Aligning Interests

Opportunities for Purchasers and Physicians to Accelerate Care Delivery, Innovation & Value

Purchaser and Physician Roundtables: Purpose, Goals, Objectives

National Alliance of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES
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Table of Contents

Executive Summary

To bring employers and physicians together to better define value in care delivery, the National Alliance of Healthcare Purchaser Coalitions (National Alliance) and the Council of Accountable Physician Practices (CAPP) sponsored strategic discussions in 2020 between employers and physician groups. The discussions identified opportunities to support improvements in how healthcare is delivered and explored possibilities for accelerating promising alternative payment models to enhance accountability for cost and quality. These sessions were a second round in a series of five 2019 employer roundtables, which revealed employer perceptions of the healthcare that employees and their families receive. In addition, these sessions identified promising strategies to better align the mutual interests of regional employers, physician group practices, and health systems. View 2019 key findings.

The 2020 strategic discussions brought coalitions, employer purchasers, and physician leaders together to discuss these key topic areas:

- Behavioral health integration with primary care
- Strategies for reducing low-value care and increasing high-value care
- Metrics for measuring performance in alternative payment models

As the COVID-19 crisis unfolded and dramatic changes occurred in both the healthcare delivery system and the workplace, its impact was highlighted in each of the discussions. In addition, the discussions focused both on the increased use of telehealth and on the total health needs of vulnerable and at-risk employees and families.

Shared Goals

- Identify aligned interests between employers and physician leaders.
- Understand the constraints and barriers each group faces.
- Explore employer needs and perspectives and how employers can best engage with physician groups.
- Discuss opportunities to contract, pay and evaluate performance differently.
- Describe and demonstrate care models that deliver better value and patient-centric care.

Shared Opportunities

- Cultivate opportunities for employers and physician groups to engage in strategic, thoughtful discussions at both regional and national levels to actively address challenges and pursue opportunities to improve overall patient outcomes.
- Understand how physician groups can best approach employers so they are not seen as vendors, but as valued partners in supporting health improvements.
- Assess current benefit design to enhance its ability to address overall workforce health and wellbeing goals, as well as disparities and inequities, and to enhance access to high-quality services and integrated behavioral health.
- Reconfigure care models to incorporate telehealth and collaborative care, combined with value-based payment.
- Collaborate in adopting alternative payment models that minimize the use of fee-for-service and enable provider groups to be more accountable for cost and quality.
- Explore joint research opportunities to inform messaging and expectations for health plan vendors, consultants and other intermediaries, and employees.

Acknowledgments

The National Alliance and CAPP thank the Pacific Business Group on Health, Midwest Business Group on Health, and Dallas Fort-Worth Business Group on Health and their leaders, staff and member employers for planning and participating in these discussions during a time of great stress and competing priorities.

We are equally grateful to the physician leaders who participated during an extremely demanding time for all healthcare workers. We appreciate their willingness to share real-time lessons and observations about opportunities to dramatically change care delivery, especially in light of shifting priorities brought about by the COVID-19 emergency. We would also like to thank Ceci Connolly, president and CEO, Alliance of Community Health Plans, and Marilyn Werber-Serafini, director of the Health Project, Bipartisan Policy Center, who moderated these sessions. Their facilitation helped build a thoughtful dialogue and supported engagement with the participating employers and physicians.

