2021 Health Plan Request for Information (RFI)

**A Questionnaire for Purchasers Seeking Effective Payment Reform, Other High-Value Strategies, and A Functional Marketplace**

Our health care system is broken and needs to be fixed. The challenges are particularly acute for employers, other health care purchasers, and those for whom they buy health care.

Providers command high prices, and they are rising primarily due to the market power many provider groups and health systems hold. Recent policy efforts aim to increase provider and plan price and quality transparency, but until policies are fully implemented and the price and quality information is usable, purchasers and their plan participants will struggle to understand from which providers they should seek services. While the percent of health care spending flowing through value-oriented payment methods has increased tremendously over the past 10 years, we still need additional evidence about the effectiveness of the various methods. Furthermore, COVID-19 will impact the progress and direction of alternative payment models and reforms in care delivery. Purchasers seek innovation in plan benefit and network designs to ensure their plan participants use their benefits as needed and seek care at the right place, from the right provider, at the right time. Purchasers are also constantly monitoring ways to improve population health, reduce disparities, and increase health equity.

In using this Health Plan RFI, purchasers have an opportunity to impact the marketplace at the “50,000-foot level” by asking questions about an Administrator’s (i.e., health plan or third-party administrator) efforts to address these foundational challenges and support specific purchaser strategies. When many purchasers and broker-consultants pose these standard questions, it sends a loud signal that the topics it asks about are high priorities for purchasers.

***NOTE:*** *We designed this RFI as an add-on to your general RFI. These RFI questions can be appended to a broader RFI in total or purchasers may select to use particular sections. If you plan to use this document with prospective Administrators or others, you may want to select “Protect Form” in the “Developer” tab. This will constrain the responder to typing into the grey form boxes and prevent alterations.* ***We also recommend you delete this page when issuing the RFI.***

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

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# Core Sections – Assessing Administrator’s Efforts to:

### Combat High and Rising Prices

Evidence shows that rising prices are the primary driver of the increasing cost of health care. As the primary negotiators with providers, plans have an outsized impact on health care prices. To help purchaser understand how Administrator is combatting the continued increase in prices and unwarranted price variation, please provide detailed responses to the following questions.

1. What is Administrator doing to combat high and rising health care prices? Cite recent results.

1. Does Administrator have a specific price or trend reduction goal? If so, what is the goal and by when does Administrator expect to achieve it?

1. Deconstruct Administrator’s book-of-business medical and pharmacy cost increases. How much is the increase driven by higher prices, higher utilization, or other causes?

1. Which services or technologies are primary drivers of total cost of care increases? Which services or technologies does Administrator anticipate will drive cost increases in the next 3-5 years?

1. Does Administrator have established criteria for when it would advocate for price regulation? If so, what are the criteria? Are there specific examples Administrator can cite when it advocated for price regulation?

1. Has Administrator ever anchored provider price negotiations to Medicare payment amounts? Cite results.

### Address Provider Market Power and Competition

In recent years, consolidation has afforded health care providers additional market power. In most geographies, there are only one or a handful of hospitals or health systems, giving them leverage in negotiations with plans. Provider market power significantly impacts purchasers, whether or not they are self-insured, along with their plan participants. Thus, purchasers have a vested interest in knowing what plans are doing to address provider market power. To help purchaser understand how Administrator is addressing growing provider market power and the reduction in provider competition, please provide detailed responses to the following questions.

1. In which geographical markets is Administrator particularly concerned about the market power of provider(s)? Cite the markets, provider(s), and use the purchaser’s census to cite the number of purchaser’s plan participants residing there.

1. Has Administrator created guidelines for when it should report anticompetitive behavior among providers or a deleterious lack of competition in any markets to regulatory agencies? Has Administrator made such reports? Please describe.

1. How does Administrator support independent physician practices and other provider types to help them remain independent? Cite specific examples and results.

1. How does Administrator raise specific market challenges with purchaser customers? Has Administrator approached regional groups of purchasers about working together to combat provider market power? Does Administrator openly discuss with purchasers that broad provider networks may mean higher prices and/or premiums due to provider market power? Cite specific examples.

