
Health Purchaser Strategies for Improving Quality of Care and Delivery System Reform

Review Conducted for Covered California by PricewaterhouseCoopers



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Introduction

Project Background: Health Purchaser Strategies

Covered California commissioned PricewaterhouseCoopers (PwC) to conduct a detailed review of measures and benchmarks and the strategies used by health purchasers to drive value in health care as part of this research. The results of the purchaser strategy review are presented here while the analysis of measures and benchmarks are presented in the companion report, [Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform](#).

Methods

The review of purchaser strategies was comprised of:

- Interviews with health purchasers representing government entities, large employers, health plans (a mix of Qualified Health Plan (QHP) and non-QHPs) and other related bodies such as the National Business Group on Health, National Alliance of Healthcare Purchasers and the Integrated Healthcare Association.

A list of organizations interviewed for the review of purchaser strategies is shown in the Table 1 below.

Table 1: Organizations Interviewed to Inform Purchaser Value Strategies	
Health Plans	
Aetna	Inland Empire Health Plan
Anthem	Kaiser
BCBS North Carolina	LA Care
Blue Shield of CA	Molina
Health Net	
Large Employers	
Boeing	Disney
CalPERS	University of California
	Walmart
Government Entities	
California DHCS (Medi-Cal)	CMS/CMMI
Other	
Conduent	Integrated Healthcare Association
Magellan	National Alliance for Healthcare Purchaser Coalitions
CVS	National Business Group on Health

- Analysis of information representing strategic initiatives being pursued by national or regional health plans as well as information from surveys of large employers performed by PwC, the National Business Group on Health, the Catalyst for Payment Reform, and other parties.

- Analysis of information related to an early version of the *Covered California Quality Care and Delivery Reform Framework* (see Figure 1: Covered California Quality Care and Delivery Reform Framework below),¹ which included information provided by Qualified Health Plans (QHPs) to Covered California as part of their contractual reporting requirements and from Covered California’s participation in business and other organizations.

In organizing the review of Purchaser Strategies based on the *Covered California Quality Care and Delivery Reform Framework*, PwC observed that there was substantial overlap among these strategies, and interviewed purchasers often struggled to distinguish between them when discussing their own strategies and priorities. These overlaps also mean the same measures may apply across strategies and measurement, and benchmarking issues often impact multiple strategies and domains.

Figure 1. Covered California Quality Care and Delivery Reform Framework

Assuring Quality Care	Assuring Effective Care Delivery	
	Major Strategies	Tactics and Settings
1. Health Equity: Reducing Disparities in Health Care 2. Preventive Services 3. Mental/Behavioral Health and SUD Treatment 4. Acute, Chronic and other Conditions 5. Major/Complex Care	6. Networks Based on Value 7. Promotion of Effective Primary Care 8. Promotion of IHM and ACO's	9. Pharmacy Utilization Management 10. Non-Hospital Sites/Care Delivery 11. Hospital Care
Foundations of Quality Care and Effective Delivery	12. Patient and Consumer Engagement 13. Population-based and Community Health Beyond Enrolled Population 14. Data Sharing and Analytics 15. Payment for Value	15. Measures that Matter 16. Benefit Designs and others (e.g., Provider QI)

This report is a summary of key findings and includes PwC’s qualitative assessment for each purchaser type’s (employer, plans, or public purchasers such as CMS) level of prioritization (from low to high) for the components of the *Covered California Quality Care and Delivery Reform Framework*. The report also discusses current and emerging activities and, when provided by interviewees, included measurement approaches related to each area.

¹ This report covers topics 1 through 13 which were the major focus of the early version of the *Covered California Quality Care and Delivery Reform Framework*. As the framework evolved, components were added or reorganized based on the review and input from Covered California.

Executive Summary

Purchaser Themes – Assuring Quality Care

Purchasers interviewed generally agree the areas identified under the Assuring Quality Care domain are important, but many are choosing to focus efforts in the near term for particular areas.

Areas of Focus

Purchasers generally acknowledge all areas are important, but Chronic Care, Major/Complex Care and Mental/Behavioral Health and Substance Use Disorder Treatment were most frequently cited as highest priority areas. Hospital Care, Preventive Services and Pharmacy Utilization Management were next cited as areas of focus, with employers giving more weight to Pharmacy Utilization Management than some of the other purchasers interviewed.

Measurement

Prioritization of efforts is generally informed by cost or financial trends for both employer and payer purchasers. Other priorities may be identified through review of standard industry measures such as Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Examples of measurement areas identified in the interviews that are not in current Covered California plan reporting include:

- Repeat emergency department utilization;
- Non-users of healthcare services; and
- Mental/behavioral health & substance use disorder treatment measures related to access to providers and identification of these conditions.

Of these measures, repeat emergency department use and non-users of healthcare services seem to be the most defined measures which can be tracked through claims. These measures can help drive improved outcomes from hospital care as well as encourage engagement from consumer. Measurements related to mental health are less defined.

Common themes include:

- Using measurement and data to inform impact with analysis of population experience being a key starting place;
- Channeling members to most effective providers in areas where opportunities exist (e.g., more competitive markets versus rural markets); and
- Payment focusing on total cost of care, paying for outcomes (emerging as a focus for pharmacy management from employers and health plans, in particular).

Interestingly, benefit designs or incentives were not prominent among purchasers as a key driver. In fact, some employers do not feel the need to further promote the high deductible model and are instead looking to target key issues, channel members to high-performing providers, and empower consumers through tools or more clinically focused customer service models.

Collaboration Opportunities

A consistent theme across purchasers is the need to standardize measurements and clinical information to better assess care effectiveness and patient outcomes, as well as deliver meaningful data to providers. Many purchasers acknowledge data and information as a major challenge to their efforts in the Assuring Quality Care domain. Among chronic care management conditions, diabetes stands out as a condition for greater consistency in messaging to providers on patient population issues.

Purchaser Themes – Assuring Effective Care Delivery

Purchasers are all pursuing integrated care delivery models as key elements on their delivery system strategy, but all acknowledge that definitions and capabilities vary.

Areas of Focus

Purchasers cited networks based on value and integrated healthcare models (IHMs) or accountable care organizations (ACOs) as highest priority areas as well as alternate sites of care delivery. Primary care promotion is also viewed as important, but those efforts are often considered to be captured in the integrated care approaches.

Alternate sites of care are predominantly focused on telehealth and, in some cases, retail clinics, for general health care use.

Additional technology solutions are also being used by employers. These sites are viewed more as convenience items rather than solutions to problems of inappropriate utilization. The exception is where telehealth is focused on select issues, such as chronic conditions or mental/behavioral health.

Employers who have pursued centers of excellence strategies continue to offer them but recognize the confusion such programs may present where integrated models are emphasized (i.e., an ACO model does not include its providers for COE).

Measurement

Generally, purchasers are not pursuing “hard targets” but all want to improve beyond where they stand today. The need for measurement consistency in integrated models was highlighted, to support efforts by providers to deploy standardized practices across lines of business (Commercial, Medicaid, Medicare). Efforts by the Integrated Healthcare Association (IHA) in California to standardize measures is one avenue Covered California could pursue to align with providers and others in the industry on measuring outcomes related to integrated models.

Measurement in alternate sites of care needs to differentiate between general healthcare use and focused areas.

Foundations of Quality Care and Effective Delivery: Key Drivers

Payment and channeling of members each play a significant role in this area and many purchasers cited the need to develop common measure sets for provider level reporting.

- Several employers interviewed cited the need to eliminate poor provider choices where possible, highlighting their move toward HMO-style or narrow network strategies. When selecting the providers these options can be valuable in directing members to cost-effective quality care.

- Where integrated models are available, risk-based models play a key role.
- Provider level coaching is more emphasized in less sophisticated markets (i.e., rural).

Collaboration Opportunities

Common measure sets for provider level reporting were frequently highlighted by the purchasers interviewed as an area of need. Employers, in particular, recognize they may not have sufficient patient volumes and value working with their health plan or other stakeholders to constructively engage with the provider community.

Chapter 1:

Health Equity: Reducing Disparities in Healthcare

Takeaway: Although health equity was not identified as a high priority among purchasers, there is increasing recognition of the importance of equity and access for all individuals.

Priority ²			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Demographics (e.g., race/ethnicity, income) • Community presence (providers' integration in the community)

Key Drivers
<ul style="list-style-type: none"> • Given that this domain is a low priority amongst private purchasers, they did not identify specific drivers.

Health equity concerns of purchasers centered on:

- **The definition of health equity varies among populations:** purchasers are looking at health equity in different ways. Employers are looking at equity through broader programs to address diversity and inclusion or differences in wages, while public entities such as Medicaid programs are considering how social determinants and basic needs, such as housing, can impact health outcomes. This results in differences in the priorities they set and initiatives they are taking on.
- **Measurement is not clear:** As a result of the varying definitions, there is limited data being collected across purchasers, and even less standardized measures. Although purchasers agree on the importance of this initiative, different groups could be looking at access, adherence, outcomes or other data points to measure equity.

Actions being taken by purchasers include:

- **Employers are not actively focusing on health equity** — instead they are looking at broader initiatives that cover more of the population as they see health disparities are often tied to a select group of their employee population.

² After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the Covered California Quality Care and Delivery Reform Framework.

- A few **health plans are considering health equity** in the form of disparities and are analyzing some demographic information, however, formal measurement efforts are limited.
- **Public entities**, such as Medicaid programs, showed the **highest focus on health equity**, looking at disparities and social determinants of health.
 - Some Medicaid plans are partnering with community-based providers to increase access, while others are going farther to also address non-health related issues such as housing.
- Even those plans that are talking about equity have **limited data analytics** in this area.

Current Initiatives

Finding 1: Focus on health equity varied by organization type, with public entities having the most prominent focus.

- This sentiment is echoed by PwC’s Health Research Institute payer survey data which shows **83% of Medicaid managed care plans are** implementing partnerships in the local community to **address social determinants of health**, compared to 38% of commercial health plans.³
- Health plans that serve more Medicaid populations had a strong focus on social determinants noting that even the most effective care will not be successful if basic necessities are not met.
 - Inland Empire Health Plan (IEHP) noted that they can be “in the business of housing” sometimes as a large part of their population is high risk and homeless.
 - **AmeriHealth Caritas (DC) is focused on social determinants of health**, current initiatives are focused on improving the assessment and identification of social determinants (e.g., homelessness), increasing awareness and violence prevention and treatments as well as leveraging respite facilities to meet the needs of the homeless. These strategies come from a strategy development summit hosted in 2017.⁴
 - **North Carolina** Institute of Medicine has formed a task force that is considering ways health systems can partner with community-based organization to address social determinants better by creating **accountable care communities**.⁵

³ PricewaterhouseCoopers. (2017). 2017 Payer Executive Survey. Health Research Institute (Internal PwC survey).

⁴ AmeriHealth Caritas. Social Determinants of Health. Retrieved from <https://www.amerhealthcaritas.com/beyond-managed-care/social-determinants-health.aspx>

⁵ North Carolina Institute of Medicine. (2019). Partnering to Improve Health: A Guide to Starting an Accountable Care Community. Retrieved from <http://nciom.org/nc-health-data/guide-to-accountable-care-communities/>

- **Employers seem to have the lowest focus on disparities** even though employer sponsored coverage is still the primary channel for individuals to get coverage.

Finding 2: Health plans pointed to access issues as one of the main issues that leads to a lack of health equity.

