



Leader Perspectives

on the impact and future of payment reform in New Jersey

A report to accompany the

**2018 NEW JERSEY SCORECARDS ON
PAYMENT REFORM 2.0**

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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 the New Jersey health care market. 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 New Jersey 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 New Jersey, the New Jersey Health Care Quality Institute (Quality Institute) served as the local sponsor 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 sector track payment reform progress, as well as any 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 to achieve the goals of better and more affordable care on a macro-level.

To this point, 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 16 health care leaders across and within four stakeholder groups: academics/multi-stakeholder groups (4), employers, public purchasers and consumers (4), health plans (3), and health care providers/systems (5).

The Quality Institute 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 five months (February – July 2018) by phone with most interviews taking approximately one hour. CPR provided each interviewee with an interview guide describing the project, the methodology, and the 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 the interviews themselves 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 New Jersey's commercial market and one on New Jersey's Medicaid market, both of which showcase how much and what types of payment reform occurred in the Garden State in 2016. Detailed information on the quantitative findings and methodology can be found at <https://www.catalyze.org/product-category/scorecards-report-cards/scorecards-on-payment-reform/>.

Payment Methods – Commercial

The most prevalent value-oriented payment method used in the commercial market in New Jersey in 2016 is shared savings. Thirty-eight percent (38%) 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 11% of payments.

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 FFS+ 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 least prevalent value-oriented payment methods in the commercial market at that time was capitation at 0.0%, followed by partial capitation (0.4%), and bundled payments (0.6%).

Payment Methods – Medicaid

In 2016, the most prevalent value-oriented payment method in New Jersey's Medicaid market was also shared savings. Six percent (6%) of health care dollars flowed through shared savings arrangements. Like the commercial market results, the second most prominent payment method in the Medicaid market was P4P at 4.5%.

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

Macro-Indicators

The quality and affordability metrics in the two New Jersey Scorecards on Payment Reform 2.0 highlight strong points as well opportunities for improvement. Notably, only 52% of commercially-insured patients and 47% of Medicaid patients with a hypertension diagnoses covered by New Jersey health plans had adequately controlled blood pressure (<140/90), and more than a third of patients with diabetes in both commercial and Medicaid New Jersey health plans had HbA1c levels indicating that their blood sugar was not adequately controlled, though almost 9 out of 10 patients with diabetes had at least one HbA1c test in 2016, meaning they were able to monitor their condition to some degree. New Jersey had worse than average rates 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 percent of adults reporting fair or poor health.⁵ Payment reform has the potential to improve these results if implemented successfully.

Overall Impression of Payment Reform Penetration in New Jersey

To ground the interviewees in the present, CPR pointed to recent national research showing that 25-50% of payments made to providers includes some type of incentive payment based on quality and efficiency,⁶ and asked the interviewees whether this range sound high, low, or about right for New Jersey. Matching the Scorecard's quantitative findings, the overwhelming majority of respondents expressed that the range sounded high or about right. A few interviewees pointed out that the range differed across market segments and type of provider. One leader of a healthcare organization concluded, "hospitals and primary care providers are in the higher range, whereas specialists are in the lower end. We are lagging when it comes to Medicaid payments. Medicare shared savings and self-funded payment reforms are ahead of the game." Indeed, 37 accountable care organizations are registered as servicing New Jersey through the Medicare Shared Savings Program (MSSP) in 2018, although measuring the payment reform penetration in the Medicare line of business is beyond the scope of this project.⁷

Why the slow start to the payment reform journey? According to a health plan leader, "Something super unique about New Jersey is that five years ago, we had more independent physicians than any other state in the country. We still have a significant number of family medicine providers that are delivering patient-centered care but not through value-based arrangements." This is not necessarily the case on the facility side with prominent hospitals joining forces in the last few years. In fact, Kerry McKean Kelly, vice

⁴ All other payment methods were 0.0%.

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

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

⁷ <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2018-Medicare-Shared-Savings-Prog/>

president of communications of New Jersey's Hospital Association was quoted in local media in 2017 in response to news of Barnabas Health and Robert Wood Johnson Health System merging into RWJ Barnabas Health System that New Jersey has "about 80 percent of the state's hospitals now part of a multi-hospital system."⁸ What does this mean for the future of payment reform? A health care researcher summarized the predicament, saying, "lots of consolidation among hospitals prepares them for risk-bearing. However, the fact that they're bigger may make them resistant to change." Only time will tell.



