



Leader Perspectives

on the impact and future of payment
reform in the Commonwealth of Virginia

A report to accompany the

**2018 VIRGINIA SCORECARDS ON PAYMENT
REFORM 2.0 PROJECT**

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Table of Contents

I.	Introduction to Scorecard on Payment Reform 2.0	3
II.	Interview Methodology	4
III.	Comments on the Quantitative Results	4
IV.	Overall Impression of Payment Reform Penetration in Virginia	5
V.	Is Payment Reform Gaining Momentum in Virginia?	6
VI.	Will Payment Reform Improve Health Care Quality in Virginia?	7
VII.	Will Payment Reform Improve Health Care Affordability in Virginia?	9
VIII.	The Role of Network and Benefit Design	10
IX.	Conclusion	11

Introduction to Scorecard on Payment Reform 2.0



As health care spending continues to grow for both public and private purchasers, many stakeholders nationwide see payment reform as an important strategy for improving the quality and affordability of health care. State leaders know that a strong economy depends on an efficient health care system that delivers value to employers and other health care purchasers and the people for whom they buy health care. To this end, both the public and private sectors are working to make fundamental changes to how they pay for health care and expand these changes over time.

Catalyst for Payment Reform (CPR) is a national, independent non-profit working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. The pioneer in tracking payment reform since 2013, CPR is piloting an expanded Scorecard on Payment Reform, known as Scorecard 2.0, with the purpose of evaluating whether payment reform is delivering on its promise to improve the value of health care.

Like CPR's previous [national](#) and [state-level](#) Scorecards on Payment Reform, Scorecard 2.0 continues to measure how much payment reform there is and of what type. Building on this base, 2.0 also includes 12 additional metrics to help shed light on whether payment reform correlates with improved health care quality and affordability across the health care system. Additionally, CPR interviewed health care leaders to obtain qualitative information about payment reform and its impact in Virginia. Through the quantitative and qualitative analyses, CPR aims to understand the progress toward CPR's goal that by 2020 at least 20 percent of payments to clinicians and hospitals are made through payment methods *proven* to improve the quality and affordability of health care. CPR also aims to arm Virginia stakeholders with baseline data on which they can make informed strategic decisions.

With grant funding from the Laura and John Arnold Foundation and the Robert Wood Johnson Foundation, CPR piloted the Scorecard 2.0 methodology at the state-level in Colorado, New Jersey, and Virginia, with the help of local organizations in each state. In Virginia, the Virginia Association of Health Plans (VAHP) and the Virginia Center for Health Innovation (VCHI) served as joint local sponsors of the effort.

The long-term goal of this project is to improve the health and health care of all Americans through helping purchasers in both the private and public sectors track progress with payment reform, as well as high-level indicators of its impact on the cost and quality of health care. Many stakeholders are betting that payment reform is an essential building block to enhancing value in health care, and this project will help ensure that such programs are helping achieve the goals of better and more affordable care on a macro-level.

While it continues to be important to evaluate each payment reform program individually, there is also much to be gained from a higher level, aggregate analysis and contextual review. The health care system is incredibly adaptive and success with one payment reform program may not be scalable, or may have negative ramifications elsewhere as health care providers seek to maintain their revenue. While Scorecard 2.0 is not able to identify direct causal relationships, it does explore the relationship between alternative payment methods taking root and concurrent changes in health care quality and cost. It is critical to determine at the system level whether this flurry of activity to reform how we pay health care providers is leading to the intended outcomes.

Interview Methodology

This paper summarizes the perspectives CPR captured through semi-structured interviews with 17 health care leaders across and within five stakeholder groups: employers, public purchasers and consumers (3), health plans (3), state government health leaders (2), health care providers/systems (6), and academic researchers/multi-stakeholder health care improvement group leaders (3).

The joint local sponsors identified health care leaders across the stakeholder groups to ensure CPR could capture important perspectives and invited prospective interviewees to participate. To preserve the integrity of the insights and the confidentiality of the participants, CPR elected to not identify any individuals or organizations who contributed to the report and instead attribute the themes and insights in this report to stakeholder groups. CPR thanks all participants for their candor, expertise, and time.

CPR conducted the semi-structured interviews over the course of four months (March– June 2018), by phone, with most interviews taking approximately one hour. CPR provided each interviewee with an interview guide describing the project, the methodology, and questions in advance. CPR's program director, Andréa Caballero, and project and research manager, Alejandra Vargas-Johnson, led and facilitated the interviews with each participant.

