Employer Health Plan Common Purchasing Agreement

for Advanced Primary Care

Purchaser Business Group on Health

Purchasing Advanced Primary Care

Purchaser Business Group on Health (PBGH) members collectively spend more than $100 billion annually buying health care for their employees and families but too often do not achieve good clinical outcomes or experience. Members of PBGH are assuming an active leadership role in health care purchasing by clearly articulating the quality, value and experience that they expect for their significant health care spend. They are setting purchasing standards on behalf of their employees and creating mechanisms for health plan accountability. The aim of these standards is to help achieve high-value equitable care and outcomes for all employees and families of PBGH member organizations.

As purchasers, we will not design clinical models but will seek partnerships with innovative clinical leaders willing to meet our standards and needs. We will look to our health plan partners to work on our behalf to implement and administer value-based purchasing that reflects our priorities.

[Insert employer name] seeks to support a higher value health care system with a strong primary care foundation. We believe that better primary care will enable a higher quality, better patient experience and outcomes and lower costs for our employees. We know the current fee-for-service payment system creates barriers for optimal primary care and we are seeking to drive change through the design and implementation of payment models that support advanced primary care (APC). The common purchasing agreement states the shared priorities and objectives of **[Insert employer name]** and the other employers who have endorsed the standards for better care at a lower cost. We recognize that achieving better care at lower costs will also require accountability of the delivery system surrounding primary care.

To achieve our aims, the Common Purchasing Agreement includes a set of clearly defined health plan requirements and accountability expectations focused on APC with a three-year implementation timeline. The requirements in this Agreement presume the need for payment changes to enable whole person and population health and are built upon a set of principles developed by employers in collaboration with the Purchaser Business Group on Health (PBGH) and rely on lessons learned from PBGH's California Quality Collaborative-led practice transformation initiative[1], National Academy of Medicine's Implementing High-Quality Primary Care report[2], and other national and regional primary care transformation efforts.

We recognize that these standards will require significant changes in contracting and operations. We also appreciate that there are varying degrees of readiness among providers and across markets. In light of this variation, we expect implementation sequencing of these requirements will depend on the level of market readiness. We believe these changes are necessary and overdue and look forward to working together with our partners to implement them in the near term. We also believe that working together we can drive multi-payer alignment on key elements of the payment model, including performance measures, attribution, data sharing (e.g., timing and formats), and benchmarking, enabling greater primary care participation through such administrative simplification.

Purchasers

- Set quality and value standards
- Select plan and provider partners
- Ensure patient/provider incentives align
- Ensure partner accountability

Health Plans

- Efficiently administer value-based payments
- Identify and transparently report on quality and value
- Enable data-sharing for care integration, management, continuous quality improvement and population health oversight
- Align and remove administrative barriers
- As advisors and experts in health care administration, offer data-driven solutions for purchaser consideration to improve quality and value

Providers

- Provide high-quality, effective, evidence-based clinical care
- Ensure patient access and optimal experience of care
- Use data for care integration, management, continuous quality improvement, population health oversight and integration and informed referrals
- Manage and improve population health

1 https://www.pbgh.org/initiative/practice-transformation/
2 https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

What we want to buy	How we enable it	How we know we have it
Integrated Whole-Person Care/Population Health Management	**Payment Method**	**Accountability**
• Employee/patient engagement and activation • Integration of physical, behavioral and social needs • Robust access spanning after hours, weekends and including virtual care options • Informed referrals and prescribing • Coordinated care • Risk stratification and care management • Health and well-being promotion • Data and information sharing to enable whole-person care	• Comprehensive primary care payment • Prospective and flexible • Care transformation or care management fee (limited duration) • Performance incentives	• Common performance measure set • Clinical outcomes • Member experience of care • Total cost of care • Access to care • Health equity

The PBGH Primary Care Payment Reform Workgroup has developed this Common Purchasing Agreement — guided by evidence-based reform principles — for jumbo employers and health care purchasers to clearly articulate their priorities to partners. It is intended to be used to remove barriers to better care and achieve optimal outcomes, better employee experience, greater value and accountability for their health care spend. The objective is to create payer contracting terms that support improved physical and behavioral health care, increased access and equity, an enhanced patient experience, and reductions in unnecessary and low-value care.