Is Payment Reform Gaining Momentum in New Jersey?

When asked whether payment reform is gaining momentum, there was full consensus that it would continue to grow at its current pace or pick up speed in the Garden State, similar to trends nationwide. A provider leader commented, "every stakeholder expects continued reform, and that's not unique to New Jersey." As it relates to provider consolidation, CPR's interviews captured opposing viewpoints that mergers and acquisitions can both promote or dampen the momentum of payment reform. Drilling down with interviewees on what facilitates payment reform also brought up differing perspectives: some leaders pointed to the Centers for Medicare & Medicaid Services (CMS) as a source of continued momentum, whereas an academic leader predicted that the "uncertainty from federal players means that state players will step up." The change in gubernatorial leadership could also present the opportunity for state players to take a leading role, as a purchaser representative expressed: "New administration, more momentum. The Commissioner of Health, Dr. Shereef Elnahal comes from the Veterans Administration under President Obama and is familiar with contracting and moving forward." Perhaps the most likely arena for accelerated growth in payment reform is in New Jersey's Medicaid program, which one leader noted would see more payment reform due to the "tight budget problems currently." Another leader of a healthcare organization noted that the new Commissioner of New Jersey Department of Human Services, Carole Johnson, worked in the Obama Administration and will be a strong proponent of embracing Alternative Payment Models and modernizing the state Medicaid program and contracts with the health plans. The [Medicaid 2.0 - Blueprint for the Future](#) project carried out by the Quality Institute provides a strong call to action as well as recommendations for a path forward.

CPR followed up by asking the leaders to identify which payment methods might be picking up the most momentum. A majority of the leaders identified bundled payments,⁹ also known as episode-based payments, as the method that has the most momentum. The Medicaid 2.0 Blueprint recommends that "the State should establish demonstration projects around three to five Episodes of Care (EOC) models... including Total Joint Replacement, Maternity, and Cardiac Care,"¹⁰ Additionally, a provider representative cited that "one of the largest health systems in New Jersey wants to move all of their services to bundled payments and will start in oncology." Given that only 0.6% of commercial and 0.1% of Medicaid payments

⁸ <http://nj1015.com/why-hospital-mergers-are-the-new-normal-in-new-jersey/>

⁹ Bundled payment is defined as a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

¹⁰ http://www.njhcqi.org/wp-content/uploads/2017/03/Medicaid-2.0-Blueprint-for-the-Future_3-3-17-1.pdf

flowed through bundled payment in 2016, as shown in the Scorecards, any growth in this method would be significant.

Shared savings was second as the payment method identified by the leaders as likely to pick up momentum. An academic researcher explained that "due to lessons learned in the MSSP program, the shared savings payment model is familiar to a lot of players," thereby explaining its large presence in the commercial market (37.9%) and presence in the Medicaid market (6.1%). Will some shared savings payments transition, or as one leader put it, "switch into shared risk"? A health plan leader explained that while "there's a desire for shared savings and shared risk in the commercial market, some state laws will dampen that movement, specifically the state ODS law - Organized Delivery System statute and rules¹¹," perhaps explaining why few leaders pointed to shared risk as picking up momentum.

Will Payment Reform Improve Health Care Quality in New Jersey?

This section of the interview sought to understand if payment reform could enable New Jersey 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 the Garden State. Multiple respondents raised the importance of patient-centered quality measures, including the use of Net Promotor Scores (NPS) and patient-reported outcomes that correspond to the patient's own pre-determined treatment or health goals. Two health plan leaders gave similar responses when defining quality of care: "Quality of care is patient-centered care (shared decision making), preventative medicine, managing chronic conditions, care coordination," and, "I see *quality* as gaps of care, like, did you have a breast cancer screening?" One stakeholder from a large physician group drew the connection between choosing metrics to focus on and improving quality of care: "It depends on what you're measuring. What I've seen is a lot of quality metrics in health care are just checking off boxes. What's interesting is, if you're able to get certain levels of information, and you focus on the right metrics, you *can* improve the quality of care that patients get."

The vast majority of stakeholders felt optimistic that payment reform can improve the quality of health care in the short term (12-18 months). A purchaser leader spoke about how "with payment reform, tracking quality has changed the mindset of organizations, and they're now documenting the better care that they are providing to patients. [Better care is] not only about outcomes but patient satisfaction as well." Some of the providers we interviewed felt that payment reform would *not* improve quality. One explained that "payment reform is more about cost savings." A purchaser

The Quality Measurement Alignment Report is an answer to "the need for alignment between the quality metrics that each payer uses" raised by a provider leader. Produced by the Quality Institute in 2016, the report harmonized 800 measures into a set of 31 core quality metrics for adults and pediatrics in order to support alignment across several New Jersey and federal quality and efficiency improvement initiatives.



