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Contracting for quality

Boundaries and opportunities of selective contracting

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SUMMARY

Many policymakers consider selective contracting – the process through which a health purchaser contracts with a select number of health care providers and channels enrollees to these providers – an important tool to control overall health care costs and improve the quality of the delivery system. Especially within systems that are based on the principle of managed competition, in which insurers and providers compete over quality and price, the application of selective contracting is generally seen as instrumental. At the same time, the literature describes clear limits to the use of selective contracting and in most managed competition systems its application is often hampered for a variety of reasons.

In the Netherlands, selective contracting – although possible within the limitations of the 2006 Health Care Act – is not applied abundantly to date. Now that risk bearing of private insurance is going up and health care costs continue to rise, active purchasing and forms of selective contracting have gained more and more attention of politicians, policymakers and health care executives. It is therefore of interest to study this phenomenon within another context, and develop lessons learned for the Netherlands specific situation.

In this study we look at the boundaries and opportunities of purchasing strategies, by studying the insurer-provider contracting process of the US Medicare Advantage (MA) program; traditional Medicare (TM) carried out by private insurance. The US has some thirty years of experience with MA and it currently represents a significant share of the overall Medicare market (around 17 million beneficiaries, some 30% of TM). Within the program, health plans compete over beneficiaries and contract with a range of health care providers. While many (quantitative) studies focus on the efficiency gains that can be achieved through some form of selective contracting, long-term effects are often unknown and not overtly convincing. Our aim is to contribute to that discussion by providing an analysis of the MA market of NY State. Through a mixed methods study, using both publicly available data from the Center for Medicare and Medicaid Services (CMS) and health plan websites, we analyze the health plan-provider relationship. We complement these findings with qualitative results from semi-structured interviews that were conducted with key stakeholders of five major health plans in the New York metropolitan area. We evaluate the concept of quality in the purchasing process, relying on a framework by the World Health Organization (WHO).

Our results suggest that, for active purchasing to be a driver of quality improvement, the most crucial elements appear to be disposing of reliable provider performance information and working towards value-oriented payment schemes. Three general observations can be made.

The first one is that health plans are highly strategic and calculating players. Any effort to promote quality through the contracting process should therefore be promulgated and supported by a payer that focuses on creating value for the consumer, for example through value-based payment arrangements. In that sense, active purchasing and selective contracting should go hand in hand. In the US, CMS is gradually moving away from fee-for-service type instruments towards value-based payments. This development shapes the Medicare market and influences the modus operandi of private plans as well, as these plans identify new opportunities for expansion and increased revenue potential. MA Health plans have increasingly embraced value-based contracts including risk sharing with providers.

The second observation is that the bottleneck for contracting for quality often is the availability of reliable, verifiable and comprehensive quality parameters. The bulk of contracts are still signed with individual physicians or practices, which often do not dispose of the requisite infrastructure and data points to assess and compare quality. Instigated by newly introduced CMS payment models, most health plans have formulated goals to 'close the care gap' or work on population health management, but these ambitions are often inhibited by a limited health management infrastructure of the provider.

The third observation is that the contracts themselves generally do not drive quality improvements. Most provider contracts handle overall business terms and rates, often supplemented with paragraphs on quality. The contracting process itself is however generally still seen as a 'rate discussion'. Improving the overall quality of health care delivery is more often achieved through the insurer-provider relationship. This is illustrated by the fact that all interviewees report that most contracts are 'evergreens' and there is under 1% of discontinuation of contracts. When discontinued, the reason mostly lies in a dispute on the rates or, at the far end of the spectrum malpractice or fraud, than in a disagreement on the quality of health care delivery.

This leads to a number of policy recommendations. Firstly, selective contracting should be supported by strategic purchasing at the level of the payer. In this study, we will see that in the US, CMS plays an important role in this regard. CMS actively engages in shaping the health care market through the implementation of quality metrics (bonus programs) and advanced payment models. This approach is distinct from that of the Netherlands in which the role of government is confined to that of legislator rather than of an active payer. For other managed competition countries, such as the Netherlands, this implies that such a health system cannot be reconciled with a laissez-faire policy towards private insurance. As payment models largely define the extent to which selective contracting drives quality improvements, this should be central to their policies. Secondly, value-based purchasing can only succeed if quality parameters are well defined and if provider performance information is widely available and comparable. An important challenge in this regard is engaging and enabling individual physicians and practices, by far still the largest number of providers, towards this end. This leads to our final recommendation, which is that being serious about improving quality through the contracting process requires economies of scale. In the case of the insurer it means having the organizational capacity in place to properly monitor contracts and take action when required. In the case of the provider it means being able to leverage demands by insurers and engage in negotiations on quality based on the requisite quality information.

Any effort to implement or foster selective contracting within a setting of managed competition, should acknowledge the bottlenecks and opportunities that exist. This study aims to contribute to that aspiration and the ongoing debate on the improvement of our health care delivery system.

1. Introduction

Within the theory of managed competition, the efficiency of a health system relies on competing health insurers and freedom of choice for consumers (Enthoven 1978, 1993). Since the introduction of managed competition[1] in the Netherlands in 2006, the country has gradually moved away from strict regulation of the supply-side of its health system; some 70% of treatments are now freely negotiable between insurers and providers. Confronted with considerable budgetary overruns and strict budgetary caps, the government has in recent years however returned to supply-side regulation through corporatist agreements that limit nominal expenditure growth of the acute care (Maarse, Jeurissen, and Ruwaard 2015). Policymakers in the Netherlands are clearly grappling with the ambition to stimulate increased competition – and thereby transferring important policy levers to the market – on the one hand, while controlling overall expenditure growth on the other hand.

Insurers that actively manage care on behalf of their beneficiaries, using reliable provider performance information and promoting preferred or exclusionary provider networks, could in theory contribute to cost control while at the same time improving the quality of the delivery system. Although the socio-cultural acceptability in the Netherlands for selective contracting is low (Shmueli et al. 2015), and a recent legislative proposal that would strengthen the insurers' role in this respect was voted down in the Upper Chamber of Parliament (Maarse, Jeurissen, and Ruwaard 2015), the attention among policymakers and politicians for more active forms of purchasing by private insurance remains unabated.

Managed competition in the United States has gained a stronger foothold over the past years (Einav and Levin 2015). Medicare Advantage (MA), private insurance that contracts with Medicare, now serves roughly 17 million beneficiaries nationwide (The Kaiser Family Foundation 2015a) and the Health Exchanges that were created by the Affordable Care Act (ACA) act as marketplaces for supply and demand of health care delivery for individual consumers. Some 13 million Americans are projected to be insured through the exchanges in the course of 2016 (CBO 2016). At the same time, the US has a longstanding tradition of managed care, through integrated delivery systems and the use of selective contracting. A variety of managed care organizations (MCOs), such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Accountable Care Organizations (ACOs) are currently active within the US delivery system.

It is of interest to explore the contracting process in the US within the context of managed competition. The US has over 30 years of experience with risk based contracting within the MA program (or its predecessor), and has experimented with a variety of policy approaches (McGuire, Newhouse, and Sinaiko 2011; Newhouse and McGuire 2014). This makes the MA program an interesting focus of research.

We are interested in what day-to-day rationales guide the purchasing behavior of health plans and the way in which the contracting process is shaped. We focus on the extent to which

[1] Note that in the literature, 'regulated' and 'managed' competition is often used interchangeably, although 'regulated competition' is more often used in the context of social insurance systems, and 'managed competition' in the context of US health reform. In this paper I choose to unilaterally use the term 'managed competition'.

contracting for quality is an integral part of the purchasing process within MA. This is a relevant focus, since active purchasing and forms of selective contracting in theory provide a good mechanism for quality selection, but in practice are often compromised for a variety of reasons (McNamara 2006). Through a mixed methods study, using both publicly available data from CMS and health plan websites, we analyze the health plan-provider relationship. We complement these findings with qualitative results from structured interviews that were conducted with key stakeholders of five major health plans in the New York metropolitan area. We evaluate the concept of quality in the purchasing process, relying on a framework by the World Health Organization (WHO). We then formulate lessons learned for the Netherlands and possibly other OECD countries that work within a context of managed competition and have selective contracting in their toolbox.

Our main research questions are:

Q1: How does the contracting process take place within the context of MA?

Q2: What is the role of insurers to promote quality in the purchasing process?

Q3: What can the Netherlands and other health systems that allow for selective contracting learn from the contracting process within MA?

Important subquestions are:

- How is quality defined and measured in the contractual relationship (throughout all stages: negotiation of the contract / monitoring the contract / reviewing the contract) with providers?
- What are the (perceived) impediments for effective selective contracting?
- What are successful active purchasing strategies? Based on which criteria?
- What are the main considerations for an insurer whether or not to contract with a provider?
- What are determinative criteria for selectively contracting with a provider?

