

2021 MODEL HEALTH PLAN CONTRACT LANGUAGE

ON PAYMENT REFORM, HIGH-VALUE STRATEGIES AND CREATING A ROBUST AND COMPETITIVE HEALTH CARE MARKETPLACE FOR EMPLOYERS AND OTHER HEALTH CARE PURCHASERS

DISCLAIMER: This Agreement is provided for informational purposes only. Before Purchaser makes any decisions as to whether to use this Agreement in whole or in part and to understand the legal implications of doing so, Purchaser should consult with a qualified legal professional for specific legal advice tailored to its situation.

Improving Value through Health Care Innovation and Reform

This Agreement is made and entered into this [#] day of [month], 2021, by and between [carrier or third-party administrator name], hereinafter called "Administrator," and [employer or other health care purchaser name], hereinafter called "Purchaser."

For the purposes of this Agreement, the term "Provider" shall refer to all health care providers for which there is health care spending. In addition, the term "Plan Participant" shall refer to Purchaser's covered population, such as employees, dependents and retirees, who are eligible to receive their health benefits under the group health plan (“Plan”).

# **Introduction**

Purchaser sponsors a Plan under which eligible employees and retirees can enroll in health insurance coverage. Purchaser sponsors the Plan to ensure that Plan Participants have coverage for and access to comprehensive, high-value health care. Administrator provides third-party Plan administration services to Purchaser, which are described in the Administrative Services Only (ASO) Agreement entered into between the parties effective on [fill in effective date of Agreement here]. To improve the delivery of health care, including outcomes, affordability, efficiency, safety, and patient-centeredness, and to reduce the prevalence of health disparities among vulnerable Plan Participants, requires changes to Provider payment models and delivery structures, and requires greater downward pressure on Provider prices. This Agreement outlines Purchaser's expectations for how Administrator shall facilitate progress in these areas:

* 1. Combatting High Prices and Stimulating Competition
  2. Transparency
  3. Provider Payment and Care Delivery Reform
  4. Benefit and Network Design
  5. Health Disparities and Care Improvement
  6. Participation, Collaboration and Reporting

These contractual commitments are included to support and advance Administrator initiatives to develop a health care market in which (a) payment to Providers reflects the effectiveness and efficiency of care, (b) Plan Participants are engaged in managing their health and empowered to select Providers and services based on quality and price, and (c) health disparities and social determinants of health are proactively measured and addressed. The Administrator will use reasonable efforts to ensure that these commitments and initiatives apply to all benefits offered under the Plan and administered by the Administrator, as applicable, to the extent such implementation is supported by the ASO Agreement and any Scope of Work related thereto. To facilitate broad consistency in payment and delivery reform efforts, Administrator should apply initiatives across all books and lines of business, including fully insured, self-insured, public and private sector, as appropriate and permitted.

Administrator will make best efforts to design products, programs and models that reflect commitments incorporated into this Agreement, and report on progress with transparency and regularity. Unless otherwise specifically provided for herein, Administrator shall comply with the obligations set forth in this Agreement in accordance with the timelines established for each initiative. Failure of the Administrator to materially meet these commitments by the applicable dates set forth in this Agreement will be considered grounds for Purchaser non-renewal of the Agreement.

# **II. Obligations of Administrator**

To advance the objectives stated above, Administrator shall promptly take actions across the following strategic priority areas:

## Combatting High Prices and Stimulating Competition

Economists agree that prices, not utilization, are the primary driver of health care cost inflation. Moreover, the gap between Medicare rates and Commercial payments continues to widen year over year. Meanwhile, Provider consolidation continues to tip market power toward the delivery system, giving powerful health systems more leverage to raise prices beyond what the market can sustain. The COVID-19 pandemic may exacerbate these trends, as independent practices experiencing declining revenue face the unfortunate choice between merging with other health care systems and shutting down for good. Diminished Provider competition and subsequent price increases place financial strain upon Purchasers and their Plan Participants.

