Purchaser Business Group on Health

Playbook for Successful and Collaborative Health Plan Management

Leveraging the Collective Power of PBGH Members to Impact Health Care Delivery

For Employers 2020

Executive Summary

Collective action among health care purchasers is one of the most effective strategies that can be implemented to send a clear message to health plans about purchaser expectations for policies that deliver higher quality, higher value care.

With a set of key performance indicators used by large private employers and public purchasers of health benefits, the Pacific Business Group on Health (PBGH) has created a tool to align employer and purchaser priorities to their health plans.

The Health Plan Playbook is a set of nine performance indicators selected by experts at PBGH in consultation with member companies, which include some of the largest private employers and purchasers of health benefits in the United States. The measures provide actionable insight into a purchaser's health plan spending that aim to incentivize both short-term change and long-term structural impact on care for its plan members.

In a first-of-its kind initiative, PBGH operates as a facilitator by directly engaging with health plans to collect and track performance metrics and the progress health plans make toward them on behalf of participating organizations. Thus far, 25 member companies have signed onto this inititiative.

The Metrics

1. Benchmarking Primary Care Spend
2. Integration of Primary Care and Behavioral Health
3. Depression Screening Utilization
4. Use of Two-Sided Risk Payment Models
5. Efforts to Avoid Low-Value Care
6. Adoption of Biosimilars
7. Site-of-Service Redirection for Administered Drugs
8. IHA-PBGH Commercial ACO Measure Set
9. Reporting on Depression Screenings and Remission Rates

1. Benchmarking Primary Care Spend

The benefits of primary care are well documented. Studies have consistently shown positive relationships between the delivery of primary care services and better care coordination, better outcomes and a reduced specialty spend, in addition to a better patient experience.[1] Conversely, concerns around an increasingly specialist-oriented health care system has led to increased national discussion and action to strengthen America's primary care foundation.

Common Challenges

Health plans and employers are often united in their support of primary care services for their plan members. However, there is growing concern that, despite demonstrated health care value, primary care physicians are compensated significantly less than physicians in other medical specialties, leading to a specialist-oriented system overall, and contributing to a shortage of primary care physicians.

What We Measure

Our goal is to ensure primary care is being appropriately prioritized.

PBGH utilizes a standardized methodological approach to measure primary care spending rates—the portion of total health care expenditures that goes to primary care—as a percentage of overall spending.

2. Integration of Primary Care and Behavioral Health

Primary care integration of behavioral health helps identify and provide access to treatment for individuals in need of mental health services. PBGH uses the Collaborative Care Model (CoCM), an approach to behavioral health integration that has been shown in multiple studies to improve patient outcomes. CoCM enhances primary care by adding key services to the primary care team: care management, behavioral health support, and psychiatric consultation as needed.

Common Challenges

In some situations, health plans will assert that few providers are meeting the requirements for the CoCM. In these cases, purchasers and health plans can discuss the actions that plans are currently taking to help providers meet the requirements for CoCM payments.

What We Measure

The number of unique providers utilizing CoCM CPT codes (99492-99494) and the total payments for these codes. By collecting data on the number of providers using these codes, we have a proxy for how many primary care providers are offering integrated behavioral health services and a baseline for promoting adoption of collaborative care.

3. Depression Screening Utilization

Depression is often under diagnosed as a mental health disorder, mostly because of public misconceptions of its signs and symptoms. Primary care is a key point of entry to the health care system for many patients and presents an important opportunity to engage patients to address their emotional and mental health needs. Primary care integration of behavioral health helps address access, identification and treatment for individuals with mental health needs. Employers want to factor and budget appropriately for this important service.

Common Challenges

If a plan does not currently reimburse for depression screenings, we encourage purchasers to ask their health plan to model the total costs for depression screening for new patient office visits or follow-up visits for existing patients with a depression diagnosis or other chronic condition. This will help purchasers and health plans make informed health care decisions and develop a roadmap for reimbursement of depression screenings.

By supporting an infrastructure for routine screening and data collection, plans can enable outcomes measurement for a range of mental health conditions.

What We Measure

The percentage of primary care visits that utilized the depression screening CPT code (96127, CPT II codes: G8510/G8431, or relevant Healthcare Common Procedure Coding System (HCPCS) codes. Additionally, if a health plan pays for depression screenings, report the number of unique providers and aggregate payments per employer.

1. Standardizing the Measurement of Commercial Health Plan Primary Care Spending, Milbank Memorial Fund. See pp 5-7, https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf

4.
Use of Two-Sided Risk

When providers assume financial risk, it creates aligned incentives that support innovation and effective use of resources. Two-sided risk payment models allow providers to perform services at costs below the benchmark share in savings while also financially disincentivizing those whose actual costs exceed the benchmark. By adopting this approach, employers can encourage innovation and competition while ultimately reducing total expenditures.

Common Challenges

There are several different methods for measuring spending, quality and participation in two-sided risk arrangements. It is key for health plans to decisively choose a valid method of measurement and maintain open communication with purchasers on its definition and parameters.