Roundtable 1: Behavioral Health Integration

Current State and Existing Barriers

CURRENT STATE	EXISTING BARRIERS
Employees have high trust in primary care physicians.	▶ Physicians have time and workflow management challenges and typically are not compensated for time/resources needed to assist patients with mental healthcare needs (except for Medicaid patients). ▶ Many physicians do not use available screening tools due to low confidence in their ability to assess, refer and follow up on care for patients needing mental healthcare services.
The Collaborative Care Model is an accepted, evidence-based model that includes mental health (Case Study: The University of Washington Model).	▶ Implementation of Collaborative Care is inconsistent across physician practices. ▶ Alternative payment models have not been developed/ adopted to encourage practices to develop capacity.
Behavioral health needs are under-identified, and stigma is an ongoing challenge, particularly among low-income workforce and families.	▶ Individuals experiencing acute, high or toxic stress often face the most challenges in seeking help. ▶ Services don't consistently or effectively address disparities across populations.
Care is fragmented.	▶ Mental and behavioral health carve-outs and employee assistance programs are not routinely integrated with other care models.
COVID-19 accelerated the need for telehealth adoption, especially for mental and behavioral health services.	▶ Telehealth vendors do not necessarily have access to behavioral health networks. ▶ Participation by in-network mental health professionals is low. ▶ State licensure and practice regulations vary.
COVID-19 prompted waivers and suspension of rules that inhibit telehealth across state lines, use of smartphones, and payment eligibility.	▶ Reverting to many pre-COVID-19 rules could inhibit wide adoption.
Other well-meaning privacy rules limit information flow across clinicians.	▶ Some rules can only be changed with federal legislation.
Evidence-based interventions and provider quality are unclear.	▶ Payment rules can limit treatment innovation and measurement. ▶ Payment type (i.e., fee-for-service) can encourage overuse/misuse.
Compliance with mental health parity in reference to access and payment.	▶ Mental health parity is stymied by challenges (e.g., authorization requirements, visit limitations, cost-sharing differentials, and payment).

Over the last few years, some health systems, providers and large employers have integrated behavioral health into primary care, although it is not a consistent current practice. With the pandemic, there is an increasing need for integration to better treat those with serious conditions. While employers have been seeking better and more timely access to behavioral healthcare providers, primary care providers have been reluctant to take on the responsibility for behavioral health screenings, which are time-consuming and for which many have not been adequately trained. Nevertheless, participating roundtable physicians are motivated to offer improved care and see the need to move forward with integration measures.

Some employers are exploring integrated behavioral health models with a single access point for mental health services. They see the value in consolidating diverse services to treat employees/patients for any situation and are open to working with provider groups to eliminate the need for multiple vendors, each providing different types of services. Today, benefits managers are challenged by managing these relationships.

There was general agreement among employers and physicians that telehealth has been a major boost to behavioral health access. A majority of behavioral health providers now provide services remotely, although there is concern that small therapy practices and sole mental health practitioners may not have the essential supporting technology or infrastructure.

Promising Practices Discussed, Strategies to Consider

Employer and physician leaders who participated acknowledged the burden of pre-pandemic undiagnosed and untreated behavioral health conditions, which have deteriorated even further during the pandemic. Work-from-home challenges, home schooling, job loss and economic uncertainty, fear of illness, and the loss of loved ones have exacerbated the need for mental health services and fully exposed long-standing access and treatment challenges. Several participants identified the University of Washington Collaborative Care model because it is evidence-based and feasible to implement. Other key points include:

- There is a need to implement/enhance incentives for integrating behavioral health with alternative payment models:
  - Prospective payment supports infrastructure investment.
  - Pay for a defined set of services that permit in-person and virtual support, then measure and monitor outcomes.
  - Small practices need the support of an accountable care organization (ACO) entity to share infrastructure and tools.
- Ensure mental health services are present in OB-GYN, pediatrics, and chronic care practices.
- Employers are testing employee assitance programs/mental health coordination with the medical side of benefits, leveraging telehealth consultations (this may require raising rates to improve in-network participation):
  - Physician groups prefer to use telehealth to strengthen local care, instead of using national platforms, which may lead to care fragmentation.
  - To combat stigma and support engagement, employers and clinicians can use strategic communications and education.
  - Employers can take steps to encourage primary care physician relationships, reviewing current networks to ensure easy access to high-quality physicians and to care teams that deliver comprehensive healthcare services.
  - Opportunities exist for employers and physician groups to work with health plans to make sure behavioral health is integrated into primary care, thus reducing the costs borne by employees and improving their access to care.