¹¹ For more information on the Organized Delivery Systems Statute from the New Jersey Department of Banking and Insurance, please refer to: https://www.state.nj.us/dobi/pn02_018.htm

leader also thought that payment reform wasn't likely to improve quality: "People are going to do good care whether they are paid for it or not, and bad care will continue to be delivered. Payment reform is making providers do more without getting much out of it." This latter statement identifies a common frustration regarding the time-consuming reporting requirements that accompany many payment reform programs. This sentiment was echoed by an operations leader at large health system who said, "There's the need for alignment between the quality metrics that each payer uses." A few other leaders expressed frustration around what happens after data collection, though a provider leader expressed confidence with the process, stating "Improved reporting is being converted into transparency which in turn leads to action."

One hurdle is knowing what to focus on, and how to get there. A leader from a healthcare organization offered this direction: "Our maternity numbers are not good in terms of C-section rates, and bundled payment could be very effective." New Jersey's 2016 Nulliparous, Term, Singleton, Vertex (NTSV)

Most interviewees felt bundled payment is the payment reform model that holds the most potential to improve the quality of care, and an academic leader commented that this is likely due to its characteristic of "requiring providers to work together," though more evidence is needed to be sure that this payment method can improve quality and reduce spending simultaneously.

Cesarean Birth rate was 28.7%, well above The Leapfrog Group's standard of 23.9%, a figure that supports the claim that maternity care should be an area of focus, as research shows medically unnecessary cesarean deliveries can lead to worse outcomes for mothers and newborns.¹² Most interviewees felt bundled payment is the payment reform model that holds the most potential to improve the quality of care, and an academic leader commented that this is likely due to its characteristic of "requiring providers to work together," though more evidence is needed to be sure that this payment method can improve quality and reduce spending simultaneously.¹³

Shared savings and shared risk received equal support, following bundled payment, as the payment method with the most potential to improve quality. Shared savings already has a strong presence in New Jersey, but shared risk, as discussed previously, only represented 1.9% of total dollars in the commercial sector; there was no spending through shared risk in Medicaid. A provider leader commented that "New Jersey is not a downside risk market yet. But shared risk has the opportunity to get better outcomes because providers are forced to partner together. The way information is delivered to providers is key, otherwise the information just sits on a shelf." Delivering quality information to providers is an important component of both shared savings and shared risk.

An academic researcher made a call to action for a different type of payment reform, saying, "I'm a strong believer in changes to the physician fee schedule. We underprice primary care and other cognitively-intensive services. Changes to the fee schedule could be a straightforward and high-impact change because simple incentives work better than complicated things." A health plan leader laid out what a shift in the fee schedule could look like and how it relates to quality, sharing that they are "talking with physicians to define quality of care... we want shared-decision making; we want providers to be seeing the 10 of the most high-risk patients in a day, and not 30+ patients a day." Changes to the fee schedule would represent what the multi-stakeholder leader called a "huge cultural shift that should continue to happen through programs like the patient-centered medical homes." The magnitude of this type of cultural shift

¹² Curtin, Sally C., Kimberly D. Gregory, Lisa M. Korst, and Sayeedha F.G. Uddin. 2015. "Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data From the Birth Certificate, 2013." *National Vital Statistics Reports* 64 (4).

¹³ <https://www.ajmc.com/contributor/suzanne-delbanco/2018/04/the-current-evidence-for-bundled-payment>

appears to be particularly large in New Jersey because, as the healthcare organization leader further elaborated, "New Jerseyans like to buzz around and see specialists, even going to New York or Pennsylvania to see specialists." The need for cultural shifts and the mixed signals of fee-for-service and pay-for-performance led many of the leaders CPR interviewed to express pessimism towards the notion that payment reform could noticeably improve quality by 2021.

