Quick Reference to State Strategies for Cost Containment
April 12, 2016

State	Market Characteristics	Role of Government in Health Reform	Key Strategies	Keys to Success	Challenges
Vermont	**Hospitals:** Fewer hospitals than any other state in the study, including Connecticut. Half of its hospitals are Critical Access Hospitals. Very little competition between hospitals as they each mostly serve one geographic area. **PCPs:** Slightly lower ratio of PCPs to population than in Connecticut; more FQHCs and RHCs than Connecticut. **Health Plans:** One state-based Blues plan dominates the market.	1. Executive and legislative branches have long been active in health care reform. 2. Legislature has given state-based agencies and the Green Mountain Care Board wide authority to implement reform.	1. Blueprint for Health, a comprehensive patient centered medical home strategy with regional control and community health teams. Evidence supporting the Blueprint for Health model is strong. 2. A robust data strategy supported by a well-functioning health information exchange and all-payer claims database, that support delivery system reform initiatives. 3. Green Mountain Care Board's ability to regulate hospital budgets, review insurance rates (in consideration of hospital budgets), and require participation in designing and testing payment and delivery system reform interventions. 4. Green Mountain Care Board's pursuit of an all payer model that would require the state to cap its cost growth to a certain percentage. Through this process, the Green Mountain Care Board is supporting the efforts to create one statewide accountable care organization.	1. Leadership across all sectors of the health care market willing to reform the system. 2. A culture of collaboration and mutual respect, and a broad acceptance of the state's active role in health reform. 3. The state has broad authority to regulate health care rates, hospital budgets and to compel providers to participate in reform initiatives.	1. The effort to support the all-payer model proposal is quite intense, with a lot of uncertainty.

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Rhode Island	**Hospitals:** Fewer hospitals than Connecticut are forming into three large systems with total market share of 83%. **PCPs:** Similar ratio of PCPs to population as Connecticut. **Health Plans:** Two dominant plans, one local and one national.	1. Office of the Health Insurance Commissioner (OHIC) has been the key agency promoting cost containment initiatives since 2008. 2. Governor Raimondo, who took office in 2015, wants to build on OHIC's successes and better coordinate state health care reform activities across agencies.	1. Use expanded OHIC powers to develop and implement Affordability Standards that must be met by health plans with at least 10,000 members. Affordability Standards require plans to achieve the following: 1) Increase primary care spending 2) Support Patient-Centered Medical Home Expansion 3) Support HIE adoption and expansion 4) Implement payment reform a. Initially focused on improving hospital quality and limiting hospital rate increases. b. Expanded to include requirements to more broadly adopt alternative payment models and to limit ACO budget increases.	1. Legislative Leadership in creating OHIC with unique areas of authority. 2. Strong and creative OHIC leadership with a vision about how to impact affordability 3. Strong stakeholder involvement in and support of the Affordability Standards. 4. OHIC has a range of meaningful enforcement powers	1. Balancing the promotion of meaningful transformation and the risk of pushing plans too far to prompt a political response. 2. Pursuing a primary care strategy when support for primary care initiatives by RI insurers is waning as focus on ACOs grows. 3. Engaging providers to implement the Affordability Standards and support payer success. 4. Having sufficient staff to perform non-traditional regulatory activities necessary to implement the Affordability Standards.

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Massachusetts	**Hospitals:** Similar to Connecticut in terms of limited number of hospitals with significant market power. **PCPs:** Similar ratio of PCPs to population as Connecticut. **Health Plans:** Highly concentrated plan market place with one dominant plan and several smaller plans; all plans are state-based, unlike Connecticut.	1. Legislature has been very influential in shaping health care policy by passing laws that create health care policy, create a state infrastructure to monitor the health system and by tasking various agencies to study health care problems, and then acting upon findings. 2. Several recent Governors have made health care reform a priority. 3. The Center for Health Information, Analysis (CHIA) and the Health Policy Commission, and the Attorney General all play an active role.	1. Promotion and use of alternative payment models 2. Transparency of fact-based information on providers and health plans which arms the policy-makers and market with data. Consumers are not the primary audience of this strategy. 3. "Light-touch" regulatory approach, with constant threat of a "heavy-handed" regulatory approach. (e.g., setting a state cost growth benchmark with no major state-imposed consequences for not meeting the benchmark).	1. The state has a culture of perseverance in transforming the health care system and has taken decades to do so; the providers have experience in alternative payment models; and relationships across state agencies are collaborative in nature. 2. The state has committed and continues to commit to robust data collecting and analyzing. 3. The state regularly reports on the cost and quality of providers in the state; and other matters of interest.	1. Variation in payer strategies of payment reform can be taxing for providers, especially safety-net providers. 2. Variation in provider prices continues to be a problem and is not solved with just alternative payment model adoption, alone. 3. Lack of formal coordination across state agencies.

