State Strategies for Leveraging Purchasing Power

Introduction
On April 21 and 22, 2015, the National Governors Association held a two-day meeting of state officials to discuss how states are transforming their health care systems. This paper provides an overview of the session focused on leveraging state purchasing power to advance payment and delivery system reform, which featured a presentation and associated panel discussion among state and federal officials and other national experts.

Key Goals
The goal of the session was to outline specific purchasing strategies and share several states’ initiatives and implementation experiences.

Challenges, Strategies, and Solutions
State purchasers of health care (through Medicaid programs, state employee health benefit programs, and health insurance marketplaces) have significant market influence. As a result, they have an opportunity to leverage their purchasing power to accelerate payment and delivery system reform. States face a continuum of options, ranging from leaving the responsibility to health plans to dictating desired outcomes in managed care contracts. Panelists discussed the following options:

- **Use requests for proposals (RFP) to identify plans that have experience and would be willing partners in advancing care delivery and payment reform.** Tennessee’s Medicaid managed care RFP asks bidders to describe their experience implementing innovative payment methodologies and how they would expand a patient-centered medical home (PCMH) model and episode-based payments to other lines of business.

- **Contract with plans that commit to specific requirements for advancing alternative payment arrangements with their network providers.** Oregon requires its coordinated care organizations to demonstrate certain metrics such as annual increases in the number of individuals covered under contracts with shared savings and support of PCMHs or similar models to ensure the level and method of compensation supports an effective primary care infrastructure.

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**Tennessee**: Tennessee’s episode-of-care model rewards providers for the delivery of high-quality and efficient care. Episode-based payment applies to most procedures, hospitalizations, and acute outpatient care, as well as certain treatments for cancer and behavioral health conditions. Tennessee’s request for proposals for Medicaid, the Children’s Health Insurance Program, and state employee benefits requires that plans include other books of business in this payment initiative.

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2 Panel participants include Heather Howard, Robert Wood Johnson Foundation; Michael Bailit, Bailit Health Purchasing; James Golden, Centers for Medicare and Medicaid Services; Darin Gordon, Tennessee Department of Finance and Administration; Carolyn Ingram, Molina Healthcare; Nathan Johnson, Washington Health Care Authority; and Nathan Moracco, Minnesota Department of Human Services.
• **Give plans leverage to advance care delivery and payment reform.** States could limit the number of contracted plans in a region to give plans more covered lives and more leverage with providers, or they could limit financial opportunity for providers who do not participate in alternative payment model contracts.

• **Consider regulatory options that advance payment reform through commercial insurers.** Rhode Island requires health insurers, by regulation, to hit annual targets for market penetration of PCMHs and increased use of alternative payment models as a condition of commercial premium rate approval.

• **Encourage plan actions to obtain quality and cost information.** Vermont requires collection of data on residents from commercial health insurers, self-insured and publicly insured health benefit plans, and the state’s Medicaid program.

• **Align performance measurement.** Washington convened a large, diverse set of stakeholders in 2015 and adopted a set of aligned measures that can be used in state and plan contracts with PCMHs, hospitals, and accountable care organizations (ACOs).

**Minnesota:** Building on existing integrated health partnerships (Medicaid provider shared risk arrangements, Medicare, and commercial accountable care organizations), Minnesota is implementing a statewide accountable health model. Through that model, Minnesota seeks to align initiatives and resources across multiple payers to promote patient-centered, coordinated care.

Panelists offered some points of caution for states, such as recognizing the need for active management, using specific language, and dedicating appropriate resources. They also noted the following critical lessons learned:

• **Lay important groundwork.** Engage with stakeholders and ensure adequate preparation and training for providers, health plans, and state staff.

• **Be flexible in the approach.** Use a mix of strategies and adapt for specific geographic needs (for example, expectations could be different for urban versus rural areas).

• **Phase in implementation.** Consider starting initiatives on a voluntary basis to allow the state to gain experience to allow for missteps and for stakeholders to become familiar with the initiatives.

• **Focus on scalability.** Strategies must be scalable for long-term viability. Increasing the percentage of the health insurance market involved in transformation is difficult. Several state panelists pointed to harnessing state purchasing power—consistent multi-payer approaches—to require that participating insurers eventually include all lines of business in payment reforms.

• **Incorporate behavioral health, long-term care, and social determinants.** Implementing change is difficult when different aspects of health care are carved out. Several panelists emphasized that payment and delivery system reform initiatives should encompass the care of the whole person.

*The National Governors Association would like to thank the Robert Wood Johnson Foundation and The Commonwealth Fund for their generous support for this meeting.*