-only AE populations All payer, statewide | Use of infrastructure payments Shared savings arrangements: upside only or shared risk/reward any additional benefit enhancements for care delivery reforms |
| Health Homes: multiple providers coordinate care for high need patients: can lower cost | Washington | - Voluntary provider participation - High-risk, high-cost enrollees with chronic disease - Focus on highly coordinated care Medicaid & Dual eligible - Voluntary participation - Health homes reimbursed PMPM | - Set of services included within a health home |
| Reference-Based Payment: defined upper limit for price or growth based on a benchmark | Montana | State employee health plan Reference-price based on Medicare rates; (average of 234% Medicare) Hospital services only Legislative reform | Benchmarks used Implementation for specific types of care |

Exhibit 3.2: Developing Value Initiatives and Decision Points

To supplement the above table, our national scan uncovered additional examples of how states are considering VBP design. For example, for its Healthy Opportunities Pilots, **North Carolina** will develop a pathway to VBP for providers and plans to include incentive payments during the first two years, withholding of payment for failure to meet defined metrics in the next two years, and a shared savings model in the final year. **Maryland's** Care Redesign Program (CRP) allows hospitals to make incentive payments to non-hospital health care provider partners who perform care redesign activities aimed at improving quality of care if they have achieved certain savings under a fixed global budget. **Washington** has committed to transitioning 90% of HCA provider payments under its PEBB and Medicaid to VBP mechanisms by 2021. It will test four payment models including an alternative payment methodology for Medicaid managed care patients who receive care at FQHCs and rural health centers.

The national scan also showed that state models often offer flexibility in VBP arrangements that allow participating plans and provides to engage in risk sharing arrangements at various levels. For example, **New Mexico** mandates its MCOs to incorporate VBP initiatives but contains flexibility to fit each member population appropriately. Plans may participate at various levels, based on the amount of risk that the plan or provider is willing to share. Level 1 includes a fee schedule-based system with financial rewards/incentives and penalties/withholdings based on achieved metrics. Level 2 involves full or partial-risk capitation through a shared savings model or two or more bundled payments for episodes of care. Level 3 can be implemented through a fee schedule-based system, full or partial-risk capitation, or global payments.

Alongside payment reforms, the state in its role as a large purchaser can use tools across payers (e.g., state health employee plans and for its Medicaid and marketplace populations) to identify high-quality providers, develop a limited network, and encourage plan members to seek care from these providers. These efforts, known as limited-network plans and tiering, offer flexibility and have shown to produce savings to states.⁶⁴

The PMC, after reviewing the national scan and previous work under the AHTP, and considering different VBP strategies, identified several areas of interest for greater exploration. In particular, the PMC expressed an interest in multi-stakeholder approaches, with regional input and considerations to enable differential implementation of VBP arrangements, including and global budgets.

- **Multi-payer approaches to reform** would align incentives for providers and reduce provider reporting and measurement burden;
- Global budgets would give facilities, such as rural health providers who face higher degrees of budgetary uncertainty, a more predictable annual budget. This could assist with workforce and other planning activities, and especially in a multi-payer environment, provides for more predictability of total health care spending and may reduce the incentive for cost shifting.

In this chapter, we provide information on these concepts, while in Chapter 5, we return to examine more specific details.

Multi-Payer and Multi-Stakeholder Alignment Are Key Elements

Multi-payer approaches are collaborative efforts between federal or state payers and commercial payers to reach shared goals by agreeing on strategic investments for care delivery transformation, such as shared

investments in primary care, enhanced payment for practice transformation and embedded care management, quality performance-based incentives, population-based payments for investments in population health and coordination, and consistent performance metrics.¹¹ Multi-payer alignment can help ensure that purchasers and payers are coordinated in their efforts to transition to value-based purchasing, by aligning payment incentives and quality reporting measures. When payers agree on common performance measures, payment reform principles and value-base payment methodologies, and share investments in infrastructure to providers, they send "common signals" to providers about

"In the presence of multiple payers, there exists an incentive for any given payer to refrain from adopting alternative payment models, while still recouping savings required of providers working under payment reform approaches implemented by other payers."

McClellan, M. B., Feinberg, D. T., Bach, P. B., Chew, P., Conway, P., Leschly, N. & Teeter, D. (2017). Payment reform for better value and medical innovation. NAM Perspectives.

expectations while also reducing "noise" and reducing provider reporting burden.¹² These approaches seek to harness the reform efforts across payers to bring about synergies in progress towards outcomes. Depending on the level and type of multi-payer alignment, a coordinated strategy across multiple payers can achieve:

- Reduction in cost-shifting and greater sharing investment responsibilities;
- Consistent messaging and incentives to providers;
- Reduction in provider administrative burden for reporting and payment reimbursement;

It is important to note multi-payer strategies can be used in a variety of settings, as our national scan demonstrated. For example, in **Maryland**, they have implemented an all-payer total cost of care model that built on their all payer hospital payment approach. In **Arkansas**, the Arkansas Health Care Payment Improvement Initiative (AHCPII) program is a statewide multi-payer initiative across several payers, including Medicaid, state and public school employees, a number of commercial health plans, and Walmart. The multi-payer initiative has three components: 1) a PCMH care delivery model; 2) Episodes of care (EOC), which pays for a bundle all the care a patient receives in the course of treatment for a specific illness, condition or medical event; and a Health home model, for persons with complex health needs. States can also enlist stakeholders over time as not all payers may be ready to participate. In **Colorado's** Colorado Framework under their Multi-Payer Collaborative, efforts are aimed at helping primary care practices throughout the state to integrate behavioral and physical health in primary care settings through alternative payment approaches. This multi-payer PCMH pilot included five private and two public health plans, convened by HealthTeamWorks, a nonprofit, multi-stakeholder collaborative. These illustrative examples simply demonstrate that states can take multi-payer approaches in a variety of care settings.

Multi-payer alignment can be thought of as a continuum, ranging from alignment on things such as quality measurement and reporting through alignment on payment strategies. Exhibit 3.3 provides examples from states on the different settings and strategies of multi-payer models.

| | Participating Payers | Payment Model | Quality Standards | Most Notable Trait |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Vermont | Medicare and Medicaid Three commercial insurers Two self-insured employers (IBM and the state) | FFS + PMPM Fees Community Health Teams: Paid for by all payers at rate of \$350k/yr per 20,000 people served | Evaluated on 30 nationally endorsed quality measures No homegrown measures | Emphasis on bolstering primary care practice capacity as well as provide multi-payer financed community health focused supports |
| Michigan | Medicare and Medicaid Managed Care BCBSM, BCN, Priority Health | FFS + PMPM Fees Additional Care Management Codes | Required accreditation standards Mostly aligned quality measures | Enhanced support and analysis of multi-payer claims data for providers |
| Arkansas | Medicaid and state employees Arkansas BCBS, Centene, and QualChoice of Arkansas | FFS with retrospective bundle risk/gain for episodes FFS + PMPM with total cost of care gain for PCMH | Quality performance threshold necessary to share in savings | Multi-payer shared savings initiative |
| New York | Medicare, Medicaid FFS, Medicaid Managed Care Commercial Payers and Self-insured | FFS + PMPY fees Frequency and methodology of enhanced fees vary by payer | Common Set of performance and quality measures | Multi-payer initiative whose impetus is to attract and retain primary care workforce |
| Wisconsin | Medicaid, state purchasers, private employers, private health plans | • N/A | Condensed set of 14 common ambulatory and hospital level measures across payers | Multi-payer collaboration strictly on quality measurement |

Exhibit 3.3: Selected State Examples of Multi-Payer Models

Source: Avalere State-Based Multi-Payer Initiatives. 2015. Available at https://classic.nga.org/files/live/sites/NGA/files/pdf/2015/1504HealthLearningBreakoutGSeidman.pdf

As discussed in the preceding sections, multiple payers in the marketplace for health care, without transparency in price and quality, results in price distortion and cost shifting, which is of no value to consumers.⁶⁵ A lack of alignment can also create administrative challenges for providers, for instance if quality measures vary across payers and provider performance is assessed differentially across these payers. Alaska has undertaken several VBP reforms, particularly with the passing of SB 74; but more widespread adoption could advance change even more rapidly with continued alignment and accountability across all payers.⁶⁶

Multi-Payer Measurement Alignment:

When payers and plans align their quality reporting and improvement goals, providers face less administrative burdens, and are more able to focus improvement efforts and target staff resources effectively.⁶⁷ Thus, a starting point for multi-payer alignment can be agreement on quality measurement alignment; that is, agreement among payers to ensure that they are deploying the same measures for hospitals and physicians. This can reduce provider reporting burden, while also drive toward a common set of standards that ensure providers are not measured differentially for the same care delivery. For example, members of the **Colorado Multi-Payer Collaborative (MPC)** advanced towards quality measure alignment through these activities:

signed a Memorandum of Understanding to work toward measure alignment;

- agreed on shared milestones to measure practice progress with integrating behavioral and physical health;
- participated in an assessment (qualitative and quantitative) of challenges and barriers to implementation and further alignment;
- agreed to work on adult primary care measures across plans.

As part of **Minnesota's** 2008 health reform law initiative, the Commissioner of Health is required to establish a standardized set of quality measures for health care providers across the state. The goal is to create a uniform approach to quality measurement to enhance market transparency and drive health care quality improvement through an evolving measurement and reporting strategy. This standardized quality measure set is called the **Minnesota Statewide Quality Reporting and Measurement System**. Physician clinics and hospitals have been reporting quality measures under the statewide system since 2010. Health plans may use the standardized measures and may not require providers to undertake reporting on measures outside of the system. While this system was put into statute in 2008, it built upon voluntary efforts among payers in the state through Minnesota Community Measurement (MNCM), where health plans agreed upon common provider measures and agreed to align their data collection through MNCM on standardized measures across plans

We now turn to discuss a specific area of interest to the PMC, the issue of global budgets. A note of distinction: all payer rate setting, described above, is a tool that can be used to establish standardized prices, or rates, paid by payers. Health care spending, however, is made up of the produce of price per unit times volume of services. Therefore, to control total cost of care, states have been interested, and some have begun to implement, more global approaches such as global budgets.

In the next section, we describe what global budgets are as well as decisions points and considerations necessary for their implementation generally. Exhibit 3.3 shows some considerations that support the development and implementation of a multi-payer global budget. We then describe in some detail the Maryland Total Cost of Care model (see the national scan for additional details), as well as efforts in several other states and provide some considerations for developing these models in rural settings.





Source: Adapted from Sharfstein, J.M., Gerovich, S., Moriarty, E., Chin, D. Global Budgets for Safety Net Hospitals. JAMA. 2017;318(18):1759-1760

Multi-payer for Hospital Global Budgets and Total Cost of Care

Global budgets can be powerful tools to control costs, and have been used for decades in other countries.⁶⁸ Global budgets can incentivize providers to limit the intensity of services used per patient (such as resources consumed during an inpatient stay), as well as the total number of events that occur (i.e. inpatient stays). The "global" budget may not actually cover all services but rather reflect a predetermined fee for certain services, and budgets may be based on historical expenditures of a facility, or based on a capitated rate for a population.

In the U.S., early models of global budgets involved HMOs paying providers on a per-member basis in the late 1980s and early 1990s. These models generally were not successful for a variety of reasons. However, new approaches to global budgeting have been used by commercial payers, and increasingly by federal and state payers. These models are more sophisticated in that they incorporate incentives for providers for shared savings and shared risk, encourage the flow of data and information to providers to fine tune care management, incorporate quality metrics, and may include infrastructure payments to help improve care delivery. For example in 2009, Blue Cross Blue Shield of Massachusetts developed the Alternative Quality Contract with seven provider organizations. Providers could participate voluntarily, and would agree to a risk adjusted, fixed annual payment for attributed patients.⁶⁹ They could receive payments for achieving certain quality benchmarks, while accepting losses for excessive spending. The model demonstrated a lower rate of cost increase compared to a control groups, more so in the second year than in the first, and averaged about 2.8% over the two years, compared to spending in

nonparticipating groups. Findings showed that providers shifted some procedures, imaging, and laboratory tests to facilities with lower fees, while also reducing utilization among some groups.

More recently, several state agencies have undertaken a global budget or TCOC approach, or are developing plans to do so. All-payer budgets have to date been most widely used in hospital setting, wherein each payer pays a hospital a prospectively set amount to cover its beneficiary population. In these hospital models, all payers have financial targets on the increase in annual hospital spending growth for inpatient and outpatient services, based on each payer's historic trend. While Medicare (and Medicaid) set limits on costs per admission, global budgets provide incentives to limit both volume and costs per admission. However, rate setting on total cost of care would also help reduce shifting costs to other parts of the health care system outside of global budgets. From a hospital perspective, the assurance of a set budget or accountability based on a target total cost of care can create an incentive to reorganize care delivery and invest in services to address preventable health conditions.

Decision Points in Implementation: There are a number of decision points in formulating these models, and there are lessons learned from other states that Alaska can apply should it pursue applying this tool. An initial decision would be the level or setting of the global payments: to date, many of the initiatives started with target limits on hospital spending, while some have advanced to limit growth in the TCOC, through either voluntary participation of payers or mandatory participation through legislation. For example, a statewide implementation, with regional adjustments, may be efficient to reduce cost shifting to geographic areas that are not participating in the model. Other issues include:

- the methodology to determine the specific budgets for each payer, for example, such as based on historical claims data or capitation based target population served, or a combination;
- the use of any reference rates or spending growth limits;
- statewide or geographically targeted, such as in rural areas;
- the methodology to determine the population attributed to each payer (the reference population);
- the methodology to adjustment for inflation and regional factors;
- the methodology to adjustment for demographics and health status changes in the reference population as well as catastrophic events;
- any shared savings or penalties and savings and loss-sharing limits;
- rewards for performance on quality measures and beneficiary outcomes;
- the handling of outliers or unusually high cost cases.

Stakeholders should agree to support providers to develop the administrative capacity to accept global payments, and use data to monitor performance and spending. Alaska could provide training to providers on these issues and work to develop readiness standards, or regulate which providers or practices could participate in global payments. Should Alaska choose to pursue a global budget approach, it will likely want to review current anti-trust legislation and obtain waivers to protect global budgets from liability regarding anti-kickback laws or gainsharing penalties. For example, CMS and the Office of the Inspector General have issued specific waivers that protect value-based models against the Anti-Kickback Statute and the physician self-referral law known as Stark Law.⁷⁰ These waivers vary in content, scope, and duration.

Global budgets could be applied to specific settings, and through partial capitation or partial global payments. In the latter, providers receive a global fee for specific services for each patient, but other services would be provided in a FFS manner with incentives for reductions. Specific services from specific providers could also be excluded from partial global payments. Similarly condition-specific capitation could be employed, which would be a global fee for all care received in treatment for the designated condition.¹⁴

In addition, when considering the level of capitation (partial or full, and which settings), payments should be designed to not penalize providers for expanding their services to new beneficiary populations, serving higher-need beneficiaries (higher compared to historical data), or using more high-value services. These factors should be accounted for, and can be, through payment design and adjustment mechanism.

The "regional ecosystem" should also be considered.⁷¹ That is, hospitals may be successful in achieving global budget targets when neighboring hospitals also participate, as this reduces the risk that providers or other professionals would increase their volume at facilities that were not participating. An additional strategy to support region-wide change would be for participating hospital to develop a set of initiatives that would be instrumental to facilitate meeting all-payer hospital budget targets. The regional approach has several other benefits. It can facilitate more collaboration and coordination across providers to address the needs of high-risk patients, as this can reduce avoidable or adverse events. It also allows payers to better examine trends in utilization, as cost would be controlled for across facilities.

State approaches to Social Determinants Of Health in payment reform

States are also increasingly aware that many of the drivers of ultimate health care cost occur far upstream. These drivers often occur outside the health care delivery system, and are frequently referred to as the Social Determinants of Health. SDOH are conditions in places where people reside, live, and work that can have an effect on health risks and outcomes.⁷² Accounting for SDOH in payment and quality improvement policies would provide health plans and providers more accurate payments for some high-risk populations, and holistically address some of the cost drivers that are beyond clinical needs. Data from these initiatives can help states understand how these factors influence cost and take actions to develop new strategies to better address these issues in a more cost-effective manner.⁷³

Federal Investments:

A prominent example on the national landscape is the Accountable Health Communities Model, led by CMS, to bridge services between community resources and clinical care. This five-year investment is an all-payer delivery system reform that provides support to community-based interventions; as of September 2018, there were 31 organizations implementing an AHC model. CMS developed the Accountable Health Communities Core Health-Related Social Needs (AHC-HRSN) screening tool to assess five critical areas of SDOH—transportation, housing instability, utility assistance, food insecurity, and interpersonal safety. The tool was developed with broad stakeholder input and from validated instruments.

A recent study found 35 states discuss SDOH or SDOH-related activities as part of their managed care coordination requirements, and are implementing either screenings or linkages with resources.⁷⁴ While Alaska's Medicaid program currently operates in a FFS environment, many of approaches taken in states that operate in a Medicaid managed care environment can be adapted. Federal regulations require MCOs to conduct an initial screening of member needs within 90 days of enrollment. Thirteen states have also included contract language focusing on SDOH in the context of Quality Assurance and Performance Improvement (QAPI) requirements. Through their MCO contract, these states are requiring performance improvement projects, data collection on indicators, and are monitoring and incentivizing performance on these goals.