Upon completion of the interviews, CPR analyzed the responses and identified key themes. The remainder of this report reflects this analysis using the same sequence of questions as in the interviews and compares and contrasts CPR's interview findings with quantitative data from the Scorecards.

Comments on the Quantitative Findings

This report is accompanied by two quantitative scorecards: one on Virginia's commercial market and one on Virginia's Medicaid market, both of which showcase how much and what types of payment reform occurred in the Virginia in 2016. Detailed information on the quantitative findings and methodology is available at www.catalyze.org.

Payment Methods – Commercial

The most prevalent value-oriented payment method in the commercial market in Virginia in 2016 was shared savings. Thirty-four percent (34%) of health care dollars¹ flowed through shared savings arrangements that year.² The second most prominent value-oriented payment method in the commercial market in 2016 was pay-for-performance (P4P)³ at 26% of payments.

The least prevalent value-oriented payment methods in the commercial market at that time were capitation at 0.0%, followed by partial or condition-specific capitation (0.1%), and bundled payments (0.5%).

Payment Methods – Medicaid

In 2016, the most prevalent value-oriented payment method in Virginia's Medicaid market was pay-for-performance. Twenty percent (20%) of health care dollars flowed through P4P arrangements. The second most prominent payment method in the Medicaid market was shared savings at 13.5%.

¹ From responding health plans.

² Shared savings is defined as arrangements between health plans and providers where there is an upside-only financial incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a FFS payment system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and will vary based on provider performance.

³ P4P provides incentives (typically financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment. The financial incentive payment that is given for achieving certain performance levels is sometimes also referred to as a bonus payment.

The remaining dollars flowing through payment reform methods in Virginia's 2016 Medicaid market were in bundled payment (0.1%).⁴

Macro-Indicators

The quality and affordability metrics in the two Virginia Scorecards on Payment Reform 2.0 highlight strong points as well opportunities for improvement. Notably, only 66% of children ages 1.5 – 3 years old, state-wide, received all recommended immunizations, whereas the national average across all states in 2016 was 71% of children for this age range. In addition, about half (47%) of Medicaid enrollees with diabetes had poorly controlled HbA1c levels, a higher percentage than that of the national average for Medicaid health plans, and a stark contrast to the corresponding 32% of Virginia's commercially-insured patients. Virginia had better than average percentages of patients who, after being discharged from acute care hospitals, reported that they were given information about what to do during their recovery at home, and as well as adults reporting their health-related quality of life in positive terms like "good," "very good," or "excellent." Virginia matched the national average for the percent of adults not accessing care due to cost concerns.⁵ While Virginia may be performing average or well in these metrics, there is still room for improvement. Stakeholders hoping to excel in these areas may look to payment reform as a potential tool to drive better results if implemented successfully.

Overall Impression of Payment Reform Penetration in Virginia

To ground the interviewees in the present, CPR pointed to recent national research showing that 25-50% of payments made to providers include some type of incentive payment based on quality and efficiency,⁶ and asked the interviewees whether this range sounded high, low, about right for Virginia. Matching the Scorecard's quantitative findings, the overwhelming majority of respondents estimated that Virginia's commercial market is on the upper end of this range, but that the range differed across market segments and type of provider. A provider leader summarized the activity and provided additional nuance, "A lot of commercial payers have programs, but the impact on provider payment is tiny. The incentive is a small portion of the total payments." A consultant pinpointed the revenue share of actual incentive dollars at "around 5% at most" for providers. Health plans indicated it is unfeasible to report only the incentive or bonus payments paid through payment reform arrangements ; therefore, the Scorecard on Payment Reform methodology asks health plans to report total dollars paid through payment reform contracts, thereby capturing the base payments plus any incentive, shared savings, or shared risk payments. The Scorecard also includes a metric on use of fee-for-service, which showed that only 1% of value-oriented dollars in the commercial market does not use the fee-for-service architecture. It also includes a composite metric showing what percent of value-oriented payments pose some financial downside risk to providers – in Virginia, only 11% of value-oriented payments in the commercial market placed providers at financial risk, and there were no arrangements under Medicaid that put providers at risk.

"A lot of commercial payers have programs, but the impact on provider payment is tiny." – Provider Leader



⁴ All other payment methods were 0.0%.

