Robert Wood Johnson Foundation

DECEMBER 2014

Advancing Delivery and Payment Reform in Managed Care Provider Networks

PART II: AN IMPLEMENTATION GUIDE FOR STATE PURCHASERS

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This implementation guide is part of a package of products to assist states interested in value-based purchasing for health care. The other parts of the package are a discussion of strategic considerations and a planning template.

State purchasers are increasingly interested in adopting new delivery and payment models that shift providers away from fee-for-service (FFS) reimbursement and toward payment methodologies that motivate and reward value or outcomes. This is one application of a larger movement referred to as value-based purchasing (VBP), wherein value is defined as providing better quality care at lower or equal cost.

While there is widespread acceptance that FFS reimbursement creates incentives to provide more—not necessarily better—care, movement by payers away from FFS and toward paying for value has been limited. Only a small percentage of health care dollars are value-oriented. According to the Catalyst for Payment Reform's *National Scorecard on Payment Reform*, fewer than 11 percent of commercial payments to providers were linked to value in 2013.[1] This percent increased dramatically in 2014 for commercial providers—responding health plans stated that 40 percent of their payments to physicians and hospitals are designed to encourage health care providers to deliver higher-quality and, in some cases, more affordable care.[2] However, this means that 60 percent of commercial providers are still paid via FFS. There is no comparable information for Medicaid.

State purchasers can accelerate the spread of adoption of new delivery and alternative payment models by more effectively leveraging their contracted health plans. However, states have historically been cautious about being too directive with VBP plans. Many states are unsure of how to incorporate delivery or payment reforms—such as medical homes, health homes, accountable care organizations (ACOs), and bundled or episode-based payments—into existing managed care arrangements. Some states have experienced strong resistance from health plans, while others are discouraged that plans are not more proactive in driving greater value from their networks.

As a result, many states are choosing to work directly with providers to reform care delivery and payment, effectively leapfrogging over health plans. While this might seem to be the path of least resistance initially, a state may find that "retrofitting" a new care model or reimbursement method into an existing managed care infrastructure may reveal operational challenges that the state did not anticipate.

This resource which draws from conversations with state and national VBP experts, was developed as a guide for states to more effectively leverage health plans in Medicaid, state employee insurance plans, and state insurance marketplaces to move the delivery system toward VBP.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, please visit *www.CHCS.org*.

ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University.

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State Levers for Driving Delivery and Payment Reform Through Managed Care Plans

A state has a variety of levers it can use with health plans to advance delivery and payment reform. These levers are not mutually exclusive. States can use multiple tactics to impart VBP strategies.

- **Use the health plan request for proposal (RFP) and contracts to identify health plans that have experience in VBP and/or will be partners in advancing delivery and payment reform.** States, such as Minnesota, Ohio, Oregon, Tennessee, and Texas, are incorporating a VBP focus into their health plan procurement strategies. Minnesota Medicaid's RFP requires plans to submit information on alternative payment reforms, such as total cost of care arrangements and other outcome-based financial incentives, used within their networks. Ohio Medicaid has incorporated Catalyst for Payment Reform's boilerplate language about alternative payment models into its health plan RFP.[3]

Procurement and Contracting Tool: Catalyst for Payment Reform

States can use boilerplate contract language from Catalyst for Payment Reform (CPR) to help develop health plan RFPs and contracts. CPR's model contract language outlines clear expectations for contracted health plans' progress on payment reform. It provides language purchasers can use to articulate their "asks" around different types of payment reforms, including value-oriented payment, price and quality transparency, and alignment with Medicare.

- **In Oregon, the state's Public Employees' Benefit Board used its RFP to ask plans questions, including whether they would commit to a limit on the growth of health care costs to less than 4 percent;** how many of their members were currently enrolled in patient-centered primary care homes (PCPCHs); how quickly they moved members into PCPCHs; how members were moved into PCPCHs; how insurers were advancing toward and investing in PCPCHs; and how much money insurers were willing to put at risk if agreed upon benchmarks regarding linking members to PCPCHs were not met.

  Similarly, Tennessee Medicaid asks bidders to describe their experience implementing innovative payment methodologies, how the plan would spread innovations to other books of business, and at what pace. In Texas, the Medicaid agency requires its plans to submit information on alternative payment structures used with providers, including the methodology and metrics used, the approximate dollar amount and number of Medicaid enrollees affected, and the process for assessing the influence of those efforts. By requesting such information in its RFP, states achieve two objectives: (1) learning more about a health plan's experience; and (2) using the information as part of the proposal scoring/evaluation process.

