

November 2017

Executive Summary

In late March 2017, the Robert Wood Johnson Foundation's State Health and Value Strategies (SHVS) program convened a meeting of public employee purchasers from multiple states to share strategies and learnings to promote value through their purchasing and benefit design work. The meeting participants described innovations in three areas: value-based payment; incentivizing selection of high-value providers; and incentivizing use of high-value services.

This brief provides an overview of these areas of value-based innovation and then affords a deeper examination into specific examples of state employee purchaser activity in California, Connecticut, Massachusetts, Minnesota, Tennessee, and Washington. Some, but not all, of these states include local public employees and manage health benefit programs that are collectively bargained. Despite their differences in size and scope, these state health care purchasers found they could learn much from their colleagues in other states as they strive to improve the value of care on behalf of public employees, their dependents, and local taxpayers.

I. VALUE-BASED PAYMENT

Episode-Based Payment

Leading state employee purchasers are engaged in innovative work involving new value-based payment models, including episode-based payment and population-based payment. Tennessee and Washington state employee purchasers have implemented very different episode-based payment models. Tennessee's State Group Insurance Program (SGIP) pursued episode-based payment as part of a coordinated purchasing strategy across state agencies separately responsible for state employee and retiree benefits, and for the Medicaid program. The initial five episodes that SGIP launched in 2017 included:

- > Perinatal (maternity) care;
- > Total joint replacement (hip and knee);
- > Colonoscopy;
- > Cholecystectomy; and
- > Percutaneous coronary intervention (i.e., angioplasty with a stent).

In contrast, Washington initially pursued an episode-based payment model for only one procedure, total joint replacement, and has done so independently of Medicaid. Washington pursued episode-based payment as part of a "center of excellence" strategy, selecting centers of excellence based on their ability to meet established quality criteria as well as cost. More detail on these episode-based payment programs is available here for [Tennessee](#) and [Washington](#).

Population-Based Payment

With rare exception, private employers do not enter into population-based payment arrangements for their population alone because they lack sufficient population size with specific providers for such an arrangement to be attractive to, and statistically feasible for providers. State purchasers, however, often have adequate size and population concentration (especially near state capitals) to make such an approach viable. California and Washington have both pursued such a strategy, and in both cases, started slowly with just one or two Accountable Care Organizations (ACOs).

In California, the Public Employees' Retirement System (CalPERS) developed a shared savings and shared risk arrangement with a Sacramento-based ACO in 2010. The Public Employees Benefits Board (PEBB) Program in Washington established an accountable care program for state employees and non-Medicare retirees in 2016. More detail on these state employer population-based payment programs is available here for [California](#) and [Washington](#).

II. INCENTIVIZING SELECTION OF HIGH-VALUE PROVIDERS

There is substantial variation in physician practice patterns within and across regions, resulting in differences in the cost and quality of health care. A number of states, including Massachusetts and Minnesota, have created innovative value-based insurance design benefits aimed at helping employees and dependents seek care from higher value providers.

The Massachusetts Group Insurance Commission (GIC), introduced tiered networks to state employees and dependents based on efficiency and quality metrics obtained from a large database. Enrollees in the tiered network plan had variable co-pays of \$30/\$60/\$90 in state fiscal year 2016 based on their selected specialist. An evaluation of the effects of tiered physician networks found that while there was a fair amount of physician loyalty, physicians in the most expensive tier lost market share.¹ The GIC also introduced a limited network plan in which high-cost providers were excluded from the network. Another evaluation found substantial savings with no difference in quality of care compared to open network plans.

Like Massachusetts, the Minnesota State Employee Group Insurance Program (SEGIP) also uses tiered networks where member cost-sharing varies based on a provider cost-based tiering system. In other words, the lower the provider cost tier, the lower the rate of cost-sharing for employees and dependents seeking care at those provider sites. In addition to influencing member behavior, Minnesota found tiering was a powerful incentive for providers to be categorized in lower-cost tiers. Providers can negotiate more favorable tier placement by accepting unit price reductions or entering a shared savings or shared risk arrangement with SEGIP. Results have shown that about 90 percent of SEGIP members chose providers in the lowest two (out of four) tiers and about 15 percent of members chose providers that had negotiated a more favorable tier placement. More detail on these programs to incentivize use of higher-value providers is available here for [Massachusetts](#) and [Minnesota](#).