Administrator shall implement strategies that place downward pressure on Provider prices across all sites of service (facility, professional, ancillary and pharmacy), and take steps to help re-balance Provider market power and protect independent Provider practices. These strategies shall include the following:

1. **Report markets and Providers with competitive issues.** Administrator is in a unique position to understand which Providers and markets charge exorbitant prices and enjoy anti-competitive practices.As an ally to Purchaser and Purchaser’s Plan Participants, Administrator shall share relevant information with Purchaser to disclose Providers who charge exorbitant prices, which markets are highly concentrated, and on any adverse impacts from recent Provider mergers or acquisitions. Specifically, for the five (5) markets comprising the majority of Purchaser’s Plan Participants’ geographic distribution, Administrator shall provide the following information annually:
   1. [The Herfindahl-Hirschman Index](https://www.justice.gov/atr/herfindahl-hirschman-index) (or HHI) for facilities and physician practices. HHI is a standard indicator of market competition, used by the US Department of Justice to measure market concentration.
   2. Hospital outpatient and inpatient paid rates relative to Medicare rates for the top five (5) hospitals utilized by Purchaser’s Plan Participants in each market.
2. **Eliminate anti-competitive provisions from Provider contracts.** Administrator shall remove and/or refuse language in Provider contracts that suppress competition. These types of provisions include, but are not limited to:
   1. Anti-tiering provisions, which require Administrator to place a Provider in the top tier of a high-performance network regardless of whether Provider meets the criteria for placement in the top tier.
   2. Anti-steering provisions, which prevent Administrator from directing Plan Participants away from high-cost health systems and toward lower-cost, high-quality Providers.
   3. Gag clauses, which prevent Administrator from displaying a Provider’s cost and/or quality data.
   4. “All or none” contracting, which prevents Administrator from excluding high-cost or low-quality facilities within a multi-hospital health system from its network.
3. **Support independent practices and other Provider types where supply is limited.** Administrator shall endeavor to prevent further market consolidation by supporting independent Provider practices. Support may include but is not limited to introducing alternative payment models that accommodate small, independent Provider practices and offering population health management consultation and additional operational support as needed. To bolster the supply of available Providers, Administrator shall also include alternative Provider types within its network, to the extent that state and federal law allow.
4. **Where possible, negotiate Provider contracts based on Medicare multiples**.Rather than negotiating Provider contracts in terms of discounts off of billed charges, Administrator shall use Medicare as a reference point in Provider contract negotiations, where applicable. Where Medicare benchmarks do not exist, e.g., pediatrics, Administrator shall endeavor to use a cost + analysis to determine rates that are appropriate, fair, and defensible.
5. **Engage local purchaser groups to combat Provider market power.** Administrator shall work with local coalitions of health care Purchasers to address specific market challenges and develop innovative market-based solutions, if appropriate.

## Transparency

Transparency is a core building block to high-value health care. To help promote quality and price transparency, Administrator shall take the following actions:

1. **For Plan Participants:** Although [evidence is mixed](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0746) on whether health care consumers consistently and effectively use transparency tools to search for care, Plan Participants have the right to know price and quality information as they decide on treatments and Providers. Moreover, the 2021 [Consolidated Appropriations Act (CAA)](https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf) requires agreements between plan sponsors (i.e. Purchaser) and service administrators (i.e. Administrator) to provide access to provider-specific cost or quality information as part of Purchaser’s fiduciary responsibilities. As such, Administrator shall ensure that its Plan Participant-facing tools include the following:
   1. Fully disclose pricing information to facilitate comparisons of Providers and services by Plan Participants.Unless expressly prohibited, Administrator’s consumer-facing price transparency tool should provide the following information and functionality to Plan Participants:
      1. Full disclosure of prices Administrator pays to Providers, based on contracted rates OR claims history for the most recent 12 months available.
      2. Plan Participants’ benefit design and accumulator status, e.g., deductible, out-of-pocket maximum, co-payments/co-insurance.
      3. Service-level prices, for services that represent at least 80% of Administrator’s medical spend in all markets.
      4. Easy accessibility via website and/or mobile application 24 hours a day, 7 days a week.
      5. Full disclosure of other important Provider and facility cost indicators to facilitate informed decision-making.
   2. Beyond disclosing prices, Administrator’s consumer-facing tool shall also meet the following specifications:
      1. Provide service-specific, nationally recognized clinical quality measures, including IHA’s [“Align Measure Perform (AMP)”](https://iha.org/performance-measurement/amp-program/measure-set/) measure set for Commercial ACOs, with a goal of including all of the measures for which there are data available. The information should disclose the performance of Providers based on established quality metrics to facilitate Plan Participants' informed choice of Provider and treatment decisions.
      2. Include Provider demographic data such as race, ethnicity, and language(s) spoken.
      3. Incorporate measures of patient experience of care.
      4. Meet other specifications as described in CPR’s “[Comprehensive Specifications for the Evaluation of Transparency Tools](https://www.catalyze.org/product/evaluating-transparency-tool/)” toolkit. Administrator shall outline for Purchaser which specifications its tool does not meet and share a timeline for meeting them.
2. **For Purchasers:** Purchasers need information about the prices and the quality of Providers and services to procure higher-value health care and assess the efficacy of network and benefit design strategy. Therefore, Administrator shall provide Purchaser with transparent, comprehensive and meaningful reporting on price, quality, utilization and Plan Participant experience, on a bi-annual basis at a minimum. Administrator shall include all results – including unfavorable outcomes – such that Purchaser can independently assess Plan performance. The disclosed information shall provide performance data for Providers accessed by Plan Participants and shall be based on nationally recognized clinical quality measures (see A.ii.a) and the contracted price of specific procedures and services.
3. **For State All-Payer Claims Databases (APCDs):** APCDs fill a critical need for health care cost transparency by gathering and often sharing *paid* amounts for health care services. In applicable markets, Administrator shall contribute complete data to state APCDs from its fully-insured book of business, and provide infrastructure for willing self-insured Purchasers to contribute their claims data.
4. **For Providers:** Transparency into cost, utilization and quality outcomes helps Providers understand their performance under alternative payment models and identify opportunities for performance improvement; price and quality data are equally important in helping Providers refer Plan Participants to high-value specialists and facilities. As such, Administrator shall:
   1. Disclose price information to Providers.Administrator shall make available the relative prices of Specialists, Facilities and Ancillary Service Providers in Administrator’s network to referring Providers for the purpose of making informed referral decisions. Reporting shall be comprehensive and use the most current data available to support Providers in making high-value referrals.
   2. Disclose quality information to Providers.Administrator shall make quality performance information available on demand to Providers so that they can assess their care practices and identify where to improve. In addition, Administrator shall make available to Providers the quality performance of other Providers in Administrator’s network to help Providers make informed referrals. Reporting shall be comprehensive and use the most current data available to support Providers in making high-value referrals.
   3. Provide infrastructure for bi-directional data exchange. Administrator shall build data infrastructure for bi-directional data exchange between Administrator and the Providers in Administrator’s network. Administrator shall leverage data it receives from Providers for the purpose of reporting on patient outcomes that require hybrid clinical/administrative data.

## Provider Payment and Care Delivery Reform

Strategies to reform Provider payment and care delivery gained significant momentum over the past decade. While health plans have made strides in increasing the prevalence of rewards-based programs (e.g., shared savings or pay for performance), opportunity remains to implement models that pose financial risk to Providers through methods like bundled payment, capitation, and shared risk (also known as “downside risk”) arrangements. By their nature, financial models that include shared risk increase Provider accountability, and evidence suggests that these models are [more likely to produce savings](https://www.healthaffairs.org/do/10.1377/hblog20201016.884678/full/) than models that include a potential upside only.