Assessing the Performance of Health Plans: the eValue8™ Tool

eValue8 was created by business coalitions and employers, including Marriott and General Motors, to measure and evaluate health plan performance. This tool can be used to ask health plans questions about how they control costs, reduce and eliminate waste, ensure patient safety, close gaps in care, and improve health and health care. It prepares easy-to-compare performance reports that allow purchasers to assess health care vendors on a local, regional, and national basis to improve their management, administration, and/or delivery of health care services. To learn more about the eValue8 tool, visit *www.nbch.org/evalue8*.

- **Use contracts with plans to drive delivery and payment reforms with their providers.** For example, to contract with Tennessee's Medicaid agency, a health plan must agree to adopt and implement the state's payment reform strategies, in a manner and timeline approved by Medicaid. In Minnesota, the state contracts with Medicaid plans that agree to contract and share savings with ACOs participating in the state's Health Care Delivery Systems demonstration. In addition to contracting, state purchasers can also use negotiations during contract renewals to set or raise expectations around driving greater reform throughout the delivery system.
- **Design a contracting strategy that gives plans more leverage with the delivery system to advance delivery and payment reforms.** Having too many contracted health plans operating within a state or region diffuses the number of covered lives each plan has, and decreases its leverage with providers. A state can limit the number of contracted health plans, giving each a higher number of covered lives and more leverage. In Oregon, Medicaid health plans competed with one another to run the state's 16 regional coordinated care organizations. In many of the regions, the chosen plans have the sole contract, establishing significant leverage to negotiate with providers.
- **Set policies that give state purchasers more negotiating power over insurers.** By establishing alignment across state agencies, states can maximize their leverage over health plans. In Minnesota, state policy requires health plans serving state employees to also serve Minnesotans enrolled in Medicaid. While this strategy in and of itself does not drive payment and delivery system reform, it does give the state greater ability to effectuate such changes.

Leveraging Health Plans to Purchase Greater Value From Hospitals in Rhode Island

To address the lack of payment reform in the state, the Rhode Island Office of the Health Insurance Commissioner instituted payment reforms that were included in all new health plan contracts with hospitals. These included:

- Limited rates of increase;
- Quality incentives;
- Efficiency-based units of service; and
- Requirements that contracts must have language for administrative simplification, transitions of care, and transparency.

- **Develop legislation, regulations, or policies that drive delivery and payment reform throughout the delivery system.** States can use legislative and regulatory authority to create and adopt new integrated care models, such as medical homes, health homes, or ACOs, with alternative payment arrangements. For example, New Jersey passed legislation in 2011 that gave Medicaid health plans the option of contracting with ACOs under an alternative payment arrangement. In Texas, the legislature recently passed legislation to require managed care plans to develop quality-based payment systems that align payment incentives for high-quality, cost-effective care. In Rhode Island, the Office of the Health Insurance Commissioner established a cohesive, long-term strategy to purchase greater value from the health care system, which included four aggressive regulatory standards that insurers had to adhere to as a condition of having their commercial health insurance premiums approved. These conditions included:
  - Increasing the portion of commercial medical spend going to primary care to 10.5 percent over five years;
  - Supporting and expanding the state's all-payer, patient-centered medical home initiative;
  - Providing supplemental electronic health record adoption incentive payments to providers; and
  - Addressing hospital payment reform through six contract elements for commercial contracts.[4]
- **Increase transparency of quality and cost information.** At the recent National Summit on Transparency in Health Care Cost, Prices, and Quality, sponsored by the Robert Wood Johnson Foundation, national experts agreed that transparency of information must be linked to payment reforms and culture changes that shift providers from volume-based to value-based payment.[5] States have the authority to drive greater transparency of quality and cost information throughout their health plans. For example, 11 states have existing all-payer claims databases to aggregate and report statewide data on diagnoses, procedures, care locations, and provider payments.[6] States can use their regulatory authority to compel commercial and public insurers to share data. For instance, Vermont law requires the collection of data on Vermont residents from commercial health insurers (including third-party administrators, pharmacy benefit managers, hospitals and health systems, administrators of self-insured or publicly insured health benefit plans, etc.) and Vermont's Medicaid program.

