



**Health Plans
October 2010**

Puget Sound Community Checkup

An Ongoing Report to the Community on
Health Care Performance Across the Region

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Puget Sound
Health Alliance
An Aligning Forces for Quality Community

Table of Contents

Introduction	3
Focus Areas in eValue8™	5
Measuring and Reporting Quality – HEDIS	8
eValue8 in the Puget Sound Area – Our Priorities	9
Using This Report	13
Health Plan Results in the Puget Sound Region	14
Health Plan Overview	15
Consumer Engagement	17
A Sample of CAHPS (Consumer Assessment of Healthcare Providers and Systems) Results	19
Provider Measurement	22
Pharmaceutical Management	24
Prevention and Health Promotion	26
Chronic Disease Management	28
Behavioral Health	30
More about eValue8	32
What eValue8 Means to Leaders across the Country	34
Acknowledgements	35

Introduction

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 follows our 2009 report, which was the first time that health plan results were included in the *Community Checkup*. Alliance participants, including many large purchasers (public and private employers and union trusts), are committed to promoting the use of national, evidence-based standards and public sharing of information on *all* aspects of the health care system. The *Community Checkup* report uses available data sources and draws from national standards. For measuring health plan activities, this report is based on scores from the national eValue8™ Request for Information (RFI) 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, then again in 2009, and most recently in 2010. By sponsoring eValue8 in the Puget Sound region, Alliance participants have these shared objectives:

1. **Generate consistency in health plan assessment** that enables greater 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 healthy behavior for wellness and informed decision-making by consumers;
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.

In 2010, five health plans participated in the process in this region:

- Three national Preferred Provider Organization (PPO) plans (Aetna, CIGNA and United Healthcare),
- One regional PPO plan (Regence Blue Shield), and
- One regional Health Maintenance Organization (HMO) plan (Group Health Cooperative).

We congratulate and thank these five health plans for their commitment to participation in the process, including completing the extensive eValue8 Request for Information, which required a significant time and resource commitment.

In 2010, eleven purchasers sponsored eValue8 in this region.

- Alaska Air
- The Boeing Company
- City of Seattle
- King County
- Pierce County
- Port Blakely Companies
- Puget Sound Energy
- REI
- SEIU Healthcare NW Health Benefits Trust
- Snohomish County
- Washington State Health Care Authority

These 16 purchasers and health plans each provided a modest level of funding to the Alliance to cover a portion of the cost of the eValue8 process, which was also supported financially by a grant from Merck, Inc.

Laying the Foundation for Reporting Over Time

Our hope is that health plans and purchasers alike 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 can show its commitment to public accountability regarding its continuous performance improvement, as measured by a process based on evidence and national standards that allows comparisons 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 second *Community Checkup* public 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 health plans. We plan to update results for participating health plans again in 2012.

While this report includes summary level information shared publicly, the participating purchasers exclusively receive *very detailed* information on the programs, services and performance of each of the health plans as measured by the eValue8 tool and scoring process, and each health plan can see how it was scored in the process

Given the complexity of health care and health plan products and programs, there is no single "perfect" approach to consistently measure and report on the quality, cost-effectiveness and value provided by health plans. We recognize that what is measured may not equate to the actual experience each individual member has with their health plan. Fortunately, the willingness of most health plans to participate in this project is a credible first step in the journey toward an evidence-based comparison of health plan

activities, based upon national standards and accreditation processes, and one that gets useful information in the hands of purchasers, health plans 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 quality measurement and public reporting over time.

Focus Areas in eValue8™

eValue8 is a robust tool that focuses on multiple areas where health plans can and do positively influence health care quality, the health status of members and efficiency. Health plans first submit online reports, along with extensive documentation, that describe their performance in a number of clinical and administrative areas. The information is then assessed with reference to accepted best practices and scores are tabulated so purchasers can compare the health plans' performance against each other as well as to national benchmarks. In addition, purchasers meet with the management of each of the health plans for an intensive discussion about select areas of focus.

eValue8 covers seven areas – or modules – as listed below. Each module is weighted differently as shown below. The percentages noted for each item reflect that item's impact *within* that particular module. So, for example, the Health Plan Overview module is worth about 13% of total eValue8 points, and measurement of efficiency and overuse is worth approximately 28% of the scoring points available *within* the health plan overview module.