III. INCENTIVIZING USE OF HIGH-VALUE SERVICES

Similar to encouraging the use of high-value providers, health care purchasers are incentivizing their members to use high-value services to reduce wasteful spending on health care treatments that may provide no clinical benefit or may even be harmful. Connecticut's Office of the State Comptroller, which oversees and manages the medical benefits for state employees, launched the Health Enhancement Program (HEP) in 2012. HEP is a voluntary program for employees and their dependents that targets preventive care and chronic disease management by requiring age-appropriate preventive screenings and care; offering lower or no co-pays for medication and treatments for individuals with certain chronic diseases and conditions (e.g., asthma and diabetes); and providing health education. In turn, HEP-participating members pay a lower or no co-pay for certain services, their monthly health insurance premium share is reduced, and their annual deductible is waived. HEP has improved the use of preventive screenings among participants compared to non-participants, reduced emergency department use, and lowered the overall costs of health care by 3.2 percent. More detail is available here for [Connecticut](#).

Conclusion

State employee purchasers are implementing a variety of purchasing and design innovations to promote value, improve care, and be more cost-effective in their provision of health benefits to public employees. All states participating in the SHVS meeting appreciated the opportunity to share value-based purchasing strategies and experiences. By learning from each other, state purchasers can add value for their employees, dependents and taxpayers through better design, implementation and expansion of value-based payment approaches; incentivize the selection of high-value providers, and incentivize use of high-value services.

Detailed State Profiles

CALIFORNIA²

The California Public Employees' Retirement System (CalPERS) has developed a five-year (2017-2022) strategic plan that includes nine initiatives to advance health care affordability by transforming health care purchasing and delivery.³ Among those initiatives is "Shared Savings Accountable Care," a program involving population-based payment to commercial ACOs.

CalPERS began its first shared savings and shared risk arrangement in 2010 in the Sacramento region. A partnership of Hill Physicians Group, Dignity Hospitals, and California Blue Shield approached CalPERS with a proposal to serve 42,000 CalPERS enrollees through a shared savings and shared risk contract that guaranteed CalPERS less than 2 percent annual per member per month (PMPM) growth in associated medical spending over a five-year time period.

The clinical interventions the ACO focused on were hospital care-based. They developed integrated discharge planning, focused on providing care coordination for high-risk individuals, emergency department utilization management, and outpatient palliative care, among other activities.

CalPERS recommended that states try to replicate savings calculated by contractors to better understand and validate the findings and implications for future work. CalPERS is still developing an evaluation approach for its Sacramento pilot. In addition, CalPERS reports that more than 20 commercial ACO arrangements exist statewide between CalPERS' two largest plan administrators and provider organizations.⁴

FOR MORE INFORMATION

Contact David Cowling, research scientist at David.Cowling@calpers.ca.gov.

CalPERS at a Glance

- > 1,400,000 covered lives
- > Serving state employees and higher education, local government and local education agencies
- > CalPERS offers six health maintenance organizations (HMOs) and three preferred provider organizations (PPOs) for non-Medicare

CONNECTICUT⁵

In 2011, Connecticut's Office of the State Comptroller, which oversees and manages the medical benefits for state employees, retirees and their dependents, launched the Health Enhancement Program (HEP), a voluntary program for employees and their dependents that utilizes incentives to encourage the use of high-value services. It was created jointly by employees' unions, the Office of Labor Relations and the Office of the State Comptroller to improve health and reduce costs.⁶ The program specifically targets preventive care and chronic disease management. It requires age-appropriate preventive screenings and care, like colorectal, cervical, and breast cancer screenings, and cholesterol screenings. HEP also offers chronic disease management education which is administered by a third-party vendor with a dedicated staff of nurses.