⁵ <https://interactives.commonwealthfund.org/2018/state-scorecard/state/virginia>

⁶ http://hcp-lan.org/workproducts/measurement_discussion%20article_2017.pdf

Leaders pointed to the state's market dynamics as the main explanation for the lack of advanced payment reform. According to an academic researcher focused on health care: "There isn't compulsion on the buyer side or the supplier side. The hospital market is carved up - there are 5 big systems that dominate different parts of the state and don't compete with each other. For the insurance market, CareFirst has the north part of the state, and Anthem has the rest." A policy leader for a large employer-purchaser pointed out that the Richmond region is "the only place where you have any dynamic competition." A health plan leader explained further: "One of the barriers to moving forward at the pace that is needed is the environment with the providers. If you're the dominant hospital, you might have an interest, but you don't have any pressure. There may be more willingness from providers in Richmond where there is some competition. Most parts of the states don't have the competition. What is the incentive for providers? Not many providers have a motivator, and so Virginia will be slower than other states in moving away from fee-for-service."

Is Payment Reform Gaining Momentum in Virginia?

Despite these market-driven barriers, most leaders believe that payment reform will continue to grow at its current pace or pick up speed in the Commonwealth. A public purchaser stressed that "continuing fee-for-service is not an option," while a health plan leader shared the view that Virginia "is just in the early stages of payment reform."

CPR followed up by asking the leaders to identify which payment methods might be picking up the most momentum. Notably, leaders identified changes to the physician fee schedule as the payment reform method gaining momentum in Medicaid, citing the Addiction and Recovery Treatment Services (ARTS) Transformation program that went into effect in April of 2017. The program expanded addiction treatment services for all Medicaid enrollees and increased payment rates to providers for these services.⁷ A state health leader delved into the activity around Medicaid expansion, which expanded coverage to an additional 400,000 people, and how the ARTS payment reform strategy in Medicaid could have positive repercussions in the commercial sector: "The payers are moving to capture the increased payments from Medicaid. If [the] Medicaid ARTS program can show cost savings with data, or a net balance of costs with more people being treated, then [the] commercial [market] will see that changing the fee schedule works. Virginia is in the midst of transitioning to a Managed Care Organization (MCO) model, and sometimes the Medicaid division and commercial division of the same insurance company are siloed despite being under the same corporate structure."

The Addiction and Recovery Treatment Services (ARTS) Transformation program provides an example of how changes to the physician fee schedule can be used to improve accessibility and quality of care in Virginia's Medicaid market.

Turning to the commercial market, a large employer predicted the following: "I think [the] commercial [market] will piggy back on what Medicare is doing. There is a growing percentage of Medicare that is at risk, and I think that will grow." Indeed, multiple leaders identified shared risk and other forms of payment reform with financial risk to providers as those with the most momentum. A health plan leader stated, "Shared risk is just an evolution from shared savings. There's more provider interest now that they're comfortable; they are willing to consider the downside." Given the low amount of shared risk activity measured by the scorecards, a finding that echoes a provider leader who said, "It's unlikely that any commercial contracts have gone to risk, and there aren't any risk contracts with Medicaid in Virginia," any growth from the 2016 baseline will represent movement.

Leaders also identified strong interest in pursuing bundled payment, with a state health care leader sharing that "a lot of organizations have requested data to support replicating bundled payment

⁷ <https://www.magellanoofvirginia.com/for-providers/arts-information/>

arrangements." A leader of a health plan shared that they are "looking at a lot of different pilots for bundled payment, trying to figure out where it works best. The obvious place is hip and knee replacements, but we're exploring as many as possible. For bundled payment, payers tend to go out with pilots and then would like to expand in other markets and other facilities." A Medicaid leader shared that, "Maternity is a big part of Virginia Medicaid, so focusing on maternity makes sense, especially through bundled payments." However, a leader from an integrated health system offered a different perspective: "The jury is out for where things will go with bundled payment." This is a statement that ties back to the fact that bundled payment adoption remains very low, not just in Virginia but nationwide, despite its popularity.

Will Payment Reform Improve Health Care Quality in Virginia?