1. How many health systems have negotiated an *anti-steering* contract provision with Administrator? What percentage of Administrator’s covered lives sought care from these health system(s) in the past 12 months? What percentage of book-of-business spend does Administrator pay to these health system(s)? Health systems, as defined by AHRQ, "include at least one hospital and at least one group of physicians that provide comprehensive care (including primary and specialty care) and are connected with each other through common ownership or joint management." This definition applies to the remaining questions in this section.

1. How many health systems have negotiated an *anti-tiering* contract provision (i.e., require being placed in network in narrow network plans or in the top tier in tiered network plans regardless of whether they meet Administrator’s criteria for such placement) with Administrator? What percentage of Administrator’s covered lives sought care from these health system(s) in the past 12 months? What percentage of book-of-business spend does Administrator pay to these health system(s)?

1. How many health systems have negotiated a “*most favored nation”* contract provision with Administrator? What percentage of Administrator’s covered lives sought care from these health system(s) in the past 12 months? What percentage of book-of-business spend does Administrator pay to these health system(s)?

1. How many health systems have negotiated a *gag clause* contract provision with Administrator that limits or prevents publishing price or quality information? What percentage of Administrator’s covered lives sought care from these health system(s) in the past 12 months? What percentage of book-of-business spend does Administrator pay to these health system(s)? What is the status of Administrator negotiating updated contracts to remove these provisions from provider contracts as a result of the Consolidated Appropriations Act of 2020?

### Enhance Price and Quality Transparency

Transparency is a core building block to high-value health care. Purchasers need information about the prices and the quality of specific services and providers to produce higher-value health care or other reforms. Plan participants have the right to know price and quality information as they decide on treatments and providers. To help purchaser understand how Administrator is enhancing price and quality transparency, please provide detailed responses to the following questions.

1. **Transparency Tool Available to Plan Participants**
2. Regarding Administrator’s transparency tool for plan participants:
   1. For how many services does the tool show prices? Do the prices reflect the most recent negotiated fees, are they based on claims history for the most recent 12 months available, or based on another methodology? Please explain.

* 1. What provider quality measures does the tool display?

* 1. Does the tool include provider quality measures on patient experience of care? According to AHRQ, patient experience data evaluates whether something that should happen in a health care setting happened and how often it happened, e.g., access to timely appointment.

* 1. Does the tool display the plan participant’s remaining deductible, co-payment/co-insurance, and out-of-pocket maximum? What is the frequency of the data refresh?

* 1. Does the tool include provider demographic data such as race, ethnicity, and language(s) spoken?

1. For the top health systems where purchaser’s plan participants seek care, provide screenshots of the above information that is available for the following services:
2. Non-specific hospitalization
3. Vaginal delivery
4. Cesarean delivery
5. Total knee replacement
6. What percent of purchaser’s plan participants does Administrator expect to conduct a search within the first year? How did Administrator arrive at its estimate?

1. Which purchaser-specific strategies does Administrator recommend to increase plan participant usage of the tool?

1. **Transparency to Purchasers**
2. Purchaser seeks an Administrator partner that provides fully transparent, comprehensive and meaningful reporting. Purchaser is not looking for reports of only positive results. A few examples of comprehensive reporting templates are Catalyst for Payment Reform’s [Standard Plan ACO Report for Customers (SPARC)](https://www.catalyze.org/product/sparc/) and [Reform Evaluation Frameworks](https://www.catalyze.org/product-category/tool-library/program-evaluation/). Does Administrator commit to provide reporting that comprehensively evaluates the effectiveness of purchaser’s high-value strategies? Does Administrator commit to reporting to purchaser using CPR’s SPAR and REFs?

1. Has Administrator set up the infrastructure to contribute purchaser’s claims data to all-payer claims databases (APCDs) if purchaser should choose to do so? To which APCDs does Administrator currently contribute claims data? Indicate if Administrator contributes only on a fully insured basis or on behalf of self-insured purchasers.

1. **Transparency to Providers**
2. What provider-specific cost and quality data does Administrator share with providers to help them improve their performance?