Key Components of Advanced Primary Care (APC) Purchasing

The key components that are integral to purchasing APC: characteristics of person-centered APC, changes to provider payments that serve as a mechanism to shift the delivery system to APC and a set of priority accountability measures that demonstrate achievement of high-quality care at lower costs. These components represent a set of approaches that can be tailored based on provider readiness. For example, provider groups that have experience participating in an alternative payment model for primary care that is based on a fee-for-service chassis may be ready to move to a fully capitated prospective payment model and may not require the care management fee that is designed to help build the care delivery infrastructure for population health management.

Exhibit 1: Advanced Primary Care Core Measure Set

			Attributes of Advanced Primary Care				
Quality Domain	**Measure**	**NQF ID**	**Person & Family Centered**	**High-Value**	**Team-Based & Collaborative**	**Accessible**	**Coordinated & Integrated**
Health Outcomes & Prevention	Asthma Medication Ratio	1800			●		●
	Childhood immunization Status (Combo 10)	0038	●		●		●
	Colorectal Cancer Screening	0034	●		●		●
	Controlling High Blood Pressure	0018			●		●
	Diabetes HbAlc Poor Control (>9%)	0059			●		●
	Immunizations for Adolescents	1407	●		●		●
Patient-Reported Outcomes	Depression Remission at 6 Months	0711	●	●	●	●	●
	Consider using a phased implementation approach over a specified time to build capacity to move from screening to outcomes. Preventive Care and Screening: Screening for Depression and Follow-up Plan	0418	●	●	●	●	●
Patient Safety	Concurrent Use of Opioids and Benzodiazepines	3389			●		●
Patient Experience	Patient Experience (CG-CARPS)	0005	●		●	●	●
High-Value Care	Emergency Department Visits	-		●		●	●
	Inpatient Utilization/ Acute Hospital Utilization	-		●		●	●
	Total Cost of Care	1604		●			

Maintaining Accountability

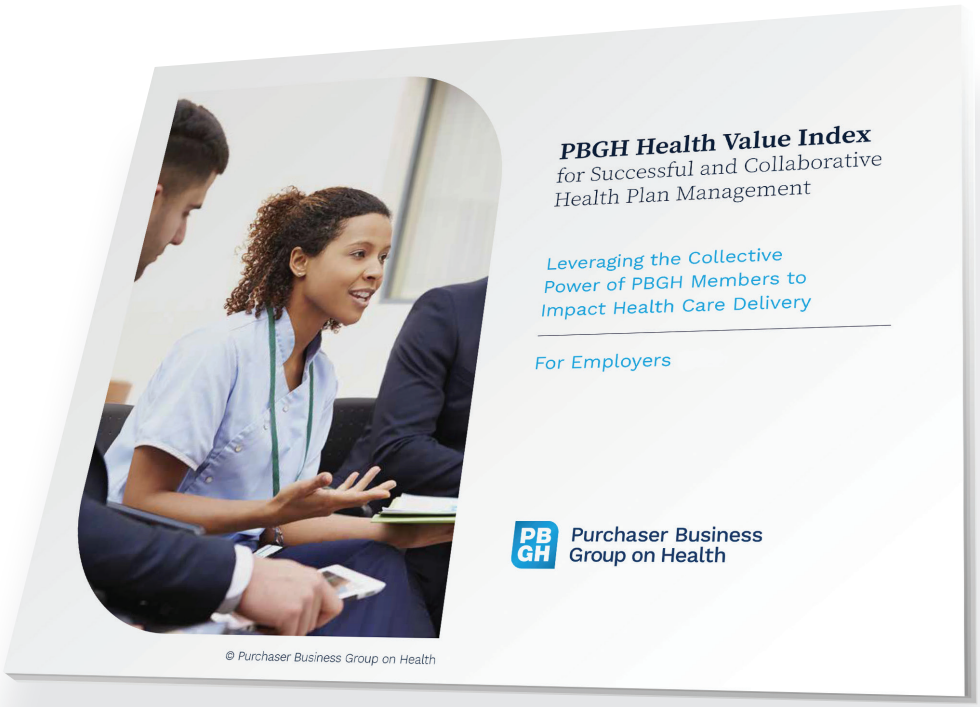
In order to identify, recognize and reward advanced primary care practices, purchasers need common measures of performance across regions and health plans. We have defined and included an initial set that reflects minimum requirements for advanced primary care (APC) (See Exhibit 1.). PBGH will be leading a process to select and require more ambitious and patient-centered measures over time. We anticipate that where feasible, the APC measure set will continue to be parsimonious and aligned with other measure sets (e.g., Centers for Medicare & Medicaid, National Committee for Quality Assurance) for health plan and provider accountability.

