Utilizing State Purchasing to Advance Delivery System and Payment Reform in Managed Care Networks

*Health Plan Contracting: Do’s and Don’t’s*

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Why focus on health plan contracts?

- Contracted health plans oversee and administer health care services provided to most state residents, including for Medicaid.
- State purchasers have an opportunity to use procurements to accelerate delivery system and payment reforms, thereby improving the quality and value of health care services.
- No other purchaser has the market influence of the state for most providers.

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1. Assume plans will advance payment reform on their own (*laissez faire*)

2. Define a vision and specify desired outcomes, but give plans flexibility to determine how they achieve those outcomes (Field of Dreams)
Five Strategic Options

3. Require, incentivize and/or sanction implementation of new provider payment models, but don’t specify which payment model(s) or how implemented (carrots and sticks)

4. Specify specific models/options and timelines (VBP)
Five Strategic Options

5. Work directly with providers on reform, and then require plans to adopt the established reform(s) (work around)
Value-Based Purchasing Cycle

1. Specify what to buy (RFP) and select the best contractor(s)
2. Measure
3. Identify opportunities for improvement
4. Set improvement goals
5. Collaborate to improve
6. Remeasure
7. Apply incentives/disincentives

Value-Based Purchasing
Six Key State Purchasing “Do’s”

1. Use RFPs to identify plans that have experience and/or will be willing partners in advancing care delivery and payment reform.

2. Contract with plans that commit to specific requirements for advancing alternative payment arrangements with their network providers.

3. Give plans leverage with the delivery system to advance care delivery and payment reform, if appropriate.
Six Key State Purchasing “Do’s”

4. Consider options for regulatory leverage to advance payment reform through commercial insurers.

5. Encourage plan actions to increase transparency of quality [and cost] information.

6. Align performance measurement across purchasers
# 1 Do

Use RFP to identify plans that have experience and/or will be willing partners in advancing care delivery and payment reform.

- TN Medicaid asked bidders to:
  - describe experience implementing innovative payment methodologies
  - how, and at what pace, the plan would spread PCMH and episode-based payments to other business
# 2 Do

Contract with plans that commit to specific requirements for advancing alternative payment and delivery models with network providers.

OR’s employee health benefit RFP asked bidders:

• how much money they were willing to put at risk if agreed-upon PCMH benchmarks were not met
• would they commit to a limit on growth of health care costs to less than 4%?
OR’s Coordinated Care Model Purchasing Framework suggests the following plan RFP and contract requirements:

- Annually increase the number of covered lives paid under a population-based contract with shared savings, and with risk sharing
- Evaluate and implement payment approaches designed to cut waste and not diminish quality
- Support PCMHs or similar transformation, ensuring that the level and method of compensation support an effective primary care infrastructure.
# 3 Do

Gives plans leverage with the delivery system to advance care delivery and pay for outcomes, if appropriate.

- Limit the number of contracted plans in a state or region to give each plan more covered lives and more leverage with providers.
- Require poorer financial opportunity be afforded to providers who chose not participate in plan alternative payment model contracts.
Consider options for regulatory leverage to advance payment reform through commercial insurers.

- RI’s strategy to advance payment reform includes regulatory standards to which health insurers must adhere as a condition of having commercial premiums approved, including:
  - hitting annual targets for PCMH spread
  - hitting annual targets for increased use of alternative payment models
# 5 Do

Encourage plan actions to increase transparency of quality [and cost] information.

- Vermont law requires collection of data on residents from commercial health insurers, self-insured and publicly insured health benefit plans, and Vermont's Medicaid program.
- The Vermont Blueprint has used the data to create profiles of practice and regional performance that can be used for rewarding PCMH performance and identify PCMH and ACO opportunities for improvement.
#6 Do

Align performance measurement across purchasers.

• Strengthen performance measurement alignment across purchasers to ease the burden of reporting for providers and establish a more accurate picture of health and performance outcomes.

• Washington convened a large, diverse set of stakeholders in 2014 and adopted an aligned measure set that can be used in contracts with PCMHs, hospitals and ACOs.
Four Key State Purchasing “Don’ts”

1. Do not equate policies or contractual requirements with compliance.
2. Do not rely on vague RFP or contract language.
3. Do not underestimate the need for staff training at the state, health plan and provider levels to achieve results.
4. Do not underestimate the demanding role of the state purchaser in measuring and supporting health plans in achieving the contractual objectives.
The Robert Wood Johnson Foundation’s State Health and Value Strategies (SHVS) published a set of 3 briefs and tools for states focused on advancing delivery and payment reform in managed care provider networks.


SHVS & CHCS will host a webinar on this topic in June.
Bailit Health Purchasing authored a brief for AcademyHealth on state purchaser value-based purchasing.

The brief can be accessed at: [www.statecoverage.org/node/2339](http://www.statecoverage.org/node/2339)