- Blue Shield of CA discussed measuring disparities beyond typical demographic factors, highlighting efforts to **focus on social determinants** which takes into account other items such as zip code and income.
- Kaiser and another health plan noted a growing program of **providing care at home**, especially after hospitalization, to ensure care is continued.
- Several health plans noted the importance of connecting with communities to help drive members to available community resources that are local and may be able to provide necessary resources outside of healthcare (e.g., housing).

Finding 3: Employers acknowledge the importance of health equity but were not focused on any specific equity initiatives; rather employers are looking at equity within other initiatives.

- National Business Group on Health’s (NBGH) survey “Changes for 2018 and the Future” shows a number of employers are increasing their focus on diversity - creating groups that support employees who are veterans, LBGTQ, or of different ethnicities. These groups are aimed at improving diversity and recognizing different initiatives, but also providing support for different groups.⁶
- Some employers that were interviewed discussed health disparities more in the context of social determinants, pointing to challenges such as understanding differences in lower paid workers or other groups.
 - Wage disparities are a driver of health outcomes — a Health Affairs article from 2017 noted employees in the lowest-wage group had disproportionate utilization relative to top-wage-group earner including:
 - half the usage of preventive care (19% vs. 38%);
 - nearly twice the hospital admission rate (31/1,000 vs 17/1,000);
 - more than four times the rate of avoidable admissions (4.3/1,000 vs 0.9 /1,000); and
 - more than three times the rate of emergency department visits (370/1,000 vs 120/1,000).⁷

⁶ National Business Group on Health. (2018). Changes for 2018 and the Future: Learnings from Large Employers in Seven Industries. Retrieved from <https://www.businessgrouphealth.org>

⁷ Sherman, B. W., Gibson, T. B., Lynch, W. D., & Addy, C. (2017). Health care use and spending patterns vary by wage level in employer-sponsored plans. Health Affairs, 36(2), 250-257.

- While employers are looking at other challenges such as improving employees access to primary care or improving well-being programs, they are not exclusively dedicated to tackling disparities.

Purchaser Issues on the Horizon

- Health plans are more focused on expanding their view on the social determinants of health.
 - A number of health plans are continuing to collect demographic information from enrollees but recognize the limits of this data and are also looking at how to incorporate additional information such as transportation options, food availability, safe neighborhoods, surrounding parks, street lighting and others.
 - Current measures are being used more to set baseline understanding of populations, not to measure outcomes.
- Government entities, especially Medicaid, are continuing to consider how social determinants are impacting health and how they can improve access and health among their populations.

Other Considerations

Federal and state resources and initiatives clearly play a role in helping to better understand health equities and promote alignment of efforts among QHPs.

Synthesis and Takeaways

This domain is of high importance to Covered California and its QHPs, but of less importance to some purchasers relative to other strategy areas within the *Covered California Quality Care and Delivery Reform Framework*, particularly employers, but also commercial health plans.

Therefore, to the extent there is purchaser interest in health equity issues, there is less alignment on how to measure disparity and the strategies to address identified differences.

Issues of health disparity are a higher priority for plans that enroll Medicaid populations because their members reflect greater ethnic and racial diversity and lower socioeconomic status that is associated with known health disparities.

Covered California has developed an agenda to identify and measure health disparities by race and ethnicity across four health conditions, diabetes, hypertension, asthma, and depression. These were selected because they occur in a high proportion of the population, and research has identified disparities in access, care, and outcomes.

Current QHP reporting of health disparities appears to be improving, but there are challenges in data collection and interpretation. Efforts should continue to improve the collection of enrollee demographic and socioeconomic data that permits QHP disparity reporting of clinical and utilization data for the four diseases before there is broad expansion of the required disparity measures.

Because the health disparity reporting is based on the QHP full book of business (excluding Medicare), the Covered California requirements have the potential, when followed by effective intervention strategies, to improve healthcare quality for the broader population.

There may be opportunities for QHPs to engage with some of their employer groups, foundations, and community organizations to target intervention strategies.

Chapter 2: **Preventive Services**

Takeaway: Purchaser focus on preventive care ranked lower compared to other domains, but all reported varying levels of activity in this category, focusing on the use of incentives, tools and targeted strategies to engage members in their health.

Priority ⁸			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Standard measures of preventive service utilization • Self-reported data (health risk assessments) • Member participation in wellness programs

Key Drivers
<ul style="list-style-type: none"> • Benefit design and incentives • Technology to engage members in physical activity and other behavior focused initiatives • Reporting tools such as gaps in care, predictive modeling

Preventive services discussions with purchasers centered on:

- **Providing incentives** for members to receive preventive services and take health risk assessments. Since preventive services are fully covered under the Affordable Care Act (ACA) there is minimal focus on these services and a growing focus on primary care more broadly.

Actions being taken by purchasers include:

- **Employers** are **providing incentives** for employees to utilize the services, particularly targeting areas such as smoking cessation and weight management.

Current Initiatives

The state of preventive services and related wellness or well-being programs is evolving, as purchasers look for these programs to engage employees in positive ways. Employers,

⁸ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

generally, have been more open to carving out wellness programs from their health plan, in efforts to create distinct offerings focused on their key areas of interest.

Finding 1: Purchasers all feel that plan designs are not the barrier to accessing preventive services as the mandated zero cost share for preventive benefits remove the financial barrier.

- **Employers now predominantly offer health risk assessments** (over 80% now do so) and many incentivize their completion through their plan to provide information to individuals on their own health as the focus is not solely on wellness, but to also engage members in healthy behaviors as some of the statistics from PwC's Touchstone Health and Well-being Survey illustrate below.⁹
 - **Physical activity programs** have increased in prevalence among employers to 78% offering. These come in the form of fitness challenges in the workforce, workplace fitness center offerings or discount programs.
 - **Weight management programs** increased from 59% of employers to 75% in the last few years alone.
 - **Tobacco/smoking cessation program offerings** rose from 66% to 83% of employers from 2015 to 2018 alone.
- **Health** plans offer many similar programs to those described above.

Finding 2: Financial incentives remain a common feature for promoting participation, either through incentives with dollar contributions to HSA/HRA accounts or other reward programs (points or dollars earned to gift card style programs). Purchasers measure the use and level of rewards earned to also understand engagement levels.

- 21% and 32% of employers are offering Health Savings Account (HSA) and Health Reimbursement Arrangements (HRA) credits respectively to employees for completing certain health or wellness actions.¹⁰
- 59% of employers with Consumer Driven Health Plans believe gaining HSA flexibility to cover preventive care would be an important or very important policy change.¹¹

Finding 3: Reporting relating to preventive service utilization is predominantly defined using existing measures such as HEDIS measures. However, other measurements offered by health plans and utilized by employers related to wellness programs include:

- Participation and/or use rates in tools with comparisons to book of business benchmarks;

⁹ PricewaterhouseCoopers. (2018). Health and Well-being Touchstone Survey. Retrieved from <http://www.pwc.com/us/touchstone2018>

¹⁰ Ibid.

¹¹ National Business Group on Health. (2018). 2018 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- Completion of programs (e.g., tobacco cessation, weight management);
- Participation in live counseling (versus engagement through a website or mobile application);
- Rewards earned (where reward or incentive program elements are offered); and
- Program satisfaction for participating members.

Purchaser Issues on the Horizon

While employers and health plans play an important role in promoting appropriate use of preventive health services, the role of the provider in reinforcing the need for visits is also vital and a key element is to incorporate the use of telephonic and digital reminders. Understanding how providers are performing in the area of preventive health service reminders can augment existing information on the use of these services to assess where there are opportunities to promote appropriate utilization.

Other Considerations

For some members in the population, their engagement with the health system is limited to areas related to preventive service utilization or related wellness offerings available through their health plan. A positive patient experience at these times is key to adopting and sustaining good health practices. Although purchaser interviews did not highlight any major new initiatives related to preventive services, continued measurement and tracking of those using (or not using) preventive services can provide insight and improve population health as well as the patient/member experience.

Synthesis and Takeaways

Affordable Care Act (ACA) requirements for coverage of preventive services have standardized the definition across multiple purchasers and therefore few purchasers highlighted specific new initiatives in this area. Many of the preventive services measures are well established and included in HEDIS reporting and these are commonly used to assess performance.

However, understanding efforts to promote the use of preventive services and broader efforts related to measuring member engagement in their health are seen as complementary to prevention utilization monitoring efforts.

- Additional areas of measurement have been identified to better understand member engagement in health promotion initiatives.
- The role of the provider as a promoter of prevention is also important. As providers adopt technology to promote digital interaction with patients — such as email and text messaging — understanding when and how these models are used to promote prevention can assist in informing efforts to promote prevention and encourage active utilization of these benefits.

Chapter 3: **Mental/Behavioral Health and Substance Use Disorder Treatment**

Takeaway: Mental/behavioral health and substance use disorders were cited as a growing priority among all purchasers. Access is highlighted as the key challenge, but there is limited data or measurement being done.

Priority ¹²			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> Limited measures being used Tangential measures have been considered, such as productivity or well-being

Key Drivers
<ul style="list-style-type: none"> Care coordination: integrating behavioral health with primary care or a broader care team

Mental/behavioral health and substance use disorder (SUD) treatment concerns of purchasers centered on:

- Access:** Members need access to behavioral health providers and, with few exceptions, many purchasers feel networks are not providing sufficient access to their membership.
- Identification:** Purchasers believe there is insufficient identification of members with behavioral health issues. Some attribute this to the stigma of seeking mental health treatment while others believe there is insufficient identification of these conditions in the delivery system.
- Effectiveness of care:** While access and identification were noted as major challenges, measurement of effectiveness relies on traditional HEDIS measures, but purchasers expressed concerns as to whether these measures are being effectively communicated to providers.

¹² After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken by purchasers include:

- **Access** issue strategies purchasers identified included assessing networks for gaps to improve availability. Some do this through analysis while others are going deeper, conducting “secret shopper” calls to determine whether in-network providers are sufficiently available to new patients. The pursuit of alternative care models was also cited — for example, promoting more telehealth options in the behavioral health space.
- **Identification** improvement strategies have two main dimensions: (1) embedding behavioral specialists in primary care or integrated care delivery models and (2) introducing tools to aid in screening for depression, substance use, etc.
- **Measurement** is a central element of promoting **effectiveness of care** pursuing more information on the use of screening tools by providers, use of collaborative care codes and understanding how HEDIS or other mental health and substance use disorder measures are being presented to providers to inform care delivery.

Current Initiatives

Finding 1: Purchasers are concerned about access to mental health services.

- Purchasers are concerned about access and taking a fresh look at their mental/behavioral health network adequacy and mechanisms to connect patients to the appropriate provider.
 - Issues around access have been identified broadly by organizations such as the National Alliance of Healthcare Purchaser Coalitions, but employers don’t have hard data within their plan to prove a lack of parity or access.
 - One employer interviewed heard concerns among employees that providers were not accepting appointments - to confirm this concern, “secret shopper” calls were being conducted to see if providers are turning patients away.
- One employer has looked at the provider types embedded within certain programs to ensure that when an employee reaches out they are connected with a psychiatrist or psychologist.
- Some employers are carving out mental health services in an effort to improve access.
 - Employers are focused on being proactive in improving access to mental health services, however there is no data or standard clearly defined measure set to rate the effectiveness of a third-party solution over a carved in program, but employers continue to utilize these solutions. Employers continue to rely on traditional measures of network adequacy (such as travel distance standards, appointment wait times, and HEDIS measures).
- All types of purchasers noted there is still a stigma surrounding mental health which can create a barrier to access for individuals — efforts to remove these barriers are increasing.
- As concern continues to grow around substance use disorders, mental health services will become a growing need.