1. Health Plan Overview (Weighting of Module, 13%)

	Weight of Scoring within Module
• measurement of efficiency and overuse in the system to identify opportunities for improvement	28%
• national accreditation status and participation in quality reporting	22%
• design of health insurance benefits to emphasize <i>value</i>	20%
• health plan activities to identify and address health disparities	18%
• proactive management of provider network and contracts	6%
• reporting capabilities that reveal opportunities for purchasers to strengthen plan design and improve health management	3%
• use and promotion of data inter-operability and electronic exchange of health information in a collaborative manner	3%

2. Consumer Engagement (Weighting of Module, 12%)

	Weight of Scoring within Module
• information and tools to help members understand the benefits and risks of treatment alternatives as well as the costs involved	25%
• provider directories available to members that include quality and patient experience information	18%
• promoting the use of portable, electronic personal health records	16%
• efforts to help members be better informed about the cost of their healthcare, including the use of cost calculators	14%
• patient experience measurement and reporting (CAHPS *)	10%
• availability of performance information about hospitals	10%
• prescription drug management and price information available to members	7%

* It's expected that health plans will routinely field the Consumer Assessment of Healthcare Providers and Systems (**CAHPS**) **patient experience survey and report their results** publicly.

3. Provider Measurement (Weighting of Module, 27%)

	Weight of Scoring within Module
• differentiation among hospitals, primary care physicians, and specialty care physicians using clinical process and outcome measures, evaluation of patient experience, utilization and efficiency	68%
• partnering with other health plans in the community to measure and improve physician and hospital performance	12%
• use of incentives, benefits design and information to promote high performing providers and facilities	17%
• support for physicians and the promotion of health information technology	3%

4. Pharmaceutical Management (Weighting of Module, 9%)

	Weight of Scoring within Module
• promote the cost-effective use of pharmaceuticals , including the use of generic prescription drugs when available and clinically appropriate	47%
• use health plan information to influence patient safety and encourage members to stay on prescribed medications (includes HEDIS measurement and reporting – see note on page 8)	40%
• programs to address cost and appropriate utilization of specialty pharmaceuticals	8%
• promote the spread of e-prescribing capabilities among providers in the health plan's contracted network	5%

5. Prevention and Health Promotion (Weighting of Module, 14%)

	Weight of Scoring within Module
• programming to address the prevention and treatment of tobacco use and obesity , including HEDIS measurement and reporting	25%
• cancer screening programs, including HEDIS measurement and reporting	24%
• obesity related education, tracking and programming	16%
• child, adolescent and adult immunizations with emphasis on member-specific interventions, including HEDIS measurement and reporting	14%
• promoting pre-conception counseling and tracking of high-risk pregnancies and interventions , including HEDIS measurement and reporting	13%
• providing and promoting the use of a health risk assessment (HRA) for members	6%
• partnering with employers on worksite health promotion and education about the risk factors associated with chronic diseases	2%

6. Chronic Disease Management (Weighting of Module, 17%)

	Weight of Scoring within Module
monitoring clinical indicators - especially in the areas of diabetes, coronary artery disease, and chronic obstructive pulmonary disease - with the goal of providing useful clinical data to doctors and other practitioners, including HEDIS measurement and reporting	58%
identifying members with chronic disease and use of interventions involving direct contact with members to address their specific needs, including staying on prescribed medication	23%
disease management programs that engage providers and facilitate the coordination of care that may involve more than one health condition, depression, alcohol and tobacco screening, and prescription drugs	19%

7. Behavioral Health (Weighting of Module, 9%)

	Weight of Scoring within Module
member support – includes use of interventions involving direct contact with members to address their specific needs, including staying on prescribed medication	32%
provider support – includes providing and monitoring the use of tools to screen members for depression and alcohol use	23%
monitoring clinical indicators and other indicators such as absenteeism and productivity -, including HEDIS measurement and reporting	23%
identification and tracking of members who require treatment for depression and/or alcohol use as well as those with multiple behavioral health and medical conditions	15%
whether they offer coverage for behavioral health in an accredited program to all of their members, with 24-hour clinical support	7%