Many states are making progress to address these factors, such as depth of poverty, education, mental illness, and homelessness in their Medicaid populations. A more limited number of states have developed ways to compensate or incentivize providers to address these concerns in their patient population. For example, states often require or incentivize their MCOs to screen for social needs but there has been more limited progress on establishing specific expectations about how to address those needs, and payment incentives for offering services that address SDOH is more limited.⁷⁴ Addressing SDOH often requires providers to develop relationships or coordination plans with other agencies or community based organizations. Exhibit 3.4 shows selected state approaches to incorporating SDOH. The specific process and measures for Alaska would need to be developed with stakeholder consensus, and the landscape of existing SDOH data would have to be assessed.

| State | Mechanism | Approach | Linkages and Tools |
|----------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| North Carolina | Section 1115 Waiver | State uses a regional approach where the lead pilot entity of each region develop, contract with, and manage a network of collaborating partners. Primary care providers will be required to embed the standardized SDOH screening questions into their Care Needs Screening instruments | State-developed standardized tool and 3 resources: 1) North Carolina Resource Platform referral platform for health care teams to connect people with community resources; 2) a "Hot Spot" Map to map resource needs and other indicators across the state; 3) a standardized SDOH screening tool. |
| Washington | Section 1115 Waiver | The state uses a regional partnership by using the ACHs, which include providers, MCOs, and community partners. The state requires MCOs to coordinate with and enroll members in the social programs that are available through other state agencies (i.e., Department of Corrections, Department of Vocational Rehabilitation). | Washington HCA is looking to support efforts to improve data on SDOH. The state uses SNAP and TANF databases to evaluate homelessness/housing stability. SBIRT is incorporated into mental health questionnaires. |
| Oregon | Section 1115 Waiver | Coordination between the health system and the social services systems, including support services and housing. Oregon requires MCOs to commit to addressing SDOH within a geographic area and utilizing community health workers. A survey is administered to stakeholders to evaluate homelessness/housing stability. | Medicaid behavior risk factor surveillance systems (MBRFSS) survey evaluates serious and persistent mental illness. EHR has screening measures for food insecurity. |
| New Mexico | Section 1115 Waiver | MCOs offer different "value-added services" which include non-medical options. MCO contracts contain specific terms requiring "full-time Supportive Housing Specialist" to provide training to the MCOs' care coordination teams. | Dependent on MCO, as this is not included in their contractual requirements to use a particular tool. |
| Colorado | MCO Partnerships | The state requires the Regional Accountable Entities to form "Health Neighborhoods" which include establishing referral processes, promoting utilization and identifying barriers to | Enrollment data; MCOs identify homeless individuals and link them with services. |

Exhibit 3.4: Selected State Approaches to SDOH in Value-Based Payments

| State | Mechanism | Approach | Linkages and Tools |
|---------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | access. MCOs must demonstrate a local understanding of health disparities. | |
| Maryland | MCO Partnerships | As part of the Total Cost of Care All-Payer Model, Primary Care Program (a voluntary program open for primary care providers) that provides funding and support for the delivery of advanced primary care. Modeled after the Center for Medicare & Medicaid Innovation's (CMMI's) national Comprehensive Primary Care Plus Model (CPC+), Facilitate access to community resources and supports for social needs | MCOs complete an assessment of their attributed beneficiaries' health- related social needs and conduct an inventory of resources and supports in the community to meet those needs using a screening tool developed for the CMS' Accountable Health Communities Model |
| Rhode Island | Section 1115 Waiver | Accountable Entities (AEs), similar to ACOs, must be certified which requires the identification of 3 key social needs domains, evidence to address them, a process for screening and managing referrals, and arranging supports to address them. Incentives for AEs are supported through the states 1115 Waiver | . Each AE proposes their own screening tools for the state to review, but the state encourages them to align with the State Innovation Model and available national models. Requires the MCO to connect members with housing supports and develop strategies to identify resources to support members experiencing homelessness |
| New York | Delivery System Reform Incentive Payment; Section 1115 Demonstration | Integrate clinical providers with behavioral health, community, and social services organizations across the entire state which includes 1) a toolkit of intervention projects; 2) community needs assessments; 3) project selection with a role for community-based organizations; and 4) implementation with continued funding tied to quality metrics. | The program uses questions from the Medicaid Analytics Performance Portal High-Medium-Low monthly billing assessment. The state uses provider fielded assessment tools to evaluated risks related to homelessness, incarceration, substance use disorder, limited English proficiency, and SPMI. |
| Massachusetts | Department of Health | Coordination between the health system and the social services systems, including support services and housing. Data from social service agencies used to risk adjustment SDOH on medical expenses. | Has used data from the American Community Survey to develop a Neighborhood Stress Score for potential use in risk adjustment. |

Screening tools are one approach state Medicaid agencies are using (see Appendix 5 for a more detailed list of tools). Some states are leveraging administrative data collected for other social services to identify risk factors for SDOH. If these are accessible, an index or score, akin to health risk scores, can be developed. Other states are also considering publically available data. For example, Massachusetts use ZIP code level data from the American Community Survey to understand socio-economic deprivation and risk. By combining administrative data with health data, providers could implement targeted screening to verify the presence of risk factors and link families to community resources, or both. This assessment could be done administratively, and may be more efficient than conducting in-person screening for every family.⁷⁵

North Carolina is the first state to establish a statewide initiative under its 1115 Demonstration waiver to test innovative models of covering evidence-based health-related social services. The Healthy Opportunities Pilot will test evidence-based interventions targeting housing stability, food security, transportation access, and interpersonal safety. In addition, MCOs will be required to screen beneficiaries for health-related social needs and connect them to social services, as appropriate. The state has developed resources to help support integration of SDOH within the pilots and more broadly, including an interactive statewide map of SDOH indicators, a standard screening tool to identify and assist patients with unmet health-related resource needs, and a statewide resource platform that helps connect patients to appropriate community resources. **Washington's** ACH organizations work with managed care plans to

address SDOH by coordinating and integrating health and social services, developing regional health improvement plans, and promote health equity. In **New Mexico**, MCOs may offer unique packages of value-added services, including enhanced transportation, infant care needs, post-discharge meals, etc. In **Oregon**, CCOs use global budgets to pay for not only physical, dental, and behavioral health care, but also fund non-medical services that address SDOH, as recommended by the Medicaid Advisory Council. **Minnesota** is requiring providers to develop plans to address these issues. In Appendix 3, we provide more in-depth examples of state efforts to screen and assess treating high social-risk populations.

The work from other states points to lessons learned and challenges that Alaska would need to overcome to address SDOH in payment reform. Principal among them are the barriers to data exchange that limit risk assessment, and lack of coordination between social services, health organizations, and providers. Payments could be made to include not only improved data linkages for screenings and assessments, but also information for referrals with regards to available services, unmet needs, and costs. Designing payment adjustments may also require establish billing codes to support payment between participating organizations. Finally, the state should be realistic about the time horizon for return-on-investments in SDOH programs, which may be accrued not only through reduced adverse health events, but also in educational and employment outcomes, in longer time horizons.⁷⁶

As this chapter illustrates, many of these payment approaches can be implemented contemporaneously and complement each other; there may be synergies and momentum from multi-stakeholder collaboratives and multi-payer approaches to shift incentives for providers.

In this chapter, we have examined the way that states are currently approaching the changing road system for health care delivery, including some illustrative examples of VBP and value initiatives. In addition, states have come to understand that they can improve the health of their populations and potentially lower health care costs by focusing on those things outside the care delivery system that impact on health costs and outcomes, the SDOH. Implementation of value-based models of care all require both the availability of data and information to inform and guide efforts, as well as a strong governance structure to ensure effective and collaborative policy development and implementation. In the next chapter, we discuss some suggested first steps for Alaska's journey.

Chapter 4: First steps on the journey: establishing leadership, data infrastructure, and analytic capacity

As discussed in Chapter 3, states are taking many paths and using many tools to pursue health system reforms, and are often pursuing goals simultaneously. A cornerstone of all such health transformation efforts is developing the infrastructure for data collection and analysis of performance and outcome data in order to monitor and evaluate health care reform efforts. In this chapter, we describe two key first steps on the roadmap: leadership governance and the development of data infrastructure and analytic capacity.

Governance structures as key

A theme that emerges from the national scan and also from the wider body of policy reform literature is that having a trusted entity that can set an agenda for policy evaluation, conduct data analyses to understand policy impacts, and make recommendations or guide health policy decision making is a key to sustainable reform. Such entities work across stakeholder groups and government to maintain neutrality and understand perspectives, so that their work is understood, trusted, and maintains broad buy-in.

Our analysis shows that these entities can be structured in a variety of ways. As the saying goes, form follows function: some models exist to carry out legislated actions and policy goals, and are situated inside state government. Others exist outside government, in a non-profit or quasi-governmental capacity, to provide a neutral data analysis, policy analysis, and convening function. Other models are situated at stand-alone centers at universities, to provide analysis and to tap the expertise of both professional staff and university faculty. Exhibit 4.1 provides a summary of selected state entities, followed by a more detailed explanation of some of the entities.

Exhibit 4.1: Selected State Entitles to Guide Value-Based Payments

| Administrating | Administrating Authority/ Mission | Policy Activities | Multi-stakeholder structure / | Data Analytics |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| The Arkansas Center for Health Improvement (ACHI) ACHI is a non- partisan, independent health policy center, established in 1998 | Authority: awarded contract from Arkansas Insurance Department (AID) to develop APCD, funded by CMS Center for Consumer Information and Insurance Oversight Legislation. Mission: ACHI is a nonpartisan, independent health policy center, aiming to be a catalyst for improving health of Arkansans through evidence-based research, public issue advocacy, and collaborative program development | Legislation established a requirement for a health data and an analytic platform; for health policy research; provided oversight to ACHI. Same legislation created an intersection between research and policy, linking the Office of Health Information Technology (OHIT) and State Health Alliance Records Exchange (SHARE). ACHI led the development of the Arkansas Health Care Payment Improvement Initiative (AHCPII) | AID oversees and funds ACHI's development of the Arkansas APCD, including data oversight, formulates data security/privacy regulations of APCD and its contributors AID is governed 13-member advisory board; ACHI is governed by its health policy board (21 members from different stakeholder groups) AHCPII partners include Medicaid, AR BCBS, AR State and Public School EHP, Centene, HealthSCOPE, QualChoice, and Walmart. | APCD |
| Center for Improving Value in Health Care (CIVHC), Colorado CIVHC is an objective, nonprofit organization, established in 2009. | Authority: legislative appointment to administrator of APCD Mission: to empower individuals, communities, and organizations through collaborative support services and health care information to advance the Triple Aim of better health, better care, and lower costs. CIVHC began as a convener of diverse stakeholders committed to changing the way care is paid for and delivered. | Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF) appointed CIVHC the Administrator of the Colorado All Payer Claims Database Legislation created advisory committee to oversee the APCD. Through work groups and task forces, CIVHC cultivated relationships with likeminded partners to fulfill mission. | C.R.S. 25.5-1-204 (2015) required that the advisory committee include stakeholders in various fields, including, academia, hospitals, dental offices, insurance claim processors, health plans, community health centers, health care advocates, nonprofits. A separate Data Release Review Committee was established to develop data release protocols and review data requests | APCD |
| HealthTeamWorks, Colorado Nonprofit, multi- stakeholder collaborative, established in 1996 | Authority: Collaborating with CO Children's Healthcare Assistance Program to support alternative payment models under the State Innovation Model. Mission: to enable health care clients to achieve measurable quality, performance and financial improvements through trusted client collaboration, informed guidance, lower costs, and healthier communities. | Support implementation of SIM, CPC+, and Better Care, Better Costs, Better Colorado (BC3) programs | For the PCMH model, HealthTeamWorks reduced fragmentation between plans by writing suggested contract language. For CPC+, HealthTeamWorks worked with 61 aligned payers in 18 regions. BC3 initiative was a Collective Impact effort to change the way Colorado communities deliver and pay for healthcare, partnership with the Colorado Health Foundation. | Using data collected directly from program work |
| Colorado Commission on Affordable Health | Authority: created through state legislation, three-year initiative. | In its three-year work plan, the commission reviewed data related to | Commission includes multi-stakeholder members from diverse fields of CO businesses and | APCD, and other |

| Administrating Entity | Administrating Authority/ Mission | Policy Activities | Multi-stakeholder structure / Oversight structure | Data Analytics |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Care, established 2014 Bipartisan legislation commission | Mission : had a three-year mission to analyze health care costs and make policy recommendations to the legislature for lowering health care costs | cost, identified paths for further work, They engaged key stakeholders to and developed recommendations to Colorado policymakers to reduce long-term health care costs while also improving health care quality. | geography. Contracted evaluations out, including an evaluation by Milliman, Inc. and Lewis & Ellis | commercial data |
| Maryland Health Care Commission (MHCC), established 1999 Independent state regulatory agency | Authority: independent regulatory agency within MD Department of Health, statutorily enacted to create/run the APCD. Mission: to plan for health system needs, promote informed decision-making, increase accountability; provide timely and information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. | Statute: The Maryland General Assembly created MHCC in 1999 to in order to steer state health policy. It permitted creating an APCD with four analytic divisions, legislatively required to evaluate, regulate, and influence planning, development and provider services through data gathering, public reporting, planning and regulation | The Maryland Medical Care Data Base (MCDB) is the private insurer portion of the All Payer Claims Database (APCD). It is the main component of the APCD. MHCC collected data directly from health care facilities, insurance companies, Medicare, Medicaid office, and quality reporting organizations. Supported by stakeholder workgroups . | APCD |
| Maryland Health Services Cost Review Commission (HSCRC), established 1971 Independent state regulatory agency | Authority: Legislative, 1971, as an independent state agency with authority to set hospital rate regulations. Mission: to constrain hospital cost growth, ensure hospitals have the financial ability to provide efficient, high quality services to all residents, and increase equity/fairness of hospital financing. | HSCRC sets the rates that hospitals can charge Medicare, Medicaid, commercial insurers and self-pay patients HSCRC helped redesign the all-payer rate-setting system. HSCRC requires hospitals to report certain financial data, to have free and reduced-cost care policies, and to notify patients of their rights, obligations, and available assistance. | HSCRC has seven governor-appointed commissioners. HSCRC collaborates with Maryland's HIE, the Chesapeake Regional Information System for Our Patients (CRISP) and the state's APCD. | Data analyses from MCCC. |
| North Carolina Institute of Medicine (NCIOM) Independent agency, with funding through appropriation from the NC General Assembly and a number of private sources. | Authority: NCIOM was chartered by the North Carolina General Assembly in 1983 Mission: to serve as a non-political, independent source of analysis and advice on major health issues facing the state. | Conducts non-partisan data and policy analysis in order to advise the formation of public policy on health and healthcare. Brings together Task Forces to identify evidence-based solutions to address health issues in North Carolina. Serves to objectively represent the public interest in its advisory and consultative role. | Board consists of CEOs from commercial firms, College and other educational administrators and academics; hospital and physician leaders. 200 members of the Institute are drawn from government, education, business and industry, the health and legal professions, the hospital and health insurance industries, private philanthropy, the voluntary sector and the public at large. Citizens are appointed to serve but cannot advocates for any particular point of view | Supported by NC Center for Health Statistics |
| New Mexico Human Services Department (HSD), Medicaid Advisory Committee | Authority: advisory body on policy development and administration for health & medical services of Medicaid program. Mission: an advisory body composed of provider, consumer, and government representatives, which contributes to | Advisory body to NM Medicaid program. Technical subgroups carry out specific requests from HSD. Meetings are open to the public and other stakeholders. | MAC represents and encourages the participation of health professionals, consumers and consumer associations or groups, advocates, public health entities and other stakeholders concerned or involved with New Mexico Medicaid. | Not yet enacted an APCD In 2016, NM released a plan to |