This section of the interview sought to understand if payment reform could enable Virginia to improve the quality of its health care and how. Given that there are myriad ways to define and measure health care quality, CPR asked participants to apply their own definition of quality when responding to the question of whether payment reform can improve health care quality in Virginia. Multiple respondents raised the importance of "incentivizing the providers to target outcomes instead of process," as well as patient-

centered metrics. The vast majority of stakeholders felt optimistic that payment reform can improve the quality of health care in the short term (12-18 months), including one researcher who said: "Smart payment reform can drive providers towards the tremendous opportunity to coordinate or integrate delivery of care in order to improve outcomes and the patient experience." A purchaser leader gave this definition of quality: "Quality care is cost-effective care. While there absolutely is some overtreatment, there is significant undertreatment as well, so I worry more about lack of preventive care. The way we do health care right now is as if we only offered employee development to workers within 5 years of retirement." This idea was echoed by a state government leader who said, "There are two avenues of improving quality: less overuse of unnecessary services, and payment reform that increases use of primary care. A lot of payment methods have potential to influence these two avenues."

When asked which payment methods have the most potential to improve quality, a provider leader stated: "Shared risk is most effective because providers need to have skin in the game in order to do things differently. However, we need to make sure providers are able to control what they are being measured on. I believe in shared savings and not capitation because capitation implies that you pay them and hope that they will get it done. Shared savings implies more collaboration between payer and delivery system - each one has a different skill set. Neither side can achieve the triple aim by itself." Another provider shared a concrete

The Virginia Health Value Dashboard

To understand how well Virginia delivers health value and to determine how best to facilitate action for improvement where necessary, the Virginia Center for Health Innovation created the Virginia Health Value Dashboard in 2017. Funded with ongoing support from the Virginia General Assembly, the Dashboard includes three aims — 1) reducing low value health care, 2) increasing high value health care, and 3) ensuring the Commonwealth has the necessary infrastructure to measure and reward value in health care. The Dashboard ties closely to VCHI's groundbreaking work to measure the occurrence and cost of 42 low value health care services through the use of the Milliman MedInsight Health Waste Calculator utilizing claims data on 5 million Virginians from Virginia's All Payer Claims Database.

Source: <http://www.vahealthinnovation.org/virginia-health-value-dashboard/>

example of payment reform improving quality of care, "In about 3 years of having enhanced clinical protocols in place on antibiotics stewardship, through the use of a HEDIS measure, I've seen how heightened awareness... and knowing how one compares to benchmarks, changes protocols and leads to increased quality scores. Absent payment reform, we would not have seen that pace [of change]." An employer offered another perspective: "A health plan taking pride in its network is the best payment reform. We want more people only going to Centers of Excellence. We also want to pay higher [rates] for primary care. Employee participation is an important lever. We've removed all financial barriers for preventive care like breast cancer screening. Finally, I would encourage plans to look at Medicare's quality metrics instead of re-inventing the wheel."

Indeed, the lack of alignment in quality measurement surfaced frequently as a challenge to using payment reform to improve quality. With this in mind, a provider leader said: "The jury is still out if payment reform can improve quality. Our health system has found that the programs, like the Medicare Shared Savings Program (MSSP), are so complex and filled with so much regulatory burden that sadly, the focus is on meeting regulatory compliance. There's the potential of improving the quality of health care, but there's challenges to focusing on that. For commercial payers, the carriers change what they are looking for every year and makes it confusing. Some measures are moving targets." A leader from a large physician group shared that, "Even if you take the 3 national plans and a working age population – the metrics are all very different. For example, we added a contract on January 1, 2018 which had 25 metrics, and 15 we had never seen before. The number of metrics and metrics themselves vary widely." Another provider leader stressed that "it's the ambulatory care side in particular that has no consistency in quality measures."

Another provider leader added more insight into this problem and pondered Virginia's path forward: "There are too many measures; stakeholders need to focus on where we can get our biggest bang for our buck. The Value Dashboard is Virginia's answer to that. The health systems need flexibility to work on the bigger outcomes, which often take longer to realize. Three-year contracts with annual goals miss the point of what we're trying to achieve. Focusing too much on the specific quality performance goals is a good thing, but it doesn't attack the bigger issues like reducing premature mortality." Accordingly, an integrated health system leader stressed the following: "Payment reform needs to address social determinants of health. As a health care system, we have to be responsible for whether patients are actually getting their prescription, whether they have transportation, whether they have a balanced meal. If a patient gets readmitted due to non-compliance to any of these issues, the hospital won't get compensated for the readmissions." A state health leader contributed further to this idea, saying "there's one or two providers in the Richmond area that are interested in capitation because it gives them the flexibility to care for these patients through innovative methods."