HEDIS: Measuring and Reporting Quality

The eValue8 tool places an emphasis on measuring and reporting HEDIS and this is reflected in how health plans score on eValue8. HEDIS – the Healthcare Effectiveness Data and Information Set – is owned and maintained by the National Committee for Quality Assurance and includes nationally standardized measures used by more than 90 percent of America’s health plans to measure performance on

improvement dimensions of care and service. In four of the seven eValue8 modules, health plans are scored on whether they measure and report on HEDIS and how well they perform:

- Pharmaceutical Management
- Prevention and Health Promotion
- Chronic Disease Management
- Behavioral Health

HEDIS is important because it provides a common language and a basis for comparison of performance across health plans within the market and against top performers nationally.

eValue8 in the Puget Sound Region

The following outlines the focus areas and priorities of eValue8 over its three-year history in the Puget Sound region. As you read, note how the areas of emphasis build on each other over time. Expectations for improved performance don't remain stagnant, but rather increase with time and experience.

2008

During the first year of eValue8, in 2008, the Alliance shared results *privately* with each of the six participating health plans (Premiera Blue Cross participated in 2008 and 2009, but not in 2010) and 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, including health care associated infections, reducing avoidable hospital readmissions, and promote the use of generic prescription drugs instead of higher-cost brand name drugs. (* For more on Never Events, 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, the purchasers' priority expectations for health plans were:

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, stimulates quality improvement practices and promotes greater value within the health plan.
2. **HEDIS Measurement and Reporting.** The purchasers want to have access to HEDIS results by individual health plan and encourage plans to submit their audited results to NCQA and the Quality Compass. Quality Compass is an interactive, web-based comparison tool that allows users to view plan results and benchmark information on important dimensions of care and service.
3. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measurement and Reporting.** Conduct the CAHPS survey, which was created by the Agency for Healthcare Research and Quality (AHRQ) and is a nationally-developed and standardized survey that assesses patient experience with their health plan. Health plans are strongly encouraged to report their results publicly through NCQA's 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 avoidable.
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 their 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 illness care 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.
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.

2010

This year, the third year of eValue8, five health plans and eleven sponsoring purchasers participated in the eValue8 process, with the shared understanding that high level summary results would be shared publicly. Although the detailed eValue8 results for each health plan were reviewed, the format for the site visit with each health plan was designed specifically to enable a focused dialogue regarding four areas of strong interest for purchasers. The topics considered in each of the four areas were:

1. **Addressing 'Waste' and the Medical Cost Trend.**
 - **Transparency** – developing a comprehensive, aggregated data base (including all major data suppliers) that includes **provider payments/transaction pricing** to facilitate measurement and reporting of variation in cost and efficiency
 - **Addressing Variation** – measuring and identifying plan-specific variation in treatment patterns, as well as interventions to address the variation

- **Medical Cost Trend** – identifying the top one or two strategies to address the cost trend in the Puget Sound market and how purchasers can support plan efforts
- **Payment Reform** – collaborating with purchasers and other health plans to initiate changes in provider payment that will better align payment with value rather than volume

2. Influencing Member Behavior

- **Coordinating with Purchasers** – health plans working effectively with purchasers to coordinate strategies to educate members about available benefits and programs and value-based care
- **Price transparency** – making better information available to employees (and dependents) to inform and drive decision-making and use of cost calculators or other strategies to improve price transparency for consumers
- **Value-based Benefit Design** – improve the design and administration of benefits that align consumer incentives with the best choices for staying healthy, controlling chronic conditions and choosing cost effective treatments and providers
- **Predictive Modeling** – using predictive modeling that links together different data sources (e.g., trend, workers comp, health risk assessments, etc.) to identify who is likely to need services and/or intervention

3. Aggressively Closing “Gaps in Care” - Is the health plan fully leveraging its information and programs to improve the health status of its members?

- **Involving Members** – health plan push information out to members to educate, coach and remind them (screenings, tests, use of medication)
- **Coordinating with Providers** – health plan linking its disease management programs to provider practices and coordinating efforts with providers to maximize the effect
- **Collaborating with Purchasers** –integration of employer data with plan data (from the health risk assessment or ‘carved out’ programs like pharmacy or behavioral health) to more effectively identify gaps in care

4. Improving HEDIS and CAHPS

Purchasers view HEDIS and CAHPS as important measures. Both HEDIS and CAHPS create a common language that enables understanding of a plan’s performance and comparison with other plans in the market and national benchmark performance.