We develop a framework by which we evaluate the concept of quality in the purchasing process. We rely on work by the World Health Organization (WHO) that divides the purchasing process into three stages (WHO 2005). The framework discusses the aspect of quality for each of these phases.

First we discuss the concept of selective contracting in more detail. Based on the literature, we discuss its origin and its application, and we discuss its boundaries and opportunities. We then discuss the Medicare Advantage program. Subsequently, we discuss the concept of quality in relation to health care. Thereafter, we provide our conceptual framework to assess quality in the purchasing process. Finally we discuss our results. We conclude this paper with a discussion of the results and we offer policy recommendations. At the end of the paper, a Dutch summary is provided.

2. Selective contracting

2.1 Origin and development

Selective contracting generally takes place within the context of managed care or managed competition, in which health purchasers and providers negotiate over the price, quality and volume of health services. Legislators can influence this process by defining the benefit package, developing and imposing risk adjustment and reimbursement schemes, setting maximum prices and/or enforcing or promoting quality standards. This in turn influences the extent of the negotiation process.

It started in the 1980s in the United States, with the emergence of managed care within various types of Managed Care Organizations (MCOs), and it has permeated several European health systems in the following decades at various speeds, in various appearances, and with varying success (Bes et al. 2013; Shmueli et al. 2015). From the outset, the idea behind selective contracting and active purchasing was that these were suitable instruments to steer both cost savings and quality of care, although developing (and disseminating) the necessary objective provider performance information that guides the contracting process has proven to be a challenge to date[2]. Selective contracting was foremost seen as a mechanism to increase insurer market power and improve the efficiency of service provision[3] (Mobley 1998; Zwanziger et al. 1994), and as a means to countervail the price-setting power of providers (Glied 2000). McNamara (2006, 171) states that the role of purchasers at that point was 'largely confined to that of financial intermediary'. Both in the US and Europe, purchasers were generally not seen as 'quality drivers'.

In much of the literature selective contracting and strategic or active purchasing are used interchangeably, although there is a difference in scope. The WHO (2005, 138) coins strategic purchasing as 'forms of purchasing in which proactive decisions are made about which health care services should be purchased, how and from whom'. Additionally, it argues that 'strategic purchasing requires a continuous search for the best interventions to purchase, the best providers to purchase from, and the best payment mechanisms and contracting arrangements to pay for such interventions' (WHO 2000, 105). This definition thus relates to the role selective contracting can play in improving the overall performance of health systems. Selective contracting should be seen as one of the mechanisms through which this goal can be attained.

In this study, we define selective contracting as:

The process through which a health purchaser contracts with a select number of health care providers and channels enrollees to these providers as a means to contain health care costs and improve the overall quality of care.

[2] See for example (Shwartz, Restuccia, and Rosen 2015) for a recent discussion on provider performance information in the US or (Thomson et al. 2013) for a four-country comparison on managed competition including a section on provider performance information.

[3] In the literature, efficiency is though often directly linked to quality, being an intermediate property of efficiency (WHO 2005).

With respect to the acute care, contracting in the Netherlands takes place between private insurance and providers. In the United States, that runs a combination of public, private and public-private programs, the process is more opaque. It has a long history of 'managed care' type institutions, through vertically integrated health insurance and health delivery concepts, such as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). The country's public programs Medicare and Medicaid either contract with providers directly or by using private insurance as a proxy (e.g. Medicare Advantage or Medicaid through managed care).

Two forms of selective contracting can be distinguished. The first one confines the use of health services to exclusionary provider networks; enrollees can generally not obtain health care outside these networks. The second form is selective contracting through the use of preferred provider networks. Consumers are free to obtain health services outside the network, but (monetary) incentives steer them towards in-network providers (Boonen, Donkers, and Schut 2011).

In the US, exclusionary networks were common within the context of HMOs throughout the 1990s. Around the turn of the millennium there was however a notable 'managed care backlash', which caused that private insurance and Medicare turned away from restrictive HMOs (Draper, Hurley, and Short 2004). Enrollees reported less satisfactory with managed care health plans than with traditional fee-for-service plans, and there were 'complaints about access to specialists, tests, and waiting times by those enrolled in managed care plans' (Blendon et al. 1998). As a result, HMO commercial enrollment in employer-sponsored insurance (covering a total of around 149 million non-elderly Americans in 2014) saw a near 20 percentage point drop to 13% in market share from 1996 to 2014. This was mainly to the benefit of the more loosely organized Preferred Provider Organizations (PPO), which saw a market share increase of 30 percentage point to 58%, thereby becoming the predominant managed care structure within that market (Kaiser 2015). The national health reform of 2010 (the Affordable Care Act) added Accountable Care Organizations (ACO) to the vocabulary of integrated delivery systems (IDSs). Within ACOs, providers share a responsibility for the quality and cost of care provided. This shared responsibility provides an incentive to offer low cost health care of good quality. Echoing the formation of ACOs under Medicare, the private market has now also embraced the structuring of the market through ACOs, as a means to move forward to value-based contracting (Barnes et al. 2014).

In the Netherlands, a revision of the Health Care Prices Act in 1992, introduced limited risk bearing of the sickness funds, together with freedom of choice for consumers. In theory, this paved the way for some form of selective contracting. However, since risk adjustment was still unrefined at this stage, the sickness funds were compensated ex post for about 97 percent of incurred loss. This removed the stimulus for effective price competition and selective contracting at this stage (Helderman 2005; Schut and van Doorslaer 1999). Schut and Van de Ven (2005) describe that the sickness funds still operated in a heavily supply constrained and cartelized market, which hampered the effective introduction of managed competition and selective contracting instruments.

The Health Insurance Act (HIA) of 2006 introduced managed competition in the Netherlands (Enthoven and Van de Ven 2007). Boundaries between non-negotiable and negotiable hospital care were gradually shifted. The freely negotiable B-segment, which roughly encompasses less complex and elective treatments, was expanded in a number of steps, until it reached approximately 70% of all treatments in 2012. At the same time, ex-post compensation mechanisms were phased out, increasing the risk bearing of individual insurers. The first years after the introduction of the HIA, selective contracting was more or less absent; an analysis on the effects of purchaser competition between 2006-2009, show almost no selective contracting between private insurance and hospitals and physicians (Schut and van de Ven 2011).

One of the limitations of selective contracting is article 13 of the HIA, which warrants non-contracted care delivery by out-of-network providers. The Rutte II Cabinet (2012-present) proposed the removal of article 13 from the HIA, which would relieve insurers from the obligation to reimburse 75–80% of the costs of non-contracted care[4]. The proposal was however voted down in the Upper Chamber of Parliament (Maarse, Jeurissen, and Ruwaard 2015).

This leaves us with a mixed picture of the extent to which selective contracting currently is a central feature of managing care in both countries. In the US, there has been resistance against narrow provider networks of some managed care organizations. This led to the decline of HMOs in favor of the more loosely organized PPOs and other forms of managed care. In the Netherlands, the law does allow for selective contracting, albeit under strict conditions of universal access and partial reimbursement for non-contracted providers. There are apparent barriers to the application of selective contracting in practice. It therefore seems important to study the boundaries and opportunities that can be derived from the literature in more detail.

2.2 Boundaries and opportunities

To get a better understanding of the boundaries and opportunities and potential breadth of selective contracting, it is important to examine its determinants in more detail. They either relate to the insurer-provider relation, the payer-provider relation, or the payer-insurer relation. The determinants are summarized in table 1, and further discussed below.

Table 1 – Determinants of selective contracting

Determinant	Description
Functioning of the market and regulatory strategies	This describes to what extent there exists sufficient insurer and provider competition, price and product differentiation and what statutory restrictions and opportunities exist.
Payment mechanisms	This describes in what way different payment mechanisms determine the purchaser-provider relationship.
Provider performance information	This describes the extent to which provider performance is available and used to steer consumers to the best performing providers.
Consumers and insurer reputation	This describes the influence of consumer and reputational factors, such as the credible commitment problem.

[4] The Act itself states that the insurer is to decide on the level of reimbursement for non-contracted care. This was later specified by the court stating that 'a lower percentage would severely restrict access to non-contracted services' (Maarse, Jeurissen, and Ruwaard 2015).

2.2.1 Functioning of the market and regulatory strategies

The scope for the introduction of market-based reforms such as selective contracting, is determined by the number of competing insurers in the system and the extent of provider competition and patient choice (OECD 2015). For the contracting process to be a driver of change, the availability of multiple competing providers seems important (WHO 2005).

Maarse, Jeurissen and Ruwaard (2015, 14) point out that within managed competition, the role of the state is determined in terms of 'providing an adequate regulatory framework, organizing effective oversight, safeguarding public values, developing policy initiatives and giving general direction to health care.' Government is positioned at a distance and a level of scrutiny is required before it intervenes in the system in order to safeguard public values.