| Administrating Entity | Administrating Authority/ Mission | Policy Activities | Multi-stakeholder structure / Oversight structure | Data Analytics |
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| Within the HSD; multi- stakeholder advisory body facilitating representation from all stakeholder groups. | policy development and program administration. | | | develop the APCD |
| Oregon Health Sciences University (OHSU) Public university that is a self-governed institution | Authority: legislative mandate, 2015. Mission: to support transparent public reporting of health care information; implement all payer database to improve transparency and benchmarking provider performance as part of a value-based purchasing strategy, | In 2015, the WA legislature designated database as a public resource (All-Payer Claims Database) Chapter 43.371.020 RCW established the rules and governance structures. | The data set is available, with an associated fee, to researchers, public agencies and others. OHSU permits providers' review & reconsiderations of their performance metrics, which are ultimately publicly reported. | APCD |
| Maine Health Data Organization (MHDO) State agency established through legislation; operates as an independent executive agency; under specific legal codes | Authority: legislative mandate, 2003 Mission: to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens. | Title 22, Chapter 1683 established Main Health Data Organization as an independent executive agency; oversees Maine Health Care Claims Database. Codes in CH270, 90-590 is the legislation that specifies which providers and which data elements are required by law to report to the MHDO. | Originally, Maine Health Data Organization, Maine Health Management Coalition and the Maine Health Info Center leveraged a voluntary aggregation pilot into a statewide initiative. | APCD |
| Massachusetts Health Policy Commission (HPC) and Massachusetts Center for Health Information an Analysis (CHIA) HPC and CHIA are independent agencies established by statute | Authority: Legislation, 2012; authorized as the independent state agency charged monitoring health care spending growth and providing data-driven policy recommendations regarding health care delivery and payment reform. Mission: HPC: monitor health care spending and provide independent policy leadership; advise policymakers on innovative investment programs. CHIA: provide information and analysis about the Massachusetts health care system | Legislation governs the reporting requirements regarding health care data and information that health care Payers and Hospitals must submit in connection with the All Payer Claims Database (APCD) and the Acute Hospital Case Mix and Charge Data (Case Mix and Charge) Databases. Created and establishes permission to mandate data promulgation from various payers | Overseen by an 11-member Board of Commissioners. Key activities include: setting the health care cost growth benchmark and monitoring provider and payer performance relative to benchmark; creating standards insurance plans; analyzing the performance of large provider groups assessing the impact of delivery innovations; conducting cost trends hearings and publishing a cost trends report | Massachus etts Center for Health Information an Analysis (CHIA) runs the APCD; APCD |
| Minnesota Department of Health | Authority: legislative statute Mission: Protecting, maintaining and improving the health of all Minnesotans | Chapter 62U, Section 62U.04. Establishes mandate to develop tools to improve costs and quality outcomes: Minnesota All Paver Claims Database | Used input from contractors and community advisors while developing APCD. | APCD |

| Administrating Entity | Administrating Authority/ Mission | Policy Activities | Multi-stakeholder structure / Oversight structure | Data Analytics |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| | 2008 legislation charged the Commissioner of Health with developing a system to create greater transparency of provider cost and quality. | (also known as the Minnesota Health Care Claims Reporting System) MDH is authorized to perform relevant analyses about variation of cost, quality, utilization and disease burden, as well as certain evaluation activities | In 2014, MDH convened advisory workgroup about how to expand uses of the APCD. | |
| Minnesota Health Collaborative Subdivision of Institute for Clinical Systems Improvement (ICSI), an independent, nonprofit health care improvement organization | Authority: subset of ICSI Mission: to collaborate to better serve our patients, families, and communities. | Part of the Regional Health Care Improvement Collaborative project. MHC multi-stakeholder workgroup that addresses major health topics, such as mental health and the opioid crisis that affect Minnesota communities. Serve to identify gaps in best practices and issues with legal barriers to care delivery reform, and create guidance to providers. | The MHC includes CEOs of health care organizations, physicians and other representatives from major healthcare organizations, member medical groups and hospitals, nonprofit health plan sponsors, and active connections with and board representation by employers and consumers. | Literature, expert consensus and community data. |
| The Oklahoma Health Care Authority (OHCA) State agency; the Chief Executive Officer is the State Medicaid Director | Authority: state legislation: OCHA operates the state's Medicaid agency Mission: "to responsibly purchase state and federally-funded health care in the most efficient and comprehensive manner possible; to analyze and recommend strategies for optimizing the accessibility and quality of health care; and, to cultivate relationships to improve the health outcomes of Oklahomans." Since 1995, OCHA has been the primary purchaser of health care for low income persons in OK. | Administers two health programs Oklahoma's Medicaid program and Insure Oklahoma, oversees the Marketplace. Composed of a number of Boards, and subcommittees, many established under different state statues (e.g.Senate bills) to carry out analysis to make policy recommendations to OHCA, such as Drug Utilization Review Board, Behavioral Health Advisory Council, OHCA State Plan Amendment Rate Committee (SPARC), Tribal Consultation Meetings, and others. | MyHealth was selected as the convening organization for the CPC initiative, a multi-payer model focused on the transformation of primary care practices into patient centered medical homes. | OCHA oversees the APCD |
| Rhode Island The RI Executive Office of Health and Human Services (EOHHS) State agency: an executive branch of state government | Authority: established through state law Mission: Administers the Medicaid program. Seeks to: strengthen the publicly-funded health care system; promote data-driven and evidence-based strategic decision making, and training in data analysis; improve information to consumers and the consumer | Legislative authority to conduct analyses to improve efficiency, transparency and accountability of the health care system The office is responsible for managing four departments: Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral | State-Based multi-payer Collaborative is convened by the Rhode Island Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services. HealthFacts RI is a multi-agency initiative between the RI Department of Health (RIDOH), the Office of the Health Insurance Commissioner (OHIC), the | APCD |

| Administrating Entity | Administrating Authority/ Mission | Policy Activities | Multi-stakeholder structure / Oversight structure | Data Analytics |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | experience; and increase efficiency, transparency and accountability of the EOHHS and its departments. Oversees HealthFacts Rhode Island Database. | Healthcare, Developmental Disabilities and Hospitals (BHDDH). | Executive Office of Health and Human Services (EOHHS), and HealthSource RI (HSRI), the RI Health Benefits Exchange. | |
| Pennsylvania Health Care Cost Containment Council (PHC4) Independent state agency | Authority: independent state agency to contain costs and to stimulate competition in the health care market; tasked with making recommendations about reform and legislation, and delivering comparative information about the performance of providers Mission: to contain costs and to stimulate competition in the health care market by: a) giving comparative information about the most efficient and effective health care providers to individual consumers and group purchasers of health services; and b) giving information to health care providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver. | Legislation enacted PHC4 reconstituted its Payment Data Advisory Group in an effort to move decisively and expeditiously forward on payment data collection, analysis, and reporting. | The Technical Advisory Group was established by the Pennsylvania Health Care Cost Containment Council to respond to issues related to research methodology, statistical expertise, and risk- adjustment methods. This group brings together professionals (including physicians, biostatisticians, and health services researchers) who offer advise the Council on best practices and current issues. | No APCD yet; strong interest. Collects hospital and ambulatory/ outpatient data from managed care plans on a voluntary basis. |

Source: NORC analysis of publically available data.

For Alaska to decide on the type and role of this entity, a starting point is to carefully consider the desired goals for reform, and the functions that existing agencies and institutions serve, and how any new entity would address any gaps. For example, if the main institutional gap is to evaluate health reform options and conduct research on cost containment strategies, then existing government agencies in Alaska may not have this capacity or authority. Likewise, no agency in Alaska is leading data collection on cost and outcomes across payers. In 2007, the federal government addressed a similar issue as it sought to develop new payment approaches in its early steps towards VBP models. In a 2007 report, the Medicare Payment Advisory Commission (MedPAC) described new value-based models, but also reckoned with a lack of any agency that could undertake the necessary comparative effectiveness research on options to increase the value of health care spending.⁷⁷ To accomplish such research, MedPAC recommended establishing an independent entity that would set research priorities, review existing evidence, produce objective information, obtain input from providers, payers, and patients, operate in a transparent process, and disseminate results to all stakeholders. The authors of the report also advised that the entity have both public and private funding sources, since all payers would able to use the information and analyses in their own payment and coverage decisions,^{xxiv} It also recommended that it have no role in making or recommending either coverage or payment decisions for public or private payers.

Thus, depending on the goals and existing capacity, Alaska can chose an organizational structure to fulfill these goals. The dimensions of these choices include (but are not limited to) the following^{xxv}:

- Funding:
- Operational Flexibilities
- Political Independence and Accountability
- Management Structure
- Public or Private

In **Minnesota**, the Health Economics Program (HEP) at the Minnesota Department of Health conducts research and policy analysis to monitor changes across all payers and providers in the health care marketplace in Minnesota. It uses data from the State's APCD and other sources (such as state surveys) to understand factors influencing health care cost, quality and access. It provides legislatively mandated reports to the legislature and assistance in the development of state health care policy. HEP is financed primarily using a small portion of the state's Health Care Access Fund (a long-standing provider and insurance tax-financed fund within the state used to pay for state's MinnesotaCare insurance program). For more information, see https://www.health.state.mn.us/healtheconomics

The **Arkansas** Center for Health Improvement, a nonprofit organization, has been a key player in the effort to transform the Arkansas health landscape. The purposeful structuring of ACHI as an independent entity with separate administrative and policy-decision bodies uniquely positions ACHI to serve as an unbiased convener. ACHI brings together diverse groups of stakeholders to accomplish a common goal in an evidence-based manner while providing for the transparent consideration of varied interests and positions. In addition to grants and contracts awarded to ACHI for specific projects, annual support for

^{xxiv} One example of a public-private entity in the report would be one with external board, akin to the Federal Reserve System, the central bank of the United States. It operate independently within government but is not independent of government. ^{xxv} These concepts are drawn from Van de Water, P. N. (2009). Designing administrative organizations for health reform. Expanding Access to Health Care: A Management Approach, 201.

ACHI's core areas of work is provided by four corporate sponsors: Arkansas Blue Cross and Blue Shield, Arkansas Children's Hospital, the Arkansas Department of Health, and the University of Arkansas for Medical Sciences. ACHI's Health Policy Board consists of 21 voting members (and two ex-officio members) from across the state who bring diverse perspectives and interests on health. This independent, self-perpetuating board identifies and establishes strategic priorities, provides direction and guidance, and serves as a forum for the exchange of ideas. The Health Policy Board guides ACHI's involvement in and position on specific policy matters, and it issues position statements that articulate the health needs of Arkansans. See https://achi.net/

In **New Hampshire**, the Institute for Health Policy and Practice (IHPP) is an applied research institute located within the College of Health and Human Services at the University of New Hampshire. IHPP conducts and disseminates applied research and policy work intended to enable health system partners to implement evidence-based strategies to improve population health. Its focal areas include Delivery System and Payment Reform, Health Analytics and Informatics, Health Law and Policy, Long Term Care and Aging, and Public Health and Health Promotion. See https://chhs.unh.edu/institute-health-policy-practice

In **Colorado**, the Colorado Health Institute (CHI) was founded as a nonprofit in 2002 to provide nonpartisan, evidence-based data and information to inform policy, advance health, promote collaboration and support better access to care for all Coloradans. CHI conducts extensive analysis of data and develops policy issue briefs and reports of interest to the Colorado policymakers, stakeholders, and the Colorado public. See <u>https://www.coloradohealthinstitute.org/</u>. Also in Colorado, the non-profit Center for Improving Value in Health Care (CIVHC) houses Colorado's APCD serves as a resource to the state government, stakeholders, and others in providing health data and analytics focused in understanding and improving Colorado's health system. See <u>https://www.civhc.org/</u>

Regional Health Improvement Collaboratives: Regional Health Improvement Collaboratives (RHICs) are non-profit organizations based in specific geographic regions of the country and are governed by a multi-stakeholder boards composed of healthcare providers, payers, purchasers and consumers. They have helped states plan, facilitate, and coordinate the many different activities required for successful transformation of their healthcare systems, mainly through convening stakeholders, identifying opportunities for improving healthcare quality and value, and facilitating the planning and implementation of strategies for addressing those opportunities.⁷⁸ RHICs overcome some of limitations government agencies may face, such as carrying multi-year healthcare transformation efforts, changes in state administrations, and changes in fiscal priorities. Collaboratives are very diverse in terms of their goals, structure, and programs because of the differences in the number, structure, and capabilities of the purchasers, payers, providers, and other community organizations in their local regions. Many RHICs have been valuable in helping providers adapt to implementing various regional variations in healthcare markets. Some collaboratives, including Alaska's local collaborative the Mountain-Pacific Quality Health, provide technical assistance to providers to implement quality improvement programs. See https://www.nrhi.org/about-collaboratives/.

States have also delegated regulatory powers and financial resources to RHICs to oversee collection and reporting of quality and cost data by providers and payers. In these states, collaboratives collect and

analyze data for performance incentives used by employers and health plans. This collaborative effort across payers reduces administrative costs for both plans and providers. For example, the Integrated Healthcare Association (IHA) in **California** assembles quality and utilization information to support the largest non-governmental pay-for-performance (P4P) system in the country. **The North Coast Health Information Network (NCHIN)** is a RHIC that developed a health information exchange (HIE) in order to provide electronic health record (EHR) interoperability between health data providers, labs, hospitals, and practices in Humboldt County, CA. Within three years, the non-profit's mission expanded to include community health improvement. In **Massachusetts:** the collaborative MHQP is the only independent organization in Massachusetts that collects and publicly reports information about patients' experiences and clinical quality of care with their primary care providers for over 500 practices. MHQP created a website, Healthcare Compass MA (www.healthcarecompassma.org), to help all Massachusetts residents learn about healthcare quality, make educated choices about where to seek care, and help them work with their doctors and other providers to receive high-value care.

Partnerships between States and Universities: In several states, universities collaborate with Medicaid agencies and through interagency service agreement (ISA) to implement program evaluations, analytics and research pertinent to the administration of Medicaid.⁷⁹ For example, in three states, Maryland, Massachusetts and Ohio, the state Medicaid agencies contributed funding and access to data and subjects, while the universities contributed expertise, analytic skills and methodological rigor. State Medicaid agencies benefited from findings and insights that provided the basis for enhancing these agencies policies and practices, while the universities benefited from funding for their health policy institutes and opportunities to do publishable research. One product of these collaborations is the **State-University** Partnership Learning Network (SUPLN), which supports evidence-based state health policy and practice with a focus on transforming Medicaid-based health care. SUPLN supports state-based partnerships between Medicaid policymakers and their resident state university research institutions to improve the health care delivery and reduce the total cost of care. SUPLN provides a multi-state forum for partnerships across states to share their successes and challenges, through virtual and face-face meetings and webinars, on best practices and lessons learned on substantive and process issues. The Network helps states engage in dialogue to better address challenges through a multistate perspective. See https://www.academyhealth.org/SUPLN

Designate or develop an entity that can conduct data analytics across payers.

Support for the analysis of health care costs and coverage is critical to understanding the drivers of health care cost growth and effects of interventions and reforms. As noted in previous chapters, one of the current challenges in Alaska is having detailed, timely, and actionable data to develop and monitor health policy. Many states now have established an APCD, which aligns data collection on spending and outcomes across multiple types of payers.

The Current Data Landscape for Alaska

There are currently a number of data sets that exist that have been or can be used to characterize the Alaska health care marketplace. For example, the CMS National Health Expenditure (NHE) Accounts provide state-level data, and those data have been used as a source for the conclusion that Alaska's health
care costs are higher than the rest of the nation and are growing more rapidly. While these data are useful as a comparison point, they have distinct disadvantages. First, they are significantly lagged (the most recent data available for Alaska through the NHE is from 2014). Second, the data is aggregated to a degree that limits its usefulness for policy analysis. Third, the data is compiled by the federal government and therefore is outside the control of Alaska.

When the state is the payer for medical services, the state has clearer access to information. For example, Alaska, like all other states, has access to its Medicaid data and data on state employees. In addition, Medicare data is accessible from CMS.^{xxvi} 8Medicare claims are generally one year to 18 months older than the commercial and Medicaid data; Medicaid data are generally lagged one year. Certain elements of Medicaid data have been made publicly available in Alaska. For example, the *Annual Medicaid Data Books* demonstrates that an exceptionally high level of detail can be achieved with state Medicaid data.¹⁰ Health benefit data for state and local employee and retirees seem to present a large convenience sample already under public control that could be used to address a variety of research questions on health care costs in Alaska.

However, the state currently has more limited access to information about the commercial insurance market. Because the state does not currently collect and require data submission into an APCD (discussed further in this chapter), any information on the commercial insurance market would currently need to be obtained from a commercial data vendor. For this report, we contacted four of the largest commercial data vendors who collect and maintain health care claims data that could potentially be used to characterize Alaska's commercial insurance market.

While some information on Alaska's commercial insurance market would be available through these vendors, there are also limitations. The cost of purchasing data from these vendors ranged from approximately \$35,000 to \$100,000. The data would be de-identified and for a limited set of procedures. In addition, the number of covered lives would likely not provide the ability to conduct regional analysis, and the data aggregation involved with these sources of information would not allow for detailed analyses of cost drivers. Therefore, while certainly useful for drawing valid inferences about commercial health costs relative to other states, they would be less useful in helping the state compare quality and costs among payees in the state. For this reason, a centralized data source, with public and private health plan data, and specific five-digit postal code data, would be valuable to understanding price variations and health care marketplace dynamics.

Alaska has a substantial opportunity to improve its data landscape as it continues its journey towards improving its health care system. Data analytics are not only foundational to VBP reforms, but also necessary to monitor how different reform efforts have improved care coordination to inform policy. In the next section, we provide background information and details on APCDs. Our national scan of states with leading reforms found that these states generally developed and maintained APCDs and utilized them to help inform policy analysis and decision-making.

^{xxvi} For more information on the process of obtaining Medicare data, see the Research Data Assistance Center website (http://www.resdac.org/) and the State Agency Data Request process (http://www.resdac.org/cms-data/request/state-agency).