Using This Report

As one aspect of the Alliance's commitment to increase accountability and transparency in health care, high-level summary results from the eValue8 process continue to be shared with the public. The most detailed eValue8 data continue to be confidential, shared only with each health plan and the participating purchasers. This is similar to the approach the Alliance takes with respect to medical group measurement where only summary results for each clinic and medical group measure are publicly available on the *Community Checkup* website, and detailed individual provider results are shared privately with each medical group.

Members of the Alliance community have agreed to the following rules in using the information in this report:

1. Each health plan may communicate about their own summary-level eValue8 results; however, health plans are prohibited from using any eValue8 results that reference or compare to another health plan's results in any public communication or promotional materials.
2. All organizations are encouraged to direct people to the *Community Checkup* report website to see the comparison of summary-level results from eValue8.
3. Any communication regarding eValue8 results must follow the media guidelines of the National Business Coalition on Health (see the guidelines at http://www.nbch.org/eValue8/Media_Protocol).

In the future, these rules may change per direction from the Alliance Board or NBCH.

Note: The *Community Checkup* report is the opinion of the Alliance. It is important to recognize that the health plan scores are determined based on information submitted directly by the health plans and a combination of quantitative and qualitative assessments that required the judgment of numerous experts. Others who use their own processes to assess the quality, cost-effectiveness and value offered by health plans in this region may reach different conclusions than the results shown in this report.

The *Community Checkup* report is not a substitute for independent decision-making that incorporates other pertinent information not included in this report. If you have concerns or questions about your medical care, health plan coverage, services or other related programs, always consult your health care provider, health plan or employer directly. Do not disregard information or advice from your health care provider, health plan or employer simply because of something you read in the *Community Checkup*.

Health Plan Results in the Puget Sound Region

Participating health plans submit information via eValue8, describing their performance in a number of clinical areas and administrative practices. The information is interpreted, scored and tabulated by eValue8 experts at the National Business Coalition on Health. Summaries of the scores for each module are presented in the following pages to enable comparison of eValue8 results for each health plan. In each section, the graph shows the high level summary 2010 scores for the five participating health plans, differentiating between plans that are PPO versus HMO, as well as the score for the PPO or HMO health plan that earned the highest eValue8 score in the country.

NOTE: This type of reporting is still relatively new in the Puget Sound region. Health plan scores may be affected by whether the health plan has pursued national accreditation, measurement and reporting of HEDIS quality and patient experience (CAHPS), completeness of the narrative submitted by the health plan, how that description and data were scored, and other information submitted by the health plan before draft scores were finalized. What is measured by eValue8 may not equate to the actual experience of individuals with their health plan.

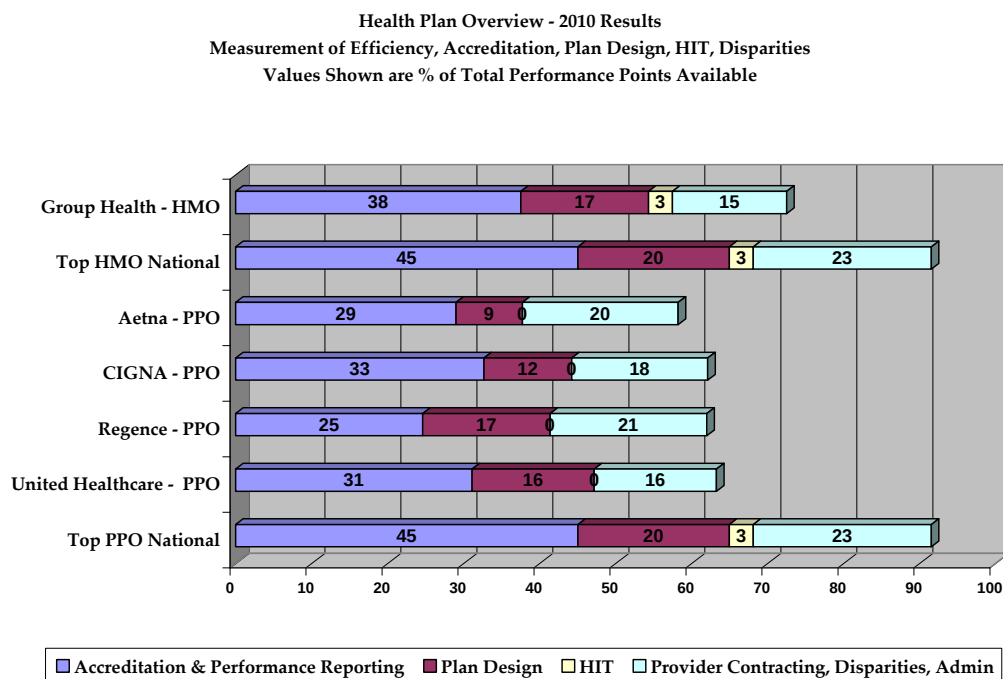
Importance of National Accreditation and Performance Reporting