1. What comparative provider data does Administrator share with providers to help them improve their performance?

1. In order to make informed referrals, can all of Administrator’s network providers access accurate information for the price and quality of services offered by other providers in the network? If not, what circumstances prevent them from accessing this information? Approximately what percent of providers are impacted? How does Administrator intend fix these issues?

1. In which circumstances has Administrator established bi-directional data sharing with provider(s)? Explain the type of data Administrator shares and receives bi-directionally.

### Reform Payment and Care Delivery

Reforming provider payment and the delivery of care have gained significant momentum over the past decade. While plans have made tremendous progress in tying payment to high-quality care delivery through shared savings payment arrangements, opportunity remains to increase provider downside risk using payment methods like bundled payment, capitation, and shared risk. To help purchaser understand how Administrator is evolving provider payment strategies and the care delivery models that alternative payment models support, please provide detailed responses to the following questions.

1. CPR’s [Scorecard on Payment Reform 2.0](https://www.catalyze.org/product/scorecard-2-0/), developed by a broad group of stakeholders including Administrators, allows Administrators to illustrate quantitatively their progress toward changing how we pay for care. Please complete the Excel file, linked to below, to report Administrator’s latest progress. If the RFI came from an employer or other health care purchaser, 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 “[Definitions](https://www.catalyze.org/payment-reform-definitions/).” Remember to share the completed Excel file with Purchaser as a separate attachment.



1. Provide an overview of each of Administrator’s payment or delivery reform programs. Administrator can provide an attachment for additional program details.

1. Which programs in Question 2 can purchaser offer to its population? Cite three programs that Administrator thinks are the best fit based on its knowledge of purchaser. Please explain.

1. Complete the table below on the three programs that Administrator thinks most aligns with purchaser’s strategy and direction.

|  |  |  |  |
| --- | --- | --- | --- |
| **Question to Administrator** | **[Program 1 Name]** | **[Program 2 Name]** | **[Program 3 Name]** |
| What are the program’s goal(s)? |  |  |  |
| What is the program launch date? |  |  |  |
| What is the program status, e.g., pilot, expanding, implemented? |  |  |  |
| What is program’s primary payment model? |  |  |  |
| Does program include downside risk for providers? Yes/No |  |  |  |
| For which lines of business is program available, e.g., commercial self-insured, Medicaid, Medicare, etc. |  |  |  |
| Into which products is program integrated, e.g., PPO, HDHP, ACO, etc.? |  |  |  |
| In which key purchaser geographies is program available? |  |  |  |
| Which provider type manages the program, e.g., PCP, specialist, hospital, etc.? |  |  |  |
| Which threshold(s) must provider achieve to qualify for program, e.g., cost, quality, both, infrastructure, etc.? |  |  |  |
| Are plan participants attributed to program or must they opt in? |  |  |  |
| Are there criteria the purchaser must meet to participate, e.g., plan design, purchaser size, enrollment, etc.? |  |  |  |
| Has the program been independently evaluated by an external third-party or internal party? Provide results. |  |  |  |
| What are Administrator’s plans to evolve the program, including shifting providers to accept downside risk? |  |  |  |
| Does Administrator include program in the quoted administrative fee or is it a buy-up? If a buy-up, what is the fee for the program? |  |  |  |

1. Across all of Administrator’s existing payment reform programs and any upcoming programs, has Administrator set an aggregate goal of the percent of total dollars it plans to pay to providers in downside risk payment arrangements (e.g., bundled payment, capitation, shared risk)? If so, what is Administrator’s goal and by when does the Administrator intend to meet it?

1. What strategies/incentives is Administrator employing/piloting to encourage providers to shift to downside risk payment arrangements?

1. CPR encourages Administrator to experiment more with bundled payment, as evidence shows its potential to reduce cost and improve quality. Describe Administrator’s existing bundled payment program and any plans to expand it, including types of episodes and key providers of purchaser interest. Is Administrator willing to use open-source standard definitions of episodes? Has Administrator set any goals for the percent of total dollars it pays to providers that will flow through bundled payment arrangements?

1. COVID-19 has adversely impacted primary care physicians financially who rely primarily on fee-for-service payment. Many PCPs have expressed interest in capitation or partial capitation payments. What progress has Administrator made toward shifting more PCPs to these payment models? Cite the percent of providers and percent of total provider payments represented. What goal(s) has Administrator set to transition more PCPs to these payment models?

