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# **2019 HEALTH PLAN REQUEST FOR INFORMATION (RFI)**

# **ON PAYMENT & DELIVERY REFORM**

Legacy health care payment methods do not reward providers for improving the quality of care they deliver or lowering the cost of care. Instead, these payments sometimes encourage overuse of unneeded services and under-use of needed services, leading to significant waste. As long as the U.S. spends significantly more per capita for care without producing superior outcomes, there is a prevailing need to scrutinize the existing incentives and rewards structure in the health care system and identify how it can be altered to produce better value. This is especially true as the legacy payment structure creates disincentives for the role of primary care, coordination among providers, and adherence to evidence-based care.

At the same time, employers and other health care purchasers remain under tremendous pressure to provide competitive benefits that offer access to high-quality, affordable health care to their populations. Additionally, health plans remain under pressure to manage costs. As a result, most purchasers and health plans seek opportunities to encourage the delivery of high-value care. However, these efforts require significant changes to legacy approaches to provider payment and/or the development of new payment methods that encourage providers to deliver high-quality care at a lower cost.

Purchasers have an opportunity to use the momentum of health care reform and the cost crisis to take a central and active leadership role in catalyzing health care delivery and payment reform. It is important for purchasers to work together on a strategic menu of options, directing health plans to focus on their capacity to plan, implement, and evaluate payment strategies that move toward the goals of high-value care. These strategies may be far ranging, from using financial rewards (e.g. rewarding providers for their efficiency and/or quality performance, such as reducing waste/overuse), to using financial disincentives (e.g. non-payment for certain hospital-acquired conditions). They may also be best supported by complementary benefit designs and provider network designs.

***NOTE:*** *We designed this RFI to serve as an add-on to your general, broader request for information. If you plan to use this document with prospective partners, you may want to prevent respondents from altering it by going to the “Developer” tab and selecting “Protect Form.” This will limit the responder to typing only into the grey form boxes. We recommend you delete this page when issuing the RFI.*

If you have any questions, please contact [info@catalyze.org](mailto:info@catalyze.org).

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# **Tracking Administrator’s Progress on Payment Reform**

Major health care stakeholders in the public- and private-sectors are focusing on new forms of payment that could potentially result in better value, including enhancements to fee-for-service, bundled payment, and capitation. However, the breadth and depth of these payment reforms will significantly impact whether they lead to higher value care. The purpose of this section of the RFI is to understand the current amount of payment that is designed to cut waste or is tied to performance, what payment methods are in use, and to measure progress toward CPR's goal of at least 20 percent of payment flowing through methods *proven* to enhance value by 2020. The following questions and corresponding metrics were developed by a broad group of stakeholders, including health plans, to illustrate quantitatively both the current state of payment and the nation’s progress toward changing how we pay for care. These questions are the same as those asked of health plans in CPR’s Scorecard 2.0. For more information on Scorecard 2.0, click [here.](https://www.catalyze.org/product/scorecard-2-0/)

The excel file, linked to below, applies to both commercial and Medicaid market segments and their Plan Participants. If the RFI came from an employer, please complete the questions/metrics for plan’s commercial business. If the RFI came from a Medicaid agency, please complete the question/metrics for plan’s Medicaid business. For the denominator and all numerators, please report in-network dollars only. For any clarification of terms, please see the following "[Definitions](https://www.catalyze.org/payment-reform-definitions/).”

Please complete this section using the following excel file. Remember to share the excel file with Purchaser as a separate attachment.



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**Assessing Administrator’s Payment and Delivery Reform Programs**

To help purchasers understand how different health care payment and delivery reforms work in the market, please provide details in response to the following questions for each health care payment or delivery reform program implemented by Administrator for the relevant lines of business (commercial, Medicaid, etc.).

1. What is the name of the payment or delivery reform program (henceforth known as "the program")?

1. Please provide a general description of the program (including its goals) and how it represents an advancement in the industry.

1. Please provide the date on which the program was launched, and indicate whether it is in pilot mode, expansion mode, or fully implemented.