A Statewide Data Platform Would Expand Capacity to Monitor and Control Costs.

Many states are working to integrate health care utilization data and population based public health systems using centralized databases, such as all-payer claims databases. For example, some states are using annual reports from all-payers to help examine and mitigate cost shifting among payers, as Massachusetts reports on cost and price trends serve to do.⁸⁰ Other states, such as Minnesota have used their APCDs to understand emerging public health issues such as opioid prescribing patterns.⁸¹ In Appendix 4, we provide a table of state APCDs, including their statutory authority, intended uses, and available information about cost and financing.

"Provider and health plan transparency of price and quality, supported by all-payer claims data, are critical in driving value-based payment innovation and cost constraint."

Conrad et. al. Emerging Lessons From Regional and State Innovation in Value-Based Payment Reform: Balancing Collaboration and Disruptive Innovation, 2014

APCDs are intended to provide comprehensive information about health and health care across all settings and providers of care by standardizing data collection on pricing and spending information from a diverse set of providers, particularly private commercial insurance and from voluntary provision by self-insured private sector employers. This information can inform efforts to control cost and improve quality, as well as to answer questions related to accessing care and patterns of utilization. The main uses of an APCD include:

- improving the capacity of public health officials to conduct rigorous population health analysis;
- analyzing payer and geographic variations in utilization and spending to drive public policy and inform decision makers;
- providing consumers with information on price and quality of health care services;
- improving clinical performance through data-driven methods of examining service delivery.⁸²

For example, providing data to employers and purchasers can help them understand differences across providers in pricing and outcomes. Moreover, one way to mitigate the potential for excessive price discrimination among private insurance payers (including both public and private employers) is to develop an annual report on private insurance price trends, such as Massachusetts has done. Analysis of the data could be performed by some combination of in-house, state capacity and support from academic researchers and private consultants. As referenced earlier in this report, the establishment of an APCD was a recommendation made by the Alaska Health Care Commission, and APCDs were used in five of the seven states in our National Scan.

A fundamental contribution of APCDs is in standardizing price and cost reporting data across a complex set of health plans. Without standardization of data reporting across payers, complexities can hamper comparing data across payers and limit the utility of analyses. The Supreme Court ruling *Gobeille v*. *Liberty Mutual* does not preclude state-mandated reporting from self-insured employer plans (governed by ERISA), which are numerous in Alaska. However, it is not uncommon for self-insured employers to voluntarily provide data to APCDs, because they have a general interest in public policies that might reduce growth in the cost of health care.

Reforms related to health IT and data analytics feature prominently in the Alaska Health Care Commission's (AKHCC) set of recommendations, including a phased implementation of an APCD for coordinating data collection, analytics, and data sharing across multiple providers and delivery systems. Continued investment in data infrastructure is crucial not only for monitoring reforms but also for increasing access to care in rural and frontier communities through the expansion of telehealth broadband infrastructure and to improve EHR adoption in rural areas. Alaska is considering strategies for expanded support for electronic health records, state health information exchange (HIE), and reimbursement for telemedicine to Alaska.

There is also wide spread census that consumer transparency on certain health care prices can help propel reform.⁸³ Providing data to consumers on pricing may help consumers pick the best value, while it may also provide information to the marketplace on pricing variation. However, lower-priced hospitals may increase prices. Transparency is an important goal, one that Alaska has seen improvements (through under the Anchorage Health Care Transparency Ordinance (AO 2017-26), enacted in 2017 and provisions under SB105), evidence is clear on whether public price information changes consumer behaviors.^{55,84} Price transparency may be a social goal for consumers that is politically acceptable to payers, but the impact on total health care costs is not clear.

APCDs usually contain data from private insurance; state employees covered under state self-insured benefit plans; any voluntary submissions from private sector, self-insured employers; Medicaid; and Medicare.^{xxvii} CMS routinely provides Medicare claims data to states with APCDs. The Tribal health system in Alaska will be partially covered in an APCD database. Hospitals, clinics, and other providers in the Tribal health system receive payments from third-party payers. Therefore, claims records from Medicaid, Medicare, and private insurers to Tribal health providers would be captured by an APCD. But the tribal health system also uses federal Indian Health Service contracted payments to provide services, and those would probably not be captured by an APCD or would require a data use agreement for sharing with the APCD administrators. IHS does have a national data warehouse containing data submitted by IHS sites.⁸⁵ A scan of APCDs in other states indicates that APCDs do not typically collect data for federal payments through Tricare, the Veterans Administration, and the Federal Employees Health Benefit program (FEHB), but databases for these exist in their respective agencies.^{86,87,88,89} Given the importance of these delivery systems and payers in Alaska, Alaska may wish to explore ensuring they are also included.

Strengths and Limitations of an APCD

As described in our prior studies, the Alaska Health Care Commission recommended that Alaska create a mandatory APCD to provide comprehensive claims data for analysis of Alaska's health care utilization and costs. The recommendation was the result of an analysis by Freedman Healthcare, which considered the experiences in other states and conducted a set of focus groups and key stakeholder interviews in Alaska.

^{xxvii} APCDs do not capture payments for care by uninsured patients, which includes both patient-paid and unreimbursed care. However, charity and uncompensated care is reported elsewhere for tax purposes.

An APCD may take several years to establish, however, this centralized model would facilitate more streamlined analysis and dissemination.⁹⁰ One advantage is that an APCD can be implemented to create

"Significant variations in provider prices should reflect real differences in costs related to their missions or to consumer preferences in wellfunctioning markets, not vagaries of negotiating leverage that might produce inequitable prices of services, placing providers in very different financial circumstances unrelated to their own performance"

Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets. NASI 2011 One advantage is that an APCD can be implemented to create a unique patient identifier that crosses different payers. This allows analysis of a patient's history even if the patient uses multiple payers at the same time or if the patient switches payers over time. Second, in contrast to commercial payer databases, it would enable more specific regional disaggregation of spending. Third, analysis of a unified APCD will be easier, and therefore less expensive for analysts, than going to three or four separate databases to capture the information available in an APCD. An APCD would also help the state understand and determine price points for contracts with third parties or providers, should it move towards greater consolidation of state-employee plan financing. Because Alaska only has a few commercial

insurers, it may be comparatively easy to negotiate data submission agreements.

While the benefits of APCDs on states' ability to capture and analyze healthcare data are evident, establishing an APCD presents challenges as well. An APCD is an inherently a long-term investment, with costs for both the state and for third-party payers. To be useful, this investment must be sustained. Making the initial investment to build an APCD without funding the maintenance would result in little or no benefit. The cost to states and to data submitters to develop, maintain, and comply with the APCD data regulations and protections can be significant. Most states with APCDs have been successful in securing start-up funds for APCDs from state legislatures or from external funding sources (including private foundations and federal demonstrations).⁹¹ In addition to cost concerns, privacy concerns are a challenge to establishing a functioning APCD. Providers may have concerns about payers reporting data about their practice, whether it will accurately reflect prices and quality, and if it will account for variations in the complexity of their cases. Consumers may also have concerns about the privacy and security of their information in an APCD. However, state legislation and regulations governing APCDs often account for or explicitly address privacy concerns in the authorizing legislation.⁹²

An APCD cannot produce more timely data (as noted above, APCDs receive data from Medicare and Medicaid that is lagged at least one year). It is not unusual for an APCD to have a lag approaching three years after the service is rendered (which is not unusual in published health care research). Once claims have been submitted, APCD administrators must ensure data quality verification. Thus, an APCD cannot be used for some analyses, such as those that focus on a specific payer type or care setting. The first data may not be available for three or more years. In addition, it will be several additional years before the database grows into a time-series of information, which is often required for analysis. In that period, any time-series of Alaska's health care costs must continue to rely on existing resources.

If Alaska decides to move towards achieving this goal, a first step may be to obtain legislative authority for the establishment and governance of the APCD. In designing an APCD, the state must determine how it will best use the data for health care transformation and who will have access. It must also consider what the initial and reoccurring costs would be, and the funding sources for it. For example, will the use

of data be limited to state agencies, or will it be accessible for use in academic research projects? Will providers be able to obtain data outputs and reports? Then, depending on the critical functions of the APCD, the state can develop core principles and requirements for reporting. This will require discussions across all stakeholders on regulations for submission and quality control, and what activities and stakeholders will be required across the phases of start-up and maintenance of the APCD.⁹³

Alaska may want to consult with the APCD Council, a learning collaborative that helps states learn and share resources and information about implementation of APCDs. It can provide early-stage technical assistance to states interested in implementing APCDs and catalyze states to achieve mutual goals. Through the APCD Council website, states can request assistance and examine what other states are doing in an interactive map. Appendix 4 provides a summary of how some states have established APCDs and how they have used the data. In addition, the National Association of Health Data Organizations, a "national non-profit membership and educational association dedicated to improving health care data collection and use," has assisted states in establishing and maximizing the use of their APCDs.

In summary, this chapter focused on two structural reforms to consider guiding the reform journey: creating a lead entity and establishing the necessary data infrastructure to support reform by enabling the state to test and evaluate policy options and decisions. We next turn to details on directions to go, focusing on options that aim to involve all stakeholders in efforts to control costs, and create incentives for providers to focus on quality and not volume.

Chapter 5. Fork in the road: decisions for Alaska

Alaska is in a pivotal position to learn from the experiences of other states. Establishing a lead agency with capacity to assess changes in the health care spending and utilization across the market combined with the data resources necessary for this analysis is a cornerstone for a long-run strategy. Then, charting a course forward will require a long-run strategy that looks at the most important factors first and seeks to

remove obstacles. The available analyses to date, as evident in Chapter 2 of this report and the Health Care Commission findings, indicate cost vary widely between payers without necessarily being tied to performance. Alaska can learn from other states efforts to shift to value initiatives and value-based based payment designs. Alaska is indeed unique, but despite wide diversity in the demographic and market contexts across other states, there are tools employed by other states that have shown promise.

"Coordinated multi-payer actions are far better positioned to send sufficiently strong economic signals to health care providers."

Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative. Watkins, L. Milbank Fund, 2014.

Having described some of the infrastructures that would facilitate reform in Chapter 4, and implementation of the tools described in Chapter 3, this Chapter provides more details on two areas the PMC expressed an interest in:

- Multi-payer approaches to payment alignment
- Global budgets, especially in a multi-payer environment

In this chapter, we move further along the alignment continuum into multi-payer examples of payment alignment. We then discuss several Alaska-specific considerations for implementing reforms and information on concepts that are intended to ensure that the reforms are implemented flexibly, recognizing that different implementation approaches may be needed across the regions in Alaska. It is NORC's expectation that as input into these approaches is received from the PMC, the design of reforms will capture region concerns.

Multi-payer Payment Alignment Models

Multi-payer approaches are collaborative efforts between federal or state payers and commercial payers to reach shared goals by agreeing on strategic investments for care delivery transformation, including payments for investments in population health and coordination, and consistent performance metrics.¹¹ We start with reviewing multi-payer models for primary care.

Multi-payer Primary Care

These models have brought together providers and payers in collaborative efforts to implement PCMHs and promote payment reform for primary care.⁹⁴ While oftentimes thought of primarily in the context of

Medicaid, it is important to note that care coordination models such as PCMHs can be considered across the population spectrum, and multi-payer approaches can be used to advance these models.

Reforms in primary care have used a combination of approaches, with the intention of allowing flexibility in designing value-based payment arrangements to work with their network providers. The key theme to multi-payer models for lower costs in primary care is agreement on how to structuring payments around performance.⁹⁵ For example, payments to providers can be partly through usual FFS for medical services, as well as a PMPM to assist in supporting medical home services. **New Mexico's Centennial Care**, a Medicaid Section 1115 Demonstration, aligns the incentives of all participating groups (the state, four insurance plans, providers, and beneficiaries) within a managed care model. Each MCO participating in Centennial Care finances and delivers health care for its enrolled Medicaid population and is reimbursed by the state using a set PMPM payment. Primary care physicians can be paid by a percentage by contractual salary in combination with a percentage that performance based payment. In 2011, Alaska began implementing a medical home (PCMH) model for three community health centers in Alaska, In 2014, this became Alaska Patient Centered Medical Home Initiative (AK-PCMH-I), a five-year, statewide, multi-stakeholder program to assist practices in transforming to a PCMH model of care. However, this PCMH program did not tie performance to payment.

A well-known Medicare model, the Comprehensive Primary Care (CPC) initiative, was a multistakeholder advanced primary care medical home model in which commercial payers coordinated with managed-care plans with a goal to lower healthcare costs and improve health outcomes for all Medicare patient populations in a particular region. It was one of the largest multi-payer initiatives ever implemented across geographically and economically diverse regions, and was then continued under CPC+ and is now continued under the Primary Care First (PCF) model.⁹⁶ The new model now provides three payment elements to support comprehensive primary care: care management fees, performancebased payments as well as a regular FFS. PCF is aimed at practices that serve complex and seriously ill patients with advanced capabilities. PCF is built on the CPC+ model, but also includes a global budget aspect of a total monthly payment through a risk-adjusted and performance adjusted professional population-based payment (PBP).

While CPC+ saved \$57.7 million to Medicare, it was not enough to offset the initiative's care management fees.⁹⁷ Nonetheless, providers were enthusiastic about the transformation activities. The partnerships between CMS and commercial payers aligned incentives, and substantially increased the financial support and sustainability for primary care transformation. Alignment and partnerships enabled provider participants to increase their access to data infrastructure for health information exchange between providers, which helped them track high care users and coordinate their needs, prioritize preventive screenings and follow up on referrals. Participants also benefited from peer-to-peer learning and resources to hire care coordinators or other staff to increase patient engagement. Factors that contributed to this successful payer collaboration included contracting with effective, neutral payer conveners, leveraging the support of payer champions, and seeking input on decisions from practice representatives and collaboration with CMS.⁹⁸

CMS also experimented with the Multi-Payer Advanced Primary Care (MAPCP) initiative in eight states (Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont).

All states required practices to achieve PCMH certification to participate in the initiatives. Each state had between three and seven other payers participate in their multi-payer PCMH initiatives, in addition to Medicare and Medicaid. Greater payer participation increased the likelihood that practices received enough support to transform. Half of the demonstration states incorporated a pay-for-performance (P4P) element into their payment model to incentivize practices to improve performance on quality measures. During the MAPCP Demonstration, practices across states made significant changes to transform their practices and enhance the care they provided to their patients. Although making these changes took considerable effort, MAPCP participants felt that their efforts improved patient care and patient experiences with care. Many practices mostly focused on hiring new staff, training, and integrating care managers.

There were no consistent impacts by the MAPCP Demonstration on quality of care, access to care, utilization, or expenditures within or across states, the overall demonstration and six of the state initiatives were budget neutral. While states and their partners and participants encountered challenges along the way, their experiences with the MAPCP Demonstration generated much knowledge and contributed many lessons learned about how to best implement state-sponsored, multi-payer PCMH initiatives and the PCMH model of care that will be useful to future primary care initiatives and those currently underway. Overall, practices felt that if they could maintain their patient-centered features in a collaborative all-payer environment and with the appropriate data and health IT infrastructure, they would experience favorable impacts on quality of care, access to care, utilization, and expenditures in the future.

Multi-payer Reference-based Pricing

Reference-based pricing (RBP) is a payment arrangement where health plans determine providers' reimbursement using a reference price, developed from a trend analysis or using Medicare reimbursement rates, for a given medical service. The plan covers medical expenses for that service up to that price, and payment growth rates are tied to set growth rate. Depending on the available alternatives in the market (that is, the degree of competition), insurers may decide that providers who agree to the reference price are "in network", while those who do not are "out-of-network." Unlike high deductible plans, which may discourage consumers from seeking needed services since they pay the "first dollar," consumers pay a usual cost sharing and then pay the "last dollar", or the avoidable cost when they go out- of-network. The RBP model works even after a consumer reaches the limit in that it can incentivize patients to seek care from those accepting the RBP, while holding patients responsible for paying all costs above the reference price. Reference-based pricing need not be limited to markets where networks are prevalent. Evidence from experiences of public and private sector employee plans shows reductions between 13% and 31%, depending on the procedures^{99, 100,101}

RBP is has usually been applied to certain medical services that are "shoppable", that is, non-urgent or elective services and for which patients have a choice of providers within a reasonable travel distance. The logic of this model is that prices are set based on expected cost, in contrast to current provider pricing that can vary widely across payers, and often have little relationship on outcomes or the quality of services.¹⁰² Different provider types and services could have different reference rates to, for example, ensure adequate payments in rural areas or for mental health care. In Alaska, this reform may require some examination of statutory provisions discussed in Chapter 2. A sufficient number of providers would have to participate to achieve savings and the state could set network adequacy standards to ensure

access. Providing price and quality information to consumers would also help them make care-seeking decisions.

There may be other legal, regulatory, or contractual barriers that would have to be addressed, and this approach is not without challenges. Determining reference prices likely requires insurers to disclose negotiated price lists, which they may be reluctant to do. In North Carolina, for example, legislation to implement reference pricing for state employees stalled due to concerns raised by various provider stakeholder groups. Consumers may also be concerned about out-of-pocket costs, since under certain reference payment and the billed charge. Employers may be concerned about limiting their network as reducing competitive advantage for labor. Insurers may not want to set reference prices for all services, and rather limit them to certain elective and non-urgent services that have a high variation in prices. In spite of some of these challenges, reference-based models are being implemented in various states for certain populations and certain higher-cost procedures.