A number of nationally-recognized health plan accreditation and reporting tools exist in the United States today. The eValue8 tool awards points to health plans that engage in external review and oversight of the health plan operations by the National Committee for Quality Assurance (NCQA) and by URAC. Health plans that have chosen to participate in other evaluation systems or have not been nationally accredited receive a lower score in the Plan Overview module. The sponsoring purchasers acknowledge that becoming nationally accredited is a time and resource intensive process for health plans; however, they also believe that the national accreditation process (1) provides a needed nationally-recognized external, independent review of a health plan's programs and policies; (2) stimulates a health plan to refine its structure and processes to focus on improving quality, customer service and value, and, (3) creates a way for purchasers and others to make "apples-to-apples" comparisons among health plans in this region and with top performers across the country.

Accreditation by a nationally recognized organization, such as NCQA, by itself represents about 22 percent of the points in the Plan Overview module and zero points in the other six scored modules; therefore, its overall impact on total eValue8 scoring is minimal (less than three percent of the total points available overall). However, if a health plan does not measure and report key HEDIS quality indicators to NCQA and Quality Compass, the impact on scores is larger.

The eValue8 tool heavily credits plans for HEDIS participation (approximately sixteen percent of the total points available) because it provides a standard set of condition-specific process and outcome measures that are audited and reported nationally. The eValue8 tool awards the most points for health plans that have achieved HEDIS results at or above the 90th percentile nationally. The eValue8 scoring break points are based on the national distribution of HEDIS results calculated from a total pool of more than 400 public and private health plan products covering about 100 million people. Health plans that have not measured and reported HEDIS, or that do not have satisfactory HEDIS results, earn lower scores in four of the seven eValue8 modules. It is possible for health plans to use other approaches to operationally achieve many of the outcomes measured by eValue8. In that case, the health plan must fully describe its activities so evaluators at NBCH are able to apply the eValue8 criteria appropriately.

Health Plan Overview



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

This section evaluates whether and how a health plan seeks to have formalized external oversight and review of its operations and practices through accreditation by a nationally recognized organization. Health plan products and services can directly influence health care decisions made by patients and providers based on how they are designed. As such, this module also considers health plan actions to offer plan designs that promote healthy behaviors as well as reduce financial barriers to patient adherence, provide advice to employers about using health benefits to promote safe and effective care, and ensure culturally appropriate services that reflect members' race, ethnicity or primary language.

What is Being Measured in Each Color Segment in the Chart?

Accreditation & Performance Reporting

Health plans are asked whether they participate in formalized external review and oversight through one or more types of national accreditation. One common accreditation comes from NCQA. This organization collects data and checks patient records to determine various levels of accreditation. Other recognized accreditation is through URAC or the Joint Commission. Health plans with accreditation at both the plan and program levels receive the highest scores on this measure. Also included is an assessment of health plan activities to measure efficiency and *potentially avoidable or unwarranted* hospitalizations and other utilization of health care services, and identify opportunities for improvement.

Plan Design

Health plans are evaluated on efforts to promote value-based benefit designs (safe, effective and affordable care). Health plans are expected to offer and administer benefit plan designs that promote healthy behaviors as well as reduce financial barriers to encourage patients to receive care that has been proven effective.