Bamezai et al. (1999), in studying HMO and PPO markets in the state of California between 1989 and 1994, found that hospitals in areas with high managed care penetration showed significantly lower cost growth, but only in case of highly competitive hospital markets. This signifies the importance of multiple competing providers in one geographical area for limited cost growth development.

In the Netherlands, state-imposed rationing policies of the past have kept the number of health care providers down. This hampered the introduction of preferred provider arrangements. Interviews with stakeholders in a qualitative study of 2013 suggested that this was at least the case for the GP-sector (Heinemann, Leiber, and Greß 2013).

Regulatory strategies define the extent to which selective contracting can take place. In the Netherlands, legislation prohibits a stringent approach to selective contracting by guaranteeing that insurers reimburse non-contracted care. In the early days of managed care in the US, in most states, legislative restrictions prevented selective contracting to take place within HMOs. These restrictions were gradually loosened, resulting in tighter provider networks and the before mentioned managed care backlash (Glied 2000).

Another regulatory constraint is the extent to which price setting is allowed. In a health system in which the purchasing process is regulated through set prices for (a number of) health services, insurers cannot negotiate prices for these services. This limits competition between insurers and providers (OECD 2015). Having a competitive market in place with freely negotiable prices can in theory contribute to the success of selective contracting as a means to contain health care costs.

2.2.2 Payment mechanisms

The choice of a payment mechanism defines the relationship between the purchaser and provider, as each mechanism provides different incentives for provider behavior. Table 2 highlights possible payment mechanisms and associated incentives for provider behavior.

Table 2 – Provider payment mechanisms and indicative incentives for provider behavior

Payment mechanism	Incentives for provider behavior		
	Prevention	Delivery/production of services	Cost containment
Line item budget	+/–	–	+++
Fee-for-service (FFS)	+/–	+++	– – –
Per diem	+/–	+++	– – –
Per case (e.g. DRGs)	+/–	++	++
Global budget	++	– –	+++
Capitation	+++	– –	+++

Source: WHO 2005

On one end of the spectrum, there are service-based payment schemes, such as fee-for-service. A fee-for-service scheme is generally associated with the risk of higher overall health costs, since providers are incentivized to offer greater volumes and more complex (and more costly) interventions. On the other end, there is global budgets and capitation. These systems provide an incentive for prevention (a healthier population is less expensive) and overall costs are more easily contained, since expenditures are capped at predetermined levels. Such payment schemes can on the other hand potentially accommodate under treatment. Payment mechanisms are hence often operated in tandem; a purchaser-provider relationship that is primarily defined through fee-for-service instruments will often be complemented by some sort of global budget, in order to contain overall costs.

Table 2 does not include the pay-for-performance instruments that have emerged in recent years. Reviews suggest that pay-for-performance can potentially be cost effective, although the evidence to date is not convincing. In addition, there is insufficient evidence to date that there is a positive effect on the quality of preventive and chronic care through pay-for-performance arrangements (Eijkenaar et al. 2013).

2.2.3 Provider performance information

Quality-based purchasing, or value-based purchasing, is a form of selective contracting that aims to improve health care through the purchaser-provider relationship. A purchaser can demand for higher quality by either enforcing quality improvements through the purchaser-provider relationship directly, or by providing performance information to consumers in order for them to push for health services of high quality from providers (Waters, Morlock, and Hatt 2004).

A comprehensive system of provider performance information and performance standards is thus paramount for purchasers to assess (the quality of) health service delivery and review contracts with providers. It is also an important tool for consumers to understand the quality of health services delivered and to proactively choose for insurers and providers based on this information (McNamara 2006; A. D. Sinaiko, Eastman, and Rosenthal 2012).

Conrad et al. (2014, 568) argue that in the US, for value-based payment innovation to be successful, there 'must be a defined set of quality, outcome and performance measures, as well as interoperable information systems'. These efforts should be led by multi-stakeholder coalitions and should result in a transition from traditional fee-for-service schemes, towards integrated care delivery and value-based payments. This position is echoed by Thomson et al. (2013) who, in a study on insurer competition in Europe, note that 'the lack of information on health care quality and costs, particularly at the level of the individual providers, is a major obstacle to the effective use of some purchasing tools, notably selective contracting […].'

2.2.4 Consumers and insurer reputation

In order to attract and maintain a solid consumer base, a health care purchaser makes a commitment to act as a reliable agent on the consumer's behalf. This implies contracting high quality health care providers at an affordable price. Selective contracting at the same time limits consumer's choice of providers.

An important contribution to the classical principal-agent theory is that of the credible commitment problem. This problem is described by Miller (2005) as a self-interest problem; the principal acts, or is perceived to act in self-interest, rather than in the interest of the agent. Within the context of selective contracting, this implies that consumers distrust insurers to purchase quality health care on their behalf, since their interests are – seemingly – not aligned. Going down this path, purchasers would exclude providers based on financial rather than on quality criteria. Consumers however, demanding health services of good quality, are suspicious of these activities. Purchasers in turn are sensitive to this display of distrust and will anticipate this by providing wider networks than they would have originally envisioned. This behavior thus directly influences the scope of selective contracting.

We have seen in what way this reputation issue has affected contracting strategies of insurers. In the US, too narrow provider networks resulted in a managed care backlash. Currently, PPO-structures are the predominant form of managed care. In the Netherlands, because of fear of losing customer base, private insurance has not explored the full potential of selective contracting to date.

3. Medicare Advantage (MA)

The Medicare Advantage (MA) program provides Medicare beneficiaries the opportunity to obtain coverage for Medicare part A (Hospital Insurance), B (Medical Insurance) and for most plans part D (prescription drugs), through private insurance (also referred to as 'part C'). Private health plans assume full risk for their enrollees and are compensated through a risk equalization scheme promulgated by the Center for Medicare and Medicaid Services (CMS). There are roughly four types of health plans available within MA; HMO, local PPO, regional PPO and Private fee-for-service (PFFS). The first two plan types are the most prevalent and currently account for almost 90% of the MA market (The Kaiser Family Foundation 2015b).

From its inception in 1985, the goals of the MA program have been twofold. First, the program expands consumer choice. It offers beneficiaries the opportunity to receive coordinated care through private plans and offers more comprehensive benefits than are offered through traditional Medicare (TM). Second, market discipline and managed care aim to make health care delivery more efficient and ultimately save 'Medicare dollars' (McGuire, Newhouse, and Sinaiko 2011). The program began with only 2% of beneficiaries (Newhouse and McGuire 2014), and currently serves some 31% of Medicare beneficiaries (The Kaiser Family Foundation 2015a). The MA market is thus sizable, both in terms of the number of beneficiaries (some 17 million in 2015) and in gross spending (totaling almost $ 200 billion in 2016).

CMS reimburses private insurance a capitated fee based on a risk adjustment formula that takes into account beneficiary demographic characteristics and county specific circumstances. Before the introduction of the ACA in 2010, reimbursement was subsequently set at 95% of traditional Medicare, based on the assumption that private insurance would provide health services at lower costs than TM. MA however on average attracted a higher percentage of healthy beneficiaries compared to TM. Reimbursement for MA was thus unduly high and unexplained by the relatively healthy status of its insured population. The anticipated overall reductions for MA were largely nullified due to the skewed characteristics of the insured population.

The Affordable Care Act (ACA) of 2010 introduced new rules, which aimed to correct this perceived flaw by varying reimbursement rates based on the level of spending of TM in the benchmarked county. If TM spending is higher in a given county, reimbursement for MA is set at a predefined lower rate (assuming that TM covers the higher cost patients in that specific county)[5]. Additionally, plans are eligible for bonuses and rebates depending on quality performance (McGuire, Newhouse, and Sinaiko 2011). The Quality Bonus Payments (QBP) program rewards health plans that achieve at least four stars in the five star system.

CMS is drastically changing the way it pays for Medicare and Medicaid services. Propelled by the ACA, the Department of Health and Human Services (HHS) is now steering towards payment models that are focused on value and care coordination (CMS 2015a). It has developed a 'payment taxonomy framework' that identifies four categories to pay providers:

[5] Plans operating in the quartile of counties (unweighted for population) with the highest TM spending face a benchmark equal to 95 percent of risk-adjusted TM costs in that area; plans in the next highest quartile face a benchmark equal to 100 percent of that area's TM costs; plans in the third highest quartile of counties face a benchmark equal to 107.5 percent of the county's TM costs; and plans in the lowest quartile of counties face a benchmark equal to 115 percent of the county's TM costs (McGuire, Newhouse, and Sinaiko 2011, 321).