- 10.2 million adults have co-occurring mental health and addiction disorders, and 60% of adults with mental illness didn't receive treatment in the prior year.
- Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for individuals aged 18–44.
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.¹³

Finding 2: Employers are moving more toward integrating mental and physical health.

- A number of employers are looking to Accountable Care Organizations (ACOs) or integrated delivery systems to provide better access through the use of primary care providers (PCPs).
- Two national employers that were interviewed noted the move from point solutions¹⁴ to providing mental health services through their health plan to promote integration.
- More purchasers are trying to use primary care as a coordination point for enrollees to access mental health.
 - One health plan is leveraging a PCP liaison model to have physicians be integrated into a specialist network and help connect individuals to care through early diagnosis of depression, anxiety and other conditions.
 - Physicians are provided a toolkit with resources to help probe patients to better understand underlying issues and therefore connect them to appropriate care sooner.

Finding 3: There is a growing use of telehealth and alternative sites of care across all purchasers.

- Currently employers are using Employee Assistance Programs (EAP) as the most common way to provide mental/behavioral health services (98% of employers are offering an EAP), but only about ¼ of employees participate in the EAP.¹⁵
- Telehealth has emerged as a possible solution to the access challenges and 65% of employers currently have a virtual solution in place for mental/behavioral health.¹⁶
 - Over half of employers believe that virtual care will play a significant role in how care will be delivered going forward.

¹³ National Alliance on Mental Illness. (2019). Mental Health by The Numbers. Retrieved from <https://www.nami.org/learn-more/mental-health-by-the-numbers>

¹⁴ Point solutions are third party companies that provided services aimed at a specific issue or condition such as mental health.

¹⁵ PricewaterhouseCoopers. (2018). Health and Well-being Touchstone Survey. Retrieved from www.pwc.com/us/touchstone2018

¹⁶ PricewaterhouseCoopers. (2017). 2017 Payer Executive Survey. Health Research Institute (Internal PwC survey).

- One of the health plans interviewed noted that the integration of mental health services was not as strong, and they are using telehealth to help expand access.
- NBGH’s Large Employer Health Care Strategy Survey shows an increasing interest in promoting behavioral health.¹⁷
 - The most utilized strategies are self-directed online resources (58%) and flexible work scheduled to allow employees to seek care during business hours (39%).
- One large employer with a centralized population is leveraging on-site clinics which are now offering mental and behavioral health to supplement telehealth services.

Finding 4: Similar concerns are shared by government purchasers that serve the Medicaid or Medicare population in terms of access to mental health providers, particularly where certain populations have higher prevalence of mental health needs.

- Some key issues identified were the complexities around engagement for patients with mental health, substance use disorders (specifically alcohol), and bringing together mental and physical health but there are shared efforts to promote better integration in the health care system, recognizing the connection of mental health to physical health.
- The California Department of Health Care Services (DHCS), in particular, is exploring coordination among county programs and managed care plans to improve the management of mental health services.
- Many of the purchasers that serve low income populations are increasingly focused on the social determinants of health.

Purchaser Issues on the Horizon

- Purchasers are looking to continue to expand access from their current position.
 - For those using telehealth, other alternative site, on-site or near site options may become more prominent.
 - It is too early to determine whether point solutions will prove successful enough to gain traction among employers and purchasers and health plan efforts to reintegrate mental health care into their programs involves significant and sustained efforts to promote better practices at the provider level.
- Some employers are looking to increase access by direct contracting with providers to increase the number of in-network behavioral health providers.

Other Considerations

- Although it is improving, there is still a stigma around mental health which may be preventing those who need it from engaging in the system and it requires more than provider level efforts to address this challenge. Understanding the efforts of QHPs to educate members is worthwhile.

¹⁷ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- Engaging with QHPs on methods to better understand mental/behavioral health and substance use disorder treatment demand merits consideration. The research and interviews highlight that purchasers believe there is more demand than there is care or treatment being provided in this area.
- As telehealth and other forms of treatment evolve (such as digital tools), new measurements are developing but much of the measurement focus is on utilization or activity. Measuring impact is evolving and needs to consider the specific role of a particular solution or model.

Synthesis and Takeaways

There appears to be common ground among purchasers in addressing the key mental/behavioral health and substance use disorder treatment concerns:

- Access;
- Identification; and
- Effectiveness of care.

The current measures used by Covered California through its contract requirements focus on care delivered through integrated models, addressing only a portion of the challenge cited by purchaser interviews and research. Purchasers are taking steps to adopt more integrated models, however, and these efforts are aligned with Covered California's objectives for this strategy.

Purchasers are recognizing the importance of improving access to mental/behavioral health and substance use disorder care providers which does not have to be limited to traditional "brick & mortar" locations. Telehealth appears poised to become more available to address these needs. This raises questions on how to address and measure telehealth impact across the dimensions of access, identification and effectiveness of care. At present, it is important to consider a broader definition of access — access to traditional providers and use of emerging technology.

The data and measurement recommendations should improve understanding of mental/behavioral health and substance use disorder needs and treatment in the Covered California population. They are consistent with those promulgated by the National Alliance of Healthcare Purchasers and other professional organizations. These recommended measures are intended to:

- Do more than measure the presence of behavioral health providers, they need to assess their availability to patients.
- Improve the identification of mental/behavioral health and substance use disorder treatment needs at the "frontline" of care — primary care.
- Suggest specific increased reporting to validate screening and identification, frequency of member contact, and provider coordination for consideration in discussions with QHPs to achieve consensus on key measures in this area.
- Establish service baselines and begin to measure mental and behavioral health improvement in the overall population.

Given the strong signals of concern expressed in purchaser interviews, there may be opportunities for collaboration with purchasers to address local market challenges of access and identification of mental/behavioral health and substance use disorder treatment as a broader community health issue.

Chapter 4:

Acute, Chronic and other Conditions

This chapter includes a variety of areas of care — such as cancer, orthopedics, maternity care, etc. — which are not discussed in detail but merit further consideration.

Takeaway: Purchasers agree that specific chronic conditions remain a strong focus area, but data across programs and conditions is limited, leading to difficulties in standardization and measurement.

Priority ¹⁸			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • HEDIS measures are used, although they are skewed towards measuring process and preventive care • Total cost of care (defined differently among purchasers)

Key Drivers
<ul style="list-style-type: none"> • Data: collecting program data to understand what interventions are improving outcomes • Provider-level coaching: standardizing practices to improve outcomes • Value-based payments

Chronic care and access concerns of purchasers centered on:

- **Specific conditions:** Purchasers tend to focus on particular **conditions that drive costs** rather than approaching chronic care as a broad bucket. Conditions receiving special attention include **diabetes, heart disease, asthma, COPD, and cancer**.
- **Attribution:** Purchasers face **challenges with associating outcomes with certain providers**, initiatives, or behaviors. This is further complicated by data interoperability issues. Purchasers with relatively little leverage may not have their own data and may rely on health plans who won't necessarily share data. This creates challenges for employers looking to assess the return on investment (ROI) of care management initiatives.

¹⁸ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

- **Access:** Primary care provider (PCP) assignment efforts are not considered sufficient substitutes for ensuring access to care. Some purchasers highlighted **challenges in rural markets** and in the behavioral health areas, for example.

Actions being taken by purchasers include:

- **Focus on value:** Employers emphasized the importance of **measuring outcomes rather than process**. The total cost of care is a common way that employers are trying to use to gauge success.
- **Drive standardization:** Some health plans may get more involved by coaching providers and facilitating the exchange and standardization of best practices. Nonetheless, some purchasers observe that **lack of consistency among health plans** may be impeding meaningful results.
- **Understand the population:** Employers concentrate resources on conditions that are particularly **prevalent in their populations**. Many employers are leveraging health risk assessments (HRA) to better understand the prevalence of conditions within the population, similarly Medi-Cal requires managed care plans to administer them.

Current Initiatives

Finding 1: Chronic care initiatives focus on particular conditions.

- Categories of chronic care that purchasers are focused on include common ones — diabetes, asthma, cardiac care — but some purchasers (employers in particular), are **adding in focus areas around cancer and musculoskeletal**.
- To identify which conditions to focus on employers are utilizing claims (primarily) or health risk assessments (HRA). Predictive modeling is also employed to focus efforts on patients most at risk and some employers have established clinical management oversight models stipulating the levels of targeted outreach by health plans on higher risk individuals (e.g., targeting the top 5% rather than the top 1% or 2%).
- Large purchasers are able to bring health plans to the table for **performance meetings and deep dives into data** to see how they are managing chronic care.
 - These meetings help to identify gaps in care, review care management practices, and help to identify best in class approaches and develop action items.

Finding 2: Measuring the success of chronic care programs is difficult and purchasers are looking at different methodologies to achieve this.

- Some employers are utilizing clinical audits to develop deeper understanding of health plan management performance.
- One purchaser monitors a cohort of individuals at risk for chronic conditions and assesses the relationship between clinical measures and claims cost over time to determine whether improvements are being made.
- Some health plans review medication regimens and make recommendations directly to the patient or physician to drive standardization and adoption of best practices.

- Many purchasers approach chronic care through the lens of whole-person health, using various strategies such as:
 - Leveraging pharmacists who have frequent touchpoints with patients; and
 - Keeping disease management programs carved in to health plans which helps to keep chronic care bundled with all other care aspects (86% of large employers with care management programs carve them in with their medical vendor¹⁹).

Finding 3: While benefit design levers were not generally emphasized, some purchasers appeal directly to patients to better manage their chronic conditions by offering incentives such as reduced cost-sharing in exchange for certain behaviors.

Finding 4: Access was cited as more of an issue in rural areas for some health plans, particularly with primary care, and for other more specialized categories such as mental health.

Purchaser Issues on the Horizon

Some purchasers are optimistic about leveraging telehealth for monitoring and treatment of chronic conditions.

Other Considerations

- There may be opportunities for collaboration on diabetes measurements, treatment, and provider interaction, as diabetes is an area of general concern across purchaser types.
 - 97% of large employers who utilize disease management programs offer one for diabetes, more than any other condition.²⁰
- Purchasers recognize the importance of provider feedback and coaching but expressed concern about “getting provider attention” due to various reporting styles by plans.

Synthesis and Takeaways

HEDIS and enrollee survey reporting are the prevalent measurement approaches used in this area, but purchasers are looking for more insight on population needs. By incorporating health risk assessment measures as well as financial measures purchasers are able to inform the identification and prioritization of key chronic condition areas such as diabetes, asthma, cardiovascular disease.

Some purchasers also want to see more focus on outcomes in chronic care areas — such as improvement in health status as well as financial outcomes — and some are following improvements in specific condition cohorts (e.g., diabetes population, asthma population).

¹⁹ PricewaterhouseCoopers. (2018). Health and Well-being Touchstone Survey. Retrieved from www.pwc.com/us/touchstone2018. Note large employers are defined as those with 5,000 or more active employees.

²⁰ Ibid.

Access issues exist in the delivery system, but current measures may not sufficiently address where there are barriers to receiving care, particularly geographic factors, and how these are impacting utilization. For example, better understanding of the drivers of utilization of the emergency department or urgent care in some rural locations may surface primary care physician access concerns. Purchaser concerns around access to behavioral health providers were addressed earlier in this in report.

There appears to be an openness to collaboration among purchasers — particularly around diabetes — to address concerns around variability in provider level reporting. As highlighted earlier in this report, differences in measure sets exist in diabetes related care. Pursuing models of reporting feedback consistently to providers in the area of diabetes may help to establish a framework to expand to other areas of common concern.

Chapter 5: **Major/Complex Care**

Takeaway: Complex care was targeted as a high priority for all purchasers; however, measurement approaches and priorities vary. Purchasers agreed that a holistic approach is required, suggesting there could be some opportunities to align on specific issues.

