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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For Employers

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 send a clear message to health plans about purchaser expectations for policies that deliver higher quality, higher value care.

The PBGH Health Value Index is a set of seven performance domains selected by experts at PBGH in consultation with member organizations, which include some of the largest private employers and public purchasers of health benefits in the United States. The measures are evidence-based and provide actionable insight into a purchaser's health plan spending. The measures align with domains identified by PBGH purchasers as high priority or where there are well-documented gaps in care and health inequities. PBGH aims to incentivize both short-term change and long-term structural impact on health care quality, equity and affordability.

Too often, health plans report on traditional utilization and quality measures that focus on past experience without a forward-looking perspective on how that data can be used to improve performance, health outcomes and overall affordability. PBGH focuses the Health Value Index on multi-dimensional aspects of care with a view towards improving value – quality and cost, member experience and overall health plan and provider accountability.

The Metrics

1.
Primary Care

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. PBGH's goal is to ensure primary care is being appropriately prioritized. PBGH is taking action to strengthen America's primary care foundation by advancing payment reform through primary care contracting principles. Through a multistakeholder process, the PBGH California Quality Collaborative also articulated the attributes of Advanced Primary Care and defined a common measure set focused on patient experience of care and health outcomes.

Common Challenges

Health plans and employers are often united in their support of primary care to coordinate services for their plan members. However, primary care physicians are compensated significantly less than physicians in other medical specialties. Inpatient and prescription drug spending have outpaced primary care in recent years, reducing the portion of overall health care spending for this vital entry point for health care access.

What We Measure

PBGH seeks to benchmark primary care spending rates —the portion of total health care expenditures that goes to primary care—as a percentage of overall spending.[1]

To promote alignment in primary care measurement, PBGH encourages health plan use of the Advanced Primary Care measure set among contracted provider organizations and primary care practices.

2.
Mental Health

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.

Common Challenges

Capturing depression screening rates in commercially insured populations through administrative claims data, clinical registries and electronic medical records remains difficult. By supporting an infrastructure for routine screening and data collection, plans can enable outcomes measurement for this high-prevalence condition and build capacity for screening additional mental health conditions such as anxiety and substance use. Mental health parity compliance and access to behavioral health providers, including pediatric specialists, is also a high priority.

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. Measures include the percent screened for depression and depression response and remission rates. PBGH also assesses how plans manage provider access, including pediatric providers.

3.
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.

Common Challenges

Despite broad campaigns such as the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely and targeted efforts such as the University of Michigan Value-Based Insurance Design, waste persists in diagnostic testing and services that the USPSTF has determined to be not evidence-based. Measuring avoidable variation in care and waste is also challenging due to clinical risk factors that may not be well-documented and inconsistent provider adoption of USPSTF recommendations.

What We Measure

Plans are asked to report on the volume and cost of advanced imaging for low back pain and excessive lab work or diagnostic cardiac screening prior to low-risk surgery among providers and provider organizations in which participating PBGH members have their largest enrollment volume.

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.
Pharmacy and Site of Care

Biosimilars may help reduce specialty drug spending by as much as $150 billion over the next ten years. It is important that purchasers, health plans, pharmacy benefit managers and provider organizations take a long-term view in weighing potential near-term rebate incentives versus adopting biosimilars to promote product and price competition.

Redirecting the site-of-care for administered drugs represents a major 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.

Common Challenges

Health plans may assert that rebates on reference products produce substantial savings on drug expenditures. Rebates do not result in discounts for the purchaser if the difference doesn't go back to the purchaser. Further, current provider "buy and bill" reimbursement structure fails to incent use of biosimilars.

What We Measure

Plans are asked to report: 1) the number of biosimilar prescriptions filled compared to the number of reference drugs prescriptions filled in the last year, and whether or not biosimilars are prioritized on the plan formulary and 2) the portion of administered drugs provided in lower-cost settings as a percentage of overall spending on administered drugs.

5.
Health Equity

Purchasers have prioritized the goal of improving health equity. While persistent variation in quality may be impacted by social determinants of health, a first step in improving health equity is to understand current differences in quality measures and outcomes among subpopulations. Capturing race and ethnicity data is a first step to identifying opportunities to reduce gaps in care and improve consumer engagement strategies. Race and ethnicity reporting by providers can also support culturally sensitive and concordant care. Understanding health plan approaches can inform employer strategies to deploy more inclusive benefit designs and align workplace strategies to improve health.