As such, Administrator shall implement health care payment and delivery strategies that reduce waste and improve the quality and coordination of care, by pursuing the following strategies:

1. **Initiate and expand contracts where Providers face financial risk for cost, care outcomes and efficiency.** Administrator shall implement strategies that require Providers to accept financial responsibility for cost, utilization and patient outcomes. Under these contracts, Providers are financially liable for overspending or failing to meet specified cost and quality targets. Examples include, but are not limited to the following:
   1. Shared risk (downside risk) contracts, where Providers are accountable for a total cost of care target for an attributed population of patients and accept financial liability if they fail to meet financial or clinical quality targets.
   2. Bundled or episode-based payment (paid prospectively or retrospectively), where Providers receive a single amount for all services to treat a given condition or to provide a given treatment or procedure. Providers assume financial risk for the cost of services for a condition or procedure as well as costs associated with preventable complications. Administrator’s bundles should be based on standard definitions of care episodes, e.g., Medicare or Prometheus.
   3. Condition-specific capitation, where Providers receive a fixed dollar payment for the care that patients receive for a specific condition (or set of conditions) in a given time period, such as a month or year.
   4. Partial or full capitation with quality: A fixed dollar payment to Providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance (quality, safety, and efficiency) and patient risk. Includes quality of care components with pay-for-performance. Full capitation on top of which a quality bonus is paid (e.g., pay for performance) is considered full capitation with quality.
2. **Include quality measures that focus on patient outcomes.** Administrator’s portfolio of alternative payment models shall, in all cases, create incentives to improve clinical quality as well as performance on financial and utilization targets. When connecting payment to the quality of care, Administrator shall use measures that assess care outcomes rather than care processes, leveraging nationally-recognized metrics wherever possible. As an example, see the IHA’s [“Align Measure Perform (AMP)”](https://iha.org/performance-measurement/amp-program/measure-set/) measure set for Commercial ACOs. Bonus payments for care outcomes should accrue to the Providers who are delivering care; they should reflect Providers’ performance and result in market efficiencies and savings for Purchaser.
3. **Support Providers in managing population health.** Administrator shall share timely, accurate and actionable population health management data to support Providers in alternative payment model contracts. Administrator shall supply Providers engaged in payment reform models with timely, actionable and meaningful data, analytics and reporting. Administrator shall also offer consultative support to help Providers identify opportunities to improve efficiency, quality of care outcomes, and patient experience.
4. **Balance payment between primary and specialty care**. Administrator shall develop, pilot and implement strategies to increase and prioritize payment for [primary care services,](https://www.milbank.org/2017/07/getting-primary-care-oriented-measuring-primary-care-spending/) including strategies to reduce payment discrepancies between primary and specialty care. Such strategies may include, but are not limited to performance-based incentive programs that emphasize primary care (e.g., shared risk arrangements may encourage Providers to reduce unnecessary referrals to specialists), fee schedule adjustments (e.g., care coordination fees or increasing the payment amount), partial or full capitation, and health care delivery system models such as ACOs. Regardless of the payment method, Administrator shall advance and support delivery of care models that improve the quality of care while also reducing health care disparities and total health care costs.
5. **Implement payment models in primary care that blend capitation and fee-for-service.** For the purposes of a) sustaining primary care Provider practices and b) encouraging continued utilization of virtual health care (i.e. telehealth) without raising costs, Administrator shall launch and evaluate the effectiveness of models with primary care practices that offer a blend of capitated payment for core activities, including virtual visits, and offer fee-for-service payment for certain in-person services, including virtual visits, and offer fee-for-service payment for certain in-person services, including some in-person visits that are outside of evaluation and management services.
6. **Pay appropriate relative amounts for services.** Administrator shall implement changes to the underlying fee schedule to establish relative amounts that encourage Providers to offer appropriate care and reduce health care disparities. In particular, Administrator shall address potentially mis-valued services by adjusting payment for services that either exceed or come up short against the actual cost required to produce them. For example, unless required by law, Administrator shall not offer payment parity for a telephonic visit when an office visit is warranted.
7. **Withhold payment for avoidable services.** Administrator shall not pay Providers for care that is deemed unnecessary or wasteful. Such strategies include, but are not limited to, non-elevated payment for hospital-acquired conditions, non-payment for all-cause readmissions within 30-days, and non-payment for elective cesarean deliveries and/or elective inductions prior to 39 weeks of gestation.

