

The Puget Sound Health Alliance (the Alliance) is the one place in this region where all stakeholders – employers, unions, doctors, hospitals, health plans, patients and others – have come together to work on constructive ways to improve the value of local health care. A centerpiece of that collaborative work is the creation and expansion of the *Community Checkup*, a report to the public about health care quality and value.

This report is the first time that health plan results are included in the *Community Checkup*. Alliance participants, including many large purchasers (i.e., public and private employers and union trusts), are committed to promoting the use of national, evidence-based standards and greater transparency for *all* aspects of the health care system. The *Community Checkup* report uses available data sources and draws from national standards, resulting in different approaches to evaluating the services provided through medical groups, hospitals, and health plans. Data related to medical group or ambulatory care is drawn from the Alliance’s large multi-payer database of claims data supplied by health plans and self-insured purchasers. Hospital-related data is drawn from state and national sources such as the federal Department of Health and Human Services “Hospital Compare” reporting process. For measuring health plan activities, this report is based on scores from the national eValue8™ tool owned and maintained by the National Business Coalition on Health (NBCH).

The Alliance, on behalf of its members, worked with NBCH to conduct a rigorous evaluation of health plans in Washington state using the eValue8™ tool, first in 2008 and then again in 2009. By sponsoring eValue8™ in the Puget Sound region, Alliance participants have these shared objectives:

1. Generate consistency in health plan assessment that enables transparency of health plan performance and permits comparison within and across markets over time, including national benchmarks and best practices;
2. Stimulate improved performance from health plans, with a particular focus on information, systems and tools within the control of the plan that can be used to encourage and support improved performance from providers and delivery systems, as well as promote consumer behavior for wellness and informed decision-making;
3. Enable purchasers and plans to work collaboratively to structure programs to reward value; and
4. Inform purchasers’ procurement decisions about health insurance for their employees and dependents.

Thus far, six health plans have participated in the eValue8™ process in this region: three national PPO plans, two regional PPO plans and one regional HMO plan. These health plans committed to participation in the process, including completing the extensive eValue8™ Request for Information, which required a significant time and resource commitment. In 2008 and again in 2009, ten purchasers sponsored the eValue8™ process in

this region. These 16 organizations each provided funding to the Alliance to cover a portion of the cost of the eValue8™ process, which was also supported financially by two generous grants from Merck, Inc.

Laying the Foundation for Reporting Over Time

The Alliance has communicated to each of the six health plans that took part in the eValue8™ process in this region in 2008 and 2009 that participating purchasers and others hope that each health plan will continue to participate in eValue8™ in future years. With ongoing participation, health plans can use the tool to clearly demonstrate to employers and to local consumers how the health plan's actions and programs are helping to promote health and provide value in the Puget Sound region. Each health plan will be able to show their commitment to public accountability and transparency regarding their continuous improvement in key areas, as measured by a process based on evidence and national standards that enables the community to compare across health plans in this market and with other health plans nationally. This kind of health plan accountability and transparency is important to purchasers and individuals throughout the region.

This is the first *Community Checkup* report on health plan performance based on results calculated by the eValue8™ program, which the Alliance believes to be the best approach currently and consistently available to measure performance across all health plans that choose to participate in eValue8™. Given the complexity of health care and health plan products and programs, there is no "perfect" approach to measuring and reporting on the quality, cost-effectiveness and value provided by health plans. We recognize that what is measured may not equate to the actual experience members have with their health plan. Fortunately, the willingness of health plans to participate in this project is a strong first step in the journey toward creating an evidence-based comparison of health plan activities, based upon national standards and accreditation processes, that gets useful information to health plans, purchasers and the public. The continued evolution of the *Community Checkup* report reflects a shared commitment among health plans, employers, union trusts, doctors, hospitals, patients and others to improve health care measurement and public reporting over time.

About the eValue8™ Measures

eValue8™ asks health plans to submit online annual standardized reports, along with extensive documentation, that describe their performance in a number of clinical and administrative areas. The information is then assessed and scores tabulated so purchasers can compare the health plans against each other as well as to national benchmarks. The areas covered by eValue8™ include:

1. **Plan Profile** – health plans are asked about: national accreditation status and participation in quality reporting; design of benefit package offerings; flexible reporting capabilities that reveal opportunities for purchaser plan design and improved health management; proactive management of provider network and contracts; use and promotion of data inter-operability and electronic exchange of health information in a collaborative manner; and activities to address health equity and disparities.