Priority ²¹			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • HEDIS and CAHPS measures • High cost claims, high cost procedures or treatment categories identified through claims review

Key Drivers
<ul style="list-style-type: none"> • COEs: in particular, for oncology, cardiac and orthopaedics. This approach becomes more challenging with ACOs. • Plan design: in some cases, waiving cost sharing to steer patients to higher quality providers

Major / complex care concerns of purchasers centered on:

- The **cost of care** with a number of purchasers noting that a small percentage of the population was driving a large portion of the cost. These cases tend to include hospitalization and more complex disease states (e.g., cancer).
- The **quality of care** received as evidenced by increasing the scope of centers of excellence strategies in areas such as cancer, cardiovascular care and major orthopedic procedures.
- Expanding the view of care to look at how different disease states interact instead of focusing on individual measures.

²¹ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken by purchasers include:

- **Analyzing** historical data to expand beyond traditional high cost or catastrophic definitions to identify expensive treatment categories where variation in outcomes and cost is problematic.
- **Selectively channeling** patients to providers with demonstrated quality, leveraging value-based payment models and, in some cases, benefit design incentives (waived cost sharing) to address cost variation and encourage patient adoption.

Current Initiatives

Finding 1: Employers emphasized a concern around complex care as it is a main driver of cost. Specifically, high cost claimants were noted as the primary driver of complex care costs

- According to NBGH's Large Employer Survey, 39% of employers noted high-cost claimants as the highest driver of cost trends (over specialty pharmacy costs, for example). Almost $\frac{3}{4}$ of employers noted high-cost claimants as one of the top three drivers of cost.²²
- 14% of employers are looking at specific diseases or conditions (e.g., cancer) as the highest drivers of cost.²³
- The interviews highlighted employer reliance upon claims data and costs to identify opportunities to address high cost claimant issues or condition categories which high costs, generally focusing on claimants exceeding a dollar threshold (e.g., greater than \$100,000 in claims) to further assess opportunities for intervention with their health plan partners.

Finding 2: The focus of health plans related to major/complex care incorporates a number of condition categories such as bariatric surgery, End Stage Renal Disease, HIV, burns, spinal cord injuries, multiple trauma (accidents) with some focusing on rare conditions such as sickle cell disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. The use of predictive modeling is common among health plans to prioritize highest risk for intervention, ranging from the top 1% to 5% for intervention efforts.

Finding 3: Centers of excellence (COE) strategies are evolving beyond traditional categories such as transplants and burn cases to address other major/complex care issues. Outside of transplants, bariatric surgery, orthopedics and cancer were most popular among purchasers for complex care.

²² National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

²³ Ibid.

- NBGH’s employer survey notes that over 30% of employers are using centers of excellence for these disease states.²⁴
- Although centers of excellence were a common strategy, employers are still relying on health plans to identify high quality providers; less than 10% of employers are leveraging direct contracts for COEs.²⁵
- Of those using centers of excellence, fee-for-service payment models remain prevalent; however, transplants and orthopedics experienced a higher use of bundled payments, 34% and 45% respectively.²⁶
- Some purchasers are using incentives for, or covering the cost of, using COEs — Walmart is one employer who covers the cost of procedures for specific issues (e.g., spinal procedures).²⁷
 - The COE program Walmart provides is aimed at providing the right care at the right time focusing on certain high cost procedures.
 - The program covers costs of associates traveling to specific facilities to provide second opinions and treatment options all for a bundled payment amount.

Purchaser Issues on the Horizon

- Purchasers recognize that major and complex care involves more than directing members to high quality providers and **health advocacy or navigational support** are also important to facilitate good outcomes.
 - For example, some purchasers are using care coordinators, typically third-party vendors (e.g., Accolade, Health Advocate, Quantum Health), to help members access the healthcare system (find a doctor), find second opinions, and navigate care over time to reduce costs and better manage conditions.
 - Some third parties providing advocacy or coordination services quote savings through early identification and engagement through non-health related issues (e.g., lost ID card) and build relationships with employees. The value proposition of these vendors is increasing the engagement of employees and improving enrollment or utilization of clinical programs.
- DHCS has launched “**Whole Person Care Pilots**” which is a collaborative effort to create systematic coordination among entities to share data, coordinate care, and evaluate individual and population progress on beneficiaries identified as vulnerable and

²⁴ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

²⁵ Ibid.

²⁶ Ibid.

²⁷ Harvard Business Review. (2019). How Employers are Fixing Healthcare. Retrieved from <https://hbr.org/cover-story/2019/03/how-employers-are-fixing-health-care>

high risk or high utilizers (measures include repeated emergency department use, inpatient use, multiple chronic conditions, etc.).

- The pilot is aimed at reducing cost and improving care working across public and private entities while also addressing social determinants of health such as access to housing or other support services.
- Purchasers are looking towards data, specifically **claims, to help identify complex cases earlier** and track outcomes.
 - While predictive analytics is growing among health plans to identify high risk cases, external reporting has generally been focused on cases after they have occurred.
 - Many employer’s historical claims data analysis of high-cost claimants to identify opportunities.
 - Additional analyses may be employed based on high cost condition categories or high cost procedure categories (which may or may not trigger a high cost claimant threshold).
 - Employers, in particular, are seeking more insight on targeting efforts and effectiveness of interventions by understanding the timeliness of when cases are identified and the subsequent intervention efforts, but real-time data is not accessible which make it difficult to do this.
- While value-based payment efforts are clearly being pursued in the area of major/complex care, the expansion beyond traditional high cost areas is causing some employers to consider **plan design incentives** to encourage use of high quality providers in exchange for lower out-of-pocket costs.
 - Employers leveraging a COE strategy have focused on bundled payment arrangements directly with facilities for various procedures.
 - Overall bundled payments and other value-based payments are of interest to employers but only those with certain scale have been able to implement.
 - While some of these payments align with ACO strategy, the intent of COEs are to manage specific condition or cases through the best care, while ACOs are intended to manage a person’s care beyond a single condition.

Other Considerations

- While centers of excellence strategies are common to a number of the condition categories covered under major/complex care, they need to align with models centered on integrated models of care such as ACOs.
- Predictive measurements to identify patients at risk for major/complex care often require some volume of claims data in history to be effective. Some of the employer efforts represented in this area are heavily reliant upon historical claims to predict and intervene on patients and may not align with the enrollment tenure of Covered California patients.

Synthesis and Takeaways

Traditionally, the definition of major/complex care focused on catastrophic conditions defined by costs or very severe procedure or diagnostic categories. Purchasers have been expanding the definition to address quality of care and cost issues.

Purchaser priorities vary based on their underlying population and this highlights the need for analysis to serve as a baseline for identification of major/complex care conditions or procedures that merit further attention and reporting. The analysis then needs to align with QHP efforts in the areas identified to:

- Inventory definitions of major/complex care used by purchasers to understand which specific conditions or procedures are included and how intervention priorities are determined using predictive models (e.g., targeting all, top 5%, etc.). The use of centers of excellence strategies should also be understood and, if possible, comparison of COE providers across health plans in the same region.
- Compare high quality providers across QHPs to determine gaps.
- Understand how members may be channeled to or encouraged to utilize such providers.

Chapter 6: **Networks Based on Value**

Takeaway: Networks based on value is a high priority item for all purchasers and will continue to be in the future, however finding ways to measure and provide meaningful data is a challenge.

Priority ²⁸			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Total cost of care • National Quality Strategy (NQS)

Key Drivers
<ul style="list-style-type: none"> • Payment • Measurement and data to inform impact • Channeling of members

Purchaser concerns around networks based on value centered on:

- **Quality and cost:** Purchasers are interested in providing consistent, quality care to members and are looking at networks based on value to do this. One of the challenges is identifying quality among providers and delivering care in the right setting. Ultimately, purchasers are looking to translate quality to better cost management. One effort in this space is looking at the total cost of care, however there is not a standard definition being used currently across purchasers.
- **Lack of critical mass:** Employers are concerned with not having the critical mass to drive value-based networks outside of what is offered “off the shelf” from health plans. Employers and other purchasers feel health plans are not providing sufficient evidence that differentiates value-based networks from broad options, but purchasers that have tried to develop alternative networks have not achieved the enrollment or uptake needed to make it successful.

²⁸ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

- **Misalignment of incentives:** Purchasers acknowledge the fragmentation in the system and agree that incentives need to be aligned towards focusing on outcomes and better value. The biggest concerns were around aligning financial incentives for providers to drive value, but data was also recognized as a challenge here.

Actions being taken by purchasers include:

- Focusing on data and improved reporting to answer questions around **quality and cost**. Some purchasers cited working together (e.g., summits or meetings) to agree on definitions and metrics to track total cost of care, outcomes, and procedural information. Ultimately purchasers are trying to identify the building blocks to measure outcomes.
- **Lack of critical mass** is being addressed by direct contracting with hospitals and centers of excellence to channel members where appropriate. Direct contracting can provide data that gives insight to the population and eventually outcomes.
- **Misalignment of incentives** between purchasers and providers is being addressed through changes in payment. All purchasers noted the importance of moving away from fee for service and more toward value-based payments. However, implementing these strategies needs to be done on a local provider level to ensure the incentives are meaningful.

Current Initiatives

Finding 1: Measuring networks based on value was noted as a challenge by all purchasers due to variations in measurements and a lack of standardization.

- One of the purchasers interviewed who is working to identify high performing networks across its health plans commented on the lack of standardization and consistency of measurement across health plans. The variations make it difficult to compare programs between health plans and consistently measure value across different programs.
- The definition of value varies among purchasers and could imply value-based payments, better outcomes, narrow or smaller provider networks, or the use of ACOs — without any standardization it is difficult for purchasers to identify value.
- Perhaps the **most consistent measures of value** noted were:
 - Reduction in total medical costs;
 - Reduction in inpatient admissions or readmissions;
 - Decreases in emergency department utilization;
 - Generic drug prescribing patterns; and
 - National Quality Forum (NQF) measures.
- Health plans can track the prevalence of value-based payment model use or Alternative Payment Models (APM) in their books of business (or the converse — the prevalence of fee-for-service payment methods).

Finding 2: Despite the variation in approaches to measurement cited by purchasers, all expressed strong interest in value-based networks and centers of excellence, but strategies differ among purchaser groups.

- Health plans and other purchasers reported a strong interest in value-based networks; however, they are still assessing whether value-based networks are doing better than broad based networks.
 - One large health plan is trying to find the balance between right providers and the location of these providers within a value-based network in order to drive individual consumers toward quality care and better outcomes.
 - Another purchaser noted a focus on using data (two years worth) within the health plans to identify higher performing providers and carve those into a high-performing network.
 - One large purchaser is bringing its major health plan partners together to align on a total cost of care evaluation model to measure how value-based networks may be performing above broad networks.
 - Health Net is also considering how they can align their network strategy across all segments of their commercial business — by working directly with providers to define measurement and incentives and then scaling those initiatives. Similarly, Blue Shield of California’s TRIO model, focusing on high quality providers and ACOs, is being deployed across various business segments.

Finding 3: Employers have considered building their own networks but have mainly relied on health plans to define value-based networks. NBGH’s 2019 survey noted 11% of large employers were pursuing direct contracting of ACOs or High-Performance Networks whereas 24% were pursuing these types of options through their health plan partners.²⁹

Finding 4: Where large employers have focused on direct contracting, it has been in select areas where population concentration is meaningful or by pursuing centers of excellence strategies to channel members to high quality care for higher cost procedures (e.g., orthopedic, cardiac).