Table 3 – CMS Payment taxonomy framework

Category	Type	Description
Category 1	fee-for-service with no link of payment to quality	Payments are based on volume of services and not linked to quality or efficiency
Category 2	fee-for-service with a link of payment to quality	At least a portion of payments vary based on the quality or efficiency of health care delivery
Category 3	alternative payment models built on fee-for-service architecture	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risks
Category 4	population-based payment	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 year)

Source: CMS 2015

Categories 2-4 contain value-based purchasing mechanisms. HHS works with private payers, including health plans that operate on the Health Exchanges, Medicare Advantage, and Medicaid to work in the same direction.

4. Quality in the purchasing process

Acknowledging the importance of securing quality in the purchasing process relates back to principal agent theory. The principal (the purchaser) wants the agent (the health care provider) to deliver good quality health care at a reasonable price. If the principal could devise a perfect set of incentives that would each time induce the agent to deliver care at the highest quality standards, measuring quality would be unwarranted (Casalino 1999). Since this is not the case, other than relying on the professionalism of individual physicians, introducing quality measures in the principal-agent relation seems necessary.

To understand in what way quality can play a role in the purchasing process, we first discuss the notion of quality as it relates to health care delivery.

We follow Sisk in defining quality of care as:

The process through which a health purchaser contracts with a select number of health care providers and channels enrollees to these providers as a means to contain health care costs and improve the overall quality of care.

Three important features of this definition deserve further elaboration. First, the focus on outcomes moves quality away from a more traditional approach on input, and thereby requires transparent and reliable outcome parameters. Second, the definition recognizes the position of consumers in health delivery. Incorporating their views and desires at a given moment in the purchasing process thus seems important. Third, the link to current medical knowledge requires a scientific approach to health care delivery. It assumes that effective interventions are based on evidence-based best practices that are incorporated into the daily routines of clinicians (WHO 2005).

As a consequence, any evaluation of the purchasing process should have a dynamic rather than a static approach. Upholding quality standards should thus require an iterative process that is tested throughout and serves as a feedback-mechanism.

Figure 1 – Quality in the contracting process within the free market logic (based on WHO 2005)

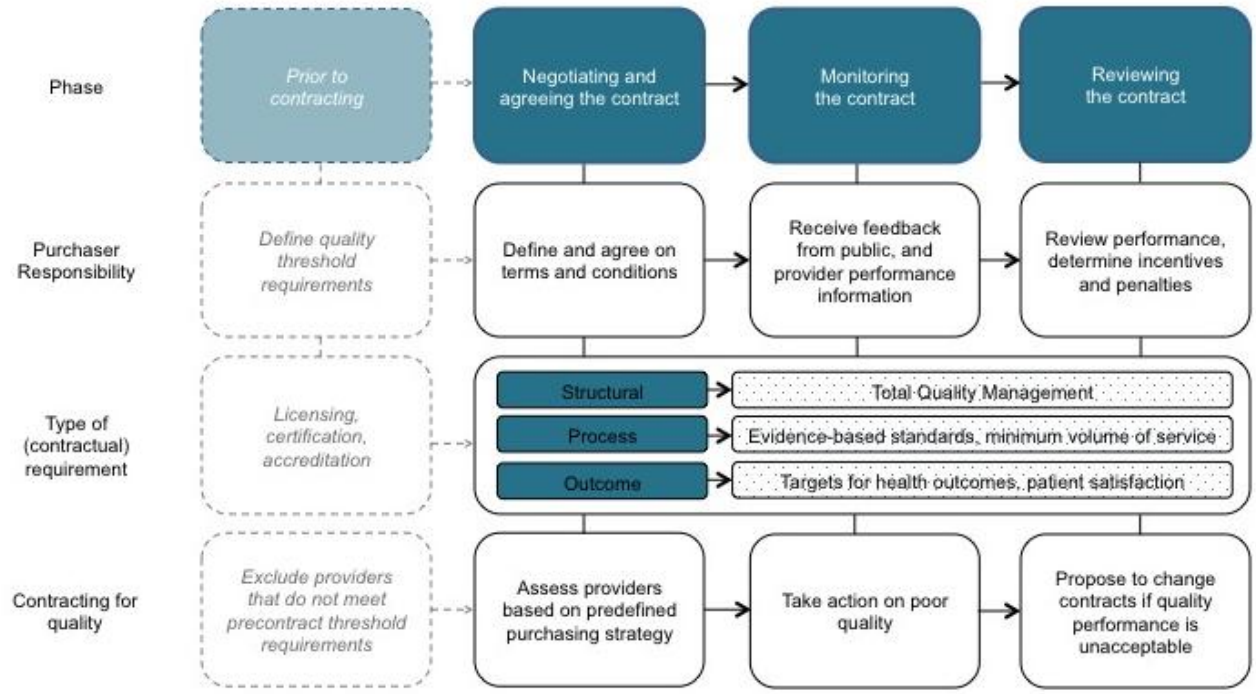
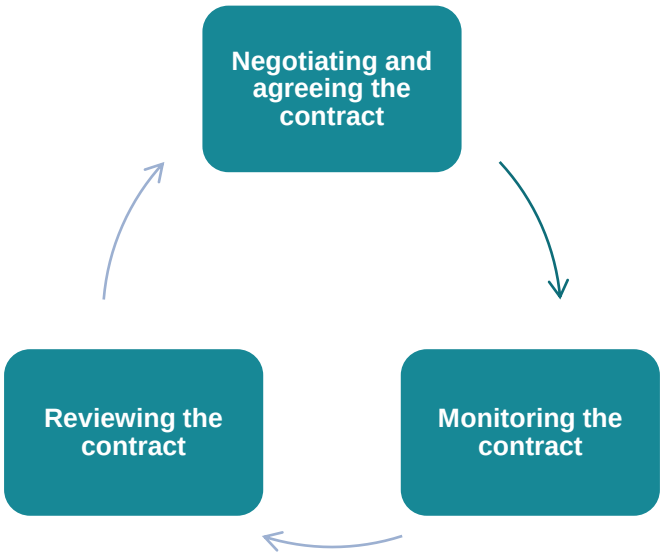


Figure 2 and 3 describe how quality can be incorporated in the contracting process. It identifies four stages of the contracting process (prior to contracting, negotiating the contract, monitoring the contract and renewing the contract) in which the purchasers and providers can negotiate quality requirements.

Before the stage of negotiating and agreeing the contract, there can be quality thresholds that keep certain providers from offering their services. This might include the availability of licensing, certification and accreditation.

Figure 2 – The contracting cycle in detail



Negotiating and agreeing the contract:

- specifying appropriate quality requirements, including access and availability;
- agreeing with the provider on responsibilities for collecting quality information;

Monitoring the contract:

- receiving provider's quality reports, and checking their validity;
- taking action on poor quality;
- receiving complaints directly from the public;
- obtaining feedback from the public about satisfaction with the service;

Reviewing the contract:

- reviewing quality performance;
- agreeing on changes to improve quality;
- proposing to change contracts if quality performance is unacceptable and there are alternative services.

When the contract is negotiated, the purchaser and provider discuss quality requirements such as access and availability of services. At this stage, a purchaser can also agree with the provider to collect quality information. By demanding uniform quality information, the purchaser can compare data with other providers and make informed decisions when monitoring or reviewing the contract. The next stage is monitoring the contract. At this stage, the purchaser assesses the provided quality reports and checks their validity. The purchaser can take action on poor quality and obtains feedback from the public on the quality of health care delivery. In the next stage, the contract is reviewed. Overall quality performance is assessed and the purchaser and provider discuss changes to improve quality. If quality performance is poor and if alternatives are available, changes to the contract are negotiated.

Quality requirements of purchasers can relate to structural, process and outcome quality. Table 4 provides an overview of the types of quality specifications in the contract.

Table 4 – Types of quality specifications in contracts

Requirements	Specifications
Structural	Implementation of systems of in-house quality management Detailed structural requirements Implementation of systems of data collection
Process	Mandating of evidence-based standards (clinical practice guidelines) Targets for indicators (for example, proportions of patients treated with…) Minimum volume of service agreements
Outcome	Targets for health outcomes (for example, proportion of patients with outcome…) Targets for patient satisfaction

Source: WHO 2005

The paragraphs above assume a situation in which purchasers can freely negotiate and contract selectively with a range of health care providers. In such a scenario, insurers are the critical purchasers of health services on behalf of their insured population and through selective contracting they seek to maintain a predefined level of quality of services for their beneficiaries. The contract allows them to define quality criteria and to act if quality requirements are not met. In paragraph 3.2 we have however seen that limitations can exist with regards to selective contracting. In the next chapter we will discuss in what way MA health plans, in their day-to-day contracting strategies, are bound by these limitations.

5. Results

In this section we will discuss the Medicare Advantage market, based on an analysis of CMS data and provider manuals, and discuss the results of the interviews. We have formulated a number of interview questions (see appendix A) that relate to the various stages of the contracting process. We are interested to learn to what extent quality is part of the contracting process and in what way purchasers contract for quality throughout the various stages.