Roundtable 2: Strategies for Reducing Low-value Care, Increasing High-value Care

Current State and Existing Barriers

CURRENT STATE	EXISTING BARRIERS
Preventable, manageable, high-cost chronic conditions are prevalent in many workforces and communities.	▶ Employee awareness of available programs is low. ▶ Employees exhibit low uptake of effective interventions for behavior change and self-management; environments and communities lack healthy food, safe streets, etc.
Some providers deliver treatments with weak evidence and high costs.	▶ Providers game in-network, out-of-network billing. ▶ Benefit design may allow over-utilization or utilization of low-quality providers.
Employers lack tools and metrics to evaluate providers on whether the care they provide is necessary and effective.	▶ Employers are challenged by too many industry definitions of quality; in general, carriers don't consistently address low-value care.
Telehealth, which has been an important alternative to in-person care during COVID-19, lacks standards for clinical appropriateness.	▶ Fee-for-service payment can lead to over-utilization/ misuse of telehealth. ▶ There is a risk of paying twice if in-person care is not avoided.
Value proposition needs to be better defined to support adoption; old fee-for-service financial models need to be addressed.	▶ Financial models don't adequately support physicians. ▶ A phased approach is needed to address issues both now and over time.
New primary care practices are emerging; employers are frustrated with uncoordinated services; some individuals seek high-value, high-quality care, while others can't afford care.	▶ Services are layered on top of services, instead of integrated, one-stop care. ▶ Too many vendors and uncoordinated services abound. ▶ Some can pay for concierge, but others can't afford it. ▶ Appropriately segmenting risk presents challenges.

Employers and physicians agree that low-value care or inappropriate care is a direct result of America's fragmented, uncoordinated fee-for-service system. Low-value care includes unnecessary care, redundant tests, defensive medicine, and care not supported by evidence-based research. In the roundtable, employers highlighted their concerns about in-network practices referring to out-of-network services. This has resulted in significant "balance billing" to patients, many of whom were not aware they had been referred to out-of-network services. Although employers need to address this issue, there have been a few medical groups that have switched to a pay-for-value model and have stopped this referral pattern because the cost now is transferred to the practice.

Employers also noted they must be vigilant about fraud and abuse. Traditional benefit design has yet to adequately address this, so employers need to push for better accountability from carriers. Also noted was a lack of tools and metrics to effectively evaluate providers on whether care is necessary.

Employers and providers agreed that developing clinical pathways for specific conditions can be a start

to supporting improvements in the standard of care and reducing variation, as well as eliminating waste and low-value care. They also agreed that investing in high-value care must start with a strong primary care foundation, citing opportunities that exist for building primary care team-based models that use technology to link them and support better patient outcomes and community wellbeing. Technology-based decision-support aids provided at the point of care can also assist clinicians in avoiding low-value care.

In addition, there are opportunities for employers to be innovative with how care is delivered to the workforce. One such way is through the use of alternative care sites, such as homes, which can ensure more consistent chronic-care monitoring and management. Especially in the pandemic environment, a patient should not have to enter an exam room for the provider to be paid. Another approach is for employers to explore the impact of paying physicians prospectively. Physician leaders indicated this would better ensure provision of the right care, at the right time, in the right setting. Once such processes are implemented, common agreed-upon national metrics could support critical measurement of the impact of such improvements and better guide employer and provider decision-making.

Promising Practices Discussed, Strategies to Consider

Employers and physician leaders are already seeing a move to "early-stage" value-based contracting with a variety of medical groups and systems. These range from larger primary care practices that offer comprehensive and reliable care to health systems that include specialty and facility care. Employers also expressed a willingness to contract with physician groups that integrate services and create better access (enabling them to reduce the number of contracted niche vendors). In turn, physicians are asking employers to consider benefit design changes such as differential co-pays and premiums that encourage employees to choose a primary care physician from a network of high-value in-network providers.

Employers and physicians agreed value-based payment models should:

- Support chronic-disease prevention and management strategies that don't require regular in-person visits.
- Make use of multi-channel technology, including texting, audio, video, and smartphone tools.
- Make use of a full team to support dietary/lifestyle changes, monitoring and outreach, as well as screening for depression and substance use disorder.

It was recommended that to build a high-value network, physician groups should demonstrate:

- Referral to high-value providers and have them in group/ACO networks.
- Use of teams, registries and data to identify patients at risk for chronic disease and those at risk of worsening chronic disease.
- Use of data for decision support and to drive down low-value testing and prescribing.
- Development and adherence to clinical pathways for complex conditions such as cancer and musculoskeletal conditions.
- Using patient survey results to improve the patient experience of care.