- Walmart, for example, is **incentivizing employees to use COEs** they directly contracted with by providing a travel companion and other assistance to associates.
- Another employer has 8 ACOs through the health plans and some direct contracts with ACOs; their **direct contract providers provide richer clinical data** and insights into population compared to ACOs delivered through health plans.

²⁹ National Business Group on Health. (2019). 2019 Large Employers’ Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- Two large national employers who have concentrated populations cited insufficient volume to do anything beyond work with health plans so have become passive on COE strategy.
- One of the alternatives purchasers noted that because care is a local, and can vary based on geography, identifying and implementing local centers of excellence can help channel members better.
- Some employers interviewed cited the need to guard against poor quality provider choices leveraging HMO-style or narrow network strategies as valuable in directing members to cost-effective quality care.
 - Overall employers are **slowing down the implementation of full replacement high deductible strategies** and focusing on HMOs or PCP oriented networks with limited networks to guide patients to the best choices.
 - While 80% of large employers offer a high deductible health plan (HDHP), only 21% have implemented a full-replacement HDHP and 24% are considering doing so.³⁰
 - According to NBGH’s survey of large employers, some are using value-based insurance design to steer members to different care options such as COEs or high-performing networks.³¹
 - A number of employers and health plans echoed the use of value-based design to channel members to specific providers but did not note this as a strong driver.

Finding 5: NBGH’s 2019 Large Employer Survey highlights employers desire to make improvements in the delivery system with 49% saying they are pursuing either driving delivery system change through high value network strategies or circumventing the system through the use of digital tools and point solutions/concierge services to create access to care or both of these options.³²

Finding 6: Plans that serve populations with lower access may find ways to promote the most effective providers without limiting network access.

- Some plans are using other forms of value-based design, such as considering provider performance when making PCP member assignments, providing support for physicians, and shared savings or shared risk payment models.

³⁰ PricewaterhouseCoopers. (2018). Health and Well-being Touchstone Survey. Retrieved from www.pwc.com/us/touchstone2018

³¹ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

³² Ibid.

Other Considerations

- Value-based networks are defined in various ways but key considerations of purchasers in these models is maintaining sufficient access to providers, delivering higher quality care cost-effectively and providing an improved patient experience. Many employers who have implemented value-based network options have done so where there is choice among options or tiered benefits to require lower cost sharing to members for using providers designated as higher quality. Purchaser interviews did not investigate specific measures of network adequacy which are obviously important, particularly where limited plan choices exist.
- As the purpose of a value-based network is to drive better overall value over time, reporting models need to not only consider results compared to book of business or other relevant benchmarks but also monitor trends within the network over time.

Synthesis and Takeaways

Purchasers are highly focused on obtaining higher value for their healthcare dollar but determining the right measures and obtaining data to evaluate network quality and costs has been challenging.

The information requested of QHPs by Covered California generally aligns with that of other purchasers but comparisons of the value of each QHP's networks is challenging from the information obtained. Covered California may be able to use reported quality data combined with published QHP network data to develop an objective assessment of each QHP's relative network quality. HEDIS quality measures can be compared between QHPs and Commercial plans to evaluate the impact of narrower networks on quality using measures already being reported. The California Department of Managed Health Care (DMHC) requires health plans to measure timely access using the *Provider Appointment Availability Survey*, and to report the results in their timely access compliance reports. Covered California should monitor these reports to ensure network adequacy. QRS also measures members' access to care through the *QHP Enrollee Survey*, and results could be compared to Commercial plans to evaluate the impact of narrower networks on access.

Continuing improvements in data collection and reporting and innovations in payment mechanisms are necessary key drivers in this area. It will require alignment and agreement among purchasers, providers, and other stakeholders on the most important measures and incentives to achieve the highest value. Value should not be limited to cost or fundamental utilization measures such as inpatient admission or emergency department utilization rates. A balance of measures focused on cost, utilization and quality should be considered and requested of QHPs, aligning with industry standard measures and other purchasers as referenced in this section wherever possible.

Chapter 7: **Promotion of Effective Primary Care**

Takeaway: Varying efforts are being pursued by purchasers to improve access to primary care — with employers taking more direct control — and health plans using analytics to target outreach while pursuing greater adoption of integrated health models in their networks.

Priority ³³			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Emergency Department utilization • Non-users

Key Drivers
<ul style="list-style-type: none"> • Payment • Measurement/data to inform impact

Primary care concerns raised by purchasers included:

- Accessibility of primary care is suboptimal. While cost is not often cited as a barrier for patients due to copay designs and zero cost preventive care, delays in access due to primary care provider availability are reflected in some purchaser actions to minimize barriers to access.
- Simplifying reporting to primary care providers to better focus efforts. Many purchasers feel providers — primary care providers (PCPs), in particular — are overwhelmed by the volume of measures being reported as well as inconsistent reporting. Diabetes was mentioned by several purchasers as an area where messaging to providers can and should be more consistent to improve understanding on opportunities.
- Technology concerns were also cited. Health plans and employers in particular highlighted the challenges primary care providers face in receiving real time information on their patient census.

³³ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken include:

- A number of large employers are electing to close the access gap through direct contracting with onsite or near site clinics. Strategies such as these do not replace traditional primary care, but they demonstrate the lengths some purchasers will go to accelerate accessibility of primary care services.
- Delivering reporting solutions and incentivized payment models to enable better primary care and to broaden this outreach to reach independent physician practices.

Current Initiatives

Finding 1: Purchasers all expressed commitment to promoting primary care efforts, but strategies vary based on purchaser type. General concerns in the area of primary care expressed by purchasers included:

- PCP availability;
- Inconsistency among payers in delivering provider level reporting; and
- The need for improved interoperability in clinical information flow.

Finding 2: Large employers have focused on efforts such as on-site health clinics or ACO models (directly contracted with the ACO provider or through the health plan) to address primary care challenges in their populations.

- One large employer has pursued onsite clinics as a key strategy to address the accessibility and convenience of primary care.
- Two of the large employers interviewed highlighted their ACO strategy as a key driver of primary care promotion.
- Another large purchaser has implemented a direct contract with a primary care provider on a pilot basis to reduce the member financial exposure and lower time to schedule barriers to patients. Patient copays are \$0 and commitments made for acute illness visits on a same or next day basis.
- Some purchasers are also looking to bundled or capitated payments to drive more effective primary care; these types of payment models are often seen in ACOs or physician groups.

Finding 3: While health plans reported PCP assignment requirements were achieving satisfactory levels, a number highlighted other specific efforts to promote primary care:

- Molina reported analyzing claims and encounter experience for non-users of health care services to inform outreach initiatives.
- Anthem noted high, discretionary emergency department use rates as an area of focus to probe for opportunities to better engage members with their primary care providers.

Finding 4: Plans are pursuing efforts to link primary care physicians to more integrated models of delivery, such as Patient Centered Medical Homes (PCMHs) or ACOs, reporting on their prevalence and linkage to value-based payment models. Health plans such as BCBS of Michigan have even linked increases in physician reimbursement to participation in integrated models with proven clinical performance.

Finding 5: BCBS of North Carolina has initiated efforts to promote primary care effectiveness among independently owned practices through a partnership with Aledade to establish physician-led accountable care models tied to primary care. The effort involves providing resources to assist primary care practices in improving chronic care management and overall health care quality by providing physicians better patient level information. Enhanced reimbursement is also a feature of these efforts along with shared savings.

Finding 6: As noted in the Mental/Behavioral Health chapter, some health plans are promoting efforts to incorporate behavioral health specialists and diagnostic tools in primary care models to improve earlier identification of mental health issues.

Other Considerations

- Purchasers interviewed as of the date of this report did not specifically highlight financial targets for primary care reimbursement as specific goals. However, enhanced payments focusing on effective primary care were cited by many purchasers.
- Rural settings with challenges to adopting team-based care models require more direct support from purchasers to promote effective care. Inland Empire Health Plan (IEHP), in particular, cited focused reporting and provider-level coaching as key drivers to promote effective primary care.
- As the use of email and text message increases among providers, it will reflect more on actual member engagement with their primary care physicians and, as such, these types of interactions merit consideration of future measurement in this area.

Synthesis and Takeaways

While many of the purchasers interviewed appreciate the importance of effective primary care, the strategies and tactics pursued vary. Common themes of concern were:

- Accessibility;
- Improved reporting to providers; and
- Addressing technology challenges that inhibit informed decision-making by providers.

Covered California has been successful in promoting primary care assignment and adopting measures to assess the availability of team-based care models and the use of value-based payment strategies. Additional focus is needed to:

- Measure primary care utilization to understand where usage rates are suboptimal;

- Assess where accessibility challenges exist in the network that may contribute to under-utilization; and
- Align primary care use and non-use experience to other measures such as emergency department utilization and hospitalizations that may be correlated to the lack of effective primary care.

Empowering more effective primary through more effective provider-level reporting may argue for standardization in Covered California's reporting requirements of plans to provide greater signal strength to providers. As a starting point, consideration should be given to diabetes care reporting which many purchasers feel presents opportunities to better care effectiveness.

The technology challenges in the delivery system domain may benefit from cross-stakeholder efforts to find common ground and establish supporting initiatives.

Chapter 8: **Promotion of Integrated Health Models and Accountable Care Organizations**

Takeaway: Many interviewees associated integrated healthcare models (IHMs) or Accountable Care Organizations (ACOs) with networks based on value pointing out value-based networks should incorporate more integrated models to improve health.

Priority ³⁴			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Cost and utilization measures • Standardized Quality ACO measures

Key Drivers
<ul style="list-style-type: none"> • Payment (e.g., capitated payments) • Reporting and data sharing among providers and plans • Predictive analytics

Purchaser concerns around the promotion of IHMs and ACOs centered on:

- **Availability of model:** While many purchasers are interested in integrated healthcare models (IHMs), many didn't differentiate between IHMs and networks based on value. In addition, many employer purchasers feel they lack the ability to directly contract with the limited number of standalone ACOs and therefore rely on ACOs available through their health plans.
- **Data interoperability:** Purchasers noted the difficulty in getting the data necessary to create an integrated system due to differences in what is being collected and measured across the system. Purchasers did agree that a standard set of measures should be built in order to create the information needed to better manage a population.

³⁴ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken by purchasers include:

- Increasing the **focus on data and outcomes** to understand if integrated models are leading to better outcomes. A number of health plans and employers voiced actions to better collect and analyze data on the networks and providers to understand where value is being added but acknowledge these efforts are still in their early stages.
- Some employers are looking to **direct contract with ACOs in order to gain access to better data** as the ones that have done so noted a richer information experience, providing more insight into how the delivery model is addressing health issues in the patient population. However, **concerns around having critical mass** or the resources to execute on a direct contract remain.
- Efforts among providers, including the Integrated Healthcare Association (IHA), have looked to **standardizing measures and improving the collection of data** in order to identify meaningful ways to measure performance and understand outcomes. A number of the purchasers interviewed expressed support for efforts like these to promote common measurement approaches.

Current Initiatives

Finding 1: Based on interviews, many purchasers do not distinguish between IHMs or ACOs and networks based on value, but all expressed strong interest in promoting ACOs.