## Benefit and Network Design

Directing Plan Participants to Providers and services that offer higher quality care at a lower cost will help Purchaser extract more value from the health care system. Administrator’s benefit designs and Provider network strategies can signal to purchasers which services are most valuable, and signal to Providers that purchasers will not support unwarranted variation in health care prices or quality.

Administrator shall act as Purchaser’s partner in this arena by developing and recommending network and benefit design strategies that will curate select Providers from among its Provider network and incentivize Plan Participants to seek out high-value services and Providers, including the following offerings:

1. **Benefit design and network products that encourage Plan Participants to seek high-value Providers and services.** Administrator shall cultivate and offer networks and products that encourage consumers to seek high-value services or care from high-value Providers and encourage Plan Participants to seek the health care services that they need. Such strategies may include, but are not limited to, tiered and narrow networks; centers of excellence; reference-based benefits; value-based insurance design; and benefit designs encouraging the use of alternative, less expensive sites of care.
2. **Benefit design and network products designed to shift Plan Participants away from low-value services and Providers.** Administrator shall offer network products that exclude hospitals that have prices significantly above the market rate and/or have clinical quality outcomes that are significantly lower than the median hospital. Administrator shall design and administer benefit incentives that discourage consumers from seeking low-value services or care from low-value Providers. Such strategies may include, but are not limited to, those services recommended by the [Center for Value-Based Insurance Design’s V-BID X.](https://vbidcenter.org/about-v-bid/)
3. **Benefit design to shift toward lower-intensity sites of service.** Administrator shall design and administer benefit incentives that encourage Plan Participants to seek care from lower-intensity sites of service – such as independent ambulatory surgery centers, freestanding imaging facilities, and infusion services delivered in Provider offices rather than in inpatient facilities.
4. **Benefit design for employees with lower incomes and their families.** Administrator shall design and administer benefit designs that accommodate the needs of Plan Participants with lower incomes; products shall include incentives for Plan Participants to seek health care services that help prevent or manage preventable or chronic conditions.
5. **Opportunity for direct and/or semi-direct contracting**. Administrator shall allow direct negotiations between Purchaser (and/or groups of purchasers) and select Provider groups; Administrator shall be willing to administer direct relationships between Purchaser(s) and Providers that cater to the needs of Purchaser’s Plan Participants.

## Health Disparities and Care Improvement

Purchaser is committed to ensuring that care is individualized and equitable, and that contracted Providers have the tools, resources, training and incentives to manage population health and improve care outcomes – particularly among vulnerable populations. The concept of individualized, equitable care means regardless of one’s circumstances, race, gender, where one lives or other socioeconomic factors, every individual deserves the best possible, personalized, cost-effective care delivered in the right setting at the right time. Historically, health plans have lagged in their progress toward improving health equity, particularly in clinical areas like maternity care and behavioral health, where quality, access and efficiency lag for *all* health care consumers, but particularly for vulnerable populations who are subjected to discrimination and racism.

