PBGH Health Value Index

for Successful and Collaborative Health Plan Management

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

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Summary Findings

Purchaser Business Group on Health

Executive Summary

Collective action among health care purchasers is one of the most effective strategies that can be implemented to improve the outcomes and experience of our employees and to send a clear message to health plans about purchaser expectations for practices that deliver higher quality, higher value care. A recent survey of C-suite executives found that 85% agreed that employers collectively can make considerable change in health care costs.

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

The Metrics

The PBGH Health Value Index is a tool to track and report health plan performance to employers and purchasers. The first report focuses on a set of nine performance indicators selected by member companies, which include some of the largest private employers and public purchasers of health benefits in the United States, in consultation with experts at PBGH. The results provide actionable insight into the effectiveness of purchasers' health plan spending and opportunities for improvement. The information may be used to incentivize both short-term change and long-term structural impact on care for their plan members.

In a first-of-its kind initiative, PBGH directly engaged with our members' health plans to collect and track performance metrics on behalf of nearly 30 employer and purchaser organizations that signed onto this initiative.

In general, the results indicated opportunities to improve primary care payment, reduce low value care and promote adoption of biosimilars to lower specialty drug spend. Data also showed a high degree of performance variation among provider organizations.

On the whole, health plans had difficulty reporting on many of the metrics, particularly behavioral health screening and outcomes measures. The reporting deficiencies reflect a range of challenges, from contractual issues at the provider group level to failure of plans to invest in the technology required to report specific indicators, as well as the absence of value-based contracting tools to document provider performance. Despite these limitations the Health Value Index produced relevant insights on the majority of performance indicators.

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. U.S. adults who regularly see a primary care physician have 33% lower health care costs and 19% lower odds of dying prematurely than those who see only a specialist. Concern about an increasingly specialist-oriented health care system has led to a national focus on primary care, and PBGH is taking action to strengthen America's primary care foundation by advancing payment reform through primary care contracting principles.

What We Measure

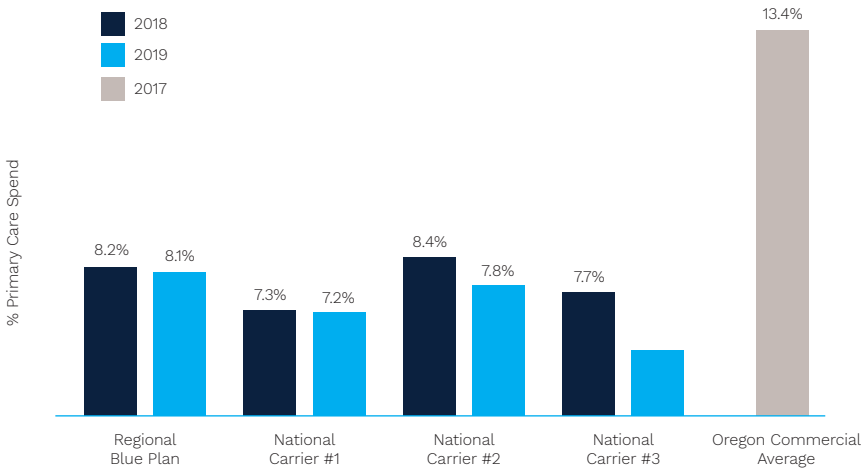
Our goal is to ensure primary care is being appropriately prioritized and resourced to meet patient needs. PBGH utilizes a standardized methodological approach to measure primary care spending rates—the portion of total health care expenditures that goes to primary care—as a percentage of overall spending.[1]

Results

Overall, the amount of primary care payments as a percentage of overall health care spending was low and often decreasing so this metric is not trending in the right direction. The average percentage of primary care spend was 8.1% in 2018 and 7.8% in 2019. Other high-performing carriers, like those in Oregon, have documented 13.4% of spending on primary care. Among 28 purchaser-payer dyads, 18 saw primary care spending decrease year-over-year, eight saw an increase and two remained the same.

Significantly, while the absolute dollars increased slightly, primary care spend fell as a percentage of total cost of care largely because hospital and prescription drug spending increased at a faster rate. Several PBGH members with directly contracted Accountable Care Organizations (ACOs) had higher rates of primary care investment.

Comparison of Primary Care Spending as a Percentage of Total Cost of Care



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

2.
Integration of Primary Care and Behavioral Health

Behavioral health care is primary care. 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.

What We Measure

The number of unique providers utilizing CoCM CPT codes (99492-99494) and the total payments for these codes. Collecting data on the number of providers using these codes offers a proxy for how many primary care physicians provide integrated behavioral health services and a baseline for promoting adoption of collaborative care.