- 35% of large employers are setting up ACOs and High Performing Networks either by directly contracting with health care providers or by working through their health plans.³⁵

Finding 2: Purchaser adoption of ACOs and integrated healthcare models continues to grow and seeking better market-specific information on how ACOs will improve employee experience and reduce costs.³⁶

- 38% of employers are **somewhat confident that ACOs will improve healthcare quality** and 15% are very confident.
- 45% of employers are **somewhat confident that ACOs reduce the total cost of care** and 16% are very confident.
- However, those that have adopted ACOs have seen strong results; one large employer noted the use of some ACOs through the health plans and some direct contracts. Of those that were directly contracted, the data provided is much more robust (greater clinical insight) and timely than that provided through the health plan.
- BCBS of North Carolina announced a concentrated effort to channel more membership to primary-care focused ACOs by partnering with 5 health systems to implement value-based payment arrangements to align financial incentives, improving data sharing

³⁵ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

³⁶ Ibid.

across the health ecosystem (through a partnership with Adelaide). The effort is designed to promote more effective primary care and serve as the platform for value-based primary care arrangements across the state.

Finding 3: A number of purchasers noted integrated models as a way to promote the role of the primary care provider.

- Conduent noted ACOs as providing strong evidence as the reason to promote the role of the provider in value-based care.
 - Their plans demonstrated meaningful data over 2-year period that shows alternative networks are working better than broad networks and these networks have also contributed to higher provider satisfaction.
 - National plans, such as Aetna and Cigna, have also highlighted success in their integrated delivery models, driving reductions in inpatient and emergency department utilization as well as high cost imaging, improvements in preventive health measures (e.g., blood pressure, cholesterol).
- Outcomes of a provider survey conducted by one of the purchasers interviewed demonstrated providers in narrow networks are feeling more effective and satisfied with how they're doing their job compared to providers in PPO networks.

Purchaser Issues on the Horizon

- Interviews suggested that purchasers are going to continue to pursue integrated healthcare models and collecting data on their outcomes.
- The expansion of the health information exchange (HIE) will play a key role in better understanding how integrated models are performing and efforts such as those being pursued by BCBS of North Carolina to promote better information sharing to primary care providers are key drivers of these integrated models.

Other Considerations

As with other functions, the ability to standardize the collection and measurement of data will be the key to continue to push integrated systems. Aligning purchasers on what measures should be collected is key to achieving standardization. The current state has adopted common measures as it relates to cost or utilization, but quality measures can vary; most are relying upon existing measure sets such as NQF or HEDIS.

Synthesis and Takeaways

Purchasers generally believe having integrated healthcare models improves health outcomes and increases the value the network delivers. Additionally, ACOs are seen as an effective way to deliver and enable effective primary care. ACO adoption is increasing, but uneven due to the lack of available ACOs, the lack of standardized measure sets, and difficulties in data collection.

Employers are cautiously adopting ACOs and waiting for better information on their value. Some are contracting with ACOs directly, in order to improve the data collection and increase accountability, but many are only able to do so indirectly through a health plan.

Commercial ACO penetration in California overall is estimated to be between 7% and 10%, with significant variation by geography. ACO penetration among Medicare FFS beneficiaries in the western states are much lower than in other regions.

There is debate about what makes some ACOs more successful than others, and CMS is revamping its ACO program in the coming years. Despite mixed results in ACO adoption and performance, the potential value improvements from integrated models merit tracking progress in the use and effectiveness of ACOs and other integrated models, and aligns with the strategies of other payers.

Chapter 9: **Pharmacy Utilization Management**

Takeaway: All purchasers cited challenges in managing pharmacy utilization but prioritization among them varies. Actions to manage utilization are most pronounced in specialty pharmacy.

Priority ³⁷			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> Traditional utilization and cost measures as well as HEDIS measures focused on medication adherence related to select conditions

Key Drivers
<ul style="list-style-type: none"> Plan design to steer to preferred therapies Although early, emerging interest in value-based payment for high cost therapies Moving rebates to point-of-sale

Purchaser concerns related to pharmacy vary based on purchaser type and the Covered California population falls between the public and employer stakeholder spectrum.

- **Transparency:** Purchasers are commonly concerned about the lack of transparency in pharmacy pricing, but none has really evolved beyond current models of evaluating drug cost and value. Perhaps the most noteworthy effort in this area relates to rebates.
- **Specialty pharmacy costs:** Of particular concern is the growth in specialty pharmacy costs. Many purchasers are relying upon traditional and emerging management techniques — prior authorization, step therapy protocols, first fill protocols, etc. — to minimize inappropriate utilization but these efforts are more transactional than value-based.
- **The silo of pharmacy:** Purchasers recognize the role appropriate pharmaceutical utilization plays in addressing the health needs of the population but acknowledge the delivery model today has room for improvement to capitalize on opportunities to deliver appropriate counseling and support to members and providers in the care continuum.

³⁷ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken by purchasers include:

- Bringing **rebates** to the point-of-sale to allow members utilizing drugs with rebates to experience the benefit of these savings. This issue was cited in employer purchaser interviews and research but has recently received attention due to an announcement by one major pharmacy benefit manager (PBM) that this will be its go forward practice.
- Pursuing **value-based payment** strategies to assess the overall effectiveness of high cost pharmaceuticals in the specialty pharmacy space. Promotion of biosimilars is another area where some plans are taking action to promote lower cost alternatives.
- **Leveraging** the supportive role of the retail pharmacy or retail clinic encounter in population health strategies.

Current Initiatives

Finding 1: Pharmacy management was cited as a challenging area for many purchasers although less of a concern for some health plans and Medi-Cal compared to employer purchasers. All commented on the challenges of transparent pricing in this area. Purchasers are showing interest in:

- **Rebates at point-of-sale**, which apply the rebate value to the drug or product with which it is associated to directly benefit the member. According to NBGH's survey of large employers, 20% implemented point-of-sale rebates in 2018 and another 7% are planning to in 2019 as well as 31% considering for 2020/2021 and beyond. Part of what explains the interest in this approach is the higher member cost sharing associated with high deductible health plans.³⁸
- **Specialty pharmacy management** efforts are also top of mind for purchasers. Key strategies being deployed include site of care management (delivering drug products through the most effective channel), clinical management initiatives (such as applying prior authorization, step therapy or quantity limit rules on specialty products) and applying similar prior authorization efforts for products delivered through the medical channel (to promote consistent management approaches for the same product whether it is delivered through the medical benefit or pharmacy benefit channel).
 - Some plans are experiencing success in promoting biosimilars as cost-effective alternatives. Kaiser has successfully switched patients from Neupogen to the biosimilar Zarxio, for example. Dean Health Plan has converted patients to Renflexis from Remicade. Aetna promotes site of care strategies for IVIG, Soliris, Remicade and Tysabri. Analysis and reporting on such efforts merit consideration.

³⁸ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- **Other efforts** gaining traction with employers include adoption of closed formularies, approving limited initial supplies of new medications for patients and zero copays for select generics.

Finding 2: Measurement efforts of purchasers generally focus on cost and utilization trends although HEDIS measures are followed primarily to address medication appropriateness. Examples of measures commonly reported on include:

- Utilization and cost trends by channel (retail brand, retail generic, mail order brand, mail order generic, specialty);
- Percent of members utilizing pharmacy benefits, generic utilization rates, formulary compliance rates;
- Proportion of days covered for select chronic condition therapies (diabetes, asthma, COPD, hypertension, depression, etc.); and
- Electronic prescribing by drug type (e.g., acute, maintenance, controlled substance).

Finding 3: As retail clinics begin to grow in popularity there is an opportunity to better coordinate care through pharmacists and PCPs. CVS has developed collaboration agreements with integrated health delivery models to leverage the retail clinic and pharmacy footprint as a driver of key population health initiatives focused on chronic care.

Finding 4: Addressing select categories for fraud, waste and abuse such as opioid use, by limiting initial dosing and fill-days. While fraud is more difficult to prove, analytics related to wasteful pharmacy use are evolving to compare pharmacy use to medical diagnoses. For example, diabetic strip utilization not tied to medical diagnosis or treatment related to diabetes.

Purchaser Issues on the Horizon

- Employers in particular are looking for more value-based approaches in this area, looking to pursue total cost of care assessment for therapies where cost is high. Health plans are also pursuing efforts along these lines.
 - One of the national employer coalitions highlighted efforts it is pursuing value-based approaches in high cost pharmacy therapies by establishing a forum on the pharmacy supply chain, gathering stakeholders such as pharmaceutical companies, PBMs, employers and the like to explore opportunities for alignment around outcomes-based payment models.
 - National health plans are likewise introducing outcomes-based models. Aetna, for example, has implemented an approach with a manufacturer where reimbursement is tied to inpatient admission reduction. Many health plans are or have implemented models such as these. Reporting of efforts in these areas

should be explored to identify the disease categories linked to such models and results being achieved.

- Rebates at point-of-sale are increasing as a tactic of employers according to NBGH's survey of large employers with 20% having implemented in 2018 and another 7% planning to in 2019 as well as 31% considering for 2020/2021 and beyond.³⁹

Other Considerations

- The focus on rebates is clearly increasing at a national level. Promoting rebates at point-of-sale obviously can reduce out-of-pocket exposure to members but such an approach is not considered a solution for the challenge of pharmacy pricing transparency.
- Purchasers recognize that pharmacy utilization management is not a PBM problem alone, as specialty pharmacy utilization does occur in the medical benefit area as well. Developing reporting that speaks to utilization, cost and clinical effectiveness in both channels is important.

Synthesis and Takeaways

Pharmacy is the area where value-based reimbursement has no defined targets, unlike for many purchasers for medical reimbursement, yet purchasers express concern over the underlying payment models.

Common pharmacy measures either focus on adherence in select medical condition categories, utilization and cost by channel but measuring the value of therapies continues to evolve. Management efforts are predominantly transactional — that is, understanding utilization or cost per script — but understanding the total cost of care associated with products is fairly limited. Specialty pharmacy, given the high cost trends, is an area where opportunities to assess the emergence of value-based payment models and Covered California should consider collaborating with health plans and the pharmaceutical supply chain to evolve opportunities in this area using data analysis on Covered California claims experience to assess initial target areas.

Biosimilars present opportunities for more cost-effective therapies. Analysis related to specialty pharmacy therapies and biosimilar alternatives and conversion strategies should be explored.

Fraud, waste and abuse in pharmacy management is growing as an area of focus. Wasteful use measurement will continue to evolve but initial measures for consideration are in the areas of opioid use and diabetic strip utilization unassociated with a diabetes medical claim.

There is a role for retail pharmacies and associated retail clinics in educating and supporting patients with select conditions. Collaborating with health plans to understand best practices and opportunities for measuring effectiveness on particular conditions — such as diabetes — merits consideration.

³⁹ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

Chapter 10: **Non-Hospital Sites/Care Delivery**

Takeaway: Although alternative sites of care are not expected to drastically reduce costs, health plans and employers are gravitating towards them to improve the patient experience and enhance access to care.

Priority ⁴⁰			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Telehealth utilization rates

Key Drivers
<ul style="list-style-type: none"> • Channeling: using incentives or communications to help patients get to the most efficient site of care

Purchaser concerns around sites of care centered on:

- **Disconnect in care:** Although all purchasers noted an increasing interest in alternative sites of care, some expressed concern that some sites such as retail clinics and urgent care centers may supplant or create a disconnect from primary care providers. However, 76% of large employers offer retail clinics as part of benefits coverage.⁴¹

Actions being taken by purchasers include:

- Expanding access to alternative sites of care, specifically telehealth and retail clinics. Most purchasers agree that alternative sites of care offer an opportunity for individuals to access care in a more convenient way. A number of purchasers also believe that expanding access to these services can help to close some gaps in care in key areas such as behavioral health.

⁴⁰ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

⁴¹ Kaiser Family Foundation. (2018). Kaiser Employer Health Benefits Annual Survey. Retrieved from <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018>

Current Initiatives

Finding 1: Alternative sites of care allow purchasers to provide more options to members.