5.1 Medicare Advantage market New York State

Table 5 shows the characteristics of the Medicare Advantage market for the US and for the State of New York.

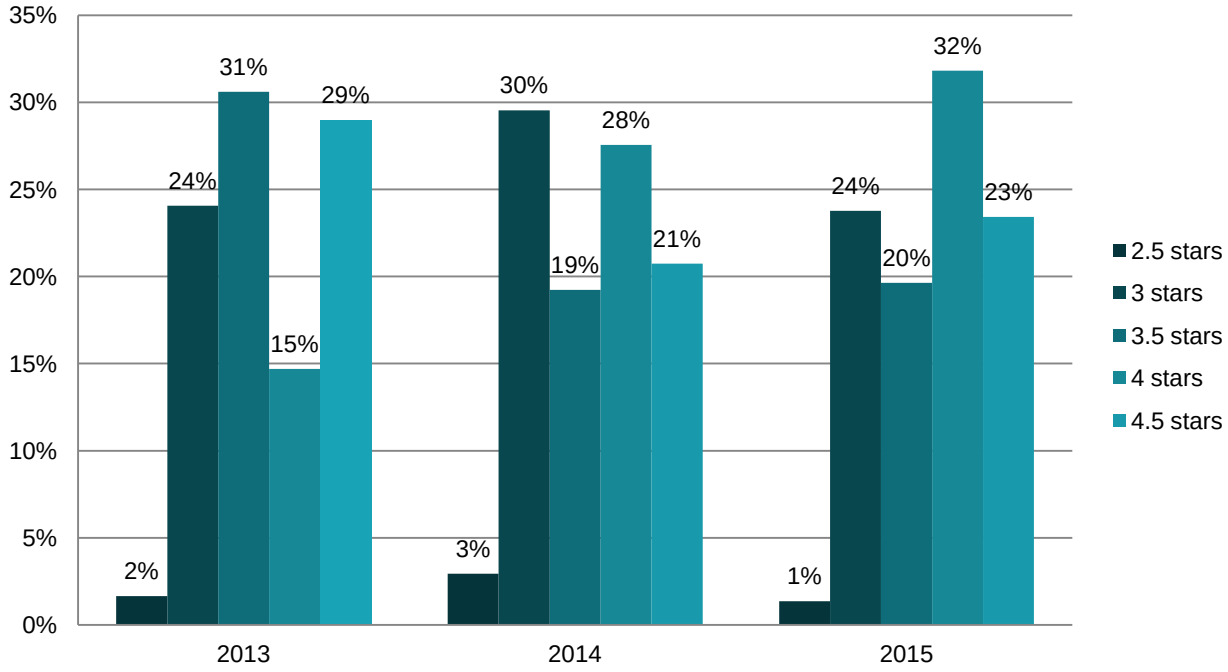
Table 5 – Characteristics of the MA market

Description	Number of beneficiaries (2015)	Percentage of total (2015)
US Medicare Advantage market	16,328,779	31% of Traditional Medicare
NY State Medicare Advantage market	1,191,011	37% of Traditional Medicare for NY State
Interviewees representation	337,498	28% of the Medicare Advantage market in NY

Source: The Kaiser Family Foundation 2015a, CMS 2015

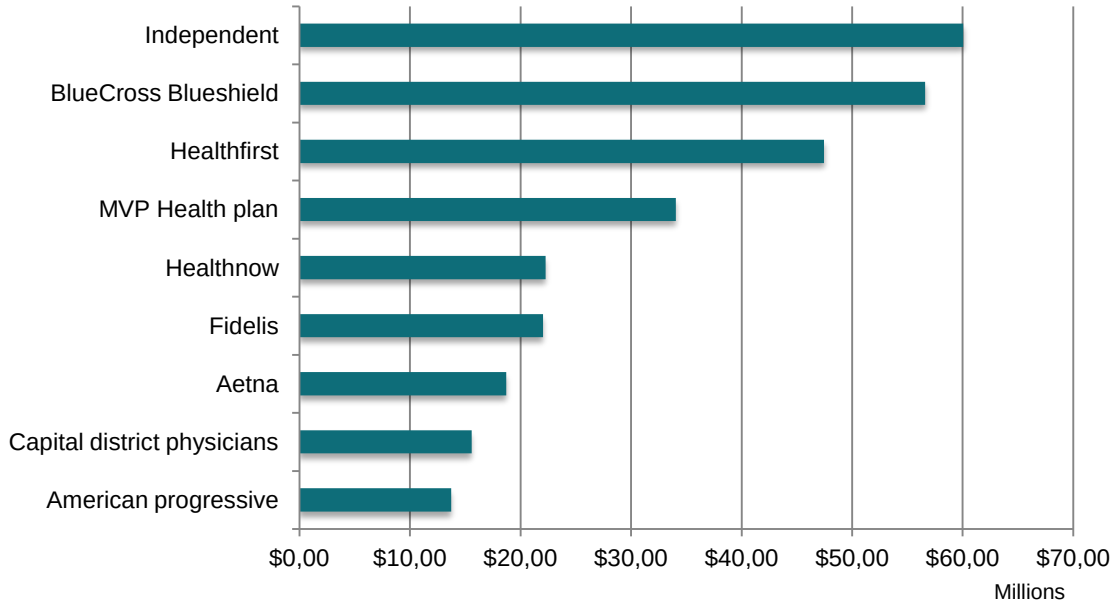
If we take a closer look at the performance of health plans in the MA market over the past years, we see that plans have increasingly responded to the quality parameters set out by CMS, resulting in a – on average – higher performance in terms of star rating.

Figure 3 – Rating distribution weighted by enrollment 2013-2015 for NY State



Source: analysis based on CMS data 2016

Figure 4 – Estimated 2015 bonus revenue by plan for NY State



Source: analysis based on CMS data 2016

In 2013 a combined 44% of insurers provided plans that were rated 4 stars or higher, compared to 55% in 2015. Health plans seem increasingly able to reach the bonus threshold. As we will see in the next sections, this is indeed central to the contracting strategies of the plans we interviewed. Figure 5 provides us with an overview of the gross estimated revenue by plan for NY State for 2015. We see that the top nine performing health plans have each received between $ 14 and $ 60 million in bonuses from CMS over 2015, which translates to around $ 300 – 650 dollars per beneficiary for that year.

Further analyzing the publicly available provider manuals of health plans, gives us a sense of how plans shape the insurer-provider relationship. If we assess the plans using the framework as put forward by the WHO, we see the following:

Table 6 – Quality requirements in the contracting process for Medicare Advantage in New York State

Plan type	Number of plans in NY State	Prior to contracting	Negotiating and agreeing the contract				Monitoring the contract				Reviewing the contract		
		Check provider credentials	Negotiate quality requirements including access and availability			Agreeing with provider on responsibilities for collecting quality information	Receiving provider's quality reports, and checking their validity	Taking action on poor quality	Receiving complaints directly from the public	Obtaining feedback from the public about satisfaction with the service	Reviewing quality performance	Agreeing on changes to improve quality	Proposing to change contracts if quality performance is unacceptable and there are alternative services
			S*	P*	O*								
Small size not-for-profit	8	Yes	6/8	5/8	0/8	5/8	6/8	5/8	7/8	7/8	7/8	2/8	2/8
Small size for profit	2	Yes	2/2	1/2	0/2	1/2	1/2	2/2	2/2	2/2	2/2	0/2	0/2
Small-medium size not-for profit	6	Yes	4/6	4/6	1/6	4/6	5/6	5/6	5/6	5/6	5/6	2/6	2/6
Small-medium size for profit	2	Yes	2/2	1/2	0/2	1/2	0/2	1/2	2/2	2/2	2/2	0/2	0/2
Large not-for-profit	3	Yes	2/3	2/3	2/3	2/3	2/3	2/3	2/3	2/3	2/3	2/3	2/3
Large for profit	2	Yes	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2	1/2

*(S) structural, (P) procedural, or (O) outcome requirement.
Source: Analysis of the 2016 provider manuals of MA health plans for NY State. If the 2016 manual was not available, the most recent manual was analyzed.

We find that the basic verification of provider credentials (and recredentialing) is done by all health plans. This is in line with regulations for all MA health plans, set out by CMS. If we look at the requirements that relate to the negotiation phase of the contract, we find that most plans include structural requirements in their contracts. There is not a large discrepancy here between not-for-profit or for-profit plans, or the size of the plan. Procedural and outcome requirements on the other hand, are commonplace for medium-size and large size health plans, and not so much for the smaller plans. This finding might suggest that smaller plans have more difficulty imposing such requirements on providers, or lack the institutional capacity to monitor the implementation of such measures. The same goes for agreeing with providers on responsibilities for collecting quality information. Larger plans seem somewhat more inclined to agree on these issues with providers.