APC providers should ensure that patients receive preventive care and screenings of demonstrated value, help them effectively manage chronic illness and address behavioral health needs — all in a primary care setting, with the least possible need for unplanned emergency care. We want primary care to help people achieve positive health outcomes, and where possible, we ask for performance reporting on key outcome indicators, such as maintaining healthy blood pressure and recovering from depression.

APC providers also are the "quarterback" of all the care that patients might need and should take responsibility for the total cost of care, working in concert with other providers in the delivery system incurred along the patient's journey through the health care system.

Our APC measure set provides a succinct snapshot of provider and plan performance on these dimensions and will evolve to increasingly focus on patients' health outcomes.

The agreement does not include any specifications for a clinical care model, which the employer believes should remain under the purview of clinicians. In implementing these requirements, the employer expects that health plans will work in collaboration with providers to help transform the delivery system. Health plans will need to account for varying levels of provider readiness and calibrate the level of technical assistance accordingly. It will be important for health plans to align around common standards and models and reduce administrative burden on providers to enable a focus on person-centered care.



Tracking Progress

To help track progress toward high-quality care, better patient outcomes and lower costs and to ensure ongoing transparency, the Common Purchasing Agreement also includes requirements for health plans to report data on behalf of their clients in a standardized format through the PBGH Health Value Index.

PBGH has defined and shared data specifications to enable tracking of progress and has shared these with our health plan partners. We will update those data requirements as needed and report back to employers and health plans on an annual basis.

Metric	Anthem Reporting Capability	Data Period
1. Benchmarking Primary Care Spend	●	2018, 2019
2. Integration of Primary Care and Behavioral Health	○	2018, 2019
3. Depression Screening Utilization	○	2018, 2019
4. Reporting on Depression Screenings and Remission Rates	○	2019
5. Use of Two-Sided Risk Payment Models	◐	2018, 2019, 2020
6. Efforts to Avoid Low-Value Care	◐	2019
7. Adoption of Biosimilars	●	2018, 2019
8. Site-of-Service Optimization	○	N/A
9. IHA-PBGH Commercial ACO Measure Set	◐	2020, 2021

● = Good ◐ = Fair ○ = Poor

Health Plan Requirements

Principle 1:

Near-term transition to flexible and prospective population-based payment to enable practices to transition to advanced primary care

Within three years, contractors are required to replace fee-for-service payment with alternative payment methods defined in the agreement. Payers also must report primary care spend as a percentage of total overall spend. Payments should help providers build care teams that include mental health providers, nonclinical and community-based team members, as appropriate; enable population health management; and help develop the digital infrastructure to deliver optimal high-value, person-centered care.

Proposed Contract Language

The Contractor shall adopt and expand the number and percent of primary care clinicians paid through Categories 3 and 4 of the Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) Framework.[3]

A. The Contractor shall use payment methods that are alternatives to fee-for-service and could include any or all of the following types of payment structures dependent on the provider readiness to function as an Advanced Primary Care (APC) practice:

   a. Comprehensive primary care payment

   b. Prospective and flexible payment method

   c. Care transformation or care management fee (limited duration)

   d. Performance incentives tied to the APC Core Measure Set developed and released by PBGH's California Quality Collaborative (CQC) and included as Exhibit 1, on page 5. The care transformation or care management fee can also be tied to performance on the APC Core Measure Set.

B. The Contractor shall report primary care spend as a percentage of total overall spend (including plan and patient portions) using the standardized methodology described in the PBGH Purchaser Health Value Index.