Members are incentivized to participate in the HEP program and utilize high-value services by having co-pays waived for preventive care and chronic disease management. Co-pays for medication for individuals with asthma, chronic obstructive pulmonary disease (COPD), diabetes, hypertension (high blood pressure) and hyperlipidemia (high cholesterol) were lowered, as seen in the table below.

Figure 1. Connecticut Health Enhancement Program (HEP) co-pays.

	HEP Chronic Condition Drugs	Standard Drugs
Generic	\$0	\$5
Preferred	\$5	\$20
Non-Preferred	\$12.50	\$35

*Note: all diabetes drugs have a \$0 co-pay.

The monthly premium share is reduced (\$100 per month), and the annual deductible is waived (\$350 individual, \$1,400 family) for employees who complete all preventive and chronic disease management program requirements. Non-participants, including those who were removed from the program for not completing requirements, are assessed a premium surcharge.⁷

Since employees need to opt in to HEP, the Office of the State Comptroller sought to make enrollment easy to understand and accessible by allowing in-person enrollment, as well as website enrollment. It launched the "Humans of HEP" campaign which shared stories about employees whose lives were saved or changed for the better as the result of HEP. About 98 percent of the 54,000 eligible state employees and retirees enrolled in the program, and 99 percent of HEP enrollees meet the program requirements.⁸

HEP has proven successful, according to the state's study of its results compared to a control group. Colorectal and breast cancer screenings and cholesterol screenings all increased by more than 8.0 percent. Emergency department use was reduced by 1.3 percent. Office visits increased by 1.7 percent—which would be expected as employees are incentivized to seek out care for screenings. Medication adherence improved for diabetes, hypertension, and hyperlipidemia compared to pre-implementation (data for congestive heart failure were not available). Finally, the overall costs of health care were lowered by 3.2 percent.

FOR MORE INFORMATION

Contact Joshua Wojcik, policy director at Joshua.Wojcik@CT.gov.

Office of the State Comptroller at a Glance

- > 210,000 covered lives
- > Serving state employees, retirees and dependents

MASSACHUSETTS⁹

The Massachusetts Group Insurance Commission (GIC) has, for many years, focused attention on how to employ its benefit design to motivate public employees and dependents to seek care from higher-value providers. The GIC has pursued both tiered network and limited network strategies that incorporate data related to provider price, efficiency, and quality.

Tiered Network Plans: The Clinical Performance Improvement Initiative

In 2003, the GIC introduced tiered networks using a claims database built with commercial book-of-business claims submitted by the GIC's six vendor partners. The database, containing claims for almost 2 million lives was used to tier physicians in 17 specialties based on efficiency and quality. The GIC used proxy costs rather than actual prices to specifically eliminate provider price differentials—which are significant in Massachusetts. The GIC has provided reports to the tiered providers to help them identify where they have opportunity to deliver care more efficiently, compared to their peers. Enrollees in the tiered GIC network plan had variable co-pays based on their selected specialists. A program evaluation during a time when the co-pays were \$20/\$40/\$60, found that while there was pervasive physician loyalty exhibited by enrollees, poor ranking resulted in lost market share among new male enrollees and among older and sicker enrollees, suggesting that tiered networking could be an impactful strategy on health care costs over time.¹⁰ Subsequently, the GIC increased the differential between tiers to \$30/\$60/\$90 to increase the incentive for employees to utilize providers in lower tiers.

Limited Network Plans

The GIC began to offer limited network plans in State Fiscal Year (SFY) 2010. High-cost providers are excluded from the limited network. An external evaluation found that the GIC-limited network plans were associated with 36 percent lower costs than comparable open network plans, and with no difference in quality of care. In SFY 2011 a three-month “premium holiday”¹¹ enrollment incentive boosted GIC limited network plan enrollment from 19 percent to 30 percent. Enrollment in such plans has plateaued, however, and stands at 33 percent in 2017. A study showed that those who enrolled in these limited network plans saved on average more than \$600 (individual) and \$1,400 (family) due to reductions in both quantity of services used and unit prices paid. In fact, the decrease in spending came entirely from spending on specialists and on hospital care, including emergency department visits. Spending on primary care rose for those GIC employees and dependents who switched during the premium holiday, suggesting that savings were the results of moving care toward primary care and away from downstream services (i.e., specialists and hospital care).