Examples of reference pricing are discussed below:

- North Carolina: Effective January 1, 2020, the State Health Plan will move away from a commercial-based payment model to a reference-based pricing model based on a percentage of Medicare rates. Provider rates will be fixed to a published schedule and consistent across government payers and commercial payers.
- In Montana, the state lawmakers authorized Montana's Health Care and Benefits Division to control increasing costs through reference pricing for state employee health plans by setting hospital reimbursement rates at a percentage of Medicare rates (at an average of at an average 230% of Medicare). Findings indicate the state plan saved \$13.6 million and hospitals did not face closures.¹⁰³ However, these results are subject to the specific conditions and market contexts, and need to be more closely studied to understand the drivers of savings as regards to changes in prices and changes in consumer behaviors.
- In California, the Public Employees' Retirement System, or CalPERS, initiated reference pricing for knee and hip replacement in 2011. Prior to starting the program, prices ranged from \$15,000 to \$100,000 with no measureable difference in quality. The state set a price at \$30,000, about the 67th percentile of allowed charges. An examination of claims from employees in preferred provider organizations (PPOs) found a greater use of in-network lower-priced facilities and average replacement expenses per member by 26.7% in the first year.¹⁰⁴ Higher-priced providers who did not accept the rate also lowered their prices to meet the rate in order to remain competitive. The CalPERS plan also provided a travel benefit to members who lived more than fifty miles from the nearest in-network facility.
- Colorado recently conducted an analysis of reference-based pricing for inpatient and outpatient charges, as a strategy to reduce payment variation and achieve savings. The Center for Improving Value in Health Care analyzed paid claims in the Colorado APCD to determine the potential impact of reference-based pricing on high volume, high price inpatient and outpatient services. They examined three reference prices: as 150% and 200% of the Medicare fee schedule, and median commercial payments across 33 commercial firms. Results showed substantial potential savings: using just the top 12 inpatient services and top 10 outpatient services, savings between

\$49 million and \$178 million annually could be achieved, depending on the reference-based pricing scenarios. Additional savings could be possible if a reference-based pricing model was applied across all inpatient and outpatient services in the state.

There may also be unintended consequences to reference-based pricing to consider: providers may increase prices for services not included under the reference rate, or increase induced demand (encourage more utilization). If rates are set for facilities fees only, providers may increase professional reimbursement, nullifying the intended effect. There may also be cost shifting to other insurers in the market or other consumers who are not under the reference pricing model (adverse spillover effects), however, this points to the importance of considering this model as multi-payer. However, in the California model, there was very little evidence that these adverse effects occurred; in contrast, researchers found that significant positive externalities: about 75% of the price reduction benefits accrued to consumers not in the CalPERS plan.¹⁰⁵

As other states have done, Alaska could examine this approach for state employees, and multi-payer partnerships could be formed with commercial insurers. Researchers using data from HCCI on employer-sponsored health insurance for people under age 65 looked at reference pricing for certain shoppable services. They examined cost savings from a reference price set at the based on the 65th, 60th, and 55th percentiles in the distribution of allowed charges. Findings showed savings between 0 and 28%, depending on the assumptions, such as how many providers accept the reference prices from payers, and how many consumers stay in-network.¹⁰⁶

Multi-payer Alignment in Episode Models

Episode-based payments are a form of payment that involves providing payment to providers based on the expected cost of a clinically-defined set of services. Episodes may also be known as bundled payments, wherein a single physician, hospital, or institution, sometimes called "Principal Accountable Provider" (PAP) is responsible for all quality and spending that occurs during a defined time period or treatment for a primary diagnosis. These have been shown to which have shown to substantially reduce hospital costs in some settings, as findings from CMS's <u>Bundled Payments for Care Improvement (BPCI)</u> initiative have shown.

Alaska has some experience with these models, as in 2013, the Alaska Hospitalists Group in Anchorage participated in BPCI to test whether a single fixed payment ("bundled payment") for all the care that providers furnish during an episode of care could lead to lower total cost for the defined episode.

Some key elements to these models that are typically required, but may vary by provide in implementation include:

- Accountability: Which types of providers and how many are responsible for the episode;
- **Payment process**: Retrospective or prospective; as well as the type of risk sharing;
- **Payment benchmark**: absolute vs. relative thresholds and the mechanics of determining provider performance in an episode model such risk adjustment and exclusions for outliers;

Episode definitions: starting and ending time points for each episode as well as the services included in the episode definition.

Payments can be risk-adjusted based on the patient's health status. The logic of the model is that by setting a fixed amount, providers are able to better plan and allocate resources, and provide enable care coordination, and it will reduce variation in the services provided during an episode, and consequently.

Alongside increased adoption of bundled payments by Medicare, several states have pursued this approach, as demonstrated by **Arkansas** in our National Scan. Arkansas is the only state so far to implement it statewide across all major payers. Launched initially with five types of episodes, the state is now pursing 16. Providers are still paid under a fee for service payment structure, but either share in savings if they are below target spending for an episode or pay back excess spending if they are above. Tennessee and Ohio have also implemented bundled payment models within their state Medicaid programs, with other states such Delaware also pursuing this approach.

"Payers are increasingly recognizing that collective action can offer a more powerful, streamlined set of expectations and incentives for providers and potentially result in greater improvement in outcomes."

Anglin, G., et al. (2017). Strengthening Multi-payer Collaboration: Lessons From the Comprehensive Primary Care Initiative The Milbank Quarterly, Vol. 95, No. 3, 2017 A promising strategy would be initially expand Alaska's current bundle payment Medicaid pilot, and align payments across commercial plans in the market place and Medicaid, and commercial payers may follow suit. As they pilot is scaled up, more episodes or bundles could be pursued, building from the bundles that have been developed in other states or for Medicare.

All-payer rate setting

In all-payer rate setting, payers to agree to common prices and price increases, set administratively, through all-payer models.⁶⁵ All-payer reimbursement rates would mitigate price discrimination across payers, and also reduce the administrative overhead associated with rate negotiation, while maintaining consumer choice among providers. Setting all payer rates would simplify billing and increase transparency by establishing known rates for each type of provider. It would also remove much of the process of rate review, and protect consumers from unjustified rate increases.^{107,108} Savings could be spent to help providers assess how to best efficiently provider care, resources freed from contract negotiations could be spent on the delivery of health services.¹⁰⁹ Employers can work with health plans to coordinate administrative functions and align state and private payers around value-based insurance designs to create affordable insurance products, and address provider market power and improve interactions between physician practices and health plans. Efficiencies gained would reduce costs both for physicians and for health plans.

This approach could be particularly in helpful in Alaska where there is currently relatively opaque price and rate setting processes. With shared goals around a high-value health care system, Alaskan payers can test value-based payment models, evaluate outcomes, and share results to drive best practices to scale. Prior consultants in Alaska have also advised that by aligning accountability and incentives across all payers, there may be a higher likelihood that providers will be willing to adopt more efficient delivery systems across all their patient populations.¹¹⁰

We now turn to discuss a specific area of interest to the PMC, the issue of global budgets. A note of distinction: all payer rate setting, described above, is a tool that can be used to establish standardized prices, or rates, paid by payers. Health care spending, however, is made up of the produce of price per unit times volume of services. Therefore, to control total cost of care, states have been interested, and some have begun to implement, more global approaches such as global budgets.

In the next section, describe in some detail the Maryland Total Cost of Care model (see the national scan for additional details), as well as efforts in several other states and provide some considerations for developing these models in rural settings. Maryland has led the way in global budgets, with a number of other states adapting versions of this approach, including New Mexico, Oregon, and Washington from our National Scan. Below we lay out in greater detail the current approach being taken by Maryland as well as some other state examples and rural considerations, including a discussion of the global budget model for rural hospitals that Pennsylvania recently adopted.

Maryland All-Payer Models:

Hospital Global Budget: While Maryland has been conducting all payer rate setting for hospitals since 1977, the hospital global budget approach was approved by CMS in 2014. This is an all-payer global budget program for all acute-care hospitals in the state; all 46 acute care hospitals operating in the state joined the model (with 10 hospitals moving from the Total Patient Revenue (TPR) to align with this model). The program limits growth in per-person total spending on hospital care, across all payers in Maryland, to a predetermined percent each year. Rates are negotiated by an independent rate Commission, the Health Services Cost Review Commission. Maryland also set other quality goals, such as reducing avoidable admissions. Operating margins increased after implementation of the All-Payer Model for most types of hospitals, as well as for all Maryland hospitals combined.¹¹¹ According to the Maryland Hospital Association, between 2014 to 2018, the program has saved the Medicare more than \$940 million on hospital care and reduced 30-day readmissions rates about 8.5%.

Total Patient Revenue system (TPR): In 2011, Maryland initiated a total patient revenue system (TPR) for 10 of its hospitals serving rural communities. The system was essentially a global budget, with each hospital's total annual revenue determined using a historical base period. The TPR rates were determined through negotiation with each hospital to ensure that fluctuations in volume and need could be taken into consideration. This projected budget provides hospitals with both stability to plan and financial incentive to manage their resources efficiently and control costs. The state also supported the formation of a collaborative to develop care strategies to support patients beyond hospitals, and improve quality of care and population heath using care management strategies and multidisciplinary clinics.

Maryland's Total Cost of Care Model: This model became effective January 2019 and builds on prior global budget models, with the goals of person-centered care, innovation in care delivery, improved population health, and constrained growth in costs through the transformation of the health care delivery system. The TCOC builds on the existing hospital all-payer rate-setting mechanisms through the addition

of a fixed global hospital budget for services connected through an attributed population of patients, along with several pay-for-performance programs.¹¹² The TCOC Model covers commercial, Medicaid/CHIP, and Medicare beneficiaries and extends beyond hospitals to include some doctors' visits and other outpatient services. Care will be coordinated across both hospital and non-hospital settings, including mental health and long term care. Initial implementation focuses on a subset of approximately 800,000 Medicare FFS beneficiaries, prioritizing the dual eligible population and patients with chronic and complex conditions. While targeting specific beneficiary subgroups, the state also set population health goals addressing six high-priority areas: substance-use disorder (SUD), diabetes, hypertension, obesity, smoking, and asthma.

Alignment Among Payers. All payers (commercial, Medicare, Medicaid) reimburse hospitals at the same rates. These rates are set by the Maryland Health Care Cost Review Commissioner (HSCRC) based on annual global budgets for hospitals to cover both inpatient and outpatient care. The global budget revenue (GBR) prospectively establishes a fixed annual revenue cap for each hospital. Each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from an historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of UCC. Annual revenue can also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

Different from the former hospital model, each hospital has a budget based on its unique population of patients, provider community, geographic settings, and other key demographics, allowing to meet flexibly different population and hospital needs. Exhibit 5.4 highlights the differences in the two payment approaches:



Exhibit 5.4: Hospital and Total Cost of Care (Hospital + Community) Models in Maryland

Source: Knudson, A. Exploring Global Budgets and All-Payer Rate Setting Approaches: How Does it Impact Rural Providers? Rural Health Reform Policy Research Center, 2016

Available at <u>https://nosorh.org/wp-content/uploads/2016/08/Exploring-Global-Budgets-and-All-Payer-Rate-Setting-Approaches-How-Does-it-Impact-Rural-Providers-Alana-Knudson.pdf</u>

Overall, reform efforts are expected to involve six million Marylanders. CMS anticipates TCOC will save Medicare more than \$1 billion by the end of 2023 while enabling new opportunities for a range of non-hospital health care providers to participate.¹¹³ The TCOC Model also includes a new voluntary program, Care Redesign Program (CRP) to improve care through better coordination. The program encourages the partnership of hospitals and providers in order to improve the quality of care in Maryland and drive down total cost of care. Below we discuss the CRP and two other programs in the TCOC model:

The Hospital Payment Program: Each hospital receives a prospective population-based payment (global payment) that is expected to cover all hospital services provided during a year. This finite amount thus creates a financial incentive for hospitals to provide value-based care while reducing the number of unnecessary and adverse events.

Care Redesign Program (CRP): This allows hospitals to make incentive payments to nonhospital health care providers who partner and collaborate with the hospital to perform care redesign activities to deliver efficient high quality care. Hospitals can only make incentive payments once savings under its fixed global budget have been attained, and the total amount of incentive payment made cannot exceed such savings. This ensures that the incentive payments under the program does not increase overall Medicare expenditures. As of January 1, 2019, 42 hospitals are participating in at least one of three active CRPs These CRPs are as follows:

- The **Hospital Care Improvement Program (HCIP)**, implemented by participant hospitals and hospital-based physician care partners. This aims to improve inpatient medical and surgical care delivery and improve care transitions, such as to the post-acute care settings. It also aims to encourage efficient use of hospital resources while ensuring quality of care and reducing readmissions.
- The **Complex and Chronic Care Improvement Program (CCIP)**, implemented by participating hospitals and community physicians and other practitioners. This aims to strengthen primary care supports for complex and chronic patients in order to reduce otherwise avoidable hospital utilization through tools such as effective risk stratification, health risk assessments, and patient-driven care profiles and plans
- The Episode Care Improvement Program (ECIP) is designed to align incentives across hospitals, physicians, and post-acute care facilities to improve care management during episodes. Providers will receive a bundled payment for certain items and services furnished during an episode of care. Hospitals in the ECIP can also provide incentive payments to care partners across the continuum of care delivered during an episode--hospitals, physicians, and post-acute care facilities. Given the high cost of care in Alaska, particularly among specialty services, designing arrangements that incorporate non-hospital providers and physicians may be a potential approach for reducing costs. Maryland modeled ECIP on CMS' Advanced Bundled Payments for Care Improvement Program. This approach intends to eliminate unnecessary and avoidable care.

Maryland Primary Care Program (MDPCP). The **MDPCP** is structured to offer incentives to providers that deliver advanced primary care services to their patients. Participating practices will receive an additional per beneficiary per month (PBPM) payment directly from CMS, intended to cover care management services. The MDPCP also offers a performance-based incentive payment to health care providers, intended as an incentive to reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements. The five primary care functions services under MDPCP are: access to care; care management; comprehensiveness and coordination; patient and caregiver experience; and planned care and population health. We summarize some model details; for more information and the current status and participating entities, see https://health.maryland.gov/mdpcp/Pages/home.aspx.

There are two tracks that advance care delivery requirements and payment options incrementally, as follows:

- **Track 1:** expands on the Five Primary Care Function services to visit based, FFS care
- **Track 2:** includes Track 1 services and redesigns visits to offer non-visit based care (e.g., phone, email, telehealth, text message, and secure portal) for more comprehensive health management

Organizations can also participate as **Care Transformation Organizations** (**CTOs**) for the MDPCP. Practices participating in MDPCP can contract with a CTO, a coordinating entity that provides care management infrastructure (nurses, pharmacists, nutritionists, health educators, community health workers, licensed clinical social workers), and resources such as technical assistance for after-hours, social support connections, "hot-spotting" areas with high and/or specific needs, pharmacist support for medication management and consultations, holding practices accountable to PCM requirements, and physician training resources.

For the MDPCP, CMS will provide funding directly to practices (and CTOs by practice designation) to strengthen and transform the delivery of primary care. The funding may be provided in several forms, as follows:

- Care Management Fees (CMF) are funds designated to provide care management to patients. Funds would be provided quarterly in advance on a PBPM basis to practices in both tracks based on the risk levels of the Medicare beneficiaries attributed to that practice. Payments range from \$6 to \$100 PBPM and average \$17 PBPM for Track 1 and \$28 PBPM for Track 2, which includes a \$100 CMF for "complex" patients. CTOs will be compensated for their partnership by receiving a portion of the practices' CMF. The Model is designed around Medicare FFS and Dual Eligible beneficiaries with the intent of expansion to all-payers. Other payers do not have to follow this CMF PBPM fee structure and payments may be lower since the acuity level for patients may be lower.
- Performance Based Incentive Payments (PBIP) would be provided to practices and CTOs on a rate of between \$2.50 to \$4.00 PBPM. Funds would be provided in advance annually and retrospectively reconciled based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.

• The **payment structure** is based on Medicare FFS under the **Medicare Physician Fee Schedule**. Track 1 receives payment from Medicare FFS as usual. In the advanced track (Track 2), the typical Medicare FFS payment system gradually transforms to a partial prepayment system with practices receiving quarterly payments in advance.

Medicare Performance Adjustment. HSCRC will utilize a Medicare Performance Adjustment (MPA), which incorporates attribution, episodes and/or geographic measures of total cost of care for Medicare into hospital value-based payments. This will provide a level of direct hospital accountability within the All-Payer Model for total cost of care and support the process of aligning physicians within the TCOC Model. For 2019, the revenue-at-risk will be 1% of Medicare hospital revenues. The HSCRC will determine the need to increase the revenue-at-risk in the succeeding years based on performance and other factors. The HSCRC will administer the MPA through a discount mechanism, subject to CMS' review of the associated calculations and specifications under a timeline to be specified in the Care Redesign Program calendar. The state will also submit proposals for efficiency adjustments through the MPA. This will allow statewide or program-specific adjustments to be made based on established methodologies approved by CMS.