Results

Despite this being a high priority for purchasers and the pronounced need for better access to behavioral health services, plans reported very limited payments for the CoCM service codes. There is a significant opportunity for health plans to educate providers about the use of these codes and for both purchasers and plans to support providers in meeting the requirements for CoCM payments.

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 improves access, identification and treatment for individuals with mental health needs. Employers want to factor and budget appropriately for this important service.

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. Plans were also asked to report the number of unique providers billing these codes and aggregate payments per employer.

Results

A small, but slightly increasing, number of providers are billing these services. While purchasers seek to advance population-based payments that support routine screening of depression and other behavioral health conditions, the intent of this metric was to examine the ability to capture screening rates in commercially insured populations through administrative claims data (as has been well demonstrated among Medicaid managed care plans). This will help purchasers and health plans make informed decisions to develop a payment roadmap for depression and other behavioral health screenings.

4.
Reporting on Depression Screenings and Remission

Depression is a common and treatable mental disorder, yet 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 and patient outcomes.

What We Measure

The rates of depression remission at six months and the utilization of depression screening, improvement and remission measures through Patient Reported Outcome Measures (PROMs).

Results

Performance on the screening and follow-up measure was generally very low and demonstrated a lack of robust data collection and/or appropriate follow-up screening. Most plans were unable to provide any data on depression remission, but the measure has been deployed among a limited number of directly contracted ACOs. While these data are hard to obtain, purchasers expect health plans to support an infrastructure for routine screening and data collection, with the goal of enabling PROMs and ultimately accountability for a range of behavioral health conditions.

5.
Use of Two-Sided Risk Payment Models

When providers assume financial risk, it creates aligned incentives for improved health that support innovation, quality and effective use of resources. Two-sided risk payment models also incent providers to manage the total cost of care. By encouraging adoption of alternative payment models, employers can promote innovation that best meets patient needs while ultimately improving care transitions and reducing total expenditures.

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.

Results

Wide variation was seen in the extent to which two-sided risk arrangements were utilized, from 1.1% of enrolled members on the low end to 12.7% on the high end, with an average of 6.3% of members across all purchasers in 2019.

For reference, the Healthcare Payment Learning & Action Network (HCPLAN) collected spending in two-sided risk arrangements for over 60% of the national commercial market in a survey fielded by America's Health Insurance Plans and the Blue Cross Blue Shield Association. HCPLAN reported 10.6% of commercial spending flowing through two-sided risk models in 2018 and aims to have 25% of commercial spending flowing through two-sided risk by 2022.

6.
Efforts to Avoid Low-Value Care

PBGH selected a small number of low-value services to assess 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" by the USPSTF are recommended against and discouraged from use in most cases as they may cause more harm than the potential benefit they provide. Additional resources include the Value-Based Insurance Design National Task Force on Low Value Care and Milliman's Health Waste Calculator.

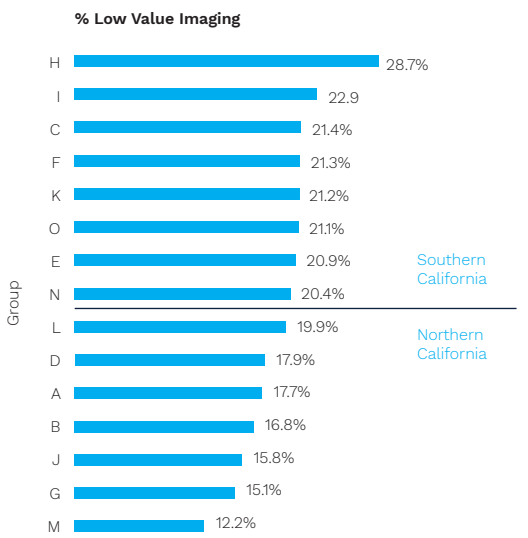
What We Measure

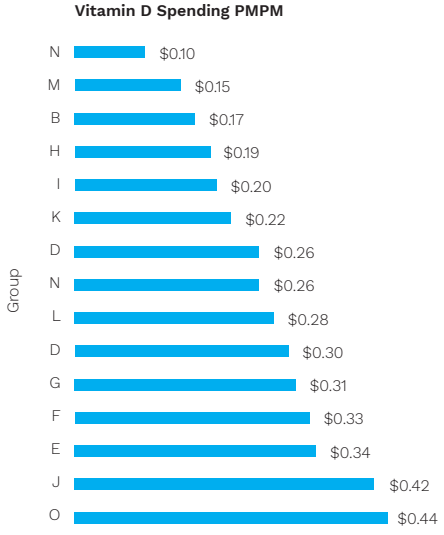
Plans are asked to report on the volume and cost of routine Vitamin D testing, advanced imaging for low back pain and excessive lab work or diagnostic screening prior to low-risk surgery among providers and provider organizations in which participating PBGH members had large enrollment volume.