GIC at a Glance

- > 436,000 covered lives
- > Serving state employees and local government
- > Six vendor partners: three fully insured and three self-insured

FOR MORE INFORMATION

Contact Andrew Stern, general counsel at Andrew.Stern@gic.state.ma.us.

MINNESOTA¹²

Minnesota's State Employee Group Insurance Program (SEGIP) is the largest employer purchaser of health care in the state. It has pursued a tiered network based on the total cost of care since 2002. Each year, primary care clinics (PCC) are preliminarily assigned to one of four tiers based on the total cost of care provided to SEGIP members who designated that PCC. The total cost of care includes all paid claims for care, regardless of the source of care, or treatment provided. The total cost of care is adjusted to take into account high-cost outliers (costs greater than \$200,000 are excluded) and population health risk, and is adjusted to reflect increases in prices for the upcoming plan year. SEGIP communicates the initial tier assignment with the PCCs, while also providing information on each PCC's cost performance by service category compared to other providers, and information on referral patterns.

In addition to influencing member behavior, Minnesota found tiering was a powerful incentive for providers to be categorized in lower-cost tiers. Providers can negotiate more favorable tier placement by accepting unit price reductions. Alternatively, providers can enter into a risk-sharing agreement where they are placed at risk based on their efficiency performance against a target. If the provider is able to beat efficiency targets it can share in a portion of the savings, contingent upon its quality scores. About 15 percent of SEGIP's members seek care from clinics that negotiated a more favorable tier placement. Finally, labor contracts with the state guarantee a clinic at or below the second tier within 30 miles of every worksite. As a result, some tier reassignment occurs to comply with labor contracts.

Results have shown that 90 percent of SEGIP members choose clinics in the lowest two tiers, and there is significant member movement in response to tier changes. A rigorous study of the effects of tiering on behavior change of employees and providers is forthcoming.

Looking ahead, SEGIP is working to improve its model and increase the impact of its value strategy. With regard to risk-sharing arrangements, SEGIP is considering expanding its use with providers, even for those in the lower cost tier, and is working to align the risk-sharing model with commercial and Medicaid payers. SEGIP is assessing the potential for other strategies, including reference pricing, bundled payment and centers of excellence. It is also building its analytical capacity to better monitor cost, quality and impact of strategies.

FOR MORE INFORMATION

Contact Galen Benshoof, assistant director in the Employee Insurance Division at Minnesota Management and Budget at Galen.Benshoof@state.mn.us.

SEGIP at a Glance

- > 150,000 covered lives
- > Serving state employees and local government
- > Three third-party administrators (TPAs)

TENNESSEE¹³

Tennessee’s State Group Insurance Program (SGIP) has pursued episode-based payment as part of a coordinated purchasing strategy across state agencies separately responsible for state employee and retiree benefits, and for the Medicaid program.

The Tennessee Health Care Innovation Initiative was launched by Governor Bill Haslam in 2013. While driven by a federal Medicaid grant, the initiative includes the commercial market. The Medicaid program (“TennCare”) implemented 20 episodes between 2013 and 2017, with 14 more in development in 2017. SGIP rolled out episode-based payment after Medicaid had initiated episodes and focused on a subset of episodes that made the most sense for SGIP. Considerations of which episodes to implement included the specific interface with SGIP third-party administrator (TPA) services (pharmacy and behavioral health care are carved out) as well as historical service volume in SGIP, spending level and cost variation across providers for the potential episodes.