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Oregon	**Hospitals:** Less market concentration than Connecticut with four large hospital systems having 30% of the discharges. Numerous rural hospitals with fewer than 50 beds. **PCPs:** Approximately same number of PCPs on a per capita basis. Approximately 50% are hospital employed. **Health Plans:** Four major plans with top two each having approximately 25% market share.	1. Legislature created a consolidated agency, the Oregon Health Authority (OHA), responsible for all state health purchasing, health policy development, HIT infrastructure and analytic support. 2. State sought a 1115c waiver to implement new strategy that provides a global payment for Coordinated Care Organizations (CCOs) which are local organizations for providing all medical, dental, behavioral health service to Medicaid beneficiaries. 3. Legislature capped employee/teacher plan rate increases at 3.4%.	1. Delivery system transformation: multi-payer efforts to promote patient-centered medical homes, including using SIM funds to create the Patient-Centered Primary Care Institute to provide technical assistance to practices. 2. Evidence-based coverage policies for health and pharmacy benefits: using well respected medical evidence review organizations, assesses comparative effectiveness of services and pharmaceuticals to make coverage recommendations. 3. CCOs: regionally based organizations at 100% risk for providing all medical, dental, behavioral health services to Medicaid beneficiaries. 4. Transparency: State publicly posts identified performance data for each CCO. Insurance Department working to make rate setting process more open; provider associations and quasi-private organizations post identified quality data on provider performance.	1. Leadership by legislature and Oregon Health Authority in setting and implementing cost containment strategies. 2. Consolidated agency (OHA) can influence state health strategies because it controls 30% of Oregon health care spend. 3. Oregon leaders have been innovative in trying new cost containment strategies (e.g., evidence-based coverage, CCOs, and creating research partnerships with local academic medical centers).	1. CCOs have not reached their potential to promote delivery system integration, in using funding flexibility to deliver non-traditional services or adopt APMs. 2. State employee and teacher plans will likely exceed cap in 2017. 3. PCMH initiatives are not as integrated with commercial payers, as hoped. 4. Oregon needs to develop sustainability model for technical support services provided to PCPs and to CCOs.

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Maryland	**Hospitals:** significantly more hospitals than Connecticut. Top 10 (out of 50) hospitals account for 44% of discharges. **PCP:** similar ratio of PCPs to population. Half the providers are employed, with the percentage increasing. **Health Plans:** The commercial market is dominated by a local Blues plan (CareFirst BCBS) with 68% of the market.	**1.** State government has been setting hospital rates for the last 40 years **2.** Legislature in 2010 initiated an all-payer patient-centered medical home (PCMH) initiative **3.** In 2014 the state negotiated a 5-year All Payer Agreement with CMS to implement Global Hospital Budgets	1. Delivery system transformation/payment reform with PCMH focus 2. All payer limit on rate of per capita health care cost increases with phase I focusing on global hospital budgets and phase II moving to limits on increases in total cost of care per capita amounts.	1. Legislative leadership in supporting hospital rate setting and the all-payer global hospital budgets and limits on per capita cost increases. The legislature has been a leader in promoting PCMH transformation. 2. The HSCRC leadership has remained largely free of regulatory capture and has provided strong independent leadership in implementing the state's rate setting program. 3. The state has been innovative in moving to an all-payer global hospital budget model	1. Hospitals lack timely data on costs utilization outside of the hospital. 2. Currently Maryland hospitals have 100% of the risk. Maryland is in the process of working out how risk will be distributed to other providers. 3. Hospitals need to develop a new culture and new skills to implement population-based care models. 4. It is unclear how the PCMH model will integrate with the hospital-focused population-based model of care. 5. Medicaid is considering several innovative models to control its non-hospital costs and is uncertain at this time which to adopt.