1. What strategies is Administrator implementing to improve the balance of payment between primary care and specialty care (so PCPs are paid more)? Has the shift to capitation or partial capitation helped with this rebalancing? Please explain.

1. What is Administrator’s perspective on payment parity for providers between virtual and in-person visits post-COVID?

1. For which avoidable and unnecessary services (e.g., never events, early elective deliveries, etc.) will Administrator not pay provider? Are these standard non-payment provisions in all provider contracts? Are there also no balance billing provisions for these and other services consistent with the Consolidated Appropriations Act of 2020 in the contracts?

### Innovate with Benefit and Network Design

Directing 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. Administrator’s benefit designs and provider network strategies can signal to purchasers which services are most valuable and to providers that purchasers will not support unwarranted variation in health care prices or quality. To help purchaser understand how Administrator is innovating with benefit and network designs, please provide detailed responses to the following questions.

1. Provide an overview of each of Administrator’s benefit design strategies, including, but not limited to benefit designs that do not discourage health care utilization particularly for employees with low wages, including value-based insurance design, reference-based pricing, strategies that shift plan participants away from low-value services, strategies that shift plan participants away from higher-intensity sites of care, centers of excellence, and ACO products. Administrator can provide an attachment with additional details.

1. Which benefit design strategies above can purchaser offer to its population? Cite three specific strategies that Administrator thinks are the best fit based on its knowledge of the purchaser. Please explain.

1. Complete the table below on the three benefit design strategies that Administrator thinks most align with purchaser’s strategy and direction.

|  |  |  |  |
| --- | --- | --- | --- |
| **Question to Administrator** | **[Strategy 1 Name]** | **[Strategy 2 Name]** | **[Strategy 3 Name]** |
| How many purchasers have implemented this benefit strategy? |  |  |  |
| How many plan participants are covered under this strategy? |  |  |  |
| If applicable, how many providers participate in this strategy? |  |  |  |
| If applicable, how does Administrator select providers for participation in strategy (cost, quality, both, etc.)? |  |  |  |
| If applicable, what percent change is there from the prior year in plan participants selecting these providers for services? |  |  |  |
| If applicable, in which key purchaser geographies is strategy available? |  |  |  |
| Has the strategy been evaluated by an external third-party or internal party? Provide results. |  |  |  |
| What are Administrator’s plans to evolve the strategy? |  |  |  |

1. Provide an overview of each of Administrator’s important network design strategies, including, but not limited to direct- and semi-direct contract administration services, narrow networks, and tiered networks. Administrator can provide an attachment with additional details.

1. Which network design strategies above can purchaser offer to its population? Cite two specific strategies that Administrator thinks are the best fit based on its knowledge of the purchaser. Please explain.

1. Complete the table below on the two network design strategies that Administrator thinks most aligns with purchaser’s strategy and direction.

|  |  |  |
| --- | --- | --- |
| **Question to Administrator** | **[Strategy 1 Name]** | **[Strategy 2 Name]** |
| How many purchasers have implemented this network strategy? |  |  |
| How many plan participants are covered under this strategy? |  |  |
| How many providers participate in this strategy? |  |  |
| How does Administrator select providers for participation in strategy (cost, quality, both, etc.)? |  |  |
| Explain Administrator’s process for removing providers that no longer meet cost and/or quality standards for strategy. |  |  |
| What percent change is there from the prior year in plan participants selecting these providers for services? |  |  |
| In which key purchaser geographies is strategy available? |  |  |
| Has the strategy been evaluated by an external third-party or internal party? Provide results. |  |  |
| What are Administrator’s plans to evolve the strategy? |  |  |

1. Does Administrator have an existing purchaser arrangement in which it provides administration services for a purchaser-organized direct contract with a provider? Detail the Administrator’s responsibilities and identify the purchaser and provider, if possible.

### Improve Population Health and Increase Health Equity

Purchaser is seeking an Administrator partner that is concerned about broader community health and takes steps to increase health equity. To help purchaser understand how Administrator is improving population health and reducing disparities, please provide detailed responses to the following questions.