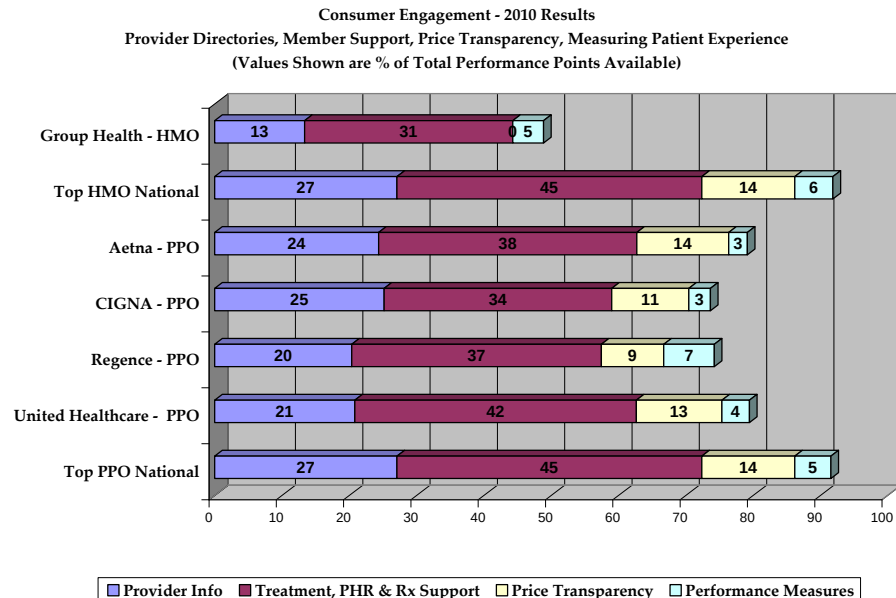
Health Information Technology (HIT)

Health plans are evaluated on the degree to which they use and promote the exchange of health information and health information technology that can be shared in a collaborative manner to improve care, safety and patient satisfaction. Health plans are also evaluated on whether they track the health information technology capability of providers and include this information in their provider directories.

Provider Contracting, Disparities, Administration

Health plans are asked about the ways in which they proactively manage their provider network and contracts (negotiated rates, board certification, etc.) with a focus on quality and efficiency. For example, health plans earn a higher score if they require their network physicians to be board certified. Health plans are assessed on their capabilities to target reporting for purchasers in ways that identify opportunities for employers to improve their benefit plan design and health management activities. The health plans are also evaluated as to whether they gather information on member race, ethnicity and preferred language, and the ways in which the health plan uses that information to better meet the needs of its members.

Consumer Engagement



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plans can provide a tremendous amount of information and support to their members, as health care consumers, employees and dependents and as patients. This module looks at the types of support that are important to consumers, such as the content and usability of a health plan's electronic provider directories, availability of performance information about hospitals and other facilities, personal health records,

information and tools to help members understand the benefits and risks of treatment alternatives and patient experience survey results.

What is Being Measured in Each Color Segment in the Chart?

Provider Information

Health plans are assessed regarding the extent to which they offer consumers detailed information about doctors and other health care providers in their network. Health plans are scored on the provider information listed in their online provider directories. This may include information on a provider's years in practice, board certifications and disciplinary actions, in addition to quality and patient experience information. Health plans are also expected to enable convenient methods of communication between providers and patients, including web-based visits. This section assesses whether the health plan makes available and encourages members to use hospital performance information, including both clinical quality and patient safety, when selecting a hospital for elective procedures.

Treatment, Personal Health Records, and Pharmaceutical (Rx) Support

Health plans are evaluated on whether they provide well-researched and objective resources to support members in making decisions about treatment options. Health plans are asked whether these tools and resources incorporate information about benefits, coverage and cost. In addition, health plans are expected to provide a variety of technology-based tools to members, including personal health records (PHR) that are populated with claims information, medication history, etc., that don't require the patient to enter that information for themselves. Ideally, patients are allowed to add other content such as over-the-counter drug use and immunizations. Health plans are expected to offer PHRs that can be "activated" as self-management tools incorporating features like outbound email reminders about gaps in care (e.g., due or overdue HbA1c / blood sugar tests for health plan members who have diabetes). This section also reflects the degree to which health plans provide information and tools to help members manage their prescription drug use and other elements covered by a pharmacy benefit, including cost comparisons and alternative choices.

