Engaging Commercial Payers on Multi-Payer Alignment:

Key Issues for SIM States

Prepared by SHADAC for the State Innovation Models (SIM) program under contract with NORC at the University of Chicago. SIM is funded by the Center for Medicare and Medicaid Innovation (CMMI).

October 2013

INTRODUCTION

In response to requests from states, this technical assistance document provides some tips to states on how to productively engage with private payers on the goal of achieving multipayer alignment in payment reform and delivery system reform initiatives. In some states, Medicaid has been a very proactive purchaser and driver of delivery system reform, and is seeking ways to encourage commercial payers to follow this lead; in others, it is the commercial sector that has been more active in driving reform and Medicaid programs are trying to figure out how to implement reforms that align with existing private initiatives. In both cases, it will be necessary to foster an open and robust dialogue between states and commercial payers on where alignment is desired and how best to achieve it.
The key considerations for states include recognizing the other challenges that commercial payers are facing; focusing on shared big picture objectives rather than alignment at a very detailed level; recognizing that multipayer alignment and delivery system reform are long-term processes that require long-term commitments; having clear definitions of success; striving for consistency while retaining flexibility for experimentation and innovation; and understanding that commercial payers may be resistant to some of the types of changes states are seeking. Each of these factors is described in more detail below. The brief concludes with a list of key "do's and don'ts" for engaging commercial payers.

1. SHARE THE SIM VISION

A key first step of engaging commercial payers will be to share the state's vision for its SIM initiative. It is important that all stakeholders understand the transformation that the state wishes to achieve. As the convener, state officials should articulate the SIM vision of implementing innovative care and payment models that improve health, improve health care delivery, and lower costs for the state population as a whole. It will be helpful to emphasize alignment between the state and commercial payers on these overall goals before delving into detailed discussions where it may be harder to achieve alignment. In addition to sharing the vision, state leaders should share the approaches and tools they plan to use to achieve system transformation, and the importance of achieving quantifiable improvements for the state's population as a whole, not just for individual payers.

2. RECOGNIZE CHALLENGES IN THE CURRENT HEALTH PLAN ENVIRONMENT

As SIM states are considering strategies to engage commercial payers, it will be important to keep in mind that health plans are operating in the most challenging environment in memory. The health plan value proposition is in question; plans are battling to retain key employer group accounts; providers are consolidating for increased market power and negotiating leverage with health plans and establishing risk-bearing entities of their own, creating new competitors; and transparent, intensified competition is coming soon as a result of health insurance exchanges. In addition, new guaranteed issue rules mean that the ability to stay profitable through underwriting on health status no longer applies.
Just as state officials are juggling many competing demands – implementing the Affordable Care Act and creating their transformation plans under SIM - plan resources are constrained and leadership is focused

on retooling and assessing market segmentation and profitability in the exchanges. Actuarial and underwriting resources trained to work in a risk selection environment are facing huge challenges in anticipating price competition and cost uncertainties. Compliance departments are struggling to understand and implement an entirely new set of regulations and requirements. Provider contracting teams are working to reform payment structures with network constituencies made up of anxious providers who are themselves struggling to make the transition from volume to value while figuring out the realities of a marketplace where providers are increasingly consolidating into larger groups, implementing EMRs and striving to maintain revenue streams.

Keeping these challenges in mind as states seek to align incentives will be important. How plans (and providers) are approached and what states seek from them will be critical to moving forward. An unwavering focus on long-term objectives and maximum flexibility in how to achieve those objectives will be essential to making headway. In addition, it will be helpful to emphasize that it is not the state's intention to replace value-based initiatives that are already under way; rather, the goal is to build upon and leverage existing initiatives.

3. FOCUS ON SHARED BIG PICTURE OBJECTIVES

As states seek to engage commercial payers, it will be essential to remain focused on the core reasons for pursuing multipayer alignment - in other words, what are states hoping to achieve?
The power of the multipayer initiative lies in sending consistent signals to delivery systems to drive change to move from a system based on volume to one based on value. There is certainly room for health plans to improve, but the core goal requires the lion's share of change to occur in the trenches of the delivery system – in other words, it depends on the financial and other incentive structures for providers.

Plans and purchasers must use their leverage to drive these delivery system changes, deploy their resources to support the information needs of providers to know where and how to make change, and align patient/member incentives to remove obstacles and to support the changes made in the delivery system. Making progress in these areas should represent a shared public/private vision and be the core goal of states' engagement with commercial payers. In some states, the largest commercial payers are also significant players in the Medicaid or Medicare managed care markets, making the idea of multipayer alignment potentially more attractive to them since it could result in streamlined internal operations across business lines.