1. **Improve health equity and reduce racial disparities in care outcomes.** Administrator shall implement the following practices and programs that hold Administrator and its contracted network accountable for improving care outcomes, addressing health equity concerns, and improving population and community health services:
   1. Collect demographic data from Plan Participants.Addressing equity in health care begins with measurement to understand the scope and specificity of underlying disparities in care. As such, Administrator shall commit to collect the following demographic information for at least 80% of Plan Participants:
      1. Race and ethnicity
      2. Income
      3. Disability status
      4. Sexual orientation
      5. Gender identity
      6. Limited English Proficiency (LEP)
      7. Spoken language
   2. Report on care outcomes by race and ethnicity.Administrator shall work with Purchaser to identify relevant metrics to report by Plan Participants’ race and ethnicity. Examples can be found in Covered California’s clinical disparity metrics.[[1]](#footnote-1)
   3. Develop remediation plan to address clinical areas where marked disparities persist across racial or ethnic categories. Administrator shall work with Purchaser to identify clinical areas that show persistently disparate outcomes across racial and ethnic categories and collaborate with Purchaser to develop a remediation strategy. Administrator shall set goals for reducing health outcomes gaps between racial groups, and report on interim progress.
   4. Screen Plan Participants regarding housing instability and food insecurity. Administrator shall collect information on Plan Participants’ access to safe housing and high-nutrition food; Administrator shall use this information to direct Plan Participants who are experiencing housing instability and food insecurity to appropriate community programs and resources.
   5. Achieve or maintain NCQA Multicultural Health Care Distinction (MHCD).As a commitment to building a program to reduce documented disparities and to developing culturally and linguistically appropriate communication strategies, Administrator shall meet the standards for the Multicultural Health Care Distinction (MHCD) by the National Committee for Quality Assurance (NCQA).
   6. Require health equity training for Administrator’s staff.
2. **Improve maternity outcomes and address care disparities.** 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, maternal morbidity and mortality, and disparities in maternal outcomes across different populations of women are unacceptably high. A top priority for Purchaser is to encourage adherence to clinical guidelines for maternity care. As such, Administrator will take the following steps with regard to maternity care services:
   1. Maternity care payment and certification. Administrator shall implement payment strategies to reduce maternal disparities, the rate of early elective deliveries, and elective cesarean deliveries. Such strategies may include, but are not limited to, bundled payment for prenatal care, labor, and delivery, and post-partum care, blended single payment amount for cesarean delivery and vaginal births, and non-payment for early elective cesarean deliveries and/or inductions. Administrator shall certify and establish a payment process for alternative maternity care Providers demonstrated to provide high-quality care at lower cost, such as certified nurse midwives, laborists, doulas, and free-standing non-hospital birth centers.
   2. Elective delivery rate. Administrator shall require that Providers achieve a rate of 5% or less of early elective deliveries prior to 39 weeks. If a Provider does not achieve this rate, Administrator shall exclude Provider from the network, or report to Purchaser each year the rationale for continued contracting with Provider, and the efforts the Provider is undertaking to improve performance.
   3. Nulliparous, Term, Singleton, Vertex (NTSV) C-Section Rate. Administrator shall contract only with hospitals that demonstrate they provide high-quality maternity care and promote the safety of Plan Participants during childbirth. Administrator shall either exclude hospitals that are unable to achieve The Joint Commission’s NTSV C-Section rate below 23.9 percent from Provider networks serving Plan Participants or report to Purchaser each year the rationale for continued contracting with Provider, and the efforts the Provider is undertaking to improve performance.
   4. Steps to address racial disparities in maternal outcomes. Administrator shall promote and encourage all in-network hospitals that provide maternity services to leverage toolkits and best practices supplied by [The California Maternal Quality Care Collaborative (CMQCC)/Alliance for Improvement in Maternal Health (AIM](https://www.cmqcc.org/resources-tool-kits/toolkits)).
   5. Measure and report results. Administrator shall provide Purchaser and Plan Participants with information related to adherence to clinical guidelines for maternity care, and the quality of maternity care among Administrator's network Providers on an ongoing basis. Administrator shall measure and report on The Joint Commission’s NTSV C-Section measure. Administrator shall require that Providers that operate in states with a maternity data registry, such as the California Maternal Quality Care Collaborative Maternal Data Center, fully participate in the registry by reporting their data to it.
3. **Improve access, quality and integration for behavioral health services.** Mental health and substance use disorder treatment, collectively behavioral health services, includes identification, engagement, and treatment of those with mental health conditions and substance use disorders. Additionally, consistent with evidence and best practice, Administrator should ensure that Plan Participants receive timely and effective behavioral health care that is integrated with primary care. Purchaser and Administrator recognize the critical importance of behavioral health services, as part of the broader set of medical services provided to Plan Participants, in improving health outcomes and reducing costs.