To conform to MACRA requirements for quality performance payment, MPAs will be increased or reduced by multiplying the adjustment by each hospital's revenue adjustment percentages for the all-cause readmissions and hospital acquired conditions quality programs. Positive MPAs will be increased and negative MPAs will be reduced for positive quality adjustments. Conversely, negative MPAs will be increased or positive MPAs will be reduced for negative quality adjustments.

Because the TCOC Model is classified as an Advanced Alternative Payment Model (AAPM) under CMS' Quality Payment Program, hospitals with Global Revenue Agreements and the Medicare Performance Adjustment are classified as Advanced APM entities under the TCOC Model. After 2019, Maryland will submit a request to CMS to introduce an MPA for non-hospital providers, which will also incorporate population health targets. The modifier could be applied to voluntary participants in the Care Redesign Program that have a direct relationship with CMS and Maryland through a Participation Agreement. For more information on adjustment, see <u>https://hscrc.state.md.us/Pages/gbr-adjustments.aspx</u>

Data Analytics: Supporting these reforms has been the state health information exchange system—the Chesapeake Regional Information System for Our Patients (CRISP). CRISP receives and exchanges information with hospitals and several other facilities and provides reporting and analytics resources to inform decision-making. In addition, the state's APCD contains data from commercial payers, third-party administrators (TPA)/self-funded payers, Medicaid, and Medicare.

Stakeholder engagement. The state, HSCRC, and MDH have conducted stakeholder engagement activities over time. For example, for the 2014 All-Payer Model waiver application process, the state and HSCRC leadership held over 50 meetings with stakeholders. More than 200 people were actively involved in the development and review of the progression plan. The HSCRC implements a broad stakeholder engagement approach to healthcare transformation through stakeholder Workgroups.



SHARED INCENTIVES BOOST COLLABORATION

See https://www.mhaonline.org/docs/default-source/presentations-and-talking-points/2019-maryland-modeloverview.pdf?sfvrsn=3a57d40d_2 for more information.

More on Rural Considerations: Rural hospitals can be particularly helped by multi-payer models, if implemented with sufficient flexibility and appropriate payments to ensure viability. Fixed payments, like the ones used in the Pennsylvania Rural Health Model described above give providers the flexibility to deliver tailored care to their community and the financial security of knowing how much they will be paid regardless of the service. Another example is In Washington's Rural Multi-Payer Model: hospitals can participate in this voluntary model that aims at total cost care--services in both primary care and hospital based services. Primary care entities receive a PMPM rate that is adjusted to the designated health service area (HSA) and the Medicare Economic Index (MEI). Budgets are set to a per-resident amount for attributed members for each participating payer and adjusted prospectively based on quality performance and inflation. Providers can maintain a great deal of flexibility in care delivery and have access to funding for innovative approaches; they will also have access to integrated, multi-payer, population health data to manage their attributed populations. In Vermont's All-Payer ACO model, part of the payment from each payer is spent on each region's primary care providers and community-based providers, such as designated mental health agencies, home health agencies, and others.^{xxviii} This reallocation of increases resources for primary care and community-based providers. In 2018, over \$25 million was deducted from

xxviii This all-payer model brings together three largest state payers (Medicare, Medicaid and Blue Cross and Blue Shield of Vermont) to coordinate care among the payers, providers and community organizations to provide financial and care support for high-risk patients in VT. Each payer negotiates a benchmark amount for the total cost of care for attributed patients. Annualized per capita health care expenditure growth for all major payers is capped. Although less geographically dispersed, the Vermont ACO model may be a suitable example of multi-payer approaches for states with small and rural populations, and more concentrated insurance markets.

hospital fixed payments to fund these providers for population health management, care management, and other community investments. Vermont's model also has a regional focus: each region, or health service area, has a team of providers from across the care continuum who provide care coordination for patients. These regional teams are based on regional primary care medical home model that includes community health teams.

Multi-payer approaches are also strategic for rural communities which serve Medicare and Medicaid patients, as well as veterans. These populations face greater challenges than individuals on private insurance, which can be exacerbated by the remote location. In addition, as with many rural areas, the lack of insurance choice in Alaska limits consumer choice in plans, but also can make the process of integrating all payers less complicated.

In Maryland, in addition to the cost containment approaches implemented through global budgets, rural communities wanted to have a voice in determining what health services are available and how to leverage resources to address SDOHs. The state passed legislature in 2016 that established a workgroup on rural health care delivery in one rural region, tasked with improving care delivery approaches in rural areas and fostering innovation in care delivery within the statewide approach. The group produced recommendations, which led to legislation in 2018 that established a **Rural Health Collaborative** and a **Rural Community Health Demonstration Program** within the Maryland Department of Health.¹¹⁴ The Collaborative aims to:

- Convene local stakeholders to examine the health care needs of a single region
- Develop strategic directions for improvements in the health system
- Manage data collection and analysis to develop regional health and social needs assessments

The Demonstration program aims to establish "Health Complexes," community-based ambulatory care settings that integrate primary and other health care services, as well as social service needs. It also works to enable better care coordination through the sharing of data and resources.¹¹⁵ Alaska could discuss the development and work of this group.

In a letter to CMMI on the issue of important concepts for the implementation of Regional Multi-Payer Prospective Budgets, the National Rural Hospital Association of America voiced its support for global budgets, but also cautioned the agency on implementation precautions. Foremost was the flexibility and adequacy of the budget for a hospital's viability. It urged that any global budget must consider the specific populations served by different facilities (rural PPS hospitals; critical access hospitals; frontier hospitals, and hospitals that serve disproportionately poor and sick populations). They also cautioned that community buy-in from providers, patients, and community leaders must also be achieved, and suggested the Community Health Needs Assessment (CHNA) tool as a process to build a foundation for assessing the feasibility of a multi-payer option. The payers should be clear about any changes to the services offered and what alternatives might be available.

However, the NRHA expressed that with improved efficiencies in care and savings, rural hospitals would face negative margins, leading to cuts in payments from Medicare, leading them to be unable to "maintain operation at such a loss, especially in a multi-payer system which would eliminate necessary cross subsidization." Further, NRHA voiced that savings should not be the initial focus or sole focus,

particularly when hospitals also investing in population health infrastructure and delivery system improvements to shift to better value. The NHRA also argued against the Sustainable Growth Rate (SGR) formula, used by Maryland, since providing population health is more expensive in rural areas for a variety of reasons including the fact that rural populations are older, sicker, and poorer than their urban counterparts, with a greater chronic disease burden.

Pennsylvania Rural Health Model: Pennsylvania has introduced a global payment model specifically focused on rural hospitals that has drawn substantial attention. According to the Pennsylvania Department of Health, over a dozen other states have reached out to the department to learn more about this model. The Hospital and Health Systems Association of Pennsylvania, the Pennsylvania Office of Rural Health, CMMI, four payers and eight hospitals have been closely engaged with the Department over the past several years preparing for launch. The model intends to address the challenges of financial stability and predictability that rural hospitals face by providing an assured cash flow. This stable revenue is intended to allow investment in care quality and population health. Providers are encouraged to focus on three levers to control costs: reducing potentially avoidable events; reduce operating expenses per admission by optimizing processes and capabilities; and optimizing revenue from expanded access to population needs and innovations that improve the patient care experience.

There are two cornerstones of this approach:

- 1) Global budgets: Participating rural hospitals are paid on a global budget based primarily on hospitals' historical net revenue for inpatient and outpatient hospital-based services from all participating payers. Each year, in a negotiated manner, each payer agrees to a proportion of the global budget, which is the total expected expenditure for the year, based on the payer's estimated number of patients expected to be served at the hospital. The payment could be done monthly or quarterly, and at the end of the year, there is a reconciliation if the volume of patients covered by the insurer was greater or less than predicted. The payment is adjusted each year to account for Transformation plan changes (described below) and market shifts. Medicare pays monthly in a fee-for-service and CMS reviews and approve the budgets for each participating rural hospital, as well as Pennsylvania's methodology for calculating the global budgets.
- 2) **Rural Hospital Transformation Plans.** Each hospital develops a plan describing how it will invest in care quality improvements and preventative care, work with community stakeholders to meet the needs of their community. Plans are incentivized to emphasize population health outcomes, and develop referrals and linkages to community based resources.

Alongside of obtaining waiver authority for the rural global budget model, Pennsylvania passed legislation to establish the Rural Health Redesign Center. Exhibit 5.6 highlights some of the roles and goals of the RHRC. A critical aspect of the model, the Center will provide free technical assistance to help rural hospitals identify solutions for challenges, including access to broadband, transportation, and behavioral health services. Other technical assistance includes to providers includes assessments of community health needs and hospital performance. The Center can also help hospitals meet their specific goals, such as offering community health worker education programs or expanding behavioral health and substance use disorder services.

Exhibit 5.6: Pennsylvania's Rural Health Redesign Center:

support for implementation of the Global Budget Model in Pennsylvania



Source: Hughes, L. Pennsylvania Department of Public Health, 2017: http://www.ncsl.org/portals/1/documents/health/LHughesRH62017_31405.pdf

CMS has agreed to provide \$25 million in funding over four years to help Pennsylvania implement the Model. Pennsylvania will use this funding to oversee the Model, aggregate and analyze data, compile and submit reports, propose and administer global budgets, approve Rural Hospital Transformation Plans, conduct quality assurance, and provide technical assistance to participant rural hospitals as they redesign the care they deliver. Pennsylvania will also contribute funding for the operation of the Model. The Pennsylvania Office of Rural Health also worked with the Federal Office of Rural Health Policy, to develop a <u>Rural Hospital Toolkit for Transitioning to Value-based Systems</u>.¹¹⁶ The Toolkit has identified best practices and strategies for improving financial, operational and quality performance to help transition rural hospitals and networks to value-based purchasing and monitoring population health. The work is accomplished through the Small Rural Hospital Transition (SRHT) Project.

A few words on Tribal Considerations:

NORC has a strong recognition of the strong and unique role of the tribal health system in Alaska. As described in Chapter 2, Alaska has a critically strong and important tribal health system. The Alaskan Tribal health system serves about 20% of the Alaska population in a state where approximately 15% of the state population is American Indian or Alaskan Native, compared to less than 2% in the rest of the United States. As also noted in Chapter 2, unlike the federally-run IHS facilities in the lower 48, Tribal

health organizations operate health care facilities under compacts with IHS.^{xxix} Tribal health clinics are the only providers in some rural areas, and they serve non-Native population in those areas. As Alaska moves forward in its reform efforts, tribal considerations will be important. There are examples from within Alaska, as well as other states such as Oklahoma and New Mexico, show that reforms in collaboration with the tribal health system can be strong and sustainable. In both of these states, Medicaid plan administrators sought contracts with tribal organizations, and both states have developed tribal consultations processes. In New Mexico, for example, Native Americans can seek care from Tribal facilities and Urban Health Programs regardless of whether the Tribal providers contract with the MCOs. Tribal providers are be paid the Office of Management and Budget (OMB) rate regardless if they contract with the MCO. The MCOs are also required to work closely with the tribal organizations to train all providers on filing claims to ensure timely processing of payments. It is hoped that tribal health facility providers who join an MCO in Centennial Care can offer patients expanded care coordination and specialty providers within the MCO network. While this draft does not provide specific recommendations in this area, we wanted to note and specifically call-out this consideration.

In this next section, we provide several targeted state examples of how other states have examined approaches in areas of interest to the PMC: regional approaches and managed fee for service in an ASO setting.

Two brief state examples to consider for SDOH approaches

As we noted in Chapter 3, states have increasingly come to understand that drivers of health care cost often times occur upstream from the health care delivery system. They are rooted in SDOH such as living conditions, economic conditions, and work environments where people dwell. In Chapter 3, we provided information on how some states are including SDOH in their health care payment models and reform initiatives. Appendix 5 provides information about screening tools used by a variety of states to screen for SDOH.

Our national scan highlighted **North Carolina**, a recent leader in addressing SDOH through Medicaid. As a reminder, they are first state to establish a statewide initiative under its 1115 Demonstration waiver to test innovative models of covering evidence-based health-related social services. The Healthy Opportunities Pilot will test evidence-based interventions targeting housing stability, food security, transportation access, and interpersonal safety. In addition, MCOs will be required to screen beneficiaries for health-related social needs and connect them to social services, as appropriate. The state has developed resources to help support integration of SDOH within the pilots and more broadly, including an interactive statewide map of SDOH indicators, a standard screening tool to identify and assist patients with unmet health-related resource needs, and a statewide resource platform that helps connect patients to appropriate community resources. This approach, of supporting the implementation of evidence-based interventions that address social determinants is an approach that Alaska can consider.

^{xxix} For details on compacting and contracting under IHS Tribal Self-Governance Program, see <u>https://www.ihs.gov/selfgovernance/aboutus/</u>

It also builds on an approach that has been implemented in **Minnesota** over the past decade. In 2008, as part of larger health reform legislation, Minnesota established the Statewide Health Improvement Partnership (SHIP). Under SHIP, local units of government (largely city and county health departments) received matched funding to implement evidence-based strategies to address underlying risk factors for chronic disease, including interventions around obesity, tobacco use, and alcohol and drug use. Communities have the flexibility to determine the area of intervention most critical to their local conditions (for instance, reducing tobacco use), and then determine an evidence-based intervention to address that issue. Communities are required to engage a wide range of stakeholders in the development and implementation of the plan (public health, employers, health care providers, consumers, and others), called Community Leadership Teams, who provide input, oversight, and direction to the evidence-based interventions.

SHIP has demonstrated a reduction in tobacco use in Minnesota, and an obesity rate that remains below neighboring states. While not specifically focused on SDOH, the concept of identifying and prioritizing SDOH, giving regional or local areas resources to implement evidence-based strategies around SDOH, and requiring broad community direction and leadership is one that Alaska could consider adapting on broad or pilot basis as it looks at ways to address SDOH.

A Closer Look at Regional Approaches

While this chapter has examined regionalization in the context of multi-payer initiatives and global budgeting, we wanted to provide some additional approaches taken by states that could add information to Alaska's knowledge and toolkit.

Oregon has 16 Coordinated Care Organizations (CCOs) that began operating in 2012. Each one is unique to its region, including one in Eastern Oregon that has brought together providers, Critical Access Hospitals, social workers and community service providers together with 12 very remote and isolated counties where previously there had not been managed care. Each county has an engaged community advisory committee that are represented across the CCO on its governing board. They have seen steady improvement in the majority of quality metrics, including improvement after adding newly eligible adults through Expansion. Oregon's statute requires Medicaid CCOs include a Primary Care Provider and a behavioral health provider on their governing boards, to ensure active participation across both communities of providers, as the two Medicaid funding streams are blended into the CCO.

Oregon has repurchased its state employee benefits using the same framework CCO framework as their Medicaid. While not asking for specific organizational re-structuring, the commercial health plans are being held to the same metrics and same cost trends as the CCOs. One CCO has become a health plan choice for state employees, and two of the health plans available for both state employees and school district employees are partners in the Medicaid CCOs. This has resulted in state savings that translated back to both fill funding gaps, and contribute to recent pay increases for state employees. Oregon's Coordinated Care Organizations reported a 21% decrease in ED visits and a 48% decrease in admissions related to asthma and chronic obstructive pulmonary disease. Oregon is currently undergoing a procurement for the CCO 2.0 models, which increases emphasis on improving the behavioral health

system and address barriers to access to and integration of care, increasing value and pay for performance, and focusing on SDOH and health equity.

Colorado recently revamped its approach to regionalization within the Colorado Medicaid program. As of July 1, 2018, Regional Accountable Entities (RAEs) are now responsible for building networks of providers, monitoring data and coordinating members' physical and behavioral health care. RAEs replace and consolidate the administrative functions of Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) that had previously been developed under Colorado Medicaid. Under the RAE model, the state is divided into seven regions. Colorado Medicaid members are attributed to a primary care medical provider (PCMP) based on where they or a family member have sought care in the past or to a primary care provider near where they live. They are then assigned to the RAE region in which the PCMP is located.