4. TIMING IS EVERYTHING

Change won't happen overnight. Both plans and purchasers (including states and self-insured employers) need to make long-term commitments to changing the incentives for providers, giving them the needed predictability to make the leap to reducing revenue and increasing value. Plan and provider executives have seen incentive structures come and go. Many may believe "this too shall pass" so they must be convinced that the status quo is not an option.

States must make credible long-term commitments (beyond the current administration, whenever possible) for it to be worthwhile to plans and providers to invest in change. It is also important to allow for minor methodological mid-course corrections without changing overall incentives.
Plan performance improvements are dependent on changes in provider behavior. However, actual change in provider behavior is very complex and can be slow. While provider organizations now understand that they will need to change, they are very attuned to the timing of changes that affect their margins. They are slow to invest in unreimbursed initiatives – even those that will lead to cost and quality improvement – and they do not want to miss the chance to continue profitable revenue streams while they are still mostly paid on a fee for service basis.

For providers serving profitable patient segments (such as commercially-insured patients, including public employee groups) under fee for service, it makes economic sense to them to drag their feet on many changes. But for patients that are not profitable for them, such as Medicaid and uninsured patients, there are immediate advantages to reducing utilization, often achieved through quality improvements like better care coordination and community support. For example, reducing admissions and ER visits for this population segment can improve the provider bottom line even when fee for service incentives still dominate. This can be an important opportunity for state, plan and provider collaboration.

5. DEFINE SUCCESS

Data measuring specific results will take time to accumulate and with small sub-populations often won't be credible. However, that doesn't mean plan and provider milestones on the path to success can't be tracked. It may be most useful for states to base early evaluations of plan performance on their success in aligning provider incentives. At an individual payer level, some of these types of indicators could include:

- Securing provider contracts that include global payment arrangements, eventually moving to downside as well as upside risk. Assumption of downside risk is a more powerful incentive than bonuses or shared savings and will be much more likely to result in behavior change at the provider or plan level;

- Measuring the percentage of patients/members covered or reimbursement through payment methodologies that are alternatives to fee for service, with a goal of increasing value-based arrangements over time;
- Contracting with providers to reward those providers and/or provider organizations that revise underlying individual physician and hospital compensation plans to align with overall goals;

- Reporting detailed, actionable data to providers in order to support provider ability to understand and improve their performance;

- Providing other support to provider initiatives to improve cost and quality such as tools for identifying and managing high-risk patients;

- Financially supporting historically unreimbursed services such as navigators, care coordinators and other non-physician patient support services in the provider setting;

- Reimbursing for innovative approaches to patient care and access such as e-visits, tele-health, group visits, etc.; and

- Contracting for quality incentives that are consistent with community and national quality metrics.

6. STRIVE FOR CONSISTENCY

Creating a stronger and more consistent signal for value-based incentives is critically important. But, even if every purchaser, payer and provider would or could agree on common methods, rewarding value is such a new phenomenon that little is known about the best way to do it. Flexibility to allow for experimentation and innovation is needed.

Inconsistencies in approach can create useless distractions from overall goals. Varying requirements of Medicaid, Medicare, ERISA, HSA, ACA and other regulatory nuances can be significant contributors to this problem. Providers are often unaware of the challenges of achieving consistency and can be expected to push back in frustration when it isn't achieved. Wherever possible, states should make every effort to conform to community standards that are in place for other purchasers and visibly work to change regulations that prevent consistency across payers. As noted above, the fact that some carriers are major players in both the commercial and public markets could potentially work to states' advantage with regard to engaging health plans in discussions about multipayer alignment.

Payment approaches: It is possible for payment approaches to differ in detail, but still strongly reward value. Consistency should be sought most aggressively where variation adds a burden on providers that distracts from the changes in which they need to invest. For example, payer differences in incentives or the existence of coverage for certain types of care such as "between visit care" by phone or email and/or non-physician care team members can lead to provider delays in implementation.

Quality measurement and reporting: With regard to consistency in quality measurement and reporting, requiring payer-specific quality metrics and reporting is costly in terms of both dollars and time. Reporting burden, small numbers, lags in measurement periods and limited population segments to which measures apply make it critical that these efforts be aligned across payers and aligned with other community or national initiatives where possible. Achieving greater consistency in quality measures will help to free up health plan and provider quality improvement resources from reporting to actually executing.

Payment and contracting: Consistency in other areas may be desirable, but less essential. Variation in degree and method of risk sharing, cash flow approach, details of risk adjustment applications, patient cost sharing, and contract language may be annoying for providers but are less likely to present real barriers for change. Because of variations in data systems, plan contract arrangements with providers, cash flow approaches and the specifics of claim payment methodologies it is unlikely that absolute consistency can be achieved on these details.