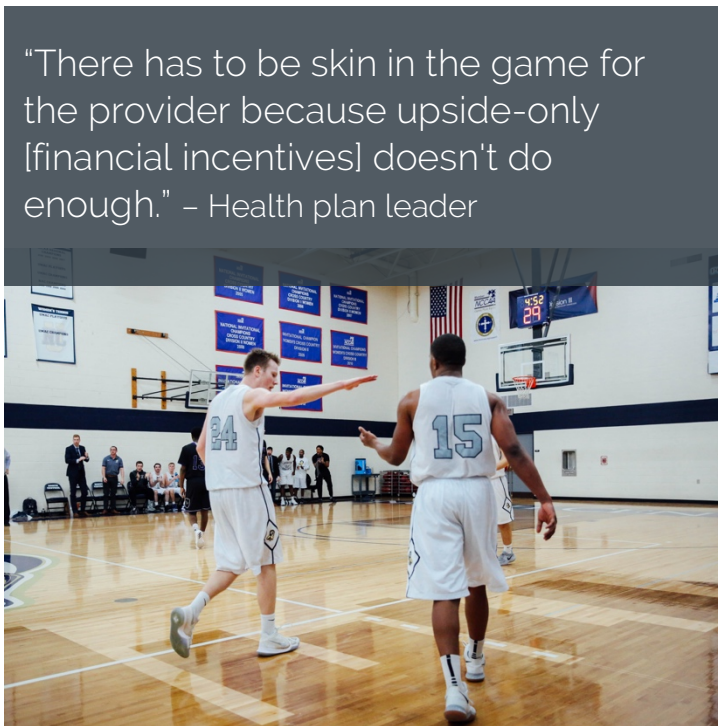
Will Payment Reform Improve Health Care Affordability in New Jersey?

Allowing interviewees to define the "affordability" of health care on their own terms, CPR inquired whether leaders believed payment reform could improve affordability in New Jersey. Most felt that payment reform could improve affordability. One health plan leader said, "For affordability, we focus on the appropriate use of health care dollars - are we avoiding unnecessary procedures? Are we reducing up-coding? Are we utilizing the appropriate site of service, including reducing regulations to allow for greater access?" Ambulatory Surgical Centers (ASCs) often dominate conversations on appropriate site of service and have been shown to lower costs for consumers; leaders mentioned them repeatedly. An academic leader was less optimistic, "I'm less convinced [that payment reform will improve affordability due to my general cynicism that the system [health plans and providers] ends up absorbing the savings; also, improving quality will require more investments." Regardless of the point of view or explanation, leaders agree that the affordability of health care is a huge issue for New Jersey, a state where 13% of the general population went without care due to concerns about cost, placing the Garden State 30th in the nation in this metric.¹⁴

Once again, leaders identified bundled payment and shared risk as payment methods with the best potential to improve affordability. A provider leader explained that, "in bundled payment, the incentives are properly aligned for a lot of pre-procedure effort, which then allows better outcomes because the provider understands the socio-economic context of the patient. It reduces admissions to post-acute rehab; it reduces post-op hospital admissions." In contrast, an academic mentioned that "the incentives [in bundled payment] don't get at the underlying big driver of costs. For instance, a hip replacement bundle doesn't resolve the incentive to do as many hip replacements as possible."

The idea that one health plan leader expressed - "there has to be skin in the game for the provider because upside-only [financial incentives] doesn't do enough" - resonated as a common impetus for selecting shared risk, despite the aforementioned challenges with legal restrictions in New Jersey. The interviewees often saw the different payment methods, including bundled payment, shared risk, and capitation, as points on a spectrum. A healthcare organization leader said that "bundled payments are a building block to shared risk and capitation." The Scorecard on Payment Reform 2.0 includes a metric that aggregates bundled payment, capitation, etc., together as "at-risk" payment methods; New Jersey had 5.5% of value-oriented dollars flowing through these in the commercial market, and 0.8% in the Medicaid market.

"There has to be skin in the game for the provider because upside-only [financial incentives] doesn't do enough." - Health plan leader



¹⁴ <https://interactives.commonwealthfund.org/2018/state-scorecard/state/new-jersey>

A common perspective was that it's not the payment method but the context of the arrangement that has the power to improve affordability. As one purchaser explained, "Direct contracting is the best way to increase affordability because you have a lot more control over what the provider is doing. If the employer has a direct contract, they can push volume." A health plan leader elaborated on this idea and shared some history of bringing interested parties together: "The employer community is not as engaged as it should be. We have sat down with employer groups and large ACOs for all parties to understand how those are set up." With these different perspectives in mind, it's possible that further multi-stakeholder education and strategic planning could expand the role of payment reform in improving the value of each health care dollar spent by employers and consumers.