1. Which payment methods most accurately describe(s) the approach to pay contracted providers (e.g., fee-for-service-based shared risk, fee-for-service-based shared savings, partial capitation, condition-specific capitation, full capitation, bundled payment, pay-for-performance, payment for non-visit functions like care coordination fees, non-payment policies for specific services, other)?

1. Please identify the line(s) of business for which this program is available (e.g., commercial self-funded, commercial full-insured, Medicare, Medicaid, other)

1. Into which products has the program been integrated (e.g., PPO, POS, EPO, HMO, HDHP)?

1. Is the program available in all market segments (e.g. commercial, Medicaid, etc.) and relevant geographic locations (city, state) where the Purchaser’s operations are currently ongoing? If not, why? Please list the geographic location(s) where the program is offered (city, state).

1. Which type of provider is primarily responsible for managing the program (primary care physicians, physician specialists, hospitals, integrated delivery systems, other)? If physician specialists, please specify which type (e.g., oncologists, cardiologists).

1. Are there specific criteria providers must meet to participate in the program (e.g., cost threshold, quality threshold, an integrated electronic health record, data analysis infrastructure)? If so, please list the criteria in order of priority.

1. Does the program have an attribution model for assigning patients to providers? If so, what is the fee associated with participating and what is the methodology used to attribute patients?

1. How does the program set targets for and assess quality performance (e.g., achievement of a certain standard of performance, achievement compared to peers, improvement over time relative to own performance, improvement of set percent per year, other)?

1. If applicable, how does the program set cost targets for and assess cost performance (e.g., regional benchmarks, historical claims data, other)? Is the cost target risk-adjusted, and if so, how?

1. Please indicate the benefit and/or provider network design strategies that Administrator has in place to incentivize Plan Participants to engage in/use the program (e.g., narrow networks, tiered networks, reference pricing, value-based insurance design, centers of excellence incentives, incentives to select lower cost site of care, preauthorization, precertification, continued stay review).

1. Are there criteria purchasers must meet to participate in the program (e.g. plan design requirements, purchaser size, minimum enrollment)? If so, please describe.

1. If applicable, does the program aggregate the savings and/or pool the risk across all participating purchasers? If so, please describe the methodology.

1. Does the program produce purchaser-specific cost, quality and utilization reports on a regular basis? If so, please attach a sample.

1. Will Administrator agree to provide comprehensive reports on the program’s cost, quality and utilization performance to Purchaser on a bi-annual basis? Please specify if reporting is on a more frequent basis for any of these categories.

1. Will Administrator agree to report on all of the metrics in the relevant Payment Reform Evaluation Framework provided by Purchaser?

1. Has the program been evaluated independently by an external third party or internally? If so, please provide any results to date (attachments permitted).

1. Describe Administrator's future plans for payment and/or delivery reform for providers across settings such as ACOs or PCMHs, and, specialty pharmacies, etc. (250 words or less each). Respondents shall provide: A description of the program, the current and planned availability of the program (including locations, specialties, etc.), and the timeline for program implementation (attachments permitted).

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**Assessing Administrator’s Abilities to Support High-Value Network and Benefit Design**

Moving patients to providers and services that offer higher quality care at a lower cost will help purchasers extract more value from the health care system. These provider network strategies and benefit designs can send a signal to providers that purchasers will not support unwarranted variation in health care prices or quality, and can send signals about which services are most valuable.

1. Which network and benefit design strategies is Administrator using to encourage Plan Participants to seek high-value care (e.g., narrow networks, tiered networks, reference pricing, value-based insurance design, centers of excellence incentives, incentives to select lower cost site of care (e.g., telehealth, etc.), preauthorization, precertification, continued stay review, other)?

1. For the strategies selected, please briefly describe how many (# and %) Plan Participants and Purchasers are participating.

1. Please describe how Administrator selects high-value providers for each of the strategies identified in question 1 above (e.g., cost threshold, quality threshold, both). Please list the criteria in order of priority.

1. Please provide the Administrator’s definition of high-value providers.

1. What percent change is there from the prior year in Plan Participants selecting high-value providers for services? If Administrator measures such changes, please report values.

1. Does Administrator facilitate claims processing for its customers who establish direct contracts with providers for services? Please describe and include any limitations.