If we look at the monitoring phase, we find that the majority of plans at least on paper closely monitor the performance of providers. Both quality reports as well as feedback from the public seem to be important to assess the overall quality of providers. We find that most plans conform their monitoring activities to the norms set out by the National Committee for Quality Assurance (NCQA).

In the final phase of contracting with providers, reviewing the contract, we again find that smaller plans have included fewer requirements in their provider manuals. Although this finding is not clear-cut, at least the smallest plans on average do not formulate clear demands and repercussions in case of non-compliance. Again, this might suggest that smaller plans lack leverage to enforce quality requirements through insurer-provider contracts.

In the next section we discuss the results of the interviews we conducted with the management (contract managers, regional VPs, Chief Medical Officers) of five different of health plans that offer Medicare Advantage throughout New York State. In total, as can be seen in table 5, these organizations represent around 337 thousand beneficiaries, which represents around 28% of the MA market of New York State, some 2% of the nationwide MA market. The health plans offer MA in the five boroughs of New York, Long Island and throughout NY State. We code the responses by the interviewees R1-R5, following the sequence of when the interviews were conducted.

5.2 Prior to contracting

Health plans typically contract with three different types of providers: individual physicians, physician groups (Independent Practice Associations, IPAs) and hospitals/larger multispecialty groups. Most health plans simultaneously form their own networks and contract with already formed networks. One approach, when expanding business into a new county, is to first talk to the largest hospital. R4: 'You start with the hospitals and then work your way down from there to form your own network.'

Over the past few decades, the provider market has consolidated. R4: '[Physician] groups have gotten larger, in order to increase negotiating leverage.' R1: 'In the beginning [...], it was quite asymmetrical, there was a lot of bargaining power coming from the health plans.'

Most plans remark that, especially in the metropolitan area, the provider market is saturated. 'The old goal was to get as thick a provider library as possible. We don't do that anymore' (R1). Instead, network formation is more about 'sculpting and maintaining the network, than anything

else' (R2). An important aspect in this phase is network adequacy; health plans look for providers that can assure adequate geographical coverage.

At this stage of the process, health plans check minimum standards such as malpractice history, fraud, and basic credentialing. R1: 'For most plans, we require board certification.' R2: 'We do perform a credential check of our providers, but that's just as a background, there's no quality checks at this point.' Two health plans report that already at this stage, more detailed quality requirements are discussed with providers. R3: 'We look at whether physicians are willing to work with us to close the 'gaps in care'. If they are not prepared to do this, we do not want to work with them.' R5: 'If there's only one network manager [and no supporting staff], that's probably not a good sign. We require some organizational structure so that we can get proper feedback. It's important that providers are like minded and forward thinking.' R5 additionally mentions the availability of Electronic Medical Records (EMR) as a requirement for contracting with a provider.

R4: '[…] Before talking about credentialing however, you talk about the rates. You say: 'here's our rate structure'. Then you enter into a credentialing discussion. Most plans go with whatever CMS has to offer. Sometimes we offer 102% of TM if a provider has the leverage.' R3: 'We look at the level of 'uncompensated care' that is delivered by a hospital, to determine whether we want them in our network. [If this is too high, the plan will likely lose money on them.] Next we look at neighborhoods and their population. If the average population can't afford the Cadillac plan, a neighborhood is more interesting to us.' Some plans at this stage seem to want to match providers and beneficiaries, as R3 points out: 'You look to bring in providers […] that have patients that are interested in your products.'

The CMS payment model stimulates some plans to work on population health management at this stage. R3: 'The only way to be successful with a fixed budget is to work with providers to mitigate health risks. We actively look for primary care providers that want to work on this aspect with us.'

5.3 Negotiating and agreeing the contract

Health plans that are active nationwide and operate throughout the state, seem more prone towards making quality improvements through the contract. R3: 'We want to incentivize providers to be efficient. If they just want 100% of [Traditional] Medicare and that's it, we're not interested. Although, in rural areas, we sometimes have to compromise on the philosophy; in those areas we are more open to having a pure FFS regime with them; given the challenges, we are then more flexible.' For these plans, the contract deals with both the rates and with quality. R3: 'Our contract consists of two parts. The first part discusses what we'll pay for what you [the provider] do. The second part of the contract is concerned with 'relationship issues'. We thereby incentivize providers to take the time to offer preventive services.'

This position is echoed by R4: 'we talk [with providers] about paying incentives to improve the quality of care. We want patients to be seen once a year. In the case of patients with high blood pressure, we are interested if they are taking their meds. It's all about gap closures.' And: 'the CMS star rating is important, as we get more money with more stars; we are incentivized to work towards quality.' R2: 'Our contracting process is value-oriented. The business has shifted from 'being a payer' to collaborating together'. Plans however acknowledge that most providers do

currently not have the infrastructure in place to be held accountable for contracting based on quality.

The Medicare Alternative Payment Model allows for different types of quality arrangements, but advanced value-based payments and financial risk sharing only takes place with providers that have the necessary infrastructure. R1: 'With IPAs we make agreements on financial risk sharing. When it comes to [monitoring] outcome requirements, for primary care, we don't have enough data points.' R2: 'We cannot do an APM three if an organization does not have the infrastructure in place. New York does not have many threes. [...] We try however to put as many as we can into three or four.' R1: 'When contracting with individual physicians, we do not gather quality information. Once they reach a certain number of members (100), we are able to measure access, utilization and satisfaction (through report cards).'

CMS is considered the 'market maker' for traditional Medicare, and health plans often follow CMS' lead. R3: 'Medicare pays for certain outcomes, process measures, such as: do you have a process by which you track diabetic patients regarding their insulin level? Then there are certain industry norms for outcome measures. CMS makes the market; we have our own 'tweaks'. There are variations across health plans. We'll pick up a lot of what CMS does, especially concerning the five star program.'

For other more locally active plans, the bottom line in the negotiation process is the rates. R1: 'It used to be a real negotiation, but now companies [health plans] have standard rates, which is pretty much a 'take it or leave it' deal. We negotiate around 85% of the Medicare rate. Providers agree to these rates, because they want the volume.'

5.4 Monitoring the contract

All health plans have a department that deals with checking claims data and maintaining provider relations. R1: 'We have a 'provider relations' department, which is in contact with the providers. You are supposed to monitor and not automatically renew the contracts, but we don't do that. This would mean an enormous amount of work.' R2: 'We monitor based on the claims, and monitor for upcoding (ffs). We have automated claims editing software that corrects for this.'

Next to monitoring basic claims data, insurers compare clinical and financial performance indicators against the terms in the contract. Clinical performance indicators are measures such as the number of emergency admissions or the way in which hospital discharges take place. R4: 'We monitor how much we are spending per specialty and we check management reports on utilization.' If the dashboard suggests that some indicator is off, this is a reason for an insurer to start a discussion with the provider on quality. You use the data in the reports to define opportunities.'

Although contracts thus define the relationship between the insurer and provider through the business terms that are included, health plans do not generally revert to it in the monitoring phase. R5: 'A good contract is written and then disappears for two years. The relationship should drive everything.'

Progress reports can also assist insurers in proactively engaging in population health management. R3: 'We have monthly tracking on expenditure, utilization and gaps in care. We

also have an expensive algorithm that monitors claims data and can signal if a patient needs an additional checkup.'

Sharing and discussing progress reports with individual physicians is however rare. All of the insurers hold surveys to establish customer satisfaction. R1: 'We do member satisfaction surveys and track health quality complaints. We also do access and availability studies. These are performed both in house and outsourced.' R2: Yes, we have an internal patient satisfactory survey. We oversample for some (larger providers) to increase accuracy.'

In the monitoring phase, the termination of a contract with a provider is rare. R1: 'You can non-renew [once every three years], if you get the timing right. A provider then has no recourse. If you terminate a provider, this is a big thing. This happens only for fraud or unintended harm.' There is also an educational component to disagreements with providers on parts of the contract; R2: 'sometimes they [providers] do things the wrong way, for example if they start billing our members instead of us.' R3: 'By and large: we want to work it out with them.' R5: 'At the far end there might be fraud at play or some indictment. Sometimes a provider won't see our members but will see other health plans members. That's a problem. We terminate with some hospitals, in case of a payment issue. Also: you don't need five podiatrists on one block.'

5.5 Reviewing and renewing the contract

In this phase of the contracting process, changes to the contract are rare, other than rate increases. R2: 'We [do] apply some cost of living increase.' It also happens that providers try to negotiate a better deal. R3: '[…] when a provider has more leverage they [will generally try to] negotiate a better deal; they want more money or better business terms.' Then, it also happens that a provider 'upgrades' its payment model. R2: '[…] If provider arrangements change, we change the contract. In those circumstances, most common changes [to the contract] are value-driven.'