2. **Consumer Engagement** – health plans are asked about: electronic provider directories available to members that include quality and patient experience information; availability of performance information about hospitals and other facilities; encouraging member access to personal health records; information and tools to help members understand the benefits and risks of treatment alternatives as well as the costs involved; fielding the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey and reporting those results publicly.
3. **Provider Measurement** – health plans are asked about: partnering with other health plans in the community to measure and improve physician and hospital performance; use of tools to identify members with potential gaps in care; differentiation among primary care physicians, specialty care physicians, and facilities using clinical process and clinical outcome measures; evaluation of patient experience, utilization, efficiency and use of health information technology; and, use of incentives, benefits design and information to promote high performing providers and facilities.
4. **Pharmaceutical Management** – health plans are asked about: promotion and use of generic drugs; monitoring and influencing the cost-effective use of pharmaceuticals; the e-prescribing capabilities of providers in the health plan’s contracted network; programs to address cost and appropriate utilization of specialty pharmaceuticals; Healthcare Effectiveness Data and Information Set (HEDIS) reporting and performance; use information under health plan's control to influence patient safety and encourage members to stay on prescribed medications.
5. **Prevention and Health Promotion** – health plans are asked about: partnering with employers on worksite health promotion and education about the risk factors associated with chronic diseases; providing and promoting the use of a health risk assessment (HRA) for members; cancer screening programs; child, adolescent and adult immunizations with emphasis on member-specific interventions; programming to address the prevention and treatment of tobacco use and obesity; promoting pre-conception counseling and tracking of high-risk pregnancies and interventions.
6. **Chronic Disease Management** – health plans are asked about: disease management programs that facilitate the coordination of care that may involve more than one health condition, depression, alcohol and tobacco screening, and prescription drugs; use of interventions involving direct contact with members to address their specific needs, including staying on prescribed medication; monitoring clinical indicators with the goal of providing actionable clinical data to doctors and other practitioners; proactively engaging providers in the health plan’s disease management program; HEDIS reporting and the monitoring of non-HEDIS indicators including absenteeism.
7. **Behavioral Health** – health plans are asked about: whether they offer coverage for behavioral health in an accredited program to all of their members; identification and tracking of members who require treatment for alcohol use and/or depression; providing and monitoring the use of screening tools for alcohol use and depression; interventions with members in areas such as staying on prescribed medications; identification and treatment of members with multiple behavioral health and medical

conditions; use of clinical guidelines and patient-specific reports for depression and alcohol overuse; HEDIS reporting and monitoring of non-HEDIS indicators including absenteeism.

Using the eValue8™ Process in the Puget Sound Region

2008

During the first year of involvement with eValue8™, in 2008, the Alliance shared results privately with each participating health plan and the ten sponsoring purchasers. During site visits with each health plan, the purchasers reviewed the eValue8™ process and results and discussed the purchasers' highest priority expectations, which were:

1. **Transparency and Collaboration.** Specifically, increase community-wide availability and use of information to motivate improvement in health system performance, and enhance plan provider directories.
2. **Focus to Continually Improve Quality.** Specifically, engage in HEDIS reporting, using information available to the plans to help promote and improve prevention and chronic disease management, and expand focus on risk reduction, obesity and tobacco cessation.
3. **Design Benefits and Reimbursement to Promote Value.** Specifically, address 'Never Events'*, health care associated infections, reducing avoidable hospital readmissions, and promoting the use of generic prescription drugs instead of higher-cost brand name drugs.

* see www.psnet.ahrq.gov/primer.aspx?primerID=3

2009

In the second year, six health plans and ten sponsoring purchasers participated in the eValue8™ process again, with the shared understanding that high level summary results would be shared publicly. During site visits with each health plan, the group of purchasers and the health plan representatives again discussed the purchasers' priority expectations and the health plan's strengths and opportunities for improvement. In 2009, these purchasers' priority expectations for health plans are:

1. **Health Plan Accreditation.** Engage in external review and oversight of health plan operations through accreditation from one or more organizations such as the National Committee for Quality Assurance (NCQA). This accreditation signifies that there is external oversight of health plan activities, assures that there are appropriate organizational and technological structures in place, stimulates quality improvement practices and promotes greater value within the health plan.

2. **HEDIS Measurement and Reporting.** Participate in measuring and reporting HEDIS, which includes specific quality metrics used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS provides a 'common language' and a basis for comparison of performance across health plans within the market and against top performers nationally. The purchasers want to have access to HEDIS results by health plan and encourage plans to submit their audited results to NCQA and the Quality Compass, an interactive, web-based comparison tool that allows users to view plan results and benchmark information on important dimensions of care and service.
3. **CAHPS Measurement and Reporting.** Conduct the CAHPS survey, which is a nationally-developed and standardized survey that assesses patient experience with their health plan. The purchasers are encouraging health plans to report their results publicly through Quality Compass.
4. **Aggregation of Claims Data for Performance Reporting.** Continue to work with the Alliance to expand the data set available for reporting to the public via the *Community Checkup* report and to enable measurement of resource use and efficiency. They also want health plans to use the *Community Checkup* report for business purposes as the common, region-wide tool for health care value measurement and incentives.
5. **Strategies to Address Waste and the Medical Cost Trend.** Provide information to purchasers about health plan initiatives to lower the medical cost trend in the Puget Sound market and how purchasers can support these efforts. They are particularly interested in actions to reduce unnecessary medical consultations, procedures and tests in addition to emergency room visits and hospitalizations that are preventable.