1. Does the program produce purchaser-specific cost, quality and utilization reports on a regular basis? If so, please attach a sample.

1. Will Administrator agree to provide comprehensive reports on the program’s cost, quality and utilization performance to Purchaser on a bi-annual basis? Please specify if reporting is on a more frequent basis for any of these categories.

1. Has the program been evaluated independently by an external third party or internally? If so, please provide any results to date (attachments permitted).

1. Please describe Administrator's future network and benefit design strategies intended to move patients to higher-value providers and services for 2019-2021, and how they relate to its overall strategy to reduce unwarranted price and quality variation.

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**Assessing Administrator’s Efforts to Ensure Price and Quality Transparency**

Transparency is a core building block to a higher-value health care system. Until there is a sufficient knowledge base about the prices and the quality of specific services and providers, there will be limited insight into the development of effective payment levels and models that will work to achieve high-value health care. For more information, read [CPR's Action Brief - Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System](https://www.catalyze.org/product/action-brief-price-transparency/). For an RFP to use with transparency tool vendors, download the [Toolkit for Selecting and Evaluating a Price Transparency Tool](https://www.catalyze.org/product/evaluating-transparency-tool/).

1. Does Administrator make available to Plan Participants an online tool that helps them compare the price and quality of health care services and providers?If so, is the tool developed by Administrator or does Administrator contract with an independent vendor to make the tool available to Plan Participants?

1. What percent of eligible Plan Participants have registered for the tool?

1. What percent of registered Plan Participants have conducted a search at least once?

1. From which product lines are Plan Participants most likely to use the tool (HDHP, HMO, PPO)?

1. What percentage of price estimates provided to Plan Participants accurately predict the patient’s actual cost for entire episodes of care?

1. Does the tool display the Plan Participant’s remaining deductible, co-payment/co-insurance, reward/cash incentive, out-of-pocket maximum, or account balances in the Plan Participant’s health care flexible spending account or health savings account based on provider-specific contracts in real time (data refreshed at least every 30 days)?

1. Does the tool show prices that reflect the most recent negotiated fees? If not, does it base prices on claims history for the most recent 12 months available? Please explain.

1. CPR has developed a Priority Measure Set of quality measures for purchasers. By referencing the link below, please list all of the measures identified in the Set that the tool currently displays, if Administrator makes such a tool available. [CPR Employer-Purchaser Priority Measure Set (table 2)](https://www.catalyze.org/product/cpr-employer-purchaser-guide-quality-measure-selection/)

1. What percentage of network providers have access to accurate price information for their own services? And, what percentage of network providers have access during patient visits to the prices of the services of other providers to which they want to refer patients?

1. Describe Administrator's future plans for supporting consumers in their health care decision-making by providing them with price and quality information.

1. What percent of professional and hospital claims dollars run through contracts that limit sharing price and quality information with Plan Participants? Please describe what Administrator is currently doing to combat this challenge and how purchasers can support these efforts?

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**Assessing Administrator’s Accountable Care Organization Strategy**

As the number of accountable care organizations (ACOs) grows, it is important to gather information on Administrator strategies to help ensure that these delivery systems meet both cost and quality goals. Particularly as providers consolidate to form ACOs, purchasers must be sure that their health plan is monitoring these developments and ensuring there is enough competition among providers in the market.

For detailed tools that can help purchasers provide adequate oversight of ACOs operated by contracted health plans, please see CPR’s [Standardized Plan ACO Reporting for Customers (SPARC).](https://www.catalyze.org/product/sparc/) In these tools, you will also find a detailed RFI to use to evaluate health plan ACO options in markets of interest.

1. How many ACOs does Administrator currently have available?

1. In what markets (if any) are attribution model[[1]](#footnote-1) ACOs built into Administrator’s basic PPO product? In tiered or narrow network products?

1. Does Administrator require that Plan Participants be placed into attribution model ACOs? If so, what fees are associated with participating?

1. Please describe Administrator’s methodology for attributing Plan Participants to the ACO program.

1. In what markets (if any) does Administrator offer an ACO as a separate product[[2]](#footnote-2) offering?

1. Are there cost and quality thresholds that provider groups who want to contract with Administrator as an ACO must meet? If so, what are they?