Looking ahead to three years from now, just about half of the leaders that CPR interviewed thought that payment reform could improve affordability within that timeline, but even they had concerns. For instance, one healthcare organization leader noted, "We could see savings in maternity and end of life costs in isolation," referring to what a purchaser leader described as "a misconception around end-of-life care: people don't know that sometimes hospice care is more appropriate than aggressive treatment at a certain point." On the side of those who were pessimistic, an academic pointed out that, "costs keep rising. You can shave a tiny bit off the point of increase, but it won't be noticed by the consumers." Consumers could notice cost savings through steerage toward higher-value providers, a move that requires transparency around options and consumer engagement. In explaining a yes vote for this question, an academic leader referenced a company in New Jersey that will actually pay employees to go to one doctor over another. While related, steerage programs fall into what is known as network and benefit design, an area that experts agree requires as much attention as payment reform. And in order for consumers to make informed choices about providers in tiers, they need price and quality information. Delivering such information to consumers is something the commercial health plans that responded to the survey appear to have invested efforts into, with three out of the three health plans providing online member support tools with customized price information, customized quality information, and featuring treatment option decision support as well.

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.¹⁵ 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.¹⁶ For this reason, CPR along with its multi-stakeholder advisory committee for Scorecard 2.0, decided to measure the prevalence of limited network¹⁷ products in the New Jersey commercial market. For the purposes of the Scorecard, tiered networks in which consumers typically have access to a health plan's broadest network but providers are placed into tiers with different levels of associated consumer cost-sharing, are not limited networks; however, Health Maintenance Organization (HMO) products are. While two of the three plans providing data for the New Jersey commercial Scorecard offered a limited network product in 2016, only 1.6% of their patient members enrolled in these products, representing only 0.42% of all commercial lives in the Scorecard data.

¹⁵ <https://www.kff.org/report-section/ehbs-2017-summary-of-findings/>

¹⁶ <https://www.healthaffairs.org/doi/10.1377/hblog20180208.408967/full/>

¹⁷ 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.

New Jersey's low enrollment in limited network products is in contrast to the uptick of limited networks nationally. State regulations present one reason for the low enrollment, as a purchaser leader pointed out: "The self-insured side may have more flexibility around limited networks, but New Jersey regulation makes it very hard to create limited networks, and regulators aren't interested in allowing these to happen." Another potential explanation is that while the products may technically be offered by health plans to their self-funded customers, not all employers choose to offer such products to employees, a nuance not captured by CPR's quantitative survey. A healthcare organization leader explained that "New Jersey is not receptive to limited networks, that's why tiering was so controversial. Everyone is concerned about if enrollees want to see a provider in New York or Pennsylvania. Some employees in New Jersey are highly skilled and compensated and view their access to certain hospitals as part of their benefits package." New Jersey's location bordered by prestigious out-of-state academic medical centers creates market dynamics that appear to dampen enthusiasm for limited network products.

Anyone familiar with New Jersey's health care industry will immediately understand the reference made by the healthcare organization leader to "controversial" tiering. Horizon Blue Cross Blue Shield NJ, the health plan with the greatest market share in the Garden State, faced backlash and litigation when it introduced the Omnia plan in 2016, a tiered network plan with consumer co-pay cost differentials for Tier 2 versus Tier 1 providers.¹⁸ Another purchaser leader provided additional context: "The Blues plan has traditionally had large networks, and the Omnia product created some hiccups where providers get left out of Tier 1. [The] jury is still out on whether these networks will improve value."

The value question stated above is important, given CPR's 2017 research finding that health plans typically do not use provider quality as the starting point to create "high-value" networks,¹⁹ a phenomenon confirmed by an integrated health system leader who stated that providers offer discounts to health plans in return for tiered or limited networks "driving more volume through your organization." Another provider leader gave a perspective: "As a specialist group, we welcome narrow networks. We are lucky enough to have that value-proposition that plans are bringing us into the narrow networks."