The initial five episodes SGIP implemented in 2017 included:

- › Perinatal (maternity) care;
- › Total joint replacement (hip and knee);
- › Colonoscopy;
- › Cholecystectomy; and
- › Percutaneous coronary intervention (i.e., angioplasty with a stent).

SGIP at a Glance

- › 276,000 covered lives
- › Serving state employees and higher education, local government and local education agencies
- › Two third-party administrators (TPAs)

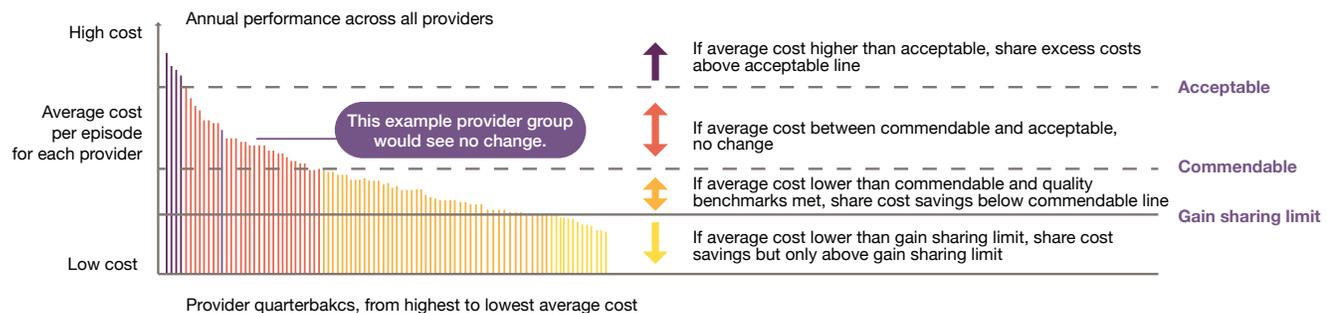
SGIP’s TPAs pay network providers delivering these services using a retrospective episode method, consistent with Tennessee’s Medicaid approach. Principal accountable providers (a.k.a. “quarterbacks”) are paid on a fee-for-service basis. Following completion of the episode, incurred SGIP costs are retrospectively reconciled against the episode thresholds to assess provider performance. Final financial settlements with accountable providers are made during the next calendar year.

Providers can earn a share of SGIP’s savings if average cost per episode falls below a threshold, and must repay SGIP if the average episode cost is above another threshold. While the TPAs are given discretion to set the threshold values, they use common quality measures and the provider’s ability to retain savings is contingent on acceptable quality performance. The TPAs are also employing the methodology with some of their other Tennessee commercial businesses.

Perinatal care and total joint replacement were the first two SGIP episodes implemented, and represented \$60 million in annual SGIP spending (2016) and a potential for almost \$3 million in annual savings.

Tennessee reported early episode-based payment implementation bumps in the commercial market, with some providers objecting to the risk provision. As a result, SGIP allowed providers to defer the shared savings/shared risk provision until 2018 to allow the state and its TPAs more time to work with affected network providers. Subsequent to the March 2017 SHVS convening of public employers, Tennessee reports that SGIP has moved to a voluntary, rewards-only program, while the Medicaid program remains a required shared savings/shared risk program.

Figure 2. This figure illustrates how the episode-based program works in Tennessee Medicaid.



FOR MORE INFORMATION

Contact Laurie Lee, executive director benefits administration at Laurie.Lee@tn.gov.

WASHINGTON

*Episode-Based Payment*¹⁴

Washington pursued episode-based payment as part of a “center of excellence” strategy, selecting centers of excellence based on their ability to meet established quality criteria from the Bree Collaborative¹⁵, as well as cost.

The Public Employees Benefits Board (PEBB) program procured a provider to contract as its total joint replacement (TJR) Center of Excellence. Total joint replacement represented \$19 million of PEBB spending in 2013. Fourteen providers responded to what the state referred to as a “high bar”—meeting Bree Collaborative requirements to adhere to specific evidence-based guidelines for the episode, apply shared decision-making with patients, and report patient-reported outcomes. Only one provider fully met the Bree Collaborative quality criteria and was selected as the single Center of Excellence for TJR for the PEBB Uniform Medical Plan (UMP) members.