1. How is Administrator working to improve health equity? Cite specific programs Administrator has implemented nationally and in key purchaser geographies.

1. For what percentage of total membership does Administrator have race or ethnicity data? If below 80%, does Administrator commit to obtaining 80% or more in the next 12 months?

1. Please report asthma, depression, diabetes, and hypertension by race. If Administrator is unable to report all data, please report available data.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Question to Administrator** | **American Indian or Alaska Native** | **Asian** | **Black** | **Native Hawaiian or Other Pacific Islander** | **White** |
| Diabetes Care: HbA1c Control < 8.0% (NQF 0575) |  |  |  |  |  |
| CBP: Controlling High Blood Pressure (NQF 0018) |  |  |  |  |  |
| AMR: Asthma Medication Ratio Ages 5-85 |  |  |  |  |  |
| Antidepressant Medication Management (Effective Acute Phase Treatment) |  |  |  |  |  |
| Antidepressant Medication Management (Effective Continuation Phase Treatment) |  |  |  |  |  |
| Admissions for Diabetes Short-term Complications among Members with Diabetes |  |  |  |  |  |
| Admissions for Diabetes Long-Term Complications among Members with Diabetes |  |  |  |  |  |
| Admissions for Uncontrolled Diabetes among Members with Diabetes |  |  |  |  |  |
| Admissions for Lower-Extremity Amputation among Members with Diabetes |  |  |  |  |  |
| Admissions for Hypertension among Members with Hypertension |  |  |  |  |  |
| Admissions for Heart Failure among Members with Hypertension |  |  |  |  |  |
| Admissions for Asthma among Older Adults with Asthma |  |  |  |  |  |
| Admissions for Bacterial Pneumonia among Members with Asthma |  |  |  |  |  |
| Admissions for Asthma among Children and Younger Adults with Asthma |  |  |  |  |  |

1. If Administrator is unable to report all data above, please provide an anticipated timeline as to when Administrator will be able to report on remaining data.

1. What opportunities does Administrator identify from above reporting, and what is Administrator’s doing to address the opportunities?

1. Does Administrator agree to select 1-2 disparity measures above with purchaser for use in assessing Administrator performance?

1. Does Administrator require health equity training for its staff? If so, which staff are required to complete the training? If not, by when will Administrator require health equity staff training? Please share a summary of the training curriculum.

1. Has Administrator earned NCQA’s Distinction in Multicultural Healthcare? If not, by when will Administrator obtain it?

1. Does Administrator conduct screenings of plan participants regarding their housing instability and food insecurity? Does Administrator use this information to refer plan participants to community resources?

1. For years, maternal mortality rates among Black women have been much higher than among other ethnicities. What is Administrator doing to address this? Cite specific results Administrator has achieved.

1. What is Administrator doing to reduce the Nulliparous, Term, Singleton, Vertex (NTSV) C-Section rate among new mothers? Cite specific results Administrator has achieved and future goals.

1. COVID-19 has exacerbated the behavioral health needs of many patients. What is Administrator doing to increase access to providers, specifically providers in purchaser’s geographic footprint?

1. Behavioral health, cancer, diabetes, maternity and musculoskeletal conditions are some of the prevalent conditions, among others, in purchaser’s population. Describe any new programs that address these conditions and whether they are fully implemented or in pilot status. Are any of these programs designed to increase health equity and, if so, how?

### Improve Maternity Outcomes

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. Purchaser efforts to require Administrator and provider accountability can improve maternity outcomes and lower costs.

1. Please report on the number of births and c-section rate for each of the strategies that the Administrator has in place. Note that these models are not mutually exclusive - if, for example, a birth occurs at a Center of Excellence maternity hospital that operates under a bundled payment contract, count it in both categories.