- Employers noted that while telehealth is not seen as a major cost reduction opportunity, it is a way to give consumers more **convenient and cost-effective options**. 74% of large employers are offering benefits utilize telehealth.⁴²
 - According to PwC’s Touchstone survey, 56% of large employers incent employees to use telehealth by applying a lower employee cost share than for traditional care.⁴³
- Although providing access to retail clinics, urgent care centers, and telehealth may not reduce emergency department utilization, and may actually increase total utilization, purchasers see **these sites as key to engaging members**
 - According to PwC’s Behind the Numbers, a projection of employer medical trend, one inflator of trend is the ability to access care anywhere at any time. Employees are demanding convenience for care and benefits, and when “you make it easier to access the healthcare system, you increase utilization.”

Finding 2: Providing alternate sites of care can create more options to help close some gaps in care.

- For plans, telehealth and retail clinics serve to close gaps in **key areas such as behavioral health** and to augment chronic care management.
 - 15% of health plans have invested in retail clinics and 21% are considering doing so. The rate is higher for commercial health plans (33% invested and 21% considering).⁴⁴
- Some health plans see alternative sites of care as an opportunity to **expand the role** of formerly side-lined providers, such as **pharmacists and nurse practitioners**, without sacrificing quality.

Finding 3: Organizations are using targeted communications and messaging to channel members towards the most efficient sites of care.

- 77% of members are willing to use virtual care, but only 19% have taken advantage of virtual offerings.⁴⁵

⁴² Kaiser Family Foundation. (2018). Kaiser Employer Health Benefits Annual Survey. Retrieved from <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018>

⁴³ PricewaterhouseCoopers. (2017). 2017 Payer Executive Survey. Health Research Institute (Internal PwC survey).

⁴⁴ Ibid.

⁴⁵ Advisory Board. (2017). Virtual Visits Consumer Choice Survey. Retrieved from <https://www.prnewswire.com/news-releases/virtual-visits-with-medical-specialists-draw-strong-consumer-demand-survey-shows-300475757.html>

- Some purchasers are using programs that may target high emergency department utilizers to promote telehealth, retail clinics, and urgent care centers as alternatives.
- Other have experimented with real-time communications to drive members to the right care, but limitations on this strategy arise due to privacy concerns.

Finding 4: Technology solutions offering convenience and access to information are another avenue that is growing in popularity, these solutions are also providing new opportunities for consumers to seek or receive care from providers, often via smartphone⁴⁶:

- Some technologies are aimed at directing employees to the right care provider and making it easy to find and book appointments (Amino), while others offer primary care through an app where employee can text questions, share photos, or request consultations (98point6).
- Other solutions or apps are dedicated to condition specific issues such as helping women through pregnancy (Ovia), or managing diabetes using clinically proven treatments and providing consumer easy access to information and doctors (Virta).
- The ability to promote self-care at home is also gaining interest with technology solutions enabling greater self-monitoring for chronic condition management or targeting specific conditions or procedures that benefit from care provided in the patient's home to reduce inpatient lengths-of-stay and costs and provide a better patient experience.

Finding 5: Some employers are channeling patients to ambulatory surgical centers rather than hospitals and shifting drug infusions to more cost-effective settings such as a physician's office or patient's home, which may also benefit patients.

Finding 6: Health plans and employers are beginning to incorporate retail clinics into their networks in recognition of the reality that members can't always see their primary care provider.

- Younger members, especially millennials, are not tied to primary care providers and are more interested in convenience and the ability to access care as needed. Retail clinics and telehealth services offer a way to access care in the moment.
- Use of alternate sites of care is **not actively being measured by employers**, metrics such as the number of telehealth or urgent care visits are available but not always used in measuring where care is delivered or the outcome of care.

Finding 7: While few employers have the ability to implement on-site clinics or pharmacies, those that do are focused on using these models to promote overall population health while also providing a more a more meaningful patient experience.

⁴⁶ Note this is not an exhaustive list of solutions but some new entrants to the space are highlighted.

Purchaser Issues on the Horizon

- Some purchasers expect that with the right incentives in place to drive adoption, new apps and digital tools may be effective at channeling younger patients towards alternative sites of care.
- Purchasers are looking to expand telehealth to increase access to mental health care (e.g. behavioral therapies, access to a psychiatrist, self-directed therapy programs), especially in rural areas.
- Retail clinics are working on better reporting back to health systems in order to integrate with the rest of care.
- Plans are considering a more targeted deployment of telehealth to manage chronic care.

Other Considerations

- Telehealth has been slow to bring sizable change (low uptake and little demonstrated impact), but purchasers continue to explore opportunities in this area. Health plans are optimistic about expanding the role of telehealth in care delivery.
 - 61% of health plans are promoting telehealth usage over traditional care, and 27% are considering it.⁴⁷
- Purchasers serving a range of populations expressed interest in using telehealth to expand access. However, low income or rural populations may have limited access to technology as well as care (e.g. cannot afford technology, poor access to Wi-Fi and mobile networks).
- Telehealth should also be viewed as an extension of existing physician-patient relationships, allowing for a digital experience (emails, secure messaging, etc.) in conjunction with a more traditional physician-patient encounters. Few purchasers highlighted this as an area of focus or measurement other than Kaiser (where it is measured) and Health Net.

Synthesis and Takeaways

Telehealth and other alternative sites of care delivery, such as retail clinics and urgent care centers, are viewed by purchasers as a means to significantly improve the patient experience and fill key gaps in access.

Stakeholders generally agree that telehealth can bring medical care into communities with limited access to health care providers, reduce wait times for patients, and be more convenient than travelling to a provider's office in both rural and urban areas. There are similar views on the benefits of retail clinics and urgent care centers. However, telehealth and other alternate sites of care are not expected to reduce costs. There is also concern that these options increase the disconnect from primary care providers and may not be as effective when delivered

⁴⁷ PricewaterhouseCoopers. (2017). 2017 Payer Executive Survey. Health Research Institute (Internal PwC survey).

independently of network providers. Some purchasers are working with retail clinics to improve connectivity to primary care or integrated delivery systems.

While concern about the effectiveness of these alternative models exist, employers continue to implement solutions that provide more convenience even though outcomes measures and other data are not readily available or that return on investment calculations may overstate results when they do not account for differences in acuity of episodes treated in these lower cost settings compared to the emergency department. The tradeoffs between convenience and in-network provider care will need to be evaluated over time as access and cost continue to drive the conversation.

Available data indicates significant increases in the use of telehealth in recent years, but that its use varies significantly by age, geography, and income. Covered California should consider analyzing its QHP encounter data to understand the utilization of telehealth services across its population (and should, if not done so already, confirm whether such information is fully represented in these data submissions). For high utilizers, Covered California may be able to determine whether access to telehealth drives differences in effectiveness or cost of care. To the extent any differences are positive, Covered California should align with QHPs and other purchasers to promote the availability of these providers.

Chapter 11: **Hospital Care**

Takeaway: Purchaser concerns in hospital care include safety measures as well as waste related measures related to outpatient utilization such as discretionary emergency department use.

Priority ⁴⁸			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> • Admissions and readmissions, discharge and transfer information, labs, etc. • Cost of care

Key Drivers
<ul style="list-style-type: none"> • Data: Predictive analytics to help identify those who may have higher utilization • Delivery system strategies: utilizing network strategies to channel patients to the providers with the greatest efficiency and/or outcomes

Hospital care concerns of purchasers centered on:

- **Inappropriate use of emergency department** care was noted as a major issue among some purchasers. Drivers of emergency use could be tied to individuals delaying care due to high cost sharing.
- The **cost of care in hospitals** and finding ways to lower or control costs in the future. Some costs are driven by hospitalization while others are part of more complex problems such as chronic conditions.

Actions being taken by purchasers include:

- **Analysis of emergency department utilization** to better understand areas of discretionary use and opportunities to re-direct to more cost-effective settings.
- **Use of alternate sites** of care such as retail clinics or telehealth are being pursued in an effort to **reduce emergency department use**.

⁴⁸ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

- **Targeting categories of high cost** — for example, redirecting infusion from the hospital setting to lower cost areas.
- Efforts to **reduce the cost of care** appear to mainly be **driven through alternative payment methods** such as bundled payments or reference based pricing.
- Some health plans are also looking at **new care delivery options** such as care at home in order to try to reduce readmissions and improve outcomes.

Current Initiatives

Finding 1: Managing inappropriate emergency department (ED) use was a common theme among purchasers.

- Both employers and health plans mentioned **promoting alternate sites of care to curb emergency department** use and get people to the right care at the right time.
 - Employers were more likely to promote retail clinics or telehealth solutions to encourage employees not to utilize the ED, although some questioned their overall effectiveness in driving down discretionary emergency room utilization.
 - Employers are also looking to engagement tools such as transparency or personalized communications to encourage care better decision-making by consumers.
- Some employers and health plans noted that as the prevalence of high deductible plans has increased, it may be contributing to delay of care until it is too late, which may be adding to the reasons for higher ED use.
 - Employers offering Consumer Driven Health Plans appear to have lower deductibles and out of pocket maximums compared to what can be found in the average Silver Plan on the public exchanges.⁴⁹
 - Anthem noted it is focused on addressing **discretionary ED use** to remind frequent users of lower cost alternatives.
- Solutions aimed at chronic care were closely tied to hospital care as a way to help members avoid ED or inpatient utilization associated with poor disease control.

Finding 2: Additional observations related to hospital care that were identified in the interviews include:

- **Post hospital visits** were identified as an area of focus:
 - Kaiser and one other health plan discussed the introduction of home care after a hospital stay in order to provide necessary check-ups, reinforce post-discharge instructions to reduce readmission risk.

⁴⁹ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- A study done at Brigham and Women’s Hospital noted that at home care led to fewer lab tests and provider consultations as well as lower direct healthcare costs (median costs were 67% lower for the acute care episode and 30 days after discharge for at home patients).⁵⁰
- Within hospital care, **end of life care** stood out as a focus area, specifically targeting individuals before hospice is required.
 - Government entities were especially focused on end of life care as population demographics tend to skew older. DHCS, for example, has initiatives related to advanced care planning and palliative care training for primary care providers.
 - These programs were not focused on palliative care, rather trying to prevent it by targeting individuals with multiple conditions before they would need serious end of life care.
- Hospitals were noted as one of the types of providers with the highest participation rate (specifically acute care hospitals)⁵¹ in health information exchanges in California to provide data around admission, discharge, transfers and lab information. However, participation is voluntary and regional or enterprise-based solutions exist across the state. Purchaser interviews highlighted the increasing importance and attention on data interoperability to facilitate more effective care delivery.

Finding 3: Controlling the cost of hospital care was also noted by all purchasers, with different payment options being the greatest key driver to move the needle.

- One employer noted the use of reference-based pricing for hospital care in select areas where price variation is high, while another purchaser is looking at bundled payments.
 - GE rolled out the Maternity Care Select program in 2016 which provides a bundled payment to care for low to moderate-risk mothers from the start of pregnancy until 90 days after birth.
- In addition to payment reforms, one employer is looking at redirecting certain care (e.g., infusions) out of hospitals to lower overall cost.

Purchaser Issues on the Horizon

Many purchasers highlighted their efforts to promote integrated care models and ACOs as a centerpiece of their hospital care strategy.

Other Considerations

The National Alliance of Healthcare Purchasers recently surveyed member organizations on employer perceptions and actions related to health care waste, finding concern in hospital care related areas such as high cost imaging, preoperative care and inpatient monitoring. While

⁵⁰ Levine, D. M., Ouchi, K., Blanchfield, B., Diamond, K., Licurse, A., Pu, C. T., & Schnipper, J. L. (2018). Hospital-level care at home for acutely ill adults: a pilot randomized controlled trial. *Journal of general internal medicine*, 33(5), 729-736.