A Closer Look at a Fee-For-Service Managed ASO Model: Connecticut's PCMH and Behavioral Health Integration

Connecticut is similar to Alaska in that the state retains full risk in its Medicaid program, and operates a self-insured model and Medicaid fee-for-service model, but contracts with three Administrative Service Organizations (ASOs) that focus on medical, behavioral health, and dental services, respectively. The state pursued this model as under the previous managed care model, providers faced challenges that limited participation, including administrative hurdles, slow payments, and variation in utilization management tools and rate schedules across plans. Data from 2010-2014 showed that Connecticut reduced its per person spending by a greater percentage (5.7%) than any other state in the country. ^{117,118} The state reported that under this model, PMPM costs declined, including 6% in 2017, with some improvements in quality of care.¹¹⁹

The state withholds a percentage of the ASO administration fees on a rolling basis, which it can earn back contingent on the ASO's success in meeting performance targets related to beneficiary health outcomes, experience of care, and provider satisfaction. ASOs conduct intensive care management, with utilization and quality performance management of providers. As the state moved away from the managed care model to its current fee-for-service model with ASOs, it worked to increase physician participation by implementing streamlined and uniform provider requirements, a statewide fee schedule and drug formulary, and bi-weekly provider payments. Officials indicate that this streamlined approach has increased participation among primary care providers and specialists.^{xxx}

The Department of Social Services (DSS) offers primary care practices two types of financial incentives to help offset the costs of becoming and maintaining a PCMH status. The first is enhanced reimbursement rates on primary care services to supplement the current Medicaid fee schedule.¹²⁰ The second is a PMPM performance-based payment to the practice based on selected health measures for members attributed to the practice during the performance period. Through the PCMH approach, the state provides care management for high-risk individuals and includes addressing SDOH, such as housing stability and

^{xxx} More information on the ASOs in this model can be found on the Medicaid site and the sites of the ASOs, for example: <u>https://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334750</u> and <u>https://www.chnct.org/about-us.html</u>

physical safety. The medical and behavioral health ASOs embed care managers in many health centers and include them in hospital discharge processes.

- The primary care medical home initiative, PCMH+, connects enrollees to PCMHs, which have extended hours, coordinate care, and use electronic health records. The Community Health Network of Connecticut, Inc. (CHN CT) is the ASO, which administers the program. DSS pays CHNCT a monthly amount to make referrals and help members make appointments, provide intensive care management for high risk patients as well as obtain prior authorizations, and conducts utilization review and quality management. The PCMHs are "participating entities" that have a shared savings arrangement, with enhanced fees and performance bonuses to PCMHs. PE's must use enhanced coordination activities focused don behavioral health integration, cultural competency, and children with special needs, and persons with disabilities. The state also required person-centered transitions of members from intensive care management to PEs.
- The behavioral health home program, Connecticut Behavioral Health Partnership, is coordinates and integrates physical and behavioral health care as well as referrals for community based services for people with a diagnosed mental illness and high Medicaid spending. Unique in the country, the Partnership is directed by Beacon health, the behavioral health ASO and across agencies including the Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS), and the DSS through the Behavioral Health Oversight Council and subcommittees. The Council works on alignment of contract incentives designed to increase access and improve outcomes. In addition to utilization and quality management, Beacon offers provider education, and administers the Provider Analysis and Reporting (PAR) Program to assist provides in performance monitoring and best practices.

One of the critical foundations of the PCMH+ is providing extensive data to providers to enable them to identify and proactively meet the needs of high-risk persons. Connecticut uses Medicaid claims data and predictive modeling to identify high-utilizers and high-risk enrollees for whom the ASOs provide care coordination and intensive care management.¹²¹ The state uses a portal to allow providers to access performance data, computed by the ASOs, including admission, discharge, or transfer (ADT) data, which they use in support of interventions for their panels. For example, Community Health Network of Connecticut, Inc., monitors a broad range of clinical and patient satisfaction measures, and uses a Johns Hopkins CareAnalyzer tool to do predictive modeling, risk stratification, and other activities to access provider performance. It also produces an annual provider practice profile report for each provider that details their performance in context of peers

The model was developed through monthly meetings and support from work groups as part of the Medical Assistance Program Oversight Council (MAPOC). The Council consists of legislators, consumers, advocates, health care providers, administrative service organization representatives and state agency/commission personnel. The Council was established by the legislature in 1994 to advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Program.

Incentivizing Consumers

Employers in Alaska may be reluctant to adopt certain models that might limit employees' choice of providers. As unemployment rates fall in most markets, employers are concerned about changing benefit designs that they see as important tools for the recruitment and retention of employees. However, in the current refocus on prices, payers in Alaska could consider strategies to incentivize changes in consumer behaviors. While transparency is pricing may motivate some to "shop" for quality, payers can consider adjusting cost sharing.

In this approach, payers can adjust prices for certain services based on the medical risk and potential benefit.¹²² Preventive services, particularly those that reduce the long-term cost of care could be offered with very little cost sharing while services for outpatient care for mild conditions could have greater cost sharing. These price levels could incentivize consumers to look for lower-cost options and also optimize resources for more severe events. Beneficiaries could also be incentivized to more actively manage chronic conditions, with greater reductions for patients that engage in care management tools and exercise programs, for example. Savings to payers from increased cost sharing could be shifted towards more necessary care, or to consumers directly. It is also possible that if costs for elective care were more fully born by consumers, there could be innovation to deliver services more affordably, as providers see declines in the utilization.

State Policies to Develop and Sustain the Healthcare Workforce

State policies are needed to incentivize the development and sustainment of the primary care workforce and to address gaps in rural areas. As Alaska implements value-based reforms and experiments with innovations in care delivery, it will need to cultivate a system of professionals with the appropriate level of skills different needed to address patients across the continuum of care settings and communities. Alaska has undertaken a series of workforce initiatives; we summarize recommendations on workforce development issues from our second report for AHTP, the Meta-analysis, in Appendix 6. The Alaska Health Workforce Coalition, a public-private partnership comprised of leadership representatives from government, health industry, educational facilities, has developed its Action Agenda for 2017-2021. Building on its 2012-2015 achievements, the comprehensive strategy was created to "develop, facilitate, implement, and support a statewide system to ensure Alaska has a well-qualified and sustainable workforce to meet the current and future healthcare needs of its residents." The coalition benefits the health care system by providing an industry-led workforce plan with actionable goals and committed resources, and uses data to establish occupational priorities. DHSS has worked with AHWC in several valuable programs that have demonstrated benefits, such as the Health Professional Loan Repayment and Incentives (SHARP) program. The Alaska Department of Labor and Workforce Development and the U.S. Department of Labor have also collaborated with AHWC to support the development and implementation of primary care, surgical, and behavioral health Apprenticeships.

State policy makers and industry leaders should continue to work with the AWHC to review action agenda and support and provide resources for specific system change and capacity building activities that

aim to develop and sustain the primary care workforce and addresses gaps in rural areas. Several states have used Section 1115 Medicaid Demonstration Waivers to help build workforce capacity. Alaska could consider obtaining similar funding. Below we provide examples of two such programs:

Rhode Island Healthcare Workforce Transformation

Rhode Island, as part of statewide health system transformation led by the Executive Office of Health and Human Services (EOHHS), established the Rhode Island Healthcare Workforce Transformation (HWT) committee. With resources from the EOHHS and in partnership with the State Innovation Model Test Grant, the committee engaged over 250 healthcare stakeholders including Medicaid officials, providers, consumers (Medicaid recipients in particular), educational institutions, organizations providing training. The committee developed a Healthcare Workforce Transformation plan that identified key priorities and strategies to educate the health system and workforce. The overarching priorities established by the HWT committee are to 1) establish accessible health care career pathways; 2) expand home and community based services (HCBS); 3) teach and implement practice transformation core concepts. The strategies are being implemented in part with funds secured through its Section 1115 Waiver. The workforce transformation is carried out through grants to institutions of higher education, training organizations, and by providers in Accountable Entities (providers who contract with Medicaid Managed Care Organizations to serve Medicaid beneficiaries).^{123,124}

North Carolina Workforce initiatives

North Carolina is implementing workforce initiatives as part of a sweeping Medicaid Managed Care redesign in the state.¹²⁵ The focus of these initiatives lies in rural and underserved areas. NC is experiencing a shortage of direct support professionals, particularly for long-term supports and services. The main stakeholders of these workforce development initiatives are North Carolina Medicaid beneficiaries, the State, policy makers, health care providers, health care consumers belonging to rural or underserved populations in the state, organizations providing training and education, and the current and potential health care workforce. The North Carolina Medicaid Redesign Workforce initiatives seek to improve access to services in rural and underserved communities through the recruitment and retention of a "well trained, multi-disciplinary" workforce. North Carolina continues to emphasize the importance of addressing SDOH through initiative activities.

Another aspect Alaska can pursue is improving the scope of practice—or the services that a health care professional is legally allowed to provide for a patient in a particular setting. Certain scope of practice laws regulate the role of nurse practitioners and physician assistants. Policy discussions around scope-of-practice laws can be challenging and carry strong perspectives. As Alaska considers its strategies, it can consult models resources, and innovative approaches to expanding the health care workface that are found on the RHIHub Project, an independent agency supported by the Health Resources and Services Administration of the HHS Rural Assistance Center for Federal Office of Rural Health Policy Cooperative.

Telehealth

Telehealth can greatly expand interactions between patients and practitioners, and the technology is advancing rapidly. Programs piloting the provision of medical services via telehealth in Alaska have found that telemedicine can spur improvement in patient outcomes and satisfaction. Avey and Hobbs (2013) found that while telehealth programs in Alaska can improve access to care for rural residents, rural telehealth sites can rapidly fall into disuse if not carefully structured for success from the developmental stages, and then adequately supported throughout the duration of the program.¹⁵ Some significant barriers to a broader adoption of telehealth programs in Alaska include: limited telecommunications infrastructure, sustained funding for partnerships and initiatives, a lack of interoperability between systems, and policy barriers such as payer disparity in telehealth reimbursement.¹⁶

Telehealth has great potential for creating health care savings while simultaneously increasing access and improving outcomes. Savings would primarily be found through decreased emergency medical service utilization as a result of increased access to primary and specialty care for Medicaid beneficiaries. DHSS contracted with Agnew Beck to convene the Medicaid Redesign Telehealth Stakeholder Workgroup.¹²⁶ The Workgroup concluded that Alaska should continue to implement and test demonstration projects that incorporate telehealth as the technology becomes more accessible and potentially more affordable.

Alaska should seek federal resources to grow the infrastructure needed to expand the communication capabilities and expand care in underserved areas. Regulatory and payment policies are needed to accelerate this expansion. With support from state and federal resources, health insurance plans may take the lead on encouraging the use of telehealth if they are adequately compensated in payment, and given recognized components of network adequacy. Alaska can encourage telehealth by reimbursing for virtual visits and including them in assessments made of network adequacy. Clinicians will likely be slow to utilize telehealth if services delivered through these methods are not directly reimbursed. However, payers may be unclear and slow to adopt payment codes for telehealth delivery of services, as it could increase total spending. However, evidence shows that coupling telehealth with payment reforms, in which providers are incentivized to deliver quality over quantity, and are paid either a salary or based on capitation can drive more rapid adoption of telehealth.¹²⁷

This chapter built on Chapter 4 by providing a potential roadmap of approaches Alaska can consider moving forward. In particular, we highlighted potential options for the PMC to AHTP to consider in the focus areas identified by the PMC:

- Multi-payer approaches to payment reform, align incentives across the market, send common purchaser signals, and reduce provider burden;
- Global budgets or all payer rate setting, to align incentives and provide predictable budgets;
- Develop approaches to address SDOH in VBP;
- Ensure that there is a recognition of the unique needs and differences that exist across Alaska, recognizing the very different nature of different areas of the state.

In our concluding Chapter, we provide recommendations on key next steps for Alaska as it charts its course.

Chapter 6. Setting a Flexible Course

As Alaska eyes the road ahead, it can harness the lessons from other states who have gained knowledge through their implementation of health care transformation. As we have shown in this report, there are varieties of pathways states have followed and Alaska can use the experiences of those states to help inform its own course forward. Chapter 5 provided some potential directions the PMC may wish to examine, including global budgets, regionalization, and the adoption of multi-payer reform models. It is important to note that, while states are adopting these types of approaches, they are also discovering there is no "single bullet," and states set a direction, commit to a path, but make corrections as needed. Reforms to the system mean charting a course, moving down along that course, and being prepared to course-correct as needed along the way. Thus, we titled this chapter "Setting a flexible course" to reflect that health reform is a journey, and like any journey, it will encounter unexpected barriers and roadblocks.

Exhibit 6.1 below is an example schematic of the concepts presented in this report for addressing reforms; it is suggestive of the elements that stakeholders in Alaska would work together on to achieve a shared vision. The diagram illustrates basic structures and processes and is not intended to provide details on processes. The state and its stakeholders will need to decide what vision they have for reforms, and how it will work to implement these, such as how it will assess and support provider capabilities, develop relationships across payers and partnerships with other agencies and community organizations. The state would also need to chart an accompanying timeline for developmental milestones, as well as the criteria by which to gauge progress towards these milestones to indicate that the state and its partnerships are making progress towards the vision.

Governance Structure

| Review of legislation required to provide entity capacity and authority; review any antitrust protection and | Data and Analytic Infrastructure | |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------|
| | Examine sources of investments for data analytics for providers | Value Alignment |
| | | Determine payment |

Prepare evidence to engage stakeholders on priorities for reforms

legal obstacles are

cleared

Convene stakeholders to obtain consensus on values and goals of reform

Balance needs of providers and pavers on goals

Secure federal and grant funding

and resources and training on quality improvement.

Develop and align data reporting requirements and performance metrics.

Initiate efforts to secure data from pavers to conduct data analytics to support and monitor reform.

Secure commitment and technical assistance for data systems Develop an HIT Strategic Roadmap

strategies and incentives for target populations. Ensure that incentives to

physicians align with payer goals.

Identify target populations of priority interests across payers. in specific care settings and in regions.

Agree on proportional distribution of shared investments.

Develop strategic work groups for social determinants of health and workforce development

Implement VBP

Implement practice transformation with regional supports for providers

Conduct multipayer data aggregation

Develop partnerships with community organizations

Assess workforce needs practice transformation needs

Other states have used tools such as driver diagrams or results framework to show how their efforts cohesively and comprehensively address the state's priorities. In addition to these conceptual models, states can conduct "readiness surveys" to assess the technical assistance needs of providers and health plans for a number of reform priorities, such as data collection and reporting and financial management. In Appendix 7, we provide an example of Minnesota's Accountability Matrix that was designed to assist the state in identifying basic capabilities, relationships, and functions that providers have to support their health care transformation goals. Providers were asked to complete self-assessments and findings were used to identify priorities for investment, and to lay out developmental milestones for providers and organizations to ensure progress towards Minnesota's reform goals.

Charting the more detailed course: agreeing on the pathway

Below we provide recommendations on some next steps for Alaska as it charts its course, supported by our analysis of the landscape of promising strategies nationwide, and reflective of the AHTP feedback to date. Each of the elements of the roadmap will require the development and fleshing out of details. This report has laid out an overall course the state can follow, but as always "the devil is in the details," and

any next steps will involve continuing to add to the detail and understanding of the direction. Given the overarching nature of the reforms, we anticipate the AHTP will likely seek to establish broadly representative working groups, consistent with the project's approach thus far. We further anticipate that as the AHTP continues to receive gathers feedback on this Roadmap, it will continue to refine these next steps through an iterative process with stakeholders, and commit to continue towards developing action plans for the agreed up on strategies, and course correct along the way. We start with areas where there are routes paved by other states, and that may be implemented with the current data capacities. Preliminary findings of this report were presented to the Alaska Healthcare Transformation Project Convening Group and Project Management Committee on July 10 and 11, 2019. The AHTP Convening Group represents a diverse body of stakeholders, including multiple payer, provider, academic, and patient representatives from different industries and disciplines. The NORC team presented recommendations and the stakeholders in the room discussed their overall level of agreement with each recommendation, pros and cons, and strengths and limitations. While the key recommendations in this final report remain consistent with the research's team key suggestions, the order and emphasis consider the actionable next steps and implementation strategies discussed by the PMC and AHTP Convening Group. As the NORC team recommendations are presented in the following pages, we make note of the insights gathered from the Convening Group and PMC. In particular, we note the AHTP recommendations as adopted by the PMC and conveyed in a letter of July 19, 2019 to the State and Foundation Funders of the project as well as subsequent Work Group Charges.

1. Develop a Governing Body to Oversee Implementation of VBP Goals. Our national scan showed that the designation of a lead entity to oversee the development of health care policy was a key to ensuring the sustainability and trust in ongoing health reforms. Having a trusted entity that can both research and recommend health policy options and conduct the analyses necessary to bring data, information, and thoughtful study to health care marketplace issues is a key to sustainable reform. Such entities can work across stakeholder groups and government, maintain neutrality but understand perspectives, so that their work is understood, trusted, and maintains broad buy-in.

Depending on state goals, there are varieties of ways that such an entity can be structured and chartered: as part of state government; as an independent non-profit; as a quasi-governmental governing board; in partnership with an academic organization; or some combination. There are strengths and weaknesses associated with each approach, but importantly such governance must be consistent with the political, social, and historical context of Alaska. The state can establish workgroup processes to:

- identify the key responsibilities of the entity;
- ensure key stakeholder input pathways and representation;
- consider the best organization structure and placement; and
- identify key initial organizational charges

In Chapter 4, we describe approaches states have used to establish leadership and governance of healthcare reform goals. Below are specific short and long-term activities for this leading entity.