All health plans report typical contract duration of one year and most contracts are considered 'evergreen contracts'. R1: '[…] if not cancelled by one of the signing parties within 6 months in advance, the contract will be renewed automatically.' This generally applies to fee-for-service contracts; contracts with more elaborate payment models can last three or up to five years. R3: 'we want to build a lasting relationship with our providers in which we share a [common] philosophy. Longer contracts not only shape the purchaser-provider relationship, but it is also seen as a 'commitment to our membership' (R5).

This is however not the norm. With individual physicians, contract duration typically is one year and contracts are mostly evergreen. All plans report a very steady provider pool; R1, R2, R3 and R4 report less than 1% of discontinuation of contracts. R5: 'We have a steady pool. We'll be approached say every two years by hospitals that want higher rates and we can't give them that. That happens.'

Besides rate changes, modifications to contracts aimed at improving the quality of care delivery are thus primarily implemented when providers move into another (value-based) payment model with the insurer. Other ways to have quality play a role in the contracting process are not taken advantage of for reasons stated earlier: the relationship between the plan and the provider guides initiatives for quality improvements rather than the terms in the contract. R5: 'you can't make them [providers] do something if they can't or won't. A contract won't force them. The reality of the situation often dictates rather than the contract.'

5.6 Interaction with the payer

Health plans unambiguously agree that CMS dictates the nature of the insurer-provider relationship. Being the market maker and 'custodian' of the Medicare market, CMS will sometimes suggest an intervention by a health plan to guarantee continuity of care. R5: 'Sometimes CMS asks us to expand our business to a new county because the only MA health plan in that particular county went out of business.'

Other ways in which CMS influences the relationship is through the five star rating program. All health plans acknowledge that this program determines their purchasing behavior. R1: 'Yes, this is very important. We currently have four stars and want to keep it that way. That's why we have a bonus program. This would be the only reason for not renewing a contract: quality. Bad quality providers are hurting the star rating. Generally around 30-40 providers aren't renewed yearly. Star rating has made quality more important.' In comparison with the thousands of contracts of this particular health plan[6], this number is however to be considered low (and still falls within the 1% of discontinuation of provider-contracts).

As health plans receive higher reimbursements for a better star rating, they are keen on maintaining or improving their current rating. R4: 'The CMS star rating is important, as we get more money with more stars. We are incentivized to work towards quality.'

[6] Clarified after email correspondence (author's personal archive).

6. Conclusion and discussion

Our theoretical model ascribes important abilities to insurer-provider contracts in terms of upholding and leveraging quality standards. At every phase in the contracting cycle, decisions on purchasing health care of good quality can be made and providers that cannot uphold quality requirements can in theory be filtered out at these various stages. By doing so, the contracting process can in theory be a driver of change and quality improvement of the delivery system.

The payer (CMS) plays an important role when it comes to promoting quality through the purchasing process. Not only does it provide an elaborate scheme of value-based payment mechanisms, it also aims to improve quality by promulgating star ratings, incentivizing health plans financially (bonus schemes) and making these ratings publicly available. At the same time, reimbursement rates for MA have been lowered substantially since the introduction of the ACA, compelling health plans to work with these new value-based initiatives.

Some health plans have embraced these changes and aim to 'close gaps in care' and work on population health management. The bulk of insurer-provider contracts however are still based on fee-for-service schemes. Provider markets are largely saturated and an important bottleneck is the availability of reliable provider performance information. Most providers simply do not have the level of technological or organizational sophistication in place to answer to the demands of health plans, which would justify more advanced payment schemes. This leads to a situation where often the same contracts are in place for many years and there is a discontinuation rate of less than one percent.

Our results suggest that, for selective contracting to be a driver of quality improvement, the most crucial elements appear to be disposing of reliable provider performance information and working towards value-oriented payment schemes. The presence of an active payer that defines quality standards and holds insurers accountable for the services provided seems important. Three general observations can be made.

The first one is that health plans are highly strategic and calculating players. Any effort to promote quality through the contracting process should therefore be promulgated and supported by a payer that focuses on creating value for the consumer, for example through value-based payment arrangements. In the US, the Center for Medicare and Medicaid Services (CMS) is gradually moving away from fee-for-service type instruments towards value-based payments. This development shapes the Medicare market and influences the modus operandi of health plans as well, as these plans acknowledge new opportunities for expansion and increased revenue potential. MA Health plans have increasingly embraced value-based contracts including risk sharing with providers.

The second observation is that the bottleneck for contracting for quality often is the availability of reliable, verifiable and comprehensive quality parameters. The bulk of contracts are still signed with individual physicians or practices, which often do not dispose of the requisite infrastructure and data points to assess and compare quality. Instigated by newly introduced CMS payment models, most health plans have formulated goals to 'close the care gap' or work on population health management, but these ambitions are often inhibited by limited health management infrastructures of providers. This is especially the case for smaller plans, as our analysis of provider manuals shows.

The third observation is that the contracts themselves generally do not drive quality improvements. Most provider contracts handle overall business terms and rates, often

supplemented with paragraphs on quality. The contracting process itself is however generally still seen as a 'rate discussion'. Improving the overall quality of health care delivery is more often achieved through the insurer-provider relationship. This is illustrated by the fact that all interviewees report that most contracts are 'evergreens' and there is under one percent of discontinuation of contracts. When discontinued, the reason mostly lies in a dispute on the rates or, at the far end of the spectrum malpractice or fraud, than in a disagreement on the quality of health care delivery.

This leads to a number of policy recommendations. Firstly, selective contracting can be successful when supported by strategic purchasing at the level of the payer. In this study we have seen that in the US, CMS plays an important role in this regard. For other managed competition markets, such as the Netherlands, this implies that such a health system cannot be reconciled with a laissez-faire policy towards private insurance. As payment models largely define the extent to which selective contracting drives quality improvements, this should be central to their policies. Our interviews indicate that insurers strategically respond to the payment models put forward by the payer. To the extent that their organization can answer to the requirements of the payer, they will do so. Secondly, value-based purchasing can only succeed if quality parameters are well defined and if provider performance information is widely available and comparable. An important challenge in this regard is engaging and enabling individual physicians and practices, by far still the largest number of providers, towards this end. This leads to our final recommendation, which is that being serious about improving quality through the contracting process requires economies of scale. In the case of the insurer it means having the organizational capacity in place to properly monitor contracts and take action when required. In the case of the provider it means being able to leverage demands by insurers and engage in negotiations on quality based on the requisite quality information.

Any effort to implement or foster selective contracting within a setting of managed competition, should acknowledge the bottlenecks and opportunities that exist. This study aims to contribute to that aspiration and the ongoing debate on improving our health care delivery system.

7. Dutch summary

Veel beleidsmakers zien selectieve zorginkoop – het proces waarbij een zorginkoper contracten afsluit met een beperkt aantal aanbieders en verzekerden naar deze aanbieders geleidt – als een belangrijk instrument om de zorguitgaven te beheersen en de kwaliteit van de zorg verder te verbeteren. Met name binnen zorgstelsels die gebaseerd zijn op gereguleerde competitie, waarin verzekeraars en aanbieders concurreren op basis van prijs en kwaliteit, wordt selectieve inkoop gezien als een belangrijk instrument. Tegelijkertijd zijn er blijkens de bestaande literatuur grenzen aan de toepassing van selectieve inkoop. In de meeste zorgstelsel die gebaseerd zijn op gereguleerde competitie wordt de toepassing van selectieve inkoop belemmerd.

Alhoewel de Zorgverzekeringswet uit 2006 de ruimte biedt voor selectieve zorginkoop, wordt het in Nederland beperkt toegepast. Nu de risicodragendheid van private verzekeraars omhoog is gegaan en de zorguitgaven harder blijven stijgen dan de economie, krijgt selectieve inkoop meer en meer aandacht van politici, beleidsmakers en zorgbestuurders. Om die reden is het interessant om dit fenomeen in een andere context te bestuderen, zodat er mogelijk lessen kunnen worden getrokken voor de Nederlandse situatie.

In dit onderzoek kijken we naar de grenzen aan en mogelijkheden van selectieve inkoop, door de verzekeraar-aanbieder relatie nader te bestuderen binnen het contracteringsproces van het Amerikaanse Medicare Advantage (MA) programma. MA is een vorm van Medicare, maar dan uitgevoerd door private verzekeraars. In de Verenigde Staten heeft men zo'n dertig jaar ervaring met Medicare Advantage en de afgelopen jaren heeft het aantal verzekerden onder MA een vlucht genomen (momenteel zijn zo'n 17 miljoen Amerikanen op deze manier verzekerd, wat neerkomt op zo'n dertig procent van alle Amerikanen die in aanmerking komen voor Medicare). Binnen het MA programma concurreren verzekeraars met elkaar om de gunst van de verzekerde en contracteren zij met tal van zorgaanbieders. Veel studies naar selectieve inkoop kijken naar de te behalen efficiency winst. De directe impact van selectieve inkoop is echter vaak niet duidelijk. Met deze studie proberen we een bijdrage te leveren aan de discussie over de mogelijke impact van selectieve inkoop, door de MA markt van de staat New York te analyseren en vast te stellen in welke mate de zorginkoop wordt bepaald door het inkopen op kwaliteit. Op basis van een *mixed methods study*, gebruik makende van publiek beschikbare data van het *Center for Medicare and Medicaid Service* (CMS; de uitvoeringstak van het Amerikaanse ministerie van Volksgezondheid) en websites van zorgverzekeraars, analyseren we de verzekeraar-aanbieder relatie. We vullen die resultaten aan met de resultaten van vijf interviews met het senior management van zorgverzekeraars uit New York die Medicare Advantage aanbieden. We analyseren vervolgens onze gegevens aan de hand van een indeling van de Wereldgezondheids-organisatie (WHO), die het contracteringsproces in vier stadia opdeelt.