Roundtable 3: Provider and Health System Performance Metrics

Current State and Existing Barriers

CURRENT STATE	EXISTING BARRIERS
Complex carrier contracts contain confusing definitions of terms and lack of accountability and monitoring of performance metrics, increasing the administrative burden for providers.	▶ Employers are over reliant on intermediaries to address contract issues. ▶ Carriers and PBMs that focus on rebates as a cost-management strategy present challenges. ▶ Some perceived incentives are misaligned and do not deliver true value.
Some "early adopter" purchasers are generally pleased with the outcomes of advanced primary care (APM) and ACO arrangements; benefit design can support lower costs.	▶ Having too many different payers is burdensome to physicians. ▶ Opportunities have increased for misaligned incentives. ▶ Smaller employers cannot take advantage of ACOs.
Direct contracting between employers and physicians has increased.	▶ Employer needs are not being met through carrier offerings (many have more robust performance metrics than what plans use). ▶ Carriers use of mainly HEDIS measures with ACOs impacts effective performance measurement.
Employers are frustrated by lack of data access, especially actionable data.	▶ Expensive and opaque "benchmarking" vendors. ▶ RAND studies reveal the need for purchasers to have access to their data.
Lack of patient-centered measures and patient-reported outcomes measures make it hard to distinguish quality outcomes of APMs.	▶ Carriers and providers rely heavily on claims-based measures and show unwillingness to invest in infrastructure to report performance metrics that incorporate clinical variables or functional assessments, whether recorded in electronic medical records and/or self-reported by patients.
Purchasers lack bandwidth to successfully implement bundles; some that do are starting with surgical bundles using specialized vendors.	▶ Slow pace of interoperability is still getting in the way of value-based care.
There is still inadequate pushback by employers to demand access to high-quality physicians and services.	▶ Not enough voices are asking carriers to build and maintain high-value networks, prospective payments, or shared savings models.

As the pandemic continues, the problems of the fee-for-service system have been on full display, revealing a fragmented and disjointed healthcare system. The ongoing struggle is how best to align expectations to address this growing threat to health and wellbeing. Reliant on visit revenues, many clinical practices (especially the smaller ones) are suffering major financial losses. The Medical Group Management Association found that COVID-19 has had a negative financial effect on 97% of the 724 medical practices it surveyed.

In the employer-physician dialogue, there was general agreement that the currently dominant fee-for-service

payment model does not work to improve care, nor is it effective at constraining cost. In addition, participants agreed it is time for the entire healthcare system to move to a pay-for-value system. There are, however, concerns that some providers may not be equipped to make this change efficiently or quickly. A move to a technology-based infrastructure may support this move. Another strategy would be independent physicians, as well as group practices, moving toward risk-based compensation models.

The physicians and clinical leaders say the ACO journey has been difficult. They expressed a need for better transparency and greater alignment in payments to support downside risk. Many providers have been unwilling to switch to an integrated approach because they don't see the opportunity for any kind of payment parity, much less incentivized payment. Further, since many physician groups lack control over rising hospital contracting rates, they see less opportunity for gain sharing. Until there are more providers experienced in global payment, interim options — focused pay-for-value programs such as direct contracting, bundled payments, and Centers of Excellence — are more promising routes for large employers.

Although some physician groups and health systems have been pioneers in using technology for clinical integration and have assisted others, including rural practices, many still do not share a common, connected electronic medical record, which physicians say is a "major barrier to delivering value."

There is concern about making changes in the aftermath of COVID-19, as it will take some time for businesses to get back to some sort of "new normal." Although some employers are exploring value-based contracting, there are issues such as downside risk, which may not be acceptable at this time. However, self-insured employers — already at full risk for costs — may find that prepayment or capitation, where they pay for costs up front, is a hard sell to the C-suite.

Participating clinical leaders say that when the country comes out on the other side of the pandemic, provider groups may be ready to embrace such arrangements, which could deliver value in ways they cannot yet comprehend. Value-based payment is the catalyst for improvement and innovation and is the solution to many problems employers face: increasing costs, "surprise" medical bills, questions about the value of the care, fragmentation of services and the attendant waste, and a disjointed and dissatisfying patient experience.