- a. Address key legal and regulatory barriers that may create obstacles toward meeting the goals of reform. As discussed throughout this report, changes to care delivery models may, in some cases, require examination and changes to existing legal frameworks. As Alaska moves down the pathway to reform, we recommend that it conduct a review of state laws and regulations that may hamper competition or act as barriers to implementation and success of preferred reform models. This review would then identify what actions could be taken to remove these barriers, and the potential consequences of these actions. For example, Alaska's Choice of Health Provider statute may need adjustments to foster competitive provider networks, should Alaska choose to move towards using more organized provider networks and incentivizing consumers to use high quality efficient providers.
- b. **Develop paths to multi-payer VBP alignment**. This could begin with identifying opportunities in service delivery, and working reciprocally with the identification of barriers to reforms. The work of the entity would also be to develop processes to measure and monitor the impact of VBP alignment on the quality of patient care. Aligning payers on quality reporting and incentive is discussed in more detail in Recommendation #3,
- c. Identify key social determinants of health (SDOH) focus areas and develop incentives for health care providers to address them. This report provides a variety of ways that states are examining and beginning to address SDOH systematically. SDOH drive costs and spending in Alaska, and getting upstream to address them is a key to controlling spending moving forward. Alaska can establish a workgroup under the leading entity that will develop a process, similar to that developed in Minnesota under its SHIP program, to identify key SDOH priorities, and evidence-based interventions around these priorities.

The workgroup would then conduct data analyses to understand costs associated with SDOH, and the costs of interventions to address them, and work with providers and community-based organizations to determine the level and type of investments and payment strategies for interventions. For example, the workgroup could develop a standardized community health needs assessment, and findings could then be the basis for requirements for state health related contracts with providers. The workgroup can also collaborate with hospital and health related foundations to fund the development and implementation of SDOH work in partnership with the state. The workgroup would also seek funding from federal and other resources to help fund the work of SDOH for local communities to address these under an overall statewide framework.

> AHTP PMC Recommendation on a Governing Body to lead reform:

The AHTP will seek to establish a group of stakeholders to provide leadership and would work with the state to be a focal point for controlling healthcare costs by developing sound policy based on evidence. This entity would have authority and resources to analyze data, and provide policy direction based on the analysis of data, and make course corrections was viewed as needed and necessary. The Project Management Committee will convene a work group to identify the scope and key responsibilities, stakeholder representation, and organizational structure and rules of engagement. Further, it is requested the Governor assign a top member of his Administration to participate in the design work of the leadership governance entity. After establishing the organizational charges and processes, the leading entity would determine long-term path to incorporate the data function, payment alignment group, including approaches to incentivize addressing the social determinants of health.

2. Initiate discussion and action plans to establish a state-wide APCD and ensure sufficient analytic capacity. The second element of our finding in Chapter 4 surrounded the importance of infrastructure to support the systematic and ongoing collection of data that can inform Alaska's development of health policy and create an environment of data-driven decision-making. The establishment of an APCD will be key in providing an ongoing and detailed source of information on Alaska's health care marketplace. Current, detailed, and complete data about Alaska's health care marketplace will be a critical to developing and comprehensively monitoring policy changes to improve the cost, quality, and access to care in Alaska. Establishing an APCD will facilitate Alaska's ongoing efforts to improve affordability and many resources are available to guide the state. Twenty states now have APCDs; our report summarizes the authority and uses of APCDs in 10 states, and more resources can be found on the APCD Council website.^{xxxif}

However, APCDs can take several years to be fully operational. Until an APCD is operational, the state can take incremental steps towards data aggregation. The state could start by discussing with stakeholders the barriers and concerns they face towards participation. With sufficient buyin attained, stakeholders can begin to establish the details of data structure, principles, and requirements for reporting that support the core purpose of the APCD. This includes agreement on measurement strategies, data submission, oversight and access to the data, as well as the timeline for implementation. The state could also require all commercial insurers to submit claims data to a centralized claims database, and encourage interested private self-insured employers to contribute to the same database. While this data aggregation is pursued, the state can also conduct analyses of the initial and reoccurring costs of an APCD, and identify funding options.

^{xxxif} For example, brief case studies of the success and challenges of five states can be found in such as "Realizing the Potential of All-Payer Claims Databases" by Freedman HealthCare. <u>http://www.statecoverage.org/files/RWJF_Realizing_Potential_of_APCDs.pdf</u>

It will also be essential that the development and oversight of the APCD collaborate closely with the leadership entity described in recommendation #1, or be supported and steered by it, so that it has sufficient analytic capacity to make data-driven decisions. One approach is for the leading entity to oversee the administration and analytics, and help secure funding for the APCD, while contracting out the development of the required technical infrastructure. The leadership entity would also work with the technical developers to maintain and update data submission and governance. Below are some initial steps towards APCD development and implementation:

- Establish core principles and requirements for reporting that support the core purpose of the APCD, whether that is broad or narrow use of the data for various audiences.
- Convene stakeholders and discuss data submission and determine how the data can be used; for example, some states sell analytic extracts to researchers. Important questions to consider in this process are if the data will be limited to use only by the lead analytic agency, if the data will be accessible for use in academic research projects, if providers will be able to obtain data outputs and reports and what uses of the data should be explicitly excluded.
- Identify the necessary statistical, systems, and analytics staffing to be able to effectively use an APCD. Begin examining developing best practices around data submission, including: how average prices are computed, quality control for data submission.
- Establish a realistic timeline for implementation that details what activities and stakeholders will be required across the phases of start-up and maintenance of the APCD.
- Consult with the APCD Council, a learning collaborative that helps states learn and share resources and information about implementation of APCDs. It can provide early-stage technical assistance to states interested in implementing APCDs and catalyze states to achieve mutual goals.

Work with employer coalitions and state reporting agencies that are dedicated to data collection and reporting on healthcare quality to assess data systems and reporting capacities.

> AHTP PMC Recommendation on Data and APCD development:

The Project Management Committee will convene a work group to identify options available to the State of Alaska to develop an APCD system to gather cost and quality healthcare dta and ensure sufficient analytic capacity to effectively analyze and use the data for understanding cost outliers, to better understand the relationships between cost and quality at the provider level, to information meaningful reforms that actually save money, and improve access and quality. The workgroup will discuss feasibility and options for incremental approach to an APCD or whether some other structure such as data warehousing is most appropriate for Alaska. If an APCD is pursued, it will:

- Identify possible out-sourcing opportunities for an APCD;
- Establish a realistic timeline for implementation that details what activities and stakeholders will be required across the phases of start-up and maintenance of the APCD or other data structure, including legislative actions and plans for sustainability;
- Identify the necessary statistical, systems, and analytics staffing to be able to effectively use the data, and best practices around data submission.

The PMC further recommended the Governor instruct the Commissioners of all Departments work in concert in any and all systems development for storage and analyses of state healthcare expenditure information.

- **3.** Set multi-payer goals for VBP reforms using the HCP-LAN framework or similar framework. Many states are now beginning to use such frameworks to develop strategic plans for moving towards value-based payment within their states. For example, in some states, Medicaid programs are surveying health plans and providers to gain a baseline understanding of the proportion of payments that are made under the various HCP-LAN categories. They then can set goals on moving the proportion of payments made that are value-based or that carry higher degrees of provider responsibility for cost and quality outcomes. Importantly, the state must be able to identify areas for savings and reform approaches that incentivize quality and changes in care delivery, and identify any barriers to achieving these goals.
 - a. Develop a multi-stakeholder working group to move in these goals by including providers and patients in VBP design discussions. In coordination with or under the guidance of the governing body, this group would bring together a payers, providers, and patients to find agreement on how to assess and implement payment and delivery reforms that takes into consideration the concerns of all parties.^{xxxiif} Cooperation and negotiation are critical and instrumental to successful implementation of VBP.^{xxxiif} This workgroup would include an even mix of providers and payers (large insurers in the state, Medicaid, state employee groups, other governmental purchases), Tribal health representatives, non-traditional providers such as pharmacists, as well patient representatives. It would convene regularly to discuss policy goals and gain feedback around specific VBP options, including quality metrics and reporting requirements, goals for addressing SDOH and aligning incentives to help providers make infrastructure or human resources changes necessary for care transformation, and establishing working groups to examine some of the additional issues raised in the report.

This workgroup would establish other work groups where necessary to examine some of the additional issues raised in this report. A recent report from the Milbank Fund and Pacific Business Group on Health synthesized lessons learned for policy makers interested in gaining buy-in from the commercial insurers, with detailed case studies of individual states.¹²⁸ Recommendations from peer states, such as in the aforementioned study, and resources at the Network for Regional Healthcare Improvement, can help the participating workgroup members communicate state VBP goals to constituents.

xxxiif At the AHTP stakeholder meeting, it was suggested the workgroup be a "Value-Based Healthcare Council".

^{xxxiii}f For example, Miller describes a number of approaches that will encourage participation by payers and providers. See Miller, H. D. (2018). Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services.

There are also initiatives in the private sector, such as Robert Wood Johnson Health System and Barnabas Health and Northwestern Medicine in Illinois (Northwestern Memorial HealthCare and Cadence Health), and the partnership between AtlanticCare and Geisinger. As the business model for care delivery changes, new resources are available to help hospital and health system management understand how to design population health management and partnership processes for decision making.¹²⁹

Alaska could survey the major payers to understand where most provider payments in Alaska falls on the HCP-LAN spectrum. While recognizing that not all payers may initially participate, participating payers could then set goals for increases over time in more value-based types of arrangements, such as those in categories 3 and 4 of the framework. This approach recognizes that each payer likely has a different starting point of the proportion of payment within each category. The multi-payer arrangement could also set a minimum threshold it seeks to achieve in categories 3 and 4 over a given timeframe. One early goal could be agreeing to tiered payment structures in state employee plans, and the use of pay for performance on an agreed upon set of outcome measures. This would allow payers to continue to innovate with providers, and give plans and providers the flexibility to try payment arrangements that are appropriate

b. Move towards a regionalized multi-payer global budget approach by building on existing care coordination efforts. The state has had some experience with VBP initiatives, mostly with Alaska Medicaid and Medicare, such as the Alaska Medicaid Coordinated Care Initiative (AMCCI) and Bundled Payment for Care Improvement (BPCI) model implemented by the Alaska Hospitalists Group approaches. Alaska can build on this key initial work and engage other payers through the multi-stakeholder workgroup, for example, to align incentives for care coordination. For example, stakeholders can work together to consider how to incrementally expand target populations of interest, e.g. persons with high behavioral needs and/or social risk factors. These aligned payment incentives, through infrastructure and/or population-based payments, can help providers make infrastructure or human resources changes necessary for care transformation and management across the delivery spectrum. For example, they can design incentives for communities and providers, health departments and social services to groups to address behavioral health and social risks, such as housing and transportation.

In addition, the experiences of Maryland, Vermont, Pennsylvania, and other states described in this report provide some excellent potential starting points for designing global budgets. These examples also demonstrate the feasibility in rural environments. By providing predictability of budgets in rural areas, they allow for structured resource allocation discussions at the local level, and can they provide an over-arching budgetary goal in nonrural areas. And, as multi-payer approaches hold maximum value for savings across the health care system (by aligning incentives and reducing provider burden), the state should pursue a multi-payer approach recognizing that it is a longer-term goal. In addition, Tribal Health Organizations already operate under a global budget with IHS funding covering their fixed costs. However, even where there is some in-state experiences and excellent starting point examples from other states, Alaska by necessity must modify those approaches to ensure they are in line with their expectations and political, social, and care delivery environments. For example, it will be very important to consider regional targets for spending growth and adapt budgets for both the facility type and case mix of patients. As mentioned in Chapter 5, there are hosts of design details that are important in examining global budgetary approaches. These include, but are not limited to:

- the methodology to determine the specific budgets for each payer, for example, such as based on historical claims data or capitation based target population served, or a combination;
- the use of any reference rates or spending growth limits;
- o statewide or geographically targeted, such as in rural areas;
- the methodology to determine the population attributed to each payer (the reference population);
- the methodology to adjustment for inflation and regional factors;
- the methodology to adjustment for demographics and health status changes in the reference population as well as catastrophic events;
- o any shared savings or penalties and savings and loss-sharing limits;
- o rewards for performance on quality measures and beneficiary outcomes;
- the handling of outliers or unusually high cost cases.

These are a few issues that will need to be examined in detail, but a workgroup will likely wish to start by determining the overall approach while allowing for regional considerations and optional approaches that make the most sense for Alaska. A workgroup could then incrementally drill down into the various elements and details that make up the overall approach.
> AHTP PMC Recommendation on Value Based Payment Goals:

The Project Management Committee will convene a work group to chart a path to move Alaska payers and populations from the fee-for-service arena to more VBP models identified in the HCP-LAN. In the short-term (over the next year), it will identify quality metrics that are consistent across all payers as a means to reduce administrative burden on providers, examine and discuss payment for preventive services, transition services, and identify new billing codes or ways to pay providers that align across payer goals. These steps will create an atmosphere conducive to conducting healthcare business as a first step towards aligning value with payment.

Also, in the short term, the PMC recommended that the Commissioner of the Department of Health and Social Services consider including three specific items in the contract for the Administrative Services Organization (Optum) to include: (1) a requirement of standardized Social Determinants of Health (SDOH) screening for all recipients served; (2) Value Based Payment development and design to include training and support of providers; and (3) a requirement for a formal linkage between Optum and the Aging and Disability Resource Centers to provide referral information for participating practitioners once a social need is identified through the SDOH screening for those individuals with a qualifying disability.

Glossary

The primary sources for these definitions are:

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Alternative Payment Models (APM): these are different types of value-based payment arrangement, as designated by CMS, in which payers hold providers accountable for performance on quality and have varying rewards for lowering spending. Providers that participate in an APM are exempt from reporting on certain quality measures and may receive a participation bonus. These include some Accountable Care Organizations (ACOs) bundled payments for episodes of care and some Patient-Centered Medical Homes.

Administrative Service Organization: Within the health care context, these organizations conduct data analytic and administrative functions of a managed care organization, such as claims processing, member/provider services, case management, and review of physician practice patterns, and information sharing to providers and consumers. In theory, these functions help the MCO maintain an efficient network of providers, increase coordination of care, and reduce unnecessary utilization or spending.

Bundled episodes: A payment approach in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care (e.g., a knee replacement surgery, or a year's worth of diabetes care). "Episode" refers to all services delivered for a defined episode of care (e.g., beginning three days prior to a knee replacement surgery and extending 30 days past a patient's discharge from the hospital for this procedure). "Bundled," refers to payments for services delivered by multiple providers can be combined into a single payment, which is then divided up between these providers as they see fit. In theory, because it provides a fixed payment for a period of time associated with hospitalizations, bundled payments provide strong financial incentives for providers to improve efficiency through enhanced coordination of care and reduction of services that do not improve care. One issue is bundled episodes may temper the current incentives to do unnecessary diagnostic tests within an episode but may actually increase the incentive to use diagnostic testing to find more treatable conditions eligible for large episode-based payments.

Fee-for-service: A payment approach in which health care providers receive a separate fee for each service they deliver. Providers are not at risk for losing any money.

Financial risk: When an entity assumes liability for the financial loss that could occur if actual costs exceed expected costs.

Gainsharing: When a hospital shares with non-employed physicians savings that the hospital generates as a result of the physicians' actions (e.g., when all of a hospital's physicians agree on a certain stent to use, thus allowing the hospital to negotiate bulk discounts on the stents).

Global payments (budgets): A single payment made to a provider organization to cover the cost of a pre-defined set of services delivered to a patient (e.g., an amount paid PMPM to cover the cost of all of a patient's health care needs for a year, instead of only the services associated with a given condition or procedure). In many cases, the provider organization (such as hospital or integrated delivery system) is responsible for reimbursing other providers for care they deliver to the patient. Global budgets vary in many design aspects, three of which are:

- 1) method of determining resources: capitation: summing up the risk-adjusted health expenditures per capita or supply-side, by summing up facility-based costs
- 2) the agent and payer relationship: contracts between the providers and payers may be developed between individuals or groups of providers and between individuals or groups of payers. Each arrangement has pros and cons, but when payers are aligned, they have greater bargaining power and may minimize cost-shifting.
- 3) Risk adjustment: a strategic approach is to typically includes adjusting payments based on

Multi-payer: collective action by health care payers to create a more powerful, streamlined set of expectations and incentives for providers and potentially result in greater improvement in outcomes. States can assume a variety of roles to promote multi-payer primary care investment: policymaker, payer, regulator, convener, and grant maker.

Partial capitation: When a payer pays for some types of services on a capitated basis (e.g., by contracting with a group of providers to deliver all of their enrollees' outpatient care) and pays for other services on a fee-for-service basis (e.g., reimbursing any hospital in their network for inpatient care delivered to their enrollees).

Reference based pricing: A payer or payers use a benchmark, such as Medicare or a historical trend for future payments to determine reimbursement to providers for delivering a defined of health care services. In some scenarios, providers may accept or decline this reference price, and consumers may bear the difference between the reimbursed amount and any additional amount the provider may charge.

Shared savings: A payment approach whereby a provider or provider organization shares in the savings that accrue to a payer when actual spending for a defined population is less than a target amount. Many purchasers also require that performance targets on quality measures be met or incentivize additional payment for performance. There are many variations of shared savings, including "downside" risk, in which providers are penalized or must pay back a certain amount of costs that exceed the target amount.

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