Results

Reporting on avoidance of low-value care showed wide variation in low-value imaging for back pain and Vitamin D screening. In one sample, the volume of inappropriate low back imaging was much higher in Southern California than Northern California, but Vitamin D screening rates were not correlated with geography. Only one plan was able to report on avoidable diagnostic screenings prior to low-risk surgery. Additionally, one plan reported results from targeted initiatives to reduce low-value care spending. Reducing low-value care represents a significant opportunity to reduce risk of unnecessary treatments and reduce total spending without limiting access to needed services.

Medical Group Variation in Low-Value Care





7.
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. Few biologics have experienced significant biosimilar competition, but the biosimilar pipeline could have a major impact in the future. It is important that purchasers, health plans, pharmacy benefit managers and provider organizations drive the use of biosimilars to promote product and price competition.

What We Measure

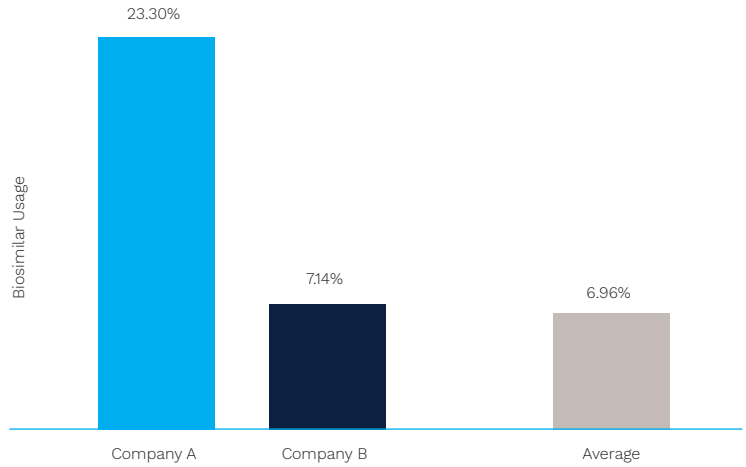
The number of biosimilar prescriptions filled compared to the number of reference drug prescriptions filled, and whether or not biosimilars are prioritized on the plan formulary.

Results

Biosimilar adoption varied greatly across purchasers as well as among health plans. Biosimilar adoption across health plans varied sharply, from under 5% to 51%, and this variation is attributable to whether or not biosimilars were prioritized on plan formularies. The highest rate of biosimilar adoption was reported by an integrated health plan and delivery system, highlighting the impact of aligned incentives.

It is important for purchasers to drive the use of biosimilars with their health plans. The reference products are highly rebated, making them a low-net cost for the plan, but that rebate never fully makes its way back to the purchaser. It is unusual for the biosimilar not to be a lower cost option for the plan sponsor. Rebates aside, purchasers must ensure a viable market for biosimilars—or face the consequences of monopolistic pricing as new drugs are developed with no threat of competition. Additionally, the current provider "buy and bill" reimbursement structure fails to incent use of biosimilars.

Employer Variation in Biosimilar Adoption under a National Health Plan



8.
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. The volume of services has also been impacted by hospital acquisition of provider practices. 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.

What We Measure

The portion of administered drugs provided in lower-cost settings as a percentage of overall spending on administered drugs. The volume of services billed with an unspecified drug code (J3490) is also addressed.