Administrator shall address Purchaser concerns about the rising costs of behavioral health care, Provider access and quality challenges, and integration with medical services, through the following strategies.

* 1. Implement new models of payment and delivery reform in behavioral health. Strategies may include, but are not limited to:
     1. Paying behavioral health Providers sufficiently to promote adequate Provider access
     2. Expanding access by offering tele-behavioral health or computerized Cognitive Behavioral Therapy
     3. Ensuring that Administrator’s behavioral health network matches the demographic, psycho-social and cultural needs of Purchaser’s Plan Participant population
     4. Integrating behavioral health Providers into primary care, including behavioral health Providers in accountable care organizations
     5. Incorporating nationally-endorsed behavioral health quality measures that address the spectrum of behavioral health needs (i.e., needs for both lower- and higher-severity conditions) into payment and delivery reforms (e.g., evidence-based care, medication assisted treatment, etc.).
  2. Report progress to Purchaser. If Administrator determines that the linkage between payment and adherence to clinical guidelines results in meaningful improvement in value and clinical outcomes, Administrator shall report to Purchaser 1) plans to expand initiatives in the short term (1 year) and long term (3-5 years); and, 2) other clinical areas where current payment approaches create financial incentives to provide care that is not evidence-based, and where a change in payment methodology could instead provide incentives for evidence-based care.

## Participation, Collaboration and Reporting

Purchaser seeks an Administrator partner in every sense. This means providing comprehensive reporting that shows the good and bad and working with purchaser to solve challenges. It means collaborating with Purchaser’s other vendor partners and participating in initiatives strategically important to Purchaser that may lie outside of the Administrator-Purchaser relationship. It means – fundamentally – that Purchaser owns its Plan Participant claims data and should have unfettered access to data and analytics that underpin Purchaser’s benefits strategy. To that end, Purchaser requests that Administrator commit to the following:

1. **Report to Purchaser.** Administrator shall report regularly to Purchaser on its efforts to achieve the objectives of this Agreement according to the timelines set forth, including, but not limited to:
   1. Progress toward expanding payment reform programs.Administrator shall demonstrate progress toward expanding alternative payment models and delivery reform initiatives calculated through Purchaser’s annual spend for the preceding calendar year using the format and calculation methodology in section one (“Tracking Administrator’s Progress on Payment Reform”) Catalyst for Payment Reform’s [2021 Health Plan RFI](https://www.catalyze.org/product/aligned-sourcing-contracting-toolkit/).
   2. Results of Administrator’s alternative payment models and delivery reform initiatives. To avoid the tendency to cherry-pick favorable results and to create standardized metrics of program success, CPR has developed standard reporting templates that guide plans to report on measures of cost, quality, and utilization for their payment reform initiatives. These templates include the [Standard Plan ACO Report for Customers](https://www.catalyze.org/product/sparc/) and [Reform Evaluation Frameworks](https://www.catalyze.org/product-category/tool-library/program-evaluation/) for bundled payment. Administrator shall provide comprehensive and complete results using these templates, and share results for Purchaser’s Plan Participants and for Administrator’s broader book of commercial business. In the context of evaluating ACO arrangements, Administrator shall fill out all components of the [Standard Plan ACO Report](http://www.catalyze.org/product/sparc/) and describe how Administrator used and distributed care coordination and administrative services only (ASO) fees.
   3. The quality, efficiency and cost of care savings gains accruing through Administrator’s high-value Provider network and/or benefit design products, using CPR’s [Reform Evaluation Frameworks](https://www.catalyze.org/product-category/tool-library/program-evaluation/) for High-Performance Networks, Centers of Excellence and Reference-based Pricing, if applicable to Purchaser’s product portfolio. Administrator shall show results for Purchaser’s Plan Participants and for Administrator’s broader book of commercial business.
2. **Report to Catalyst for Payment Reform and its member organizations.** CPR is a nonprofit organization that measures the implementation of payment reform and whether these reforms are producing higher-value care and health outcomes. Purchaser has a vested interest in Administrator’s transparency regarding which payment methods Administrator utilizes and which succeed at producing higher-value care.
   1. Upon invitation, participate in CPR’s Health Plan User Group meetings.During the year, CPR hosts Health Plan User Group meetings, which provide opportunity for CPR members to hear directly from health plans on CPR member-generated topics of interest. Administrator will work with CPR to provide updates on progress toward CPR member-directed goals and topics of interest. Such updates include, but are not limited to, completion and sharing of the CPR Health Plan User Group progress report and other prescribed reporting templates and presentations to CPR members on timely topics, delegating to subject matter experts as needed.
   2. Provide data for CPR’s Scorecards on Payment Reform**.** CPR created the first national mechanism to track the implementation of payment reform in 2012. CPR aggregates data on annual spend flowing through alternative payment models, enabling CPR to continue to generate its Scorecards on Payment Reform. When requested, the Administrator shall provide information to CPR about its approaches to paying Providers to support the implementation of its Scorecards on Payment Reform, hereinafter called "Scorecard."
      1. Data provided by Administrator for the Scorecard shall be aggregated with other submissions and de-identified, unless specifically agreed to otherwise and only as permitted by applicable law.
      2. Administrator shall provide data during the specified data collection period on an annual basis. Information will be for the most recent 12 months’ data available.
      3. CPR will review its Scorecard definitions and metrics regularly for relevance in the current marketplace and will clarify definitions and retire or add new metrics as appropriate. If CPR modifies definitions and/or adds new metrics to the Scorecard, CPR will consult with health plan Administrators on the feasibility of collecting the data to calculate any new metrics.
3. **Report to other stakeholder external entities.** Improving the efficacy, affordability and value of the health care ecosystem cannot happen in a vacuum. Purchaser expects and anticipates that Administrator will readily and willingly collaborate with selected external entities who have a mutual purpose of pursuing these goals. This includes, but is not limited to, the following:
   1. Participate in external price and quality transparency initiatives including, but not limited to, contributing data to RAND’s Hospital Price Transparency Study and all-payer claims databases.
   2. Commit to hiring an independent evaluator to review Administrator’s payment reform, benefit/network design, and quality improvement program(s), releasing the results publicly.
   3. Multi-stakeholder feedback suggests health plans have become more restrictive with data sharing in recent years. Products and services that drive Plan Participants to higher-value Providers like navigation, advocacy, and transparency tool vendors, data warehouse and analytics companies, and benefits consultants all cite challenges in obtaining data from health plans. Administrator shall commit to sharing relevant information with Purchaser’s contracted support vendors like navigation, advocacy, and transparency tool vendors, data warehouse and analytics companies, and benefits consultants to enable these partners to provide services to Purchaser and Purchaser’s Plan Participants.

## ACKNOWLEDGEMENT

[OPTIONAL SECTION.Include if the ASA does not address this issue generally.]

Administrator acknowledges that the Purchaser is relying on Administrator’s experience and expertise in providing the evaluative and analytic information described in this Agreement and that Administrator represents that it will use its best efforts to achieve the objectives set forth in this Agreement. Aside from the circumstance where Purchaser has established a direct contract with a Provider, Administrator and Purchaser agree that Administrator has full and complete responsibility **for negotiation, execution** and maintenance of the contracts governing its Provider network and that the Purchaser has no authority with respect to or control over the terms of such contracts, including methods and rates of payment and evaluation of Provider performance.

1. <https://hbex.coveredca.com/stakeholders/plan-management/PDFs/proposed-2022/Proposed%202022%20Attachment%207%20QHP%20IND%20Clean_3-18-21.pdf> (section 1.02.2) [↑](#footnote-ref-1)