Levels of Application With Health Plans

States can adopt varying approaches to advance reforms, from laissez faire to more prescriptive.

- **Assume the plans will purchase value on their own.** The simplest and most hands-off approach is for the state to assume that health plans are advancing reforms within their provider networks on their own. Forward-thinking health plans recognize that the industry is moving away from FFS for many reasons and are proactively choosing to do the same. Furthermore, in some markets, providers are taking the lead in seeking alternative payment methods. For example, in states like Minnesota and Oregon, federally qualified health centers are advocating for global payments in exchange for greater accountability for the quality and cost of patient care.

  But the hands-off approach can also protect the status quo. If a plan is making an acceptable financial margin with an existing FFS delivery system, it is rational that a plan would not voluntarily change.

  Interviewees noted several other downsides when the state does not use its purchasing power to drive common vision and expected outcomes. State purchasers may help perpetuate fragmented delivery and payment reform strategies, which can lead to inefficiencies in reform efforts, confusion for providers, and delays in progress. Furthermore, when states do not communicate a strategy on the front end, they will likely have to adopt more aggressive oversight on the back end through data analytics and/or public reporting to confirm that plans are implementing alternative payment methods with providers.
- **Set the larger vision and required outcomes, while giving plans the flexibility to determine how they achieve those outcomes.** Most interviewees felt that states should establish the vision and expected outcomes, but give plans the flexibility to determine how to achieve the expected outcomes. (For more insights on strategically setting the vision, refer to the strategic considerations guide.) Once the state has set the strategic vision, it can give each plan the flexibility to operationalize it.

  For example, Arizona's Medicaid program has developed a plan to achieve payment modernization. It requires its plans to

link at least 5 percent of revenue to a shared savings or other alternative payment arrangement with its provider network. The state withholds 1 percent revenue to achieve plan compliance with this requirement. Each plan then determines how it will achieve the goal within its network of advancing providers along the continuum of greater accountability.

- **Encourage and/or sanction—but stop short of requiring plans to participate in VBP efforts.** A state can use financial or other incentives to persuade health plans to advance system reforms. Health plan engagement may vary based on the size and type of the incentive offered and/or the plan's capacity. For example, the capacity of a smaller, Medicaid-only plan in a single market to bring reforms to its provider network may be more limited than a larger plan with other product lines operating in multiple markets. States that have strong partnerships with plans may be in the best position influence change without having to require it.

  The Medicaid agency in Pennsylvania automatically makes an efficiency adjustment to each plan's capitation rate based on the assumption that the health plan will work with its providers to reduce inappropriate utilization (e.g., inappropriate emergency department use). The agency identifies the level of inefficiency via analysis of each plan's claims data. It is then up to the plan to determine whether and/or how it will take action to get greater value from its delivery system.

  A state should seek input from its plans and providers about what would motivate their behavior to participate in system reform. For example, a plan might be motivated to adopt episode-based payments if it is allowed to keep a portion of the savings generated from the alternative payment, rather than have its future capitation rates reduced. Or, a plan might be motivated if the state supports plans that seek repayment from providers who exceed their episode-based payment. Plans would also want to understand the type and amount of support providers would need to implement these changes. For example, plans would need to know what kind of information providers would need and how often, so that they can make more informed medical management decisions.

- **Set payment strategies and require plans to adopt them.** A state can take a more prescriptive approach by setting payment terms and then require health plans to adopt them. A state might take this route if health plans have been obstacles to delivery system reform. This approach may also infuse competition into the health care system, particularly when reforms (e.g., ACOs or health homes), may be perceived as having potentially overlapping responsibilities with health plans.

  Examples of states that have worked directly with their delivery system to drive VBP include:

  - The state of Maryland has been setting private and public sector hospital prices for decades, which health plans are required to use when reimbursing hospitals.
  - In South Carolina, the Medicaid agency in partnership with commercial payers will not reimburse for early elective deliveries, defined as prior to 39 weeks gestation. In this case, the evidence linking poorer quality outcomes and higher costs for early elective deliveries was clear and compelling. The provider type and service are very targeted, so there is less need to give plans wide berth to determine how to effect change.

Assessing the Effect of Health Plan Efforts

States can set goals for health plans around advancing VBP alone, or states and plans can set goals together. A companion to this document, *Advancing Delivery and Payment Reform in Managed Care Provider Networks: Strategic Considerations for State Purchasers*, provides insights on setting long-term goals for VBP. A plan can agree to goals as part of the proposal process, during contract negotiations or the contract renewal process, or as part of its ongoing partnership with the state.