Data sharing and transparency: Data sharing with purchasers and providers has historically been a particularly sensitive issue for plans. There are advantages to consolidating data across plans such as creation of consistent results and methodologies, and the ability to generate larger patient populations for evaluation purposes. However, while creating a common data infrastructure across payers seems like something that could be done centrally, many efforts to achieve this have stalled. Technical and political barriers have proven to be difficult, though not always impossible to overcome. In states where creating an all-payer database is not currently a realistic option, an alternative could be for states to insist on plans sharing data with them as a purchaser, sharing data with providers as a tool to improve performance, or publicly reporting data using a common set of standards.

With regard to sharing data between plans and providers, sharing actionable data with providers and helping them understand its meaning is one of the most important roles plans can play. More sophisticated provider organizations are increasingly capable of using data. However, not all providers are at this level, and even when providers are able to obtain and analyze data on their own services, they are generally missing detail on half or more of all health dollars spent on their patients. These other dollars are going to providers not affiliated with the primary care doctor or organization, for pharmaceuticals and for other services that can't be independently tracked by the primary care site. Plans have the data to fill in these gaps. Further, plans can help providers by benchmarking their performance against others and by analyzing data to pre-identify patients that would benefit from more proactive interventions.

7. MINIMIZE PAIN

As plans are working to deal with a rapidly changing market, they are also struggling to reinvent the incentives in their provider contracts. Because providers also are challenged in this difficult transition period, plans need to amass sufficient purchasing leverage to make progress. States can be helpful to plans by serving as an external force requiring them to put faster, harder pressure on providers for change. Conversely, because states represent such a large purchasing block, states that have not aligned with other payers' initiatives can be a barrier for change.

However, plans may be wary of state efforts and they may not welcome a new initiative by the state. While well-intentioned, public purchasing initiatives are often complex with many specific, unique requirements and sometimes feel onerous to plan leadership and staff. Most plans are already straining their resources sorting out how to respond to requests from large employer groups and with their product design and pricing for the exchanges.

Seeking plan suggestions for how to proceed will be useful in formulating the state's strategy and will build a base for collaboration. Plans will be especially interested when the state's purchasing power can build upon and accelerate their own efforts, especially if alignment can also translate into improved performance for other clients (total cost of care, maternity care and "hot spot" cost and quality improvement are good examples). States' willingness to streamline requirements and align with other existing initiatives would make purchasing efforts more likely to be met with enthusiasm and success. There are several unavoidable issues that plans are likely to be concerned about. Plans are fearful of loss of control and losing their role as an intermediary between purchasers and providers as ACOs become more institutionalized. They are under pressure to prove value in areas that they have come to see as part of their core business such as disease/care management, which is becoming more provider-based, and member wellness programs whose impact is being questioned. In addition, data that was historically a carefully guarded and powerful plan asset that is fast becoming more transparent. Most alignment initiatives will put pressure on these sensitive areas, so states should expect to make changes over time and ideally in conjunction with other powerful purchasing entities.

Engaging Commercial Payers: Do's and Don'ts

Do:

- Look for common ground. Learn what other initiatives are in the works and seek plan ideas on how your purchasing can help support their other activities.
- Keep your eye on the prize and err on the side of flexibility. This is a long-term effort and no one knows the best way to go forward. We can expect many mid-course corrections to occur over time.
- Look for ways your benefits, communications and purchasing efforts can help get patients on board and aligned.
- Understand the difficulty plans have in getting providers to change and figure out how you can help as well as what you are doing that creates obstacles to change.
- Understand that the role of the health plan is changing in ways that are already causing significant anxiety for plans.
- Be aware of unique issues for Medicaid populations and be creative in how you can reduce obstacles to patient alignment.
- Be clear on what you want to achieve, but open on how. Be ready to give on some things and be willing to consider new approaches to rules that have been established in special ways for your purchasing in the past.

Don't:

- Expect immediate results. This will take time to design, more time to implement, and even more time for altered incentives to trickle down into provider changes. Even if things are working, proving it will take time.
- Do this alone. Join with other large purchasers wherever possible to increase leverage and consistency.
- Settle for weak provider incentives over the long term. Providers must make difficult business model changes. These changes need to be supported by clear changes in their payment models. Moving to programs with greater provider accountability (such as downside financial risk) will create an environment that can actually support provider change. Transition periods are fine, but the end point should be as clear as possible.
- Dig your heels in on methodologies. No one knows the right way and each payer will have their own operational, contractual, and political challenges to deal with.