Price Transparency

Efforts to help members become more involved in the financial aspects of their health care are encouraged. In this case, the more specific the information provided to the member by the health plan, and the more interactive the information, the better. As such, searchable information is more valued than display-only information.

Performance Measures

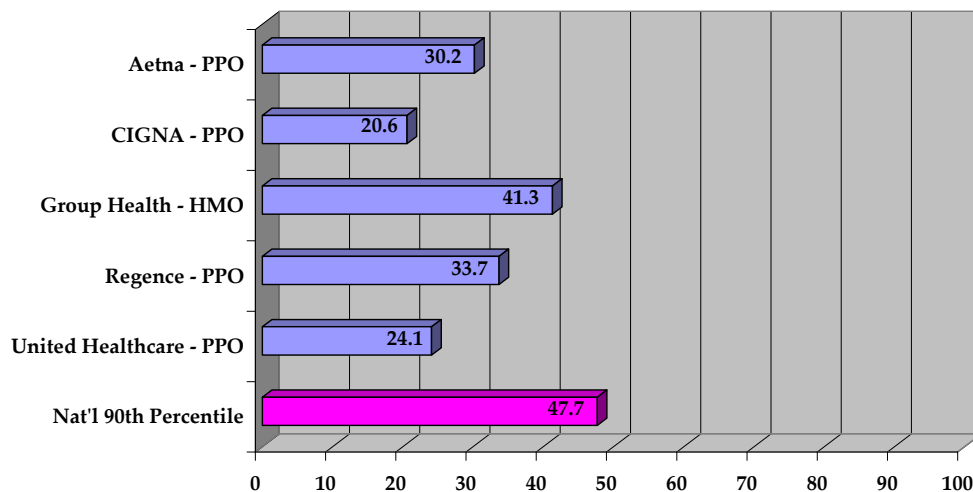
This section assesses how members rate their health plan in areas like overall satisfaction, customer services and ability to access and receive needed care. Health plans are expected to field the CAHPS health plan survey and report results publicly. Select CAHPS results are shown below.

A Sample of CAHPS Results

Overall Rating of Health Plan

This graph shows the percentage of CAHPS respondents who rated their health plan a 9 or a 10 (on a scale of 10, with 10 being the highest score). Results were reported in 2010 and reflect consumer experience in 2009.

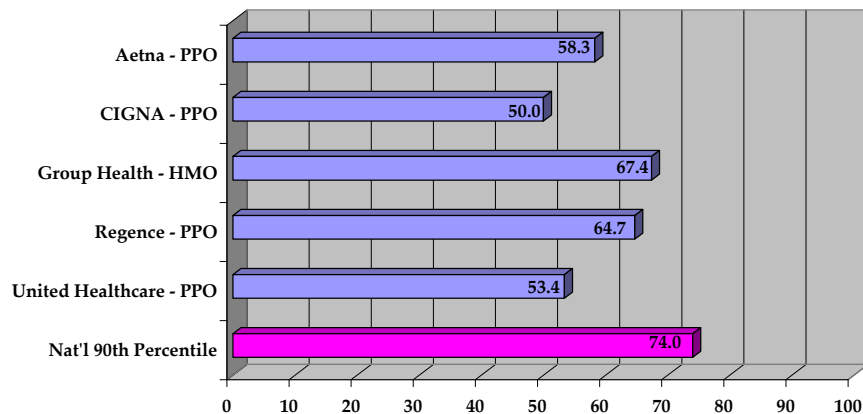
Overall Rating of Health Plan (% Scores 9 + 10)



CAHPS – Satisfaction with Access to Information on Cost

This graph shows the percentage of CAHPS respondents who indicated that they could always or usually find out from their plan how much they would have to pay for a health care service or equipment. Results were reported in 2010 and reflect consumer experience in 2009.