C. The Contractor shall report (See attached Principle 1 template.):

   a. The number and percent of its contracted primary care clinicians paid using the HCP LAN APM categories

   b. The number and percent of its enrollees who are cared for by primary care clinicians paid using each HCP LAN APM category

3 http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

Health Plan Requirements

Principle 2:

Removing payment barriers to the integration of mental health care for mild-to-moderate conditions

Within three years, contractors are required to support primary care physicians in the adoption of evidence-based approaches to behavioral health integration and pay for behavioral health screening and treatment within the primary care setting. Payments to clinicians will be structured to facilitate integration of physical and behavioral health services, with an initial focus on depression, anxiety and substance use disorders.

Proposed Contract Language

A. The Contractor shall ensure that the payment methodology assures behavioral health screening and treatment within primary care. The Contractor shall support primary care physicians in the adoption of evidence-based approaches to behavioral health integration, such as use of Collaborative Care Model.[4]

B. The Contractor shall share data (when permissible) with primary care physicians to manage behavioral health needs and shall report on behavioral health outcome measures listed in Exhibit 1, on page 5.

C. The Contractor shall assess and report through the PBGH Health Value Index the use (volume of unique providers) and where applicable[5], payment (total aggregate payment per employer, including plan and patient portions) for Collaborative Care Management (CoCM) codes (CPT codes 99492-99494) per employer. The Contractor shall report use (volume of unique providers) and payment (aggregate payment per employer of depression screening [96127, CPT II codes: G8510/G8431 or relevant HCPCS codes]). In addition, the Contractor shall report utilization rates of mental health and substance use services through the PBGH Health Value Index.

D. The Contractor shall report the screening for depression and follow-up plan measure included in the APC Core Measure Set (See Exhibit 1.).

4 https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
5 In the event of providers receiving population-based payments, it may not be feasible to report payments associated with these codes.

Health Plan Requirements

Principle 3:

Resources to build and support advanced primary care

Contractors must identify and pay for technical support and resources that enable primary care practices to transition to, and sustain, advanced primary care. These include, but are not limited to, practice readiness assessments, care management support, staffing model transformation, specialist referral management and the provision of digital platforms for virtual patient access and shared decision-making tools. Technical assistance, tools and resources should be based on best practice and developed and deployed through aligned regional programs to facilitate practice change.

Proposed Contract Language

In addition to limited duration care transformation or care management fee payments, the Contractor shall identify and pay invest in resources to enable primary care practices to transition and sustain advanced primary care. To streamline the provision of such technical assistance to practices, the preferred approach would be for health plans to provide resources to and work with a regional collaborative (e.g., CQC) where available, which, in turn, will provide technical assistance to the primary care practices. The contractor shall report on their initiatives to directly provide or support provision of technical assistance to providers that could include:

A. Assessment of practice readiness, including readiness to use data securely and optimally

B. Implementation of a team-based care approach to advanced primary care

C. Implementation of care management protocol, including coordination with a hospitalist and management of care post-discharge from hospital

D. Development of digital platforms for virtual patient access and shared decision-making tools

E. Support for holistic care that includes consideration of preventive care, family needs and other social determinants of health factors

F. Access to information for high-value specialist referrals, including second opinions, e-consults for behavioral health and in-sourcing of simple specialty care, and prescribing

G. Support primary care practices in developing a robust data infrastructure (e.g., interoperable EHRs and combining data from different sources) that will enable providers to use the data at the point of care and improve care coordination

H. Establishing cooperative agreements with specialists and ensuring referrals and connections to Centers of Excellence

I. Promoting health and wellness among enrollees, including tobacco cessation, mental wellness, substance use disorder, weight management and diabetes prevention.

Health Plan Requirements

Principle 4:

Resources to acquire data and information to manage patient care

Contractors must share timely data and reports with primary care practices to ensure better management of individual patients as well as optimal population health management. The focus of the data and reports should include risk stratification, care transitions, medication management, formulary management and optimization of biosimilars, use of low-value services, gaps in care, claims data and bidirectional payer-provider data flow to support clinical decision-making.