What We Measure

The proportion of overall spending attributable to two-sided risk arrangements, and the percentage of plan participants enrolled in or attributed to these arrangements.

5.
Efforts to Avoid Low-Value Care

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine that provides recommendations on the value for preventative services. In this system, services given a rating of "D" are recommended against and discouraged from use in most cases as they may cause more harm than the potential benefit they provide. These services—along with other services such as lower back pain imaging and excessive lab work prior to low-risk surgery—are generally considered low-value care and coverage should be covered only when appropriatley delivered. The specific measures selected by PBGH are based on measures outlined by the VBID National Task Force on Low Value Care.

Common Challenges

Health plans may find measurement challenging due to the nuanced nature of the methodologies available to do so. However, data specs for select measures are publicly available. In addition, health plans can access Milliman's Health Waste Calculator, or engage Milliman directly for assistance.

What We Measure

The spending attributable to preventative services rated "D" by the USPSTF. Additionally, plans should measure the spending on services highlighted by Milliman's Health Waste Calculator, which identifies and quantifies wasteful healthcare spending and potentially unnecessary services.

6.
Adoption of Biosimilars

Biosimilars have a significant role to play in controlling specialty drug spending—one of the fastest growing health expenditures for employers in the past decade. Health economists estimate that robust biosimilar competition could reduce prescription drug spending by as much as $150 billion over the next ten years. However, at the tie of publication, only 7 biologics have seen any biosimilar competition, and adoption has been sluggish. It is important that purchasers adopt biosimilars to ensure they will continue to be available on the open market.

Common Challenges

Health plans may assert that rebates on reference products produce substantial savings on drug expenditures. In these cases, health plans and purchasers should review documentation on the areas where employers are paying less or receiving certain rebates. Rebates do not result in discounts for the purchaser if the difference doesn't go back to the purchaser.

What We Measure

The number of biosimilar prescriptions filled within the last six months, the number of reference drugs prescriptions filled in the last six months, and whether or not biosimilars are prioritized on the plan formulary.

7.
Site-of-Service Optimization

Redirecting the site-of-care for administered drugs represents a significant opportunity for savings and a better member experience. The average cost for outpatient infused drugs at hospital-related facilities is often significantly higher than the cost of receiving the same therapy at physician office suites, home infusions or specialty pharmacies. By redirecting administered drugs to physician offices and/or the patient's home instead of outpatient hospital facilities, purchasers can save $16,000 to $37,000 per patient per year for the top-five conditions, accounting for over 75% of spending on administered drugs.

Common Challenges

Health plans and purchasers may highlight administrative difficulties in monitoring the site-of-care for administered drugs. Many studies and plans have developed methods for tracking this data, and sample data specifications and reports can be used as a starting point for health plans.

What We Measure

The portion of administered drugs provided in lower-cost settings as a percentage of overall spending on administered drugs.

8.
IHA-PBGH Commercial

To make performance measurement more meaningful and less burdensome for accountable care organizations (ACOs), the Integrated Healthcare Association (IHA) and PBGH partnered to develop a standardized measurement and benchmarking program for commercial ACOs. This effort based in California, (but with nationwide relevance), identified 18 core measures and 17 developmental measures that promote high-quality, affordable, patient-centered care—otherwise known as high-value care. Twenty leading ACOs and health systems as well as five plans (Aetna, Anthem, BSCA, Health Net, UnitedHealthcare) have endorsed this set of measures.

Common Challenges

In some cases, the data required for the core measures is unavailable, and health plans may express hesitance to open ACO contracts to include these measures.

In addition, there has been a proliferation of commercial health plan ACO contracts, each with different quality measures and payment incentive designs. Many rely on traditional quality measures, where provider performance varies little. Purchasers can maintain dialogue with their plans and request a roadmap for plans' inclusion of these measures in their ACO contracts.

What We Measure

The percentage of the plans' ACOs in which the core measures of the IHA-PBGH Common ACO Measure Set are routinely captured. These emphasized measures are clinically impactful and represent high-value care, including measures of behavioral health, maternal health and opioids.

9.
Reporting on Depression Screenings and Remission

Depression is a common and treatable mental disorder, and a key measure within the IHA-PBGH Commercial ACO Measure Set. The estimated cost of depression in the United States is $83 billion each year, mostly due to lost productivity and increased medical expenses. Despite depression being a treatable condition, only one-third to one-half of primary care providers detect major depression in their patients with the condition. Appropriate and reliable follow-up with those patients is highly correlated with improved treatment response and remission scores, ultimately improving the delivery of care.

Common Challenges

Health plans may express concerns that the data is hard to obtain or simply unavailable. In these cases, purchasers and health plans can work in tandem to maintain a roadmap for the adoption of PROMs for depression screenings and remission rates.

What We Measure

The rates of depression remission at six months, and the utilization of depression screenings and remission measures through Patient Reported Outcome Measures (PROMs). These are designated as developmental measures and may require additional resource investment.

For more information or to join the PBGH Health Plan Playbook initiative, contact: info@pbgh.org