Onze resultaten laten zien dat selectieve inkoop pas in de volle breedte kan plaatsvinden wanneer aan een aantal criteria is voldaan. De belangrijkste is dat verzekeraars kunnen beschikken over betrouwbare prestatie-informatie van de zorgaanbieders. Ook het gebruik maken van kwaliteit-gedreven vergoedingen (*value-oriented payment schemes*) kunnen bijdragen aan het verbeteren van de kwaliteit van de zorg. Hierbij plaatsen we drie observaties.

Ten eerste merken we op dat verzekeraars in hoge mate strategische spelers zijn. Iedere poging om de kwaliteit van zorg te verbeteren via het contracteringsproces moet daarom gepaard gaan met gericht beleid vanuit de overheid. Een manier waarop dit kan worden bewerkstelligd is *value-based payments*. We zien in de VS, dat CMS in toenemende mate traditionele vaste tariefsstructuren (*fee-for-service*) vervangt door betalingsregimes gebaseerd op prestatie (*pay-*

for-performance). Deze ontwikkeling beïnvloedt de Medicare-markt en de wijze waarop private verzekeraars binnen Medicare Advantage opereren. Hierbij zij opgemerkt dat de Amerikaanse overheid een dubbele taak vervult. In de eerste plaats geeft zij de zorgmarkt vorm via haar taak als wetgever. Deze rol is vergelijkbaar met die van de Nederlandse overheid. In de tweede plaats is zij ook 'payer' en beïnvloedt zij via CMS de zorgmarkt door direct in te grijpen in de verzekeraar-aanbieder relatie. Calculerende verzekeraars concentreren zich op die activiteiten die gestimuleerd worden binnen de vigerende betalingsregimes. *Active purchasing*, waarbij de overheid zich direct mengt in de relatie aanbieder-verzekeraar, lijkt van grotere invloed op de kwaliteit van zorg dan selectieve inkoop door verzekeraars.

Ten tweede lijkt het knelpunt ten aanzien van selectieve inkoop te liggen in de beschikbaarheid van betrouwbare, toetsbare en allesomvattende kwaliteitsparameters. Het merendeel van de contracten wordt nog steeds afgesloten met individuele artsen en aanbieders, die vaak niet beschikken over de benodigde infrastructuur of robuuste patiëntgegevens om kwaliteit te toetsen en te vergelijken. Aangespoord door nieuwe vergoedingsregimes vanuit CMS, hebben de meeste verzekeraars ambities geformuleerd ten aanzien van het 'slechten van de zorgkloof' of het werken aan gezondheidsmanagement van de verzekerde populatie, maar deze ambities worden vaak gedwarsboomd door een beperkt beschikbare infrastructuur van de aanbieder.

Een laatste observaties is dat de contracten zelf niet direct tot kwaliteitsverbeteringen leiden. We zien dat de meeste aanbieders contracten afsluiten met daarin generieke bepalingen ten aanzien van de overeengekomen diensten en de vergoeding daarvoor, vaak aangevuld met paragrafen over kwaliteit. Het contracteringsproces wordt echter voornamelijk gezien als een discussie over tarieven. Het verbeteren van de kwaliteit van zorg lijkt meer besloten te liggen in de onderlinge relatie tussen de verzekeraar en de aanbieder. Dit wordt geïllustreerd door het feit dat vrijwel alle geïnterviewden aangeven dat de meeste contracten zogenoemde 'evergreen' contracten zijn, die zelden worden opgezegd. Indien een contract wordt opgezegd, is de reden veelal dat er onenigheid is over de vergoeding, of is sprake van grove medische fouten of fraude, dan dat er onenigheid bestaat over de kwaliteit van de geleverde zorg.

Dit leidt tot een aantal beleidsaanbevelingen. Ten eerste verdient het de aanbeveling dat selectieve inkoop door verzekeraars gepaard gaat met gericht overheidsbeleid. In dit onderzoek hebben we gezien dat in dit verband CMS een grote rol speelt. Voor Nederland kan dit betekenen dat het stelsel van gereguleerde marktwerking niet samen kan gaan met een *laissez-faire* houding ten aanzien van het contracteringsproces. Gericht beleid om dit te ondersteunen lijkt van belang.

Ten tweede kan het inkopen van zorg op basis van kwaliteit alleen slagen als kwaliteitsparameters goed gedefinieerd zijn en als prestatie-informatie van goede kwaliteit is en wijd beschikbaar. Het lijkt van belang om individuele aanbieders aan te sporen en mee te krijgen om dergelijke data te verkrijgen en beschikbaar te stellen. Een laatste aanbeveling is dan ook dat, indien men de kwaliteit van zorg wil verbeteren via het contracteringsproces, schaalgrootte van belang is. In het geval van de verzekeraar betekent dat het beschikken over de organisatorische capaciteit om contracten goed te monitoren en bij te sturen indien noodzakelijk. In het geval van de aanbieder betekent dit de mogelijkheid te creëren om aan de vraag van verzekeraars te kunnen voldoen voor wat betreft het beschikbaar stellen van goede kwaliteitsparameters.

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Appendix A – Interview questions Medicare Advantage

Get confirmation on the following:

- The CMS website states that you offer MA plans since … ? Would you say this is accurate?
- I understand you offer the following types of MA plans …? Would you say this is accurate?
- I understand that your organization offers MA plans for … number of beneficiaries. Would you say this is accurate?
- I understand that your organization offers MA plans in the following regions … . Would you say this is accurate?

<u>Prior to contracting:</u>

1. Do you form your own networks or do you contract with already existing networks? -- If the latter, how do you choose which network?
2. Do providers have to meet certain criteria in order to become eligible for obtaining and retaining contracts?
   - Are there certain quality thresholds?
   - Are the requirements/criteria imperative to be considered?
   - In chapter 11 of the Medicare Managed Care Manual, *procedure and contract requirements* between MA organizations and providers are outlined.
     - What additional information do you put in the contract? (Note that the CMS contract requirements relate to: privacy and confidentiality, payment procedures (to providers and beneficiaries), accountability issues, and provisions under the Code of Federal Regulations.)
     - Do you gather quality information from providers (and patients) beyond what is required in the Medicare Managed Care Manual and other Federal Regulations?
   - Do you collect provider performance information? What kind of information do you collect? What do you do with this information?

<u>Negotiating and agreeing the contract:</u>

3. Please elaborate somewhat on the negotiation process:
   - What – to your organization – are the most important conditions/requirements for contract with a certain provider? Why?
   - What type of information is included in the contracts with providers?
     - There are different types of requirements that can be put in a contract. The first one is a *structural requirement*, for example: a requirement that a provider has a certain system of data collection. The second one can be a *process requirement*, for example: a minimum volume of service agreement. The third one is an *outcome requirement*, for example: a target for patient outcomes, or patient satisfaction.
     - Which of these requirements do you put in a contract with a provider?
   - Are contracts uniform for the same type of service, or tailor made? Is this different for hospitals, medical groups, labs, specialists etc.?
   - Do you negotiate financial rewards/incentives for better performance? Why (not) and how?
   - What's the typical duration of a contract with a provider?

Monitoring the contract:

4. How do you monitor the contract?
5. Do you compile progress reports?
6. Do you collect customer feedback? How? To what end?
7. What if a provider does not honor (parts) of the contract?

Reviewing the contract:

8. Do you make changes to a contract when you renegotiate? What are the most important reasons for this? What are the most common changes?
9. Do you have a steady provider pool? Or are there a lot of changes from year to year? Why so?

General questions:

10. (How) Does the CMS star rating policy affect your purchasing behavior? Has the introduction of the CMS star rating policy led to any changes in your contracting process?
    - Can you elaborate/give an example?
11. (How) Do other public quality ratings (NCQA/HEDIS) affect your purchasing behavior?
    - Can you elaborate/give an example?
12. With regard to non-HMO plans: How many people go out of network? Do you know what the reason is for them to do so?
13. Do you have different contracting strategies for different regions? Do you encounter different problems in different regions?