Proposed Contract Language

The Contractor shall work with other health plans, employers and providers in a market to develop a common data infrastructure that can generate and share timely standardized data and reports with primary care practices to ensure better management of individual patients as well as optimal population health management. The data and reports shared with the practices should reflect the practices' entire patient panel. The Contractor shall report on proportion of primary care practices that routinely receive data and reports that, at a minimum, include the following:

A. Patient risk stratification

B. Timely utilization data (e.g., ED visits, hospital admissions and discharge)

C. Medication management

D. Optimization of use of biosimilars and formulary management (e.g., RA, Crohn's disease)

E. Use of low-value services, such as those identified by Choosing Wisely[6]

F. Gaps in care based on evidence-based guidelines

G. Member enrollment/attribution information

In addition, the Contractor shall:

H. Feed claims data to providers to enable them to combine with clinical data upon ensuring that the practices have the requisite IT security to receive these types of data and have a robust platform to ingest claims data

I. Facilitate collection of data directly from patients and families (e.g., PHQ-9 data collection) and share data with providers in a timely manner to promote appropriate care delivery

J. Ensure bidirectional data flow between primary care practices and health plans that includes clinical data to support decision-making and clinical outcomes reporting

K. Work with primary care practices to ensure that patients have access to their medical records in an easy-to-use and "portable" format

L. Submit all requested data for the PBGH Health Value Index to PBGH on behalf of their members

6 https://www.choosingwisely.org/clinician-lists/

Health Plan Requirements

Principle 5:

Payment that supports resources needed to avoid unnecessary and low-value care

Contractors will provide payments, data and other support to help practices avoid unnecessary and low-value care. These efforts will include identifying low-value, unnecessary services using clinical guidelines and initiatives, such as the Choosing Wisely campaign, establishing primary care quality improvement collaboratives, redirecting specialty care to specialists who minimize low-value care, and connecting to Centers of Excellence to ensure service use optimization.

Proposed Contract Language

The Contractor shall provide payments and other supports to primary care practices that help avoid unnecessary and low-value care and help ensure that resources are instead channeled to high-value and evidence-based services. The performance incentive payments listed under Principle 1 should be structured to reward primary care providers that refer patients to high-quality, efficient specialists. The Contractor shall undertake efforts to reduce low-value care, including, but not limited to:

A. Use payment methodology that promotes informed shared decision-making between patients and their care team

B. For complex patients with multiple morbidities, collaborate with providers to implement an evidence-based transitions in care intervention (e.g., Community Cares North Carolina)

C. Identify and report unnecessary and low-value services by provider using clinical guide lines and efforts, such as Choosing Wisely

D. Share data and reports on unnecessary and low-value services, including peer benchmarking reports

E. Establish primary care quality improvement collaboratives to reduce the use of unnecessary and low-value services

F. Work with primary care providers to redirect needed specialty care for patients to specialists who minimize low-value care (or initiate care under consultation with a specialist prior to patient referral)

G. Assure that primary care physicians connect to and use Centers of Excellence to ensure service use optimization and better patient outcomes

H. Share relative cost/price and outcome data of specialists with primary care practices for informed referrals

Health Plan Requirements

Principle 6:

Payment to collect and transparently share patient-reported outcome and experience measures with purchasers and patients

Contractors will implement the Advanced Primary Care Core Measure Set released by the California Quality Collaborative and PBGH, and will include in its contracts with primary care physicians, payment for the collection and reporting of the PHQ-9 patient-reported outcomes measure. Within three years, practices should be able to report and use multiple patient-reported outcome measures.

Proposed Contract Language

The Contractor shall measure and transparently report, at the practice level, the following:

A. The Contractor shall implement the APC Core Measure Set shown in Exhibit 1, on page 5, into its contracts with providers, including the use of the PHQ-9 standardized tool.

B. In addition, the Contractor shall ensure that the payment methodology shall support the collection and reporting of the PHQ-9 patient-reported outcome measure (PROM), provided the primary care physicians are not already paid on a capitated basis. The Contractor shall also develop and share a plan for moving from collection and reporting of PROMs to the use of the patient-reported outcome performance measures that are tied to payment.[7]

C. The Contractor shall work with primary care practices to ensure use of shared decision-making tools in the development and implementation of care treatment plans.