Promising Practices Discussed, Strategies to Consider

- Smaller employers and those just getting started with value-based contracting can use national vendors, that offer scale and standardization in products like surgical bundles. This approach can also be used to build Centers of Excellence.
- Employers must often intervene with carriers to collaborate on the design of high-value networks that share data with employers:
  - Examine whose interest is served by contract terms that limit data sharing.
  - Explore alternative sources of actionable data for employers and clinicians.
- Stated quality-measurement efforts at the physician group level can be used to educate employees and support better decision-making.
- Use cases for how telehealth can be scaled with alternative payment models:
  - Behavioral health
  - Primary care consults with specialists
  - Partnerships with safety-net providers in rural, urban areas
  - Care for patients located out of the service area (students, leisure and business travelers)
- Return-to-work metrics help employers evaluate value-based care models.
- Unit costs for a procedure or visit may be higher, but if utilization downstream is avoided, return to work is faster, and unnecessary procedures are avoided,

the savings or avoided costs can offset higher initial costs (e.g., travel costs associated with using Centers of Excellence).

- Convene stakeholders (e.g., employers, providers, healthcare finance professionals) to discuss specific models, such as Centers of Excellence, behavioral health integration, and accountable care organizations, with the goal of exploring alignment and providing feedback to plans and consultants.
- Explore opportunities for local employer coalitions to aggregate willing employers and streamline administrative costs for value-based payment models.

Potential Next Steps

Coalitions are well positioned to help employers amplify their voices and identify ways they can work in concert to address key healthcare issues. The roundtables revealed areas of aligned interests and priorities. The shared opportunities identified throughout this paper are summarized here:

- Employers and physician groups need to cultivate opportunities to engage in strategic and thoughtful discussions, at the regional and national levels to actively address challenges and pursue opportunities to improve overall patient outcomes.
- There is a need to determine how physician groups can best approach employers, so they are not seen as vendors, but as valued, trusted partners in supporting health improvement.
- Employers need to assess current benefit designs to address overall workforce health and wellbeing goals, as well as disparities and inequities, and to enhance access to high-quality services and integrated behavioral health.
- Physicians and employers can work together to re-configure care models to incorporate telehealth, Collaborative Care, and value-based payment.
- Employers and physician groups can explore joint research opportunities that inform messaging and expectations for:
  - Payers
  - Other intermediaries
  - Employees

An important next step is to examine the patient experience and understand patient preferences in order to provide a connected, coordinated healthcare experience. This could help ensure that employees are able to successfully navigate the healthcare system and make informed decisions.

Although many patients rely on physician advice when making healthcare choices, others rely on the experiences of family and friends. Because some employees are reluctant to change providers and are not swayed by quality messages or scores, it is up to employers to educate them about the meaning and value of high-quality care.

Physicians can partner with employers to align key messages that help patients overcome their resistance to engaging in their health to help them feel prepared and confident when seeing a new provider and to highlight the value of integrated care.

Gaining access to quality metrics has been a challenge for employers. There is an opportunity for employers and providers to partner and identify common measures that support value reporting.

Employers and physicians can focus communication and outreach efforts on select populations that need additional support, such as young adults and low-income workers.

Most important is the need for a common set of quality measures. Employers and physicians agree that the adoption of common quality metrics would enable providers to deliver better value and performance. There are examples of robust quality metrics in states like Minnesota, but national standards are needed. Obtaining quality metrics from health plans — especially PPOs —has been a challenge for employers. Health plans all define quality differently, and some base quality metrics on their own criteria, leading to even greater employer frustration. This provides an important opportunity for providers to work together with employers to identify common measures that support value reporting. Efforts should be coordinated with national organizations like the National Committee for Quality Assurance (NCQA), which provides accreditation to health plans. Employers need to insist that accreditation be in place as they contract with carriers.

US employers are major purchasers of commercial health insurance, providing coverage for more than 180 million people. Despite their efforts to demand greater value and responsiveness from health plans and healthcare services, costs continue to outpace general inflation, and wasteful and sometimes unsafe low-value and low-quality providers continue. This has compromised the consistent delivery of high-value patient services.