|  |  |  |
| --- | --- | --- |
| **Question to Administrator** | **# of Births** | **% Cesarean Section (CS) Rate** |
| All maternity |  |  |
| Bundled Payment (single payment for a maternity episode of care) |  |  |
| Centers of Excellence (High-performance designation specific to maternity care) |  |  |
| Pay for Performance (Payment incentives for adherence to guidelines designed to promote superior birth outcomes) |  |  |
| Blended Payment (Single rate for vaginal and c-section births) |  |  |
| Other (please describe) |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question to Administrator** | **Numerator** | **Denominator** | **% of spend** | **% CS Rate** |
| Please report 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 (especially c-sections) during labor and delivery.  Examples of such incentives are listed (but not limited to) the list in Question 1. | Total dollars paid for maternity care through contracts that include incentives that reduce unnecessary elective medical intervention (especially c-sections) during labor and delivery. | Total dollars paid to hospitals for maternity care. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question to Administrator** | **Numerator** | **Denominator** | **Total** |
| Please report the nulliparous, term, singleton, vertex (NTSV), i.e., low risk moms, CS rate (%) for the most recent Calendar Year (CY) or 12 months, for your book of business. | Total number of births by NTSV CS for the most recent CY or 12 months. | Total number of births for the most recent CY or 12 months. |  |
| Please report the early elective delivery rate (deliveries before 39 weeks with no medical indication for early delivery) (%) for the most recent CY or 12 months, for your book of business. | Total number of births by early elective delivery for the most recent CY or 12 months. | Total number of births for the most recent CY or 12 months. |  |
| Please report the portion of births delivered by midwife (%) for the most recent CY or 12 months, for your book of business. | Total number of births delivered by midwife for the most recent CY or 12 months. | Total number of births for the most recent CY or 12 months. |  |

1. Please confirm annual reporting capabilities in the following areas:

|  |  |  |
| --- | --- | --- |
| **Question to Administrator** | **Administrator requires that hospitals report on these metrics annually:** | **Administrator reports annually to Purchaser on these metrics:** |
| Cesarean Section (CS) rate |  |  |
| Nulliparous, term, singleton, vertex (NTSV) CS rate, 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) |  |  |
| % of births by midwife |  |  |

1. Please confirm that you will provide the following information to Plan Participants.

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

      Access to birth centers in directories and through customer service

      Access to information on maternal quality or outcomes by facility

1. Please confirm that Administrator has an active process to contract with free-standing birth centers where they are available.

1. Note how many free-standing birth centers are available to purchaser in 3 geographies with highest Plan Participant count:

      Geography 1

      Geography 2

      Geography 3

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

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

1. If the answer to Question 9 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)](https://www.cmqcc.org/) or the [Alliance for Innovation on Maternal Health (AIM)](https://safehealthcareforeverywoman.org/aim/) guidelines.)

      Obstetrical hemorrhage

      Preeclampsia

      Preventing blood clots

      Addressing cardiovascular disease

1. Does Administrator require that preferred providers report to Administrator what they are doing to assess and reduce racial disparities in pregnancy outcomes?

1. Please describe how Administrator addresses 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, etc.).

1. Not including educational strategies, please share upcoming or planned initiatives to reform maternity care payment and delivery. Examples may include, but are not limited to: 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.

CPR, in partnership with 32BJ Health Fund and with funding from New York State Health Foundation, developed a question set and several other resources to help purchasers build a high-value maternity network which can be found in a separate [toolkit](https://connect.catalyze.org/maternity-network-toolkit).

### Comprehensively Report and Collaborate

Purchaser is looking for 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. To help purchaser understand how willing Administrator is to collaborate, please provide detailed responses to the following questions.

1. Catalyst for Payment Reform (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. Does Administrator agree to provide data so CPR can continue generating its Scorecards on Payment Reform?

1. Purchaser wants to understand the relationship between the prices providers charge and the quality of care. Will Administrator 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?

1. CPR hosts health plan user groups, during which CPR staff and affiliated purchasers track plans’ progress in transparency, payment and delivery reform, and condition-specific areas. Plans also have the opportunity to present to purchasers (current customers and prospects) on topics of their choice. Does Administrator agree to participate in CPR’s health plan user group and/or a potential user group hosted by another coalition in which purchaser participates?

1. In order to determine which of Administrators’ strategies and programs improve value, there must be independent formal evaluations and public reporting of results. Does Administrator commit to hiring an independent evaluator to review Administrator’s program(s) and releasing the results publicly? If so, which programs will Administrator evaluate and with what frequency?