D. The Contractor shall implement within a 12-month period, the PBGH telehealth patient experience survey.

E. The Contractor shall submit all requested data for the PBGH Health Value Index to PBGH on behalf of their members.

7 https://www.qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx

Health Plan Requirements

Principle 7:

Payment models that promote and enable equitable access and outcomes

Contractors shall ensure measurable reduction in health disparities.

Advanced primary care (APC) providers should ensure that patients receive preventive care and screenings of demonstrated value, help them effectively manage chronic illness and address behavioral health needs all in a primary care setting, with the least possible need for unplanned emergency care. We want primary care practices to help people achieve positive health outcomes, and where possible, we ask for performance reporting on key outcome indicators such as maintaining healthy blood pressure and recovering from depression. APC providers are also the "quarterback" of all the care patients might need and should take responsibility for the total cost of care incurred along the patient's journey through the health care system. Our APC Core Measure Set provides a succinct snapshot of provider and plan performance on these dimensions and will evolve to increasingly focus on patients' health outcomes. The APC Core Measure Set, shown in Exhibit 1, is on page 5.

Proposed Contract Language

The Contractor shall support primary care practices in advancing health equity. Specifically, the Contractor will work with and support primary care practices to:

A. Collect race/ethnicity/gender/language data on its members and report identified health disparities to purchasers and practices. The Contractor may directly collect these data from members to support primary care practices.

B. Stratify the APC Core Measure Set in Exhibit 1, on page 5, by at a minimum race/ethnicity/language and gender and report stratified performance measure data to the employer and PBGH.

C. As requested by the purchaser, the Contractor will ensure that all enrollees have a relationship with a care provider or have technology-based alternatives to access primary care. Provisionally assigned members should be notified by the Contractor and given the opportunity to select a primary care physician. When assigning a primary care clinician, the Contractor will use commercially reasonable efforts to assign a primary care clinician consistent with an enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment and any prior primary care clinician.

D. To address health disparities, performance incentive payments will need to be (over) weighted based on: (a) improvements to health disparities and (b) achievement of overall quality targets related to addressing health disparities (e.g., maternal mortality or morbidity, 30-day mortality related to cardiac events).

E. The Contractor shall include in the provider manuals requirements to ensure that providers address implicit bias issues to ensure achievement of equitable outcomes.

F. The Contractor shall implement accountability requirements in contracts with primary care practices that at a minimum include the following:

   a. The APC Core Measure Set shown in Exhibit 1

   b. Access to Care Requirements

   1. Right care at right time — 24/7, including evening or weekend appointments

   2. Same-day appointments

   3. Virtual (video/audio visits, emails) visits and access to regular primary care physician or primary care team

   4. In-home or on-site options

   5. Asynchronous consultation with a care team

   6. Minimize fragmentation of visits and data by coordinating as needed with stand-alone telehealth vendors that are different than an enrollee's usual source of care

G. The Contractor shall report performance rates on the measures in Exhibit 1 through the PBGH Health Value Index.

Health Plan Requirements

Principle 8:

Primary care should be equipped to leverage community and employer resources to address social determinants of health (SDOH)

Contractors will work with primary care practices to address social needs. Practices should be supported to implement a social risk factor screening tool and use results for health improvement. Contractors will support providers by establishing networks of community-based organizations that providers can use to refer members for their social needs.

Proposed Contract Language

The Contractor shall address health and social needs to enable optimal whole-person health.

A. The Contractor shall collaborate with employers, other health plans and providers in a market to select a social risk factor screening tool. The Contractor shall work with the primary care practice (PCP) or the professional care team to implement the selected social risk factor screening tool. The Contractor shall share results from social risk factor survey with the employer and PBGH through the PBGH Health Value Index.[8]

B. The Contractor shall support the practice by establishing a network of community-based organizations that providers can use to refer members for their unmet social needs, such as food, housing, and transportation.

C. The Contractor shall ensure that the PCP or the professional care team uses the network of community-based organizations or resources to address unmet social needs.

8 https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Authors and Reviewers

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