Other strong areas of interest for health plan actions communicated by the sponsoring purchasers are:

6. **Health Plan Price Transparency and Cost Calculators for Members.** Build the capacity to provide ongoing, real-time information to health plan members regarding the cost of care, including the member's out-of-pocket expense.
7. **Link Medical/Lab/Pharmacy Claims and Proactively Identify Gaps in Care.** Leverage their information about member-specific gaps in preventive and chronic-care services by using that information to motivate plan members, their doctors, and other health plan resources to close those gaps and improve members' health status.
8. **Support Members to Change Behaviors to Achieve Better Health and Health Care Value (Health Risk Assessments, Benefit and Program Design).** Partner with purchasers to increase members' completion and use of health risk assessments, with particular interest in assistance from the health

plans in analyzing data and designing benefits and programs to encourage and support individual behavior change.

9. **Physician and Hospital Directories.** Expand the content and functionality of provider directories to better meet individual member needs. This includes information that is searchable, detailed and regularly audited. Emphasis should be placed on information related to access, clinical quality, patient safety, and patient experience. Ideally, health plans will integrate clinic, medical group and hospital results from the Alliance's *Community Checkup* report into their physician and hospital directories for use by members.
10. **Screening for Depression and Substance Abuse.** Given that depression and substance abuse often go undiagnosed and untreated and yet have profound effects on employee productivity and absenteeism, actively promote the use of effective screening tools and then monitor whether and how providers use those tools with their patients.

More About eValue8™

The eValue8™ tool is a nationally-recognized health care quality improvement assessment process developed by the National Business Coalition on Health (NBCH) to help purchasers buy health care products and services. It was created in collaboration with concerned employers and union trusts that purchase health care ("purchasers"). In 2002, several coalitions and large employers across the country gathered to develop a means by which purchasers could evaluate health plans based on real value, not just on price. The concept of quality was introduced and has become the overarching principle in the eValue8™ process. The eValue8™ tool conveys purchaser expectations for health plans, based on the best available evidence and expert agreement on innovative approaches to improving health and health care. Today, more than 20 coalitions and more than 100 health plans across the country participate in this process.

Using a standard request for information based on national standards, eValue8™ asks health plans to submit information about clinical quality and administrative efficiency so purchasers (i.e., public and private employers and union trusts) can compare plans against one another and against national benchmarks. Hundreds of benchmarks are gathered in critical areas such as:

- Health information technology
- Member and provider communications and support
- Disease management
- Provider performance measurement, transparency and rewards
- Patient safety
- Pharmaceutical management
- Behavioral health
- Prevention and health promotion

The following organizations work with NBCH to develop and update the eValue8™ tool and scoring method:

- Centers for Disease Control (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Agency for Healthcare Research and Quality (AHRQ)
- National Committee on Quality Assurance (NCQA)
- The Joint Commission
- URAC
- American Board of Internal Medicine (ABIM)
- eHealth Initiative (eHI)
- The Leapfrog Group
- The Pharmacy Quality Alliance
- Pennsylvania State University
- George Washington University

Once the health plans have electronically submitted their data, a certified eValue8™ scoring team verifies the information to ensure that all the information is accurate and comparable, and then scores the information. In the local region, purchasers review the information in meetings with each of the health plans to discuss strengths, best practices and opportunities for improvement. Purchasers, working through coalitions such as the Puget Sound Health Alliance, also use the information to discuss community-wide opportunities for health improvement through collaboration.

Purchasers ultimately use the information gathered through eValue8™ - the comparative charts, detailed health plan responses and the knowledge gained through site visits with the health plans - to compare health plan value, based on their own criteria. In other parts of the country, some purchasers use the information to negotiate pricing with health plans or set the employee share of premiums, with employees paying less when they choose a health plan that the purchaser considers to be higher quality. Equally important to pricing, purchasers working with coalitions use the information and the subsequent feedback with health plans as a unique opportunity to stimulate market-wide improvements in health care quality.

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Participating Health Plans

- Aetna (PPO)
- CIGNA HealthCare (PPO)
- Group Health Cooperative (HMO)

- Premera Blue Cross (PPO)
- Regence Blue Shield (PPO)
- United Healthcare (PPO)

Sponsoring Employers

- Alaska Air Group
- The Boeing Company
- City of Seattle
- King County
- Pierce County
- Port Blakeley Companies
- Puget Sound Energy
- Recreational Equipment, Inc.
- Snohomish County
- Washington State Health Care Authority

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The Puget Sound Health Alliance (www.pugetsoundhealthalliance.org) is a non-profit organization made up of those who provide, pay for and use health care, working together to improve quality of care at a price more people can afford. More than 150 organizations, plus individuals, have joined the Alliance, including many employers, clinics, hospitals, consumer groups, unions and trusts, health plans and others. The Alliance produces the Community Checkup, a report on health care performance in the region. For the full report, go to www.WACommunityCheckup.org.