The TJR episodes in Washington are paid prospectively and the contracted provider assumes full financial responsibility. Washington defined the episode to include pre-surgery visits; surgery; hospital stay; anesthesiology; inpatient rehabilitation services; member parking, transportation and lodging for the member and a caregiver; and a 90-day warranty.

Washington was unable to utilize its TPA to administer the program, which required the ability to process a prospective payment to the provider, but instead procured another vendor solely to administer the episode contract. The vendor sends the member a welcome packet, gathers medical records for the provider, and arranges the surgery schedule, travel, and lodging for the patient and caregiver. The vendor acts like a patient concierge service with personalized assistance. This concierge treatment has been important to patient and family satisfaction and their willingness to travel longer distances to go to the identified center of excellence. This episode-based payment model also includes a financial component for state employees. In addition to getting the extra patient concierge services, the employees are not subject to cost-sharing requirements that might otherwise apply if they obtained TJR from another provider

While Washington implemented the TJR Center of Excellence program on schedule, it encountered challenges. For PEBB staff, publicizing the procurement to providers and explaining what “center of excellence” entailed were more difficult than anticipated.

*Population-Based Payment*¹⁶

The Washington State Health Care Authority PEBB program established “UMP Plus” in 2016. PEBB describes this as an accountable care program for state employees and non-Medicare retirees. Initially established with two provider partners (Puget Sound High-Value Network and University of Washington Medicine Accountable Care Network), PEBB is seeking to achieve three goals with UMP Plus:

- › Improved patient experience;
- › Improved mind and body care; and
- › Financial and clinical accountability.

UMP Plus involves provider network assumption of shared financial risk with financial rewards for cost containment linked to quality performance.

PEBB at a Glance

- › 370,000 covered lives
- › Serving state employees, retirees and dependents
- › Two third-party administrators (TPAs)

Figure 3. Washington State Health Care Authority PEBB UMP Plus program model.

Shared Risk Model	<ul style="list-style-type: none"> > Multi-year trend > Quality model subset of Statewide Core Measure Set > Quality model rewards improvement and target achievement
Member Experience	<ul style="list-style-type: none"> > Timely care > Expanded service hours, dedicated call center and website
Care Transformation	<ul style="list-style-type: none"> > Patient centered medical home and IT requirements > Annual quality improvement plans based on Bree Collaborative > Shared decision-making
Timely Data	<ul style="list-style-type: none"> > Daily inpatient and monthly medical and prescription data feeds on members
Benefit Design	<ul style="list-style-type: none"> > 30% reduced premium from UMP PPO plan > Preventative and in-network primary care visits covered at 100%; mostly specialty and hospital care at 85% > No medical deductible if wellness plan and follow-up completed

What gives special distinction to PEBB’s initiative is a requirement for the UMP Plus networks to emphasize patient-centered medical home status for their primary care practices and for the networks to implement the evidence-based guidelines developed by the Bree Collaborative in the following areas:

- > Total knee and hip replacement;
- > End-of-life care;
- > Obstetrics; and
- > Low back pain and spine fusion.

With 16,000 enrollees in UMP Plus as of January 2017, PEBB is seeking to expand UMP Plus statewide as part of the next open enrollment and more than triple the membership to about 50,000 enrollees. PEBB’s lessons thus far include: learning that building custom provider networks for state employee groups is challenging, and there is significant developmental work required to create necessary data channels that are essential to networks’ delivery of quality care and management of financial risk.

FOR MORE INFORMATION

Contact Marcia Peterson, manager benefit strategy and design at Marcia.Peterson@hca.wa.gov.

Endnotes

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ABOUT STATE HEALTH AND VALUE STRATEGIES — PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs.

The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.statenetwork.org.

ABOUT BAILIT HEALTH

This brief was prepared by Michael Bailit, Megan Burns and Mary Beth Dyer. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.