1. Under what circumstances would Administrator NOT contract with a health system or provider group to form an ACO (e.g., culture is not aligned, providers not able to take full-risk, quality or cost is not at a favorable level, governance structure)?

1. Please describe the protocols in place to push an ACO to improve performance or to remove the ACO when it is not performing well. Please describe these protocols for an individual provider within the ACO.

1. Does the Administrator delegate care coordination to any ACOs? If so, what requirements does Administrator enforce and does Administrator report on care coordination activities to Purchaser?

1. The Integrated Healthcare Association and the Pacific Business Group on Health have developed an ACO Measure Set with support from across the health care industry, including from CPR. By referencing the link below, please list all of the measures in the Set that Administrator uses to assess ACO provider performance: [IHA-PBGH ACO Measure Set](https://www.iha.org/sites/default/files/resources/my2018_measure_set.pdf). Please list any additional measures Administrator uses to measure ACO provider performance.

1. Which payment methods does Administrator use to pay the ACO for the care it provides (e.g., fee-for-service-based shared savings, fee-for-service-based shared risk, capitation-based shared risk, care coordination fees, pay-for-performance)?

1. Please describe the methodology Administrator uses to set target budgets for each ACO (e.g., regional benchmarks, historical claims data, risk adjustments, other).

1. Do Administrator's ACOs need to meet both cost and quality thresholds to share in savings?

1. What proportion of the Administrator's contracted ACOs utilized contracting practices that create exclusive contracts or "most favored nations" clauses with participating providers, e.g. physicians, physician groups, hospitals, and ambulatory surgery centers, such that they are precluded from entering into contracts with other ACOs or commercial payers?

1. Does Administrator provide Purchasers with purchaser-specific cost, quality and utilization reports on a regular basis? If so, please attach a sample.

1. Will Administrator agree to provide comprehensive reports on the ACO’s cost, quality and utilization performance to Purchaser on a bi-annual basis, such as CPR’s [Standard Plan ACO Report](https://www.catalyze.org/product/sparc/) provided by Purchaser? Please specify if reporting is on a more frequent basis for any of these categories.

1. Have Administrator’s ACOs been evaluated independently by an external third party or internally? If so, please provide any results to date (attachments permitted).

1. Describe Administrator's future plans for ACOs.

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**Assessing Administrator’s Maternity Care Strategy**

The costs associated with maternity care, including pregnancy, labor, delivery, and any potential complications, are a significant factor in the rising cost of health care for purchasers. Cesarean delivery rates remain among the highest in the world, and the United States is the only developed country with a rising level of maternal mortality. Employer efforts to require health plan and provider accountability can lower costs and improve our maternity outcomes. For more information, read CPR's [Action Brief: Maternity Care Payment](https://www.catalyze.org/product/maternity-care-payment/) or [The Cost of Having a Baby in the United States](https://www.catalyze.org/product/2013-cost-baby-united-states/).

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| --- | --- | --- | --- | --- |
| **#** | **Question to Program Administrator** | **Numerator** | **Denominator** | **Total** |
| 1a | Please report for Calendar Year (CY) 2018, or the most recent 12 months, the percent of total dollars paid for maternity care to hospitals with contracts that include incentives to adhere to clinical guidelines, which, if followed, would reduce unnecessary elective medical intervention during labor and delivery. Examples of such incentives include bundled payment, blended payment, or non-payment for care that is not evidence-based. | Total dollars paid for maternity care to hospitals with contracts that include incentives to adhere to clinical guidelines, which, if followed, would reduce unnecessary elective medical intervention during labor and delivery in the past year. Examples of such incentives include bundled payment, blended payment, or non-payment for care that is not evidence-based. | Total dollars paid to hospitals for maternity care in CY 2018 or most recent 12 months. |  |
| 1b | Please report the Cesarean Section (CS) rate (%) for Calendar Year (CY) 2018, or the most recent 12 months, for your book of business. | Total number of births by CS for CY 2018 or most recent 12 months | Total number of births for CY 2018 or most recent 12 months. |  |
| 1c | Please report the NTSV (nulliparous, term, singleton, vertex – i.e. low risk moms) CS rate (%) for Calendar Year (CY) 2018, or the most recent 12 months, for your book of business. | Total number of births by NTSV CS for CY 2018 or most recent 12 months | Total number of births for CY 2018 or most recent 12 months. |  |
| 1d | Please report the early elective delivery rate (deliveries before 39 weeks with no medical indication for early delivery) (%) for Calendar Year (CY) 2018, or the most recent 12 months, for your book of business. | Total number of births by early elective delivery for CY 2018 or most recent 12 months | Total number of births for CY 2018 or most recent 12 months. |  |
| 1e | Please report the portion of births delivered by midwife (%) for Calendar Year (CY) 2018, or the most recent 12 months, for your book of business. | Total number of births delivered by midwife for CY 2018 or most recent 12 months | Total number of births for CY 2018 or most recent 12 months. |  |