1. In recent years, plans have tended to cherry pick the positive results of their programs when reporting to purchasers. Because purchasers want to have meaningful and comprehensive information about program results, CPR has developed standard reporting templates that guide plans to report on measures of cost, quality, and utilization. These templates include the [Standard Plan ACO Report for Customers](https://www.catalyze.org/product/sparc/) (SPARC) and [Reform Evaluation Frameworks](https://www.catalyze.org/product-category/tool-library/program-evaluation/) (REFs) for bundled payment, centers of excellence, high-performance networks, and reference-based pricing. Does Administrator commit to reporting program results on all of the metrics in these templates?

1. Anecdotal feedback suggests plans have become more restrictive with data sharing in recent years. Solutions 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 plans. Given the vendors with whom purchaser contracts, what data sharing challenges do you anticipate and how will you work with purchaser’s other partners to eliminate these challenges?

# Supporting Materials – Assessing Administrator’s Strategies:

### Accountable Care Organizations

CPR hosted a small workgroup collaborative, *Holding Health Plans Accountable for their Accountable Care Organizations*, during which CPR, collaborative participants, and a subject matter expert developed questions that purchasers could use to evaluate a prospective or incumbent health plan’s ACO strategy. The questions are part of CPR’s [Standardized Plan ACO Reporting for Customers (SPARC) Toolkit](https://www.catalyze.org/product/sparc/).

### Bundled Payment

CPR hosted a collaborative, Advancing Bundled Payment, during which CPR, participants, and a subject matter expert developed and piloted questions that purchasers could use to evaluate a health plan or vendor’s bundled payment solution. The questions are part of CPR’s [Advancing Effective Bundled Payment Toolkit](https://www.catalyze.org/product/toolkit-bundled-payment-options/).

### Mental Health

CPR hosted a collaborative, *High-Value Mental Health Strategies*, during which CPR, participants, and a subject matter expert developed and piloted questions that purchasers could use to evaluate a prospective or incumbent health plan’s or vendor’s mental health performance across access, quality of care, and integration with medical care. The questions are part of CPR’s [Evaluating High-Value Mental Health Care Toolkit](https://www.catalyze.org/product/toolkit-evaluating-high-value-mental-health-care/).

### Price & Quality Transparency Tool

CPR developed a toolkit that can help purchasers to evaluate health plan and other vendors’ price & quality transparency tool. CPR’s [Evaluating & Selecting a Price Transparency Tool Toolkit](https://www.catalyze.org/product/evaluating-transparency-tool/) includes questions that a purchaser could use to evaluate a prospective or incumbent health plan’s tool.

### Total Joint Replacement

CPR developed a toolkit that can help purchasers to design, evaluate, and implement a total joint replacement strategy. [CPR’s Total Joint Replacement Bundled Payment Toolkit](https://www.catalyze.org/product/tjr-bp-toolkit/) includes questions that a purchaser could use to evaluate a prospective or incumbent health plan’s total joint replacement bundled payment program.

### Genetic Testing

CPR hosted a collaborative, *Applications of Genetic Analysis*, during which CPR, participants, and a subject matter expert developed questions that purchasers could use to evaluate a health plan’s genetic testing strategy and program management. The questions are part of CPR’s [Unraveling Genetic Testing How-To Guide](https://www.catalyze.org/product/value-genetic-testing-benefits/).

### Serious Illness Care

In partnership with the Center to Advance Palliative Care (CAPC), CPR developed resources that purchasers could use to implement a comprehensive palliative care strategy, including questions that purchasers could use to evaluate a health plan’s palliative care program. The questions are part of CPR’s [Palliative Care Resources for Employers and Other Health Care Purchasers Toolkit](https://www.catalyze.org/product/palliative-care-purchaser-resources/).

### Data Warehouse & Analytics

CPR formed a workgroup to understand purchaser priorities for data warehouse & analytics solutions. The workgroup developed and piloted questions that purchasers could use for vendor evaluations. The questions are part of CPR’s [Evaluating High-Value Data Warehouse & Analytics Solutions](https://www.catalyze.org/product/data-warehouse-analytics-evaluation/). While this question set is directed to data warehouse companies, purchasers could leverage certain content in evaluating a health plan.