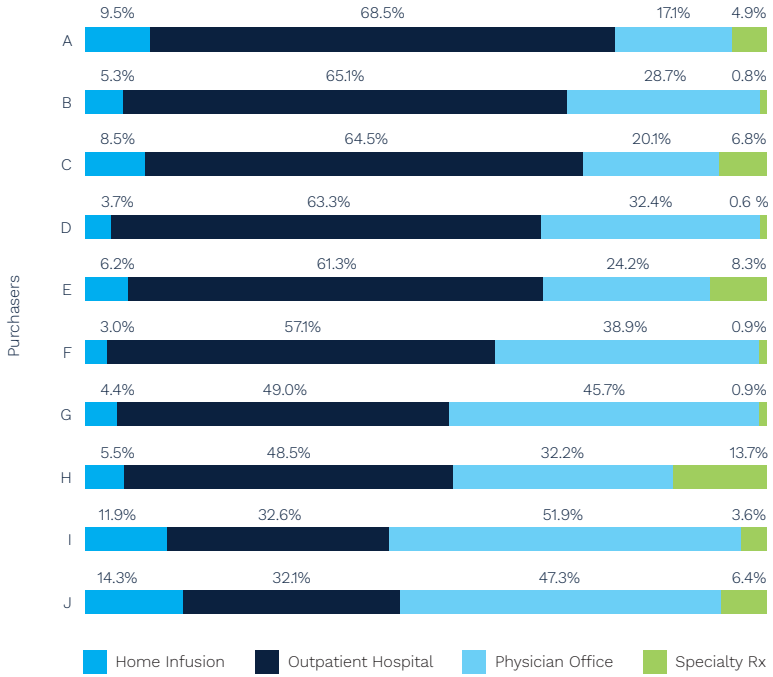
Results

There is tremendous variation among health plans and purchasers. The percentage of spending for the high-cost outpatient hospital setting ranged from 32% to 69% among 10 PBGH purchasers for one plan, and 39% to 99% for another plan, highlighting significant opportunities for site-of-care redirection for those at the upper end of the range.

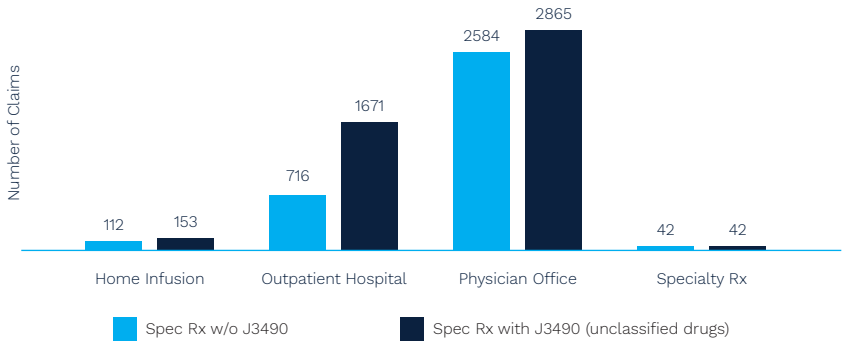
Relative to other sites of care, a considerable portion of outpatient hospital infusion services included payment for the J3490 unspecified drug code. Purchasers and plans can require use of standardized NDC drug codes to improve management of this high-cost service.

One plan reported that several employers had adopted a site-of-care optimization program with demonstrated results. However, it should be noted that in some regions, a health plan may have preferred contracts with a hospital outpatient surgery site, making it more cost-effective than a standalone ambulatory surgery center.

Employer Variation in Site of Service under a National Health Plan



High Rate of Hospital Outpatient Infusion Claims with J3490 Unspecified Drug Code



9.
IHA-PBGH Commercial ACO Measures

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, including patient-reported outcomes. Twenty leading ACOs and health systems representing over 50 provider organizations, as well as five plans (Aetna, Anthem, Blue Shield of California, Health Net, UnitedHealthcare) have endorsed this set of measures.

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 highlighted measures are clinically impactful and represent high-value care, including measures of behavioral health, maternal health and opioid management.

Results

ACO measure set adoption varied widely by health plan, from seven of 18 core measures and two of 17 developmental measures on the low end to 18 of 18 core measures and nine of 17 developmental measures on the high end. Higher levels of adoption among certain plans demonstrates that it is feasible to report some of these more challenging measures and that pathways to data acquisition exist when a health plan is committed to outcomes-based measurement.

Purchasers expect their health plan partners to advance outcomes-based measures in their ACO contracts to raise performance expectations and differentiate higher-performing medical groups.

10.
Looking Ahead

Based on initial findings, PBGH will share more detailed reporting specifications to refine the Health Value Index. Purchasers have also identified future areas of measurement to address high value care.

Additional Measures

PBGH members have identified the following additional priority measurement areas:

- Ability to measure and report PBGH Advanced Primary Care Measures (see table) at the provider organization, practice and/or physician level
- Perinatal and post-partum depression screening
- Percentage of population for which demographic data are collected and used to advance health equity
- Maternal outcomes as measured by C-section rates and frequency of low birth weights by race and ethnicity
- Provision and management of high-value telehealth services

Advanced Primary Care Metrics

Quality Domain	Measure	NQF ID
Health Outcomes & Prevention	Asthma Medication Ratio	1800
	Childhood Immunization Status (Combo 10)	0038
	Colorectal Cancer Screening	0034
	Controlling High Blood Pressure	0018
	Diabetes HbA1c Poor Control (>9%)	0059
	Immunizations for Adolescents	1407
Patient Reported Outcomes	Depression Remission at 6 months	0711
Patient Safety	Concurrent Use of Opioids and Benzodiazepines	3389
Patient Experience	Patient Experience (CG-CAHPS)	0005
High Value Care	Emergency Department Visits	-
	Inpatient/Acute Hospital Utilization	-
	Total Cost of Care	1604

For more information or to join the PBGH Health Value Index, contact: info@pbgh.org