1. Please confirm that you will report to the client the following rates on at least an annual basis:

      Cesarean Section (CS) rate

      NTSV CS rate (nulliparous, term, singleton, vertex – i.e. low risk moms)

      Early elective delivery rate (deliveries before 39 weeks with no medical indication for early delivery)

      % of births by midwife

1. Please confirm that you will provide the following information to members:

      Access to certified nurse midwives in the electronic and printed provider directories

      Access to birth centers in directories and through customer service

      Access to information on maternal quality or outcomes by facility

1. Please confirm that you have an active process to contract with birth centers where they are available.

1. Note how many birth centers are available to client members in 3 geographies with largest employer concentration:

      Geography 1

      Geography 2

      Geography 3

1. Please confirm whether you require that hospitals have a medical staff bylaw or other rule that prohibits early elective deliveries.

1. Do you have a maternity center of excellence program or preferred tiering for maternity care in place?

1. If the answer to Question 6 is Yes, please note the maximum CS and NTSV rate to be a preferred provider.

      CS

      NTSV

      No maximum rate

1. Are preferred maternity facilities restricted to those which have rules that prohibit early elective deliveries?

1. Are preferred maternity providers required to report maternity results to The Leapfrog Group?

1. Are preferred maternity providers required to have in place programs to prevent avoidable maternity morbidity or mortality from pregnancy and delivery?  (Note, many hospitals use California Maternal Quality Care Collaborative (CMQCC) or the Alliance for Innovation in Maternal Health (AIM) guidelines.)

      Obstetrical hemorrhage

      Preeclampsia

      Preventing blood clots

      Addressing cardiovascular disease

1. Do you require that preferred providers report to you on what they are doing to assess and reduce racial disparities in pregnancy outcomes in their facility(ies)?

1. Do you require that hospitals that are in your center of excellence or preferred tier report to your plan on the following measures?

      Cesarean Section (CS) rate

      NTSV CS rate (nulliparous, term, singleton, vertex – i.e. low risk moms)

      Trial of Labor after CS

      Vaginal birth after CS

      Early elective delivery rate (deliveries before 39 weeks with no medical indication for early delivery)

      Portion of births by midwife

1. Not including educational strategies, what strategies does Administrator employ to address the rate of elective cesarean deliveries and inductions (e.g., bundled payment, blended payment for cesarean delivery and vaginal births, financial incentives or penalties to reduce elective cesarean deliveries and/or inductions, contracts establishing required changes in facility policy regarding elective births prior to 39 weeks, certifying and establishing payment processes for alternative maternity care providers, such as certified nurse midwives, laborists, doulas, and free standing non-hospital birth centers)?

1. Please describe how you address provider contracts when the provider does not adhere to clinical guidelines for early elective deliveries or low-risk primary cesarean section in first birth deliveries (e.g., terminate contract, work with providers to improve performance)?

1. Please include information on any upcoming or planned initiatives to reform maternity care payment and delivery.

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**Assessing Administrator’s Pharmacy Strategy**

With the use and price of drugs on the rise, purchasers' costs for supporting those in need of these medications are also increasing. Some generics, traditionally cheaper alternatives to brand name drugs, are now becoming more expensive, along with the high costs of specialty medications. The current and potential medical benefits of pharmaceuticals are enormous; however, the costs are exorbitant, the pricing mechanisms and distribution channels are complex, and there is variation in how these drugs are handled under the pharmacy benefit versus the medical benefit. There is no easy solution to the complex issues purchasers face, but there are various strategies they can consider with their health plan or vendor.