Given these broad ranges of ideas and definitions of quality, it's not surprising that there was no clear consensus as to whether the quality of care will improve in the next 3 years. A Medicaid leader identified the following barrier: "We have struggled with data issues in Virginia in being able to identify the problems we want to solve. Maternity would be a good option because our birth outcomes are not where they should be. The complexity of the current data structure is a non-starter. We need to step back and make it simple before we can actually drive change through a focused and clear manner." A provider leader also brought up data as a challenge: "Data sharing is a critical component. Many ACO's do not have the wherewithal to truly appreciate the over- and under-utilization that affects quality and cost. Sometimes I think payers are measuring the wrong thing. There needs to be more collaboration on what is being measured." Finally, a health care researcher brought it back to the payment arrangement: "The soft shared savings models don't push the quality needle very far. The incentive structure needs to be deeper."

Will Payment Reform Improve Health Care Affordability in Virginia?

Allowing interviewees to define the “affordability” of health care in their own terms, CPR inquired whether leaders believed payment reform could improve affordability in Virginia. For most leaders, affordability centered around cost-savings for the consumer, a goal that leaders felt will be challenging. An employer-purchaser leader shared these thoughts: “Commercial insurers aren't passing their savings along to anybody, they're just using them to increase margins. But self-insured customers could see savings; there's real potential there for self-insured employers to pass savings along.” A provider leader expressed less optimism: “Another mechanism has to be introduced to pass savings down to consumer. Insurers take the savings and/or providers receive it. Brokers do not see any of the cost savings being passed along to the self-insured employer or to the patient.”

The ability to improve affordability by tackling waste in the health care system arose multiple times during the interviews. A provider leader stated that, “We know that there is a lot of waste and inappropriate utilization of services. There is also unnecessary administrative burden that providers have to deal with, paperwork that occurs in order for providers to get paid. Payers only deny 2% of the procedures that they review for pre-approval, so that's a lot of waste going on there.” Another leader from the purchaser perspective went further, “Payment reform offers potential to reduce health care waste, but this isn't enough to improve affordability.”

According to the interviewees, there are some viable paths to affordability through payment reform. A state health leader suggested “Payment reforms should increase shop-ability and transparency, which in turn should decrease total cost.” Changes to the physician fee schedule and capitation were identified as the top methods to increase affordability. For example, a provider leader explained that “in theory, changing the fee schedule could translate to the lowering the price of services and increased affordability to consumer, but this assumes that the health plan passes it along.” A leader from an integrated health system suggested various tactics: “Changes to the physician fee schedule to encourage more high-value care could increase affordability. Increased utilization management, a site differential approach, and a narrow network approach will also drive a lot of cost out of the system.”

“The reason to do payment reform is to lower what premiums would otherwise have been. Meanwhile, lowering the co-pays for the care that patients should be receiving is a good way of getting to affordability.” – Health care researcher



The majority of interviewees do not think payment reform will improve affordability in the next 3 years, but that doesn't mean that leaders aren't committed to trying. An integrated health system shared how they are approaching affordability, but on a different timeframe: “We are doing early interventions; we are going into the schools to talk about diabetes prevention. These investments will improve affordability in the long-run. We need to prevent instead of only treating people in the midst of their acuity.” A health plan leader commented that, to achieve better affordability “we would have to get the purchasers into the discussion, like the self-funded employers and the individual consumers. The purchaser voice needs to be better represented.” A health care researcher synthesized with the following: “The reason to do payment reform is to lower what premiums would otherwise have been. Meanwhile, lowering the co-pays for the care that patients should be receiving is a good way of getting to affordability.”

The Role of Network and Benefit Design

With ongoing pressure to lower health care costs and spending, the use of network and benefit design to steer patients toward certain providers is gaining traction nationwide. According to the Henry J. Kaiser Family Foundation's 2017 Employer Health Benefits Survey, employers of all sizes are offering a high-performance or tiered network, and six percent of private purchasers said that they or their insurer eliminated a health system from a network to reduce the plan's cost during the past year.⁸ The popularity of tiered networks, along with their more limited counterpart - narrow networks - are an economic signal that purchasers and payers are using to bring down health care costs for the purchaser and consumer.⁹ For this reason, CPR, along with its multi-stakeholder advisory committee for Scorecard 2.0, decided to measure the prevalence of limited network¹⁰ products in Virginia's commercial market. For the purposes of the Scorecard, CPR did not consider tiered networks, in which consumers typically have access to a health plan's broadest network but face different levels of cost-sharing for providers in different tiers, to be the same as limited networks (though it does consider Health Maintenance Organizations (HMOs) to be limited). In 2016, three of the five plans providing data for the Virginia commercial Scorecard offered a limited network product, and 19% of their patient members enrolled in these products, representing 16% of all commercial lives in the Scorecard data.