Common Challenges

Employers may routinely capture race and ethnicity data through employment applications, but these data often are not captured in benefit enrollment systems. Employees may also voluntarily share information through a health risk appraisal or directly with the providers, but these data sets often are not integrated with health plan enrollment information. It is key for purchasers and health plans to collaborate and establish standardized coding practices. Safeguarding patient reported information and transparency in how such data may be used is also important.

What We Measure

Plans are asked to report on: 1) the percentage of population for which race and ethnicity are captured, 2) strategies to improve health equity and reduce disparities in care, and 3) the NCQA HEDIS 2023 Health Equity measures set.

6.
Maternity

C-sections are frequently performed unnecessarily leading to higher costs for purchasers and potentially poor health outcomes for birthing persons and/or infants. Additionally, maternal health outcomes are a bellwether for health equity. C-section rates and maternal mortality rates continue to be much higher among black women. Low birthweight also disproportionately impacts Black, Indigenous, and people of color (BIPOC).

PBGH convened a Comprehensive Maternity Care Workgroup which recommended a broad set of metrics to support high quality care and advance culturally competent care and health equity. In addition to clinical outcomes and social needs screening, the Workgroup recommended further assessment of strategies to encourage access to certified nurse midwives and doulas that can foster culturally concordant care.

Common Challenges

Data integration across the continuum of prenatal, perinatal and post-partum care remains complex, particularly with respect to mental health screening, need for psychosocial support and hospital-based services. Credentialing and access to midwives varies by state and is further complicated by differences in hospital provider policies. Coverage for doula support is often coordinated outside of medical claims.

What We Measure

Plans are asked to report on C-section and low birth weight, screening for perinatal and post-partum depression, social need screening, care coordination and management of severe obstetric complications. Plans are also asked about provider management strategies to measure patient experience and efforts to support access to midwives and doulas.

7.
Telehealth

Telehealth service use has grown significantly as a result of the COVID-19 pandemic. Telehealth for primary care and most specialty medical services has leveled off. Tele-behavioral health remains higher than pre-pandemic norms, affirming the importance of this modality in improving access to services.

Utilization patterns vary with respect to adoption of standalone telehealth networks and access to existing providers via video or telephonic visits. There is also significant variation in unit costs. In consideration of health policy and coverage strategies, purchasers seek to understand ways in which to assess high-value telehealth services.

Common Challenges

Telehealth services are offered through existing provider networks and can be augmented by dedicated suppliers. Few commercial claims are billed with pre-defined procedural codes with a defined the scope of services. Trending the volume and costs for telehealth services is complicated by the use of variable modifier codes and place of service codes.

What We Measure

Total utilization and claims paid for telehealth services in primary care and specialty care, including behavioral health.

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

8.
Measure Summary

Domain	Measures
Primary Care	• % of primary care spend • Use of PBGH Advanced Primary Care measure set
Mental Health	• % screened for depression (PROMS, NCQA DSF) • Depression response* and remission rates (PROMS, NCQA DRR-E) • Payment for depression screening • Assessment and management of provider access, including pediatric providers (plan actions to address "ghost networks")*
Low Value Care	• Inappropriate imaging for low back pain (NCQA (LBP)) • Diagnostic cardiac and lab procedures prior to low risk surgery (limited subset*)
Pharmacy	• Targeted measurement of high-volume biosimilars • Site of care for select medications
Health Equity	• % of population for which demographics are collected • Assess plan approaches to addressing health disparities, including stratification of quality measures (HEDIS Health Equity 2023)

Maternity	• Maternal outcomes
	  • C-Section (not limited to NTSV) (employer-specific)
	  • Screening for perinatal and post partum depression (NCQA PND and PDS)
	  • Post-Partum Follow-Up and Care Coordination (NQF # 336)
	  • Social Need Screening and Intervention (plan-wide, NCQA SNS-E)*
	  • Severe Obstetric Complications (plan-wide)*
	  • Patient Experience (CAHPS or HCAHPS plan-wide tools in use, sampling method issues/ unlikely to get data)*
	  • Use of Certified Nurse Midwives in deliveries (plan-wide), including provider availability, credentialing practices*
	  • Use of doulas in maternal care*
	  • Low Birth Weight

Telehealth	• Telehealth utilization impact in primary care; high value telehealth

*New metrics for Health Value Index 3.0