1. Please describe how Administrator considers value in its selection of medications for use in its formulary. Description should include the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering on its standard benefit designs.

1. Is Administrator's construction of formularies based on total cost of care or on drug cost alone?

1. Please describe Administrator's capabilities and experience in managing, monitoring, and adjudicating specialty pharmacy claims that are administered in a physician’s office, hospital, or other professional care setting.

1. Please describe the Administrator's approach to working with purchasers who want to implement new payment and benefit designs for generic, brand, and specialty pharmacy. Please provide specific examples.

1. Are 100% of pharmacy rebates passed on to customers? If not, what percent is passed on, if any?

1. Do all contracts with providers who can prescribe medications require that specialty drug claims made by the provider contain appropriate coding that identifies the specific drug (by brand) and standardized units (dose and strength) that the provider administered?

1. To address quality and costs for non-specialty pharmacy, which payment models does Administrator currently support (e.g., bundled payment, incentive payments, reference pricing, non-payment policies, outcomes-based contracting, other)?

1. To address quality and costs for specialty pharmacy, which payment models does Administrator currently support (e.g., bundled payment, incentive payments, reference pricing, non-payment policies, outcomes-based contracting, other)?

1. For non-specialty pharmacy, which standard clinical and cost management principles does Administrator currently support (e.g., prior authorization, step therapy, quantity limits, formulary management, exclusive formulary, mandatory generic, other)?

1. For specialty pharmacy, which standard clinical and cost management principles does Administrator currently support (e.g., prior authorization, step therapy, quantity limits, formulary management, exclusive formulary, mandatory generic, other)?

1. Please include information on any upcoming or planned initiatives to reform pharmacy.

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**Assessing Administrator’s Behavioral Health and Substance Use Disorder Strategy**

In the last several years, behavioral health care has become front and center for employers and other health care purchasers. Costs are beginning to rise at an unprecedented rate due to a variety of factors, including an increase in mental health care needs and substance use disorders among many populations. Many in need of behavioral health care do not receive services because of poor access to providers and continued stigma. Therefore, purchasers are looking for solutions through payment and delivery reform.

1. Can Administrator support purchaser-customers who would like to integrate behavioral health care and substance use disorder services with medical services (no longer carving them out)?

1. Please list the behavioral health and substance use disorder vendors that Administrator partners with and what each partner does to ensure that its behavioral health and/or substance use disorder services meet Purchaser's needs (e.g., AbleTo, Lyra Health).

1. Please list the quality measures Administrator uses to measure a provider’s performance in offering behavioral health care and substance use disorder treatment to Plan Participants.

1. Is the performance of behavioral health and substance use disorder providers on the quality measures listed in the response to Question 3 reviewed prior to accepting a provider into the network and/or monitored on an ongoing basis?

1. Is the performance of behavioral health and substance use disorder providers on the quality measures listed in response to Question 3 reported to the providers themselves? The Purchaser?

1. Please describe how Administrator encourages the integration of behavioral health care and substance use disorder care with primary care, such as co-locating behavioral health and substance use disorder providers in primary care settings.

1. Please describe any current payment reform, delivery reform, benefit design, or provider network design strategies Administrator has in place to improve behavioral health care and substance use disorder treatment.

1. Please describe any planned strategies to address the behavioral health and substance use disorder needs of Plan Participants in the future (2020-2022).

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**Assessing Administrator’s Payment Strategies for Total Joint Replacement**

Hip and knee replacements are two of the most commonly performed surgeries in the U.S. As both the demand for and cost of hip and knee replacement surgeries grow, along with the large variation in prices for these services, covering these procedures will continue to present challenges to purchasers, payers, and patients.

For a guide to help with implementation of a TJR strategy, visit CPR’s [Total Joint Replacement and Bundled Payment Toolkit](https://www.catalyze.org/product/tjr-bp-toolkit/)

1. Does Administrator currently contract with provider group(s) through bundled or episode-based payments for hip/knee replacements? If so, please describe the program and the applicable market(s).