"Payers have an enormous ability to influence the behavior based on who is in- and out- of the network, and this can effect care tremendously." –Integrated health system leader



Drilling down to understand limited networks in the Virginia context, CPR heard the following perspectives. A provider explained that, "for payers, a limited network presents a trade-off between driving volume to certain providers in order to get a steeper discount. When we talk to employers in the market, they say that there's no desire to limit choice for employees because it creates noise." One employer illustrated that "Virginia has only 3% unemployment, so talent competition makes limiting [provider] options a non-option." Meanwhile, a consultant familiar with the purchaser perspective explained that, "We are seeing a lot of limited network activity in the individual market, where decisions are driven by price."

A few leaders raised the issue of network adequacy. A state leader shared: "I'm supportive of insurance companies choosing to credential a limited set of providers as long as there is network adequacy, but I don't define network adequacy in the same way that health plans do. I think these products should only be offered in high population density areas. It gets tricky when you drill down to how insurance companies measure the quality of care of providers." A benefits consultant also questioned the quality aspect of narrow networks: "Health plans say these are driven by quality, but really these networks are price-driven. Health plans seem to be choosing the reasonably priced physicians and drawing a line in the sand to separate them from the others."

⁸ <https://www.kff.org/report-section/ehbs-2017-summary-of-findings/>

⁹ <https://www.healthaffairs.org/doi/10.1377/hblog20180208.408967/full/>

¹⁰ CPR defines a limited network as a network of contracted providers that has fewer providers (hospitals, specialists and/or PCPs) than the health plan's broadest network.

That said, an integrated health system leader made a call to action for health plans to use network design to drive quality: "Payers have an enormous ability to influence the behavior based on who is in- and out- of the network, and this can effect care tremendously. Payers need to get more involved in excluding these bad providers. The system can be short-sighted in this regard - the system can identify the poor clinical judgement, but [payers] don't pay attention to it because it doesn't affect them short-term."

Conclusion

The Commonwealth's employee health benefits program

Referred to as a "bright light" by a leading health care researcher, the state employee health benefits program has taken innovative steps, including a Value-Based Insurance Design program for members with diabetes; a bariatric surgery education program; the Healthy Beginnings maternity management program; and the introduction of online doctor visits and a near-site clinic located in downtown Richmond, to improve quality of life and cost of care for its 99,000+ members,

Source: Department of Human Resource Management, Health Benefits Annual Report, Fiscal Year 2017.

The unique dynamics of Virginia's health care market will continue to shape the future of payment reform efforts. Reflecting at the end of the interviews, leaders offered their different perspectives: A large employer emphasized that "this is a bipartisan effort; keeping it bipartisan is very critical." Beyond partisanship, a health plan leader noted: "Having all of the constituents come together with a single voice is the only way to exert pressure on these dominating players, the systems that have acquired physician resources and have a lot of clout in the market." Sticking with the theme of hospital consolidation, a leading health care researcher noted that "The structure of the market dominance protects the status quo. Given all that, the fact that Virginia's costs are not as high as the national average creates a lack of urgency toward payment reform; to counter-veil the market power it has to come from the state or the government. The state employee plan is very progressive and has done innovative things. They are a bright light."

Regarding the Medicaid market, a Medicaid leader pointed out that Virginia has "a lot of dual eligible Medicare/Medicaid enrollees. We should be focusing on value-based payments with this

population. A lot of the outcomes for Medicare drive Medicaid costs. This is a struggle that the state needs to get a handle on." Another leader from a multi-stakeholder group also identified an opportunity in working within the Medicare Advantage framework: "The payers are stopping the momentum towards capitation. Once the providers are able to manage risk in a capitated way, they are going to take the business from the health plans. Growth of Medicare Advantage plans is going to be the place where we see providers going into the payer space in Virginia, and this will move the market. The aging of the population also accelerates this process."

Reflecting on how far Virginia has come, a hospital director offered a dose of optimism, "The state of the conversation in Virginia is very different now than it was 5 years ago; it's in a better place. Everybody is looking for a path to change. You may hear that things are slower than they should be, but we also haven't had in any financial catastrophes in the state." With a 2016 baseline of payment methods and the perspectives of a diverse set of leaders in hand, Virginia will continue its journey to create a strategic path forward to control health care spending and improve the quality of care for all Virginians.