At the same time, healthcare providers are organizing into larger systems of care and physician group practices are growing. These systems and delivery models have the potential to deliver more seamless, coordinated care. Using data, health information technology, and multidisciplinary teams, integrated systems can minimize waste, lower unwarranted variation in care, adopt evidence-based practices and pathways, and provide a more coordinated and personalized care experience for patients. COVID-19 has presented a number of opportunities for providers and employers to engage in thoughtful, strategic dialogue that can help build a healthcare system for the future.

Recommendations for Employers

- Explore integrated behavioral health models that have a single access point for mental health services, consolidating diverse services to holistically treat patients.
- Ease delivery of care by working directly with provider groups to eliminate the need for several vendors.
- Review current networks to ensure that high-quality physicians are promoted and behavioral health is integrated.
- Address waste, fraud and abuse by requiring carriers to provide an action plan to ensure accountability.
- Request effective metrics that evaluate provider performance.
- Work directly with providers to develop clinical pathways for specific conditions to support

improvements in the standard of care, reduced variation, and elimination of waste and low-value care.

- Collaborate in adopting alternative payment models that minimize the use of fee-for-service and make provider groups more accountable for cost and quality.
- Explore value-based payment models that support chronic disease prevention, encourage use of multi-channel technology, and utilize a collaborative care team to support comprehensive patient care, including monitoring, outreach, screening for depression and substance use disorder, and monitoring return-to-work metrics.
- Consider national vendors with scale and standardization in products like surgical bundles and Centers of Excellence, especially when looking at value-based contracting.
- Insist on being at the table during contract discussions with carriers — alongside consultants and other intermediaries — paying special attention to contract terms, especially those that limit data-sharing and do not provide access to actionable data
- Insist on collaboration with carriers when designing high-value networks.
- Determine how telehealth can be scaled with alternative payment models for behavioral health, primary care consultations with specialists, partnerships with safety-net providers in rural and urban areas, and care for patients living beyond in-network service areas.
- Convene meetings with other healthcare stakeholders, including providers, healthcare finance professionals, and others, on specific models, such as Centers of Excellence, Behavioral Health Integration and ACO, with the goal of exploring alignment and providing feedback to plans and consultants.
- Explore opportunities to participate in local employer coalition events or join a coalition to engage with and learn from other employers.
- Assess current benefit-design planning to address overall workforce health and wellbeing goals, as well as disparities and inequities; ensure that benefit design encourages access to high-quality services and integrated behavioral health.
- Educate the workforce on the value of high-quality, integrated care, aligning key messages with those from providers.
- Set expectations for employees, helping them overcome their resistance to engaging in their own health and highlighting the value of integrated care.
- Focus efforts on reaching populations that need additional support, such as young adults and low-income workers.
- Work with regional coalitions to cultivate opportunities with local physician groups to engage in strategic, thoughtful discussions; actively address challenges; and pursue opportunities that improve overall patient outcomes.
- Partner with physician groups to identify common measures that support value reporting. Efforts can and should be coordinated with national organizations like the National Committee for Quality Assurance (NCQA), which accredits health plans.

Resources

- American Psychiatric Association Collaborative Care Model
- University of Washington Collaborative Care Model
- Collaborative Care in the time of COVID-19
- Achieving Value Through Advanced Primary Care Report
- Achieving Value Through Advanced Primary Care Infographic
- Hospital Payment Strategies: Setting Price and Quality Expectations
- High-value Preventive Care During COVID-19: Special Focus on Health Screenings, Primary Care, Mental Health Care, Chronic Conditions
- High-value Preventive Care During COVID-19: Special Focus on Preventive Care and Immunizations
- 2019 CAPP National Alliance Report (http://accountablecaredoctors.org/wp-content/uploads/2020/07/capp_bth_employer-physician-collabs.pdf)
- Action Brief: What Makes Primary Care Advanced Primary Care (APC)
- Action Brief: Integrating Mental Health Services and Primary Care

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Driving Innovation, Health and Value

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