1. How much would Administrator charge a purchaser to provide the services necessary to implement a bundled payment program including: 1) network selection criteria and network development for this specific program; 2) benefit implementation including benefit design changes, offering health coaches, developing and distributing Plan Participant communication; and 3) operations including claims processing, reporting, and reconciliation.

1. Please describe the support Administrator provides to Plan Participants for preadmission services, case management, pre- and post- procedure programs.

1. Please describe any specific inclusions/exclusions from the program or from the warranty portion.

1. Is Administrator designing, piloting, or in the process of implementing strategies to encourage Plan Participants to select higher-value providers for joint replacement procedures? If so, please describe.

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**Assessing Administrator’s Genetic Testing Strategy**

The number of available genetic tests is increasing by the day. Employers and other health care purchasers are unable to keep up with understanding which tests provide high-value and which ones do not. And the number of tests conducted and the cost for those tests is increasing faster than other areas of health care. As a result, it’s important that administrators develop and maintain the expertise to stay on top of this rapidly expanding area of health care.

1. What is the health plan’s medical policy for genetic testing coverage? How does the health plan stay up-to-date on the latest evidence in this rapidly evolving area?

1. Which genetic tests are covered under the preventative care benefit and what makes these tests high-value? Are other tests covered under the lab copay/coinsurance? Are there tests or services that fall outside of these two benefit categories, and if so, how are they covered?

1. Does the health plan cover pre- and post-genetic testing counseling?

1. What is the health plan doing to manage the increasing cost and utilization associated with genetic testing?

1. How does the health plan manage its provider network? Are there specific certifications required for physician geneticists and genetic testing counselors? Are the providers and their certifications shown on the provider search tool?

1. What are the health plan’s standards for approving a lab for genetic testing and how are labs monitored on an ongoing basis?

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**Assessing Administrator’s Serious Illness Care Strategy**

1. Please describe any specific benefits for identified seriously ill plan participants that provide additional support for symptom management, including specialty palliative care services. Limit response to 250 words.

1. Does Administrator have defined processes (i.e. processes that are data-driven, evidence-based, and proactive) to identify plan participants living with serious illness and/or multiple chronic conditions?

1. Does Administrator provide access to case managers with specific training on: serious illness clinical care, symptom assessment, advance care planning and goals-of-care conversations, as well as knowledge of the specific services available?

1. Does Administrator use payment incentives to ensure network providers have advance care planning and goals-of-care conversation skills and/or competencies in clinical efforts to prevent, reduce and/or eliminate symptoms (“symptom management competencies”)?

1. Does Administrator ensure that providers specialty-trained in palliative care are included in the network?

1. Does Administrator require a documented palliative care assessment and care plan as a component of prior authorization for services involved in treating a serious illness?

1. What services does Administrator provide to improve the quality and number of advance care planning and goals-of-care conversations among those who would benefit from them? Please select all that apply.

      Educate plan participants on advance care planning

      Provide advance care planning documents and referrals to community resources, such as advance care planning workshops hosted by community organizations

      Track and report on advance care planning conversations facilitated by case managers

      Track and report on advance care planning conversations billed by network providers, including primary care providers

      Share advance care planning documents, care plan, and chart notes with plan participant’s care team

      Disseminate guides to plan participants on how to talk to their doctor about their values and what kinds of care are most important to them

      Require advance care planning conversation and documentation as part of prior authorization process for services for plan participants with serious illness (e.g. chemotherapy, left ventricular assist device, etc.)

Other. Please list any other services not described above. Limit response to 100 words.

1. Does Administrator provide programs and/or services to assist family caregivers of plan participants experiencing serious illness?

1. Does Administrator offer improved hospice policies over those required under the Medicare hospice benefit? (i.e. allow for concurrent palliative care and curative treatment, eligibility with up to a 12-month life expectancy).

1. The health plan assigns members to an ACO based on the number of encounters they have had with a provider in the ACO during a certain time period. [↑](#footnote-ref-1)
2. A health plan offering that members actively select during open enrollment. [↑](#footnote-ref-2)