⁵¹ California Association of Health Information Exchanges. Health Information Exchange (HIE) Landscape: HIE in California. Retrieved from <http://www.ca-hie.org/initiatives/hie-in-ca/>

these areas are not exclusively associated with hospital care, they highlight concerns by some in the purchase of certain outpatient services, many of which are delivered in hospitals.

Synthesis and Takeaways

There are well established hospital data reporting systems, such as the National Healthcare Safety Network of the Centers for Disease Control and Prevention (CDC),⁵² and aggregate safety ratings, such as the Leapfrog Group and California Hospital Compare, that annually report hospital clinical safety measures. Covered California can continue to leverage these sources to measure hospital safety and reduce QHP data reporting burden.

Many of the current measures are appropriately focused on hospital safety but concerns expressed by purchasers in the hospital care strategy area also focused on cost effectiveness and appropriateness.

- Measuring discretionary emergency department use or other areas of waste in health care delivery is increasing as an area of interest and many plans have developed measurement approaches to identify the subset of emergency department where utilization may not be appropriate.
- Redirecting infusions from the hospital to lower cost settings and unnecessary high cost imaging reflect on purchaser concerns about whether the right setting or right care is being delivered.

Collaborating with health plans on selecting measures and methodologies to address the areas above merits consideration.

⁵² Center for Disease Control and Prevention. National Healthcare Safety Network (NHSN). Retrieved from <https://www.cdc.gov/nhsn/index.html>

Chapter 12: **Patient and Consumer Engagement**

Takeaway: All purchasers are focused on improving engagement, mainly through technology and communication, but use varying approaches to reach their populations.

Priority ⁵³			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> Limited measurement used in this space — varies based on definition, some purchasers noted tracking: <ul style="list-style-type: none"> — Encounters — Use of tools/programs — Completion of task (e.g., health risk assessment)

Key Drivers
<ul style="list-style-type: none"> Other: technology and communication

Patient and consumer engagement centered on:

- Variation in defining engagement: All purchasers noted increasing engagement among members was a priority, but there is no standard definition for engagement.
 - Some purchasers are looking at encounters within the system, for example doctor’s visits or other services.
 - Others rely upon utilization metrics of tools or programs such as entering a transparency site, looking up the cost of a service, or completing a health risk assessment to measure if consumers are engaging in their plan.

Actions being taken by purchasers are:

- Most purchasers are looking to **leverage technology to improve engagement** whether it be an app, portal or some other third-party communications vendor. The ultimate goal

⁵³ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

is to **connect to members early on in a personalized way** in order to keep them informed.

- One purchaser is trying to leverage data from electronic health records (EHR) to better understand member issues and engage with them at key points in the care continuum. While this strategy is being used in a limited way, it offers one potential source of standardized data that can be used to help identify and communicate with members.
- Employers are looking at implementing **engagement platforms** for their populations but finding the right messaging can be difficult.

Current Initiatives

Finding 1: While patient engagement was frequently mentioned as a challenge, purchasers define it differently leading to difficulty in identifying strategies that are effective in tackling this issue.

- Some employers are looking at engagement within tools (e.g., cost and quality tools) or programs (e.g., chronic condition programs or disease management programs), which can be a single interaction or prolonged use.
- Other employers are trying to utilize incentives and health risk assessments to get members to engage in the system with varying levels of success. One employer expressed concern that the health risk assessment was being utilized mainly by those that are already healthy.
- One of the government purchasers noted the engagement is measured as members engage with the system - typically called an encounter.

Finding 2: Employers are looking to engagement platforms and other technology to help engage members.

- These platforms are intended to aggregate or integrate point solutions, such as cost or quality tools, to ease use for employees.
- Over 80% of employers believe emerging engagement platforms have the ability to deliver value for things such as aggregation, interoperability, personalization, and navigation services.
- However, less than 40% believe they are capable of meeting these needs right now.⁵⁴

Finding 3: Health plans are also turning to technology to engage members.

- One of the national health plans has built an app for members which provides access to tools and information regarding plans and providers.

⁵⁴ National Business Group on Health. (2019). 2019 Large Employers' Health Care Strategy and Plan Design Survey. Retrieved from <https://www.businessgrouphealth.org/benchmarking/survey-reports/surveys-of-large-employers/>

- Kaiser has also built an online portal that is used to on-board members and continues to provide information throughout the year; the online portal currently has a 70% utilization rate among members.
 - Health Net noted the success of this platform in getting members to engage early with the technology which can be a good method to push key information (e.g., preventive exam reminders).

Finding 4: Although there are concerns around engagement, purchasers — especially employers — are not considering it as part of other strategies.

- Only 11% of employers indicated consumer experience as #1 consideration when selecting a health plan.⁵⁵
- Value-based plan design is one way that purchasers (mostly employers) are channeling patients to more effective care. 42% of large employers are considering a value-based plan design and 18% have already implemented one.⁵⁶
- Few employers offer incentives for participation in disease management programs (less than 25%).⁵⁷

Finding 5: Health literacy and understanding the system was voiced by some purchasers as a potential issue for poor engagement.

- One of the coalitions noted that populations vary within employers and health plans, so it can be difficult to find the right strategy to reach all members.
 - Different populations can present engagement challenges; for example, employers are struggling with engaging spouses as they don't have direct access to those individuals.
- Another purchaser highlighted that members don't engage with the healthcare system until they need it, as a result programs that help members navigate care when they need it instead of providing cost estimator tools can be more effective.
- The use of consumer driven health plans has not driven patient engagement within the system.
- Common engagement tools include cost transparency tools — according to PwC's Touchstone survey, 49% of employers are offering these tools through the health plan while 12% are offering through a carve-out vendor.⁵⁸

⁵⁵ PricewaterhouseCoopers. (2018). Health and Well-being Touchstone Survey. Retrieved from <http://www.pwc.com/us/touchstone2018>

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

- While many employers offer these tools not all employees are utilizing them when care is needed, as a result many purchasers, especially employers, are moving toward advocacy or care coordination.
- There are certain metrics that help identify if a tool would be used by employees such as net promoter score and user interface (e.g., navigation and mobile vs. web), but effectiveness of these tools is not consistently being measured among employers.

Purchaser Issues on the Horizon

- Employers are looking strongly at engagement platforms to help increase employee participation in care programs.
- Health plans are turning to technology to support engagement.

Other Considerations

- While health plans are utilizing engagement tools, integrated delivery systems are incorporating efforts to digitally connect with patients too. Understanding engagement models at the health plan and provider level is important to consider.
- While some engagement tools suggest adding value, such as cost and quality tools, patients don't always know how to use or when to engage with them — providing support for patients when they need care (or any information) may be a better way to engage all consumers.

Synthesis and Takeaways

Purchasers do not have a standardized definition of engagement but agree that it is a high priority and are using various strategies to measure and increase patient and consumer engagement, with the ultimate goal being to connect to members early on in a personalized way in order to keep them informed. Different strategies need to be considered depending on the population due to differences in available technology, health literacy, and other factors, and most often use incentive programs to encourage participation.

Covered California has waived the reporting requirements for the measures under this strategy in order to focus on other priorities. External comparative data for the measures are not readily available. Increased patient and consumer engagement is desirable, but the definitions and measurement are not standardized and the technologies used to drive and track these issues are under-developed.

Chapter 13: **Population-based & Community Health Promotion Beyond Enrolled Population**

Takeaway: Purchasers are mindful of promoting community health, but interviews and research indicate variation in efforts and initiatives pursued and purchasers generally ranked this area as lower in priority compared to others.

Priority ⁵⁹			
Employers	Low	Medium	High
Plans	Low	Medium	High
Public	Low	Medium	High

Measures Used
<ul style="list-style-type: none"> Measurement varies depending upon the initiatives in focus. Common examples of measurement include dollar investment, geographies with active initiatives and, where specific services are being delivered, utilization or outcomes being tracked.

Key Drivers
<ul style="list-style-type: none"> Due to low priority/focus of purchasers at this time, no drivers identified Common areas of focus include initiatives related to opioid use and promoting health screenings for at-risk populations

Purchaser concerns around community health promotion are:

- Identifying community providers:** All purchasers recognized the advantage of including community based providers (e.g., community health workers, social services providers) within networks to increase access and better meet the health needs of individuals. However, purchasers are challenged in identifying community providers and partnering with them in communities, as well as identifying communities with a large population of their members.
- Health plans identified a variety of areas of focus related to community health promotion, addressing issues such as maternal and child health, chronic disease, substance use disorders (with opioid use being a common area of focus).

⁵⁹ After interviews were completed, PwC grouped purchasers into the following three categories: employer, plans, or public purchasers. To highlight the level of prioritization, PwC then performed a qualitative assessment of low, medium or high using purchaser interview responses and other information provided that was related to the topics in the *Covered California Quality Care and Delivery Reform Framework*.

Actions being taken by purchasers are:

- Varied with some partnering with local health systems or community organizations on topics and others introducing resources such as digital tools/applications to promote better decision-making by consumers or to better enable providers in their delivery of care.

Current Initiatives

Finding 1: Government purchasers and regional health plans are looking to identify the communities of their members and partner with providers.

- Purchasers serving Medi-Cal members are currently ahead of most purchasers in trying to work with providers within specific communities to make sure individuals have access to care where they are. One of these purchasers noted there were various languages and differences among communities that could pose barriers to health; leveraging providers within these communities can limit these issues.
- Similarly, Magellan, a specialty provider, is working with community health centers to help deliver better mental and behavioral health services.

Finding 2: Employer efforts are generally tied to broader corporate responsibility initiatives which may include community health issues.

- During the interviews, employers suggested addressing population and community-based health within their employee base, but no major community health initiatives were tied to their overall employee health care strategy.

Finding 3: Examples of efforts of national health plans include initiatives such as:

- Anthem has developed tool kits to support community-based organizations on issues and strategies related to opioid abuse. In addition, it offers members and providers access to digital tools related to cancer care. It also has programs targeting maternal and child health, supporting healthy behaviors and rewarding smoking cessation.
- CVS Health / Aetna similarly has initiatives focused on opioid use, is leveraging its retail footprint to promote wellness screenings for at-risk or underserved populations, partnering with community organizations to promote these screenings.
- Cigna has promoted colorectal cancer screenings among African-Americans by working with Maryland Center for Health Equity at the University of Maryland to educate barbers and beauty salons.

Purchaser Issues on the Horizon

Community health initiatives clearly vary and health plans are working with a variety of stakeholders and engaging in efforts to leverage digital technology to support and promote health beyond their enrolled populations.

Other Considerations

Reporting on initiatives is variable due to differences in focus, partnerships and design. Common measures, however, include costs, population/geography targeted and, where services are delivered, utilization or participation levels.

Synthesis and Takeaways

Health plans, particularly those serving lower income populations, are increasing involvement in community and population health promotion activities. Medicaid programs, for example, are typically requiring managed care plans to describe how they will address social determinants of health in their population. Employers, on the other hand, are not generally focused on community health beyond their own employees and dependents.

The greatest potential impact could be achieved if health plans and other purchaser align their community efforts with programs to improve particular health issues and disparities identified in their populations. Health plans appear to be commonly focused on areas such as opioid use and promoting health screenings, for example. The effectiveness of these activities could be evaluated over time by analyzing trends in reported population health and disparity measures.

As Covered California seeks more insight on QHP initiatives, visual aids showing programs being deployed by geography, type of initiative and/or demographic group may further enhance understanding of how these efforts align with community health needs identified in the state.