Leaders were generally favorable toward limited and tiered networks. A provider leader provided a persuasive analogy: "I can't think of any other industry where you need to have every single option available to consumers. If you're Best Buy, you don't have to have every type of television for sale at the store, so why do you have to have every provider in your network?" New Jersey regulation is in place to protect consumer access to providers, requiring that, "for the Omnia network, each network tier individually had to meet network adequacy regulation," as a purchaser leader explained, going on to add that "it's a balance because people have been complaining about the cost of health care but are resistant to ideas like this that can bring the costs down." Enrollment in limited network products in the commercial market may grow in the future, especially in the arena where they are most prevalent: the individual health insurance market. In August 2018, CMS approved New Jersey's 1332 State Innovation

"I can't think of any other industry where you need to have every single option available to consumers. If you're Best Buy, you don't have to have every type of television for sale at the store, so why do you have to have every provider in your network?" – Provider leader

¹⁸ Susan K. Livio "Backlash over Horizon's OMNIA health plan drives lawmakers to push tougher rules" NJ Advance Media for NJ.com. April 4, 2016.

https://www.nj.com/politics/index.ssf/2016/04/omnia_backlash_drives_lawmakers_to_push_for_more_c.html

¹⁹ <https://www.healthaffairs.org/doi/10.1377/hblog20180208.408967/full/>

Waiver Request to create a state reinsurance program.²⁰ Policymakers expect to lower premiums by approximately 15% and strengthen the prospects of New Jersey's individual health insurance market. The individual market, which CPR includes in its definition of the commercial market, is where limited networks are most common because "consumers there are very price sensitive," as an academic leader explained. Governor Murphy's state-based individual mandate law, the second in the nation, also provided a stabilizing force to the New Jersey exchange for years to come.²¹

Conclusion

The unique dynamics of New Jersey's geographic, regulatory, and political landscape will continue to shape the future of payment reform and the health care market. In closing comments, leaders offered the following notable perspectives. A provider leader stated, "There's an interest among all stakeholders in New Jersey to put in place things that are working well in other places," implicitly reinforcing the need for more evidence from payment reform programs nationally. A health plan leader ended with the importance of aligning payment reform and benefit design sharing that "the first question ACOs ask when we talk about going to [financial] risk is 'who are we going to risk for, and what is their benefit design?'" In other words, providers in the ACO want to ensure that if they are taking on financial risk, they understand who is in their patient population and that the members of that population have benefit design incentives to seek care from the ACO. Another necessary milestone to advance shared risk, the payment reform program that a majority of leaders identified as having strong potential to increase quality and affordability, will be increasing provider readiness for shared risk arrangements, as the same health plan leader commented: "I think there are *only* two provider groups in New Jersey that are *ready* to go to risk. The rest are not clinically integrated enough; there is too much of a disconnect between the ACO and what goes on in their hospital." To resolve this disconnect would likely require improving data sharing capabilities and putting systems in place to change how care is delivered, something that recent research shows is not happening as fast as expected due to the fact that at-risk payment arrangements do not constitute a large enough proportion of provider revenue to provide the business case for such investments. Nevertheless, benefit design alignment plays a role toward building provider readiness, not just for shared risk but for all payment reform programs, including bundled payment, which was identified as having both the most momentum and potential to deliver on its promise of improving quality and affordability.

Regarding the Medicaid market, the future may lessen the differences between payment reform penetration in the commercial and Medicaid markets. The Medicaid 2.0 Blueprint for the Future aims to modernize Medicaid and calls for programs like bundled payments and patient-centered medical homes (PCMH). It's clear that strategic action is top of mind for New Jersey's health care leaders. A purchaser leader closed with a warning: "We have a really low, old fee-for-service fee schedule. An office visit for Medicaid is reimbursed at \$11 dollars per visit. Unless we raise the salaries for primary care physicians, we will lose workforce due to the high cost of living." Such an individual may support Patient Centered Medical Home (PCMH) models that advance the use of primary care services, a model included in the Medicaid 2.0 Blueprint's list of recommendations. A leader familiar with the Medicaid 2.0 Blueprint noted that the PCMH model being considered by policymakers would follow Washington State's successful approach.²²

²⁰ State of New Jersey Department of Banking and Insurance, "Announces Federal Approval of Section 1332 State Innovation Waiver to Create Reinsurance Program." Press release. August 16, 2018.

<https://www.state.nj.us/dobi/pressreleases/pr180816.html>

²¹ <http://www.nispotlight.com/stories/18/05/31/murphy-signs-law-to-create-nj-s-own-health-insurance-mandate/>

²² <https://www.pcpcc.org/initiative/health-homes-washington-state>

With a 2016 baseline of payment methods and the perspectives of a diverse set of leaders in hand, New Jersey will continue on its journey to create a strategic path forward to control health care spending and improve quality of care for all New Jerseyans.