Performance Measures and Tracking Progress

Each goal should be linked to one or more performance measures. Examples of measures include:

- Trends in the growth rate of costs;
- Utilization of specific high-cost services (e.g., avoidable readmissions);
- Members directly connected to medical homes, ACOs, etc.;
- Average spending per member;
- Plan revenue tied to alternative payment arrangements;
- Providers receiving value-based payments; and
- Covered lives receiving care from providers with outcomes-based payment arrangements.

While performance measures should be consistent across the health plans, how and when each plan achieves progress toward the overall goals will vary. For example, as noted above, plans will vary in how aggressively they are able to shift providers away from FFS reimbursement arrangements.

The state can develop a scorecard or dashboard report that tracks health plan progress against the performance measures. The state and/or plan can calculate the plan's performance and update and discuss the scorecard or dashboard report on a regular basis (e.g., quarterly or biannually).

States and plans should discuss progress toward performance measures. For example, if the measure is the number of providers with alternative payment arrangements, the state and plan could discuss what type of providers are best positioned to accept payment for outcomes, the effect those arrangements could have on quality and cost, what supports or resources are needed to bring along more reluctant providers, and how the plan proposes to spread new care and payment models throughout its network. Goals, measures, and target timeframes can be revisited over time as they are achieved or as states and plans learn together about the potential to achieve greater value from the delivery system.

One expert commented that selected measures should be directly related to savings, because payers will prioritize these. For example, avoidable inpatient readmissions and inappropriate emergency department visits are measures that are tied directly to cost savings for the health plan.

In terms of setting targets and timeframes, one interviewee suggested starting with a relatively simple target that is not overly ambitious and ratcheting it up over time. For example, the plan may be expected to have an increasing proportion of its payments to providers each year tied to alternative payment arrangements. The state and health plan could also negotiate the level of financial risk and reward tied to meeting performance outcomes. One incremental approach would be to assess a health plan's efforts on quality or cost over a grace period (e.g., the first 12 months) with no financial risk. This would give plans time to figure out the best strategies for working with networks to adopt alternative payment methods.

Creating a Culture of Learning

In addition to meeting one-on-one with each health plan to discuss progress toward goals, states can consider convening plans as a peer group to determine how the delivery system as a whole is advancing toward value-based reimbursement. In Arizona, the state convenes its health plans to discuss progress and barriers to shifting providers toward alternative payment methodologies. When barriers are identified, the state and plans develop strategies for overcoming them. Arizona's Medicaid agency also convenes providers, health plans, and other stakeholders with expertise in payment modernization to guide and inform the agency.

Acknowledgments

We thank the many state, industry, and policy experts who shared their expertise around VBP strategies: Bill Bernstein, Manatt Health Solutions; Brooks Daverman, state of Tennessee; Matthew Ferrara, state of Texas; Bill Hagan, United Healthcare Community Plan; Carolyn Ingram, Center for Health Care Strategies; George Jacobson, state of Arizona; John Kaelin, CareFirst BlueCross BlueShield; Tom Kelly, Schaller Anderson; Debbie Kilstein, Association of Community Affiliated Plans; Chris Koller, Milbank Memorial Fund; Sean Kolmer, state of Oregon; Kathleen Loretz, state of Oregon; Nathan Moracco, state of Minnesota; Jim Przybilla, PrimeWest Health; Jeanene Smith, state of Oregon; and Julie Sonier and Donna Spencer, State Health Access Data Assistance Center.

Endnotes

1. "National Scorecard on Payment Reform." *Catalyst for Payment Reform*. Accessed March 4, 2014. *www.catalyzepaymentreform.org/images/documents/NationalScorecard.pdf*.

2. "National Scorecard on Payment Reform." *Catalyst for Payment Reform*. Accessed October 16, 2014. *http://www.catalyzepaymentreform.org/images/documents/nationalscorecard2014.pdf*.

3. "2014 Model Health Plan Contract Language on Payment Reform." *Catalyst for Payment Reform*. Accessed March 4, 2014. *www.catalyzepaymentreform.org/images/CPRModelHealthPlanContractLanguage_FINAL.docx*.

4. The six elements are: limited rates of increase; quality incentives; efficiency-based units of service; and contract language related to administrative simplification, transitions of care, and transparency.

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