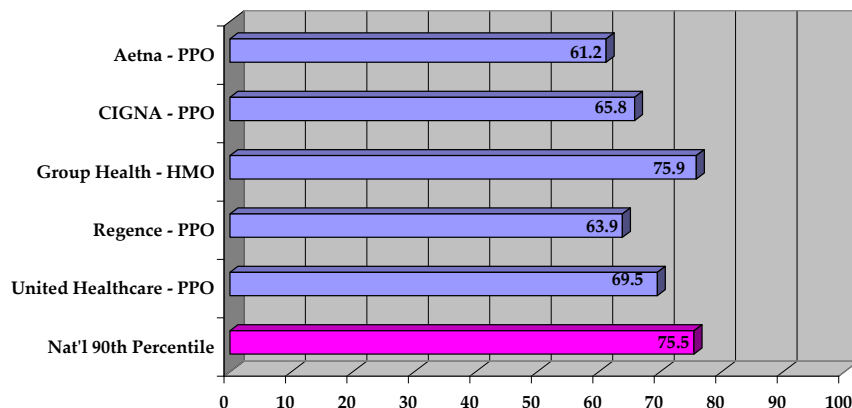
How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment? (% Always, Usually)



CAHPS – Satisfaction with Access to Information on Cost

This graph shows the percentage of CAHPS respondents who indicated that they could always or usually find out from their plan how much they would have to pay for a specific prescription medicine. Results were reported in 2010 and reflect consumer experience in 2009.

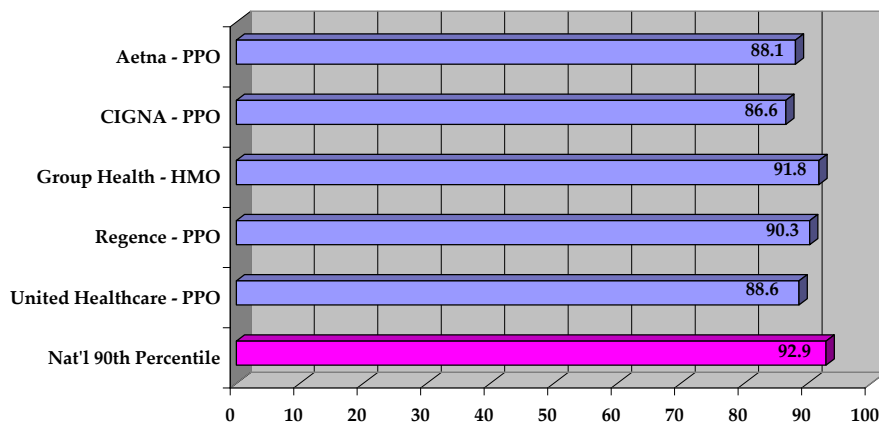
How often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? (% Always, Usually)



CAHPS – Satisfaction with Getting Needed Care

This graph shows the percentage of CAHPS respondents who indicated that they always or usually felt it was easy to get the care they thought they needed through their health plan. Results were reported in 2010 and reflect consumer experience in 2009.

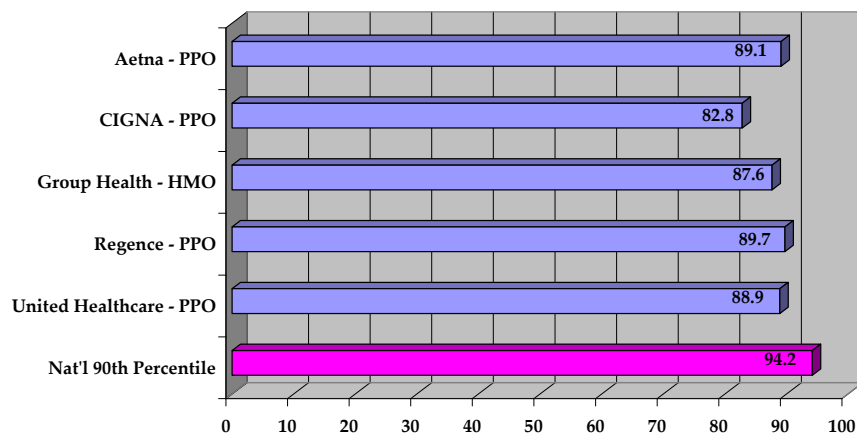
How often was it easy to get the care, tests, or treatment you thought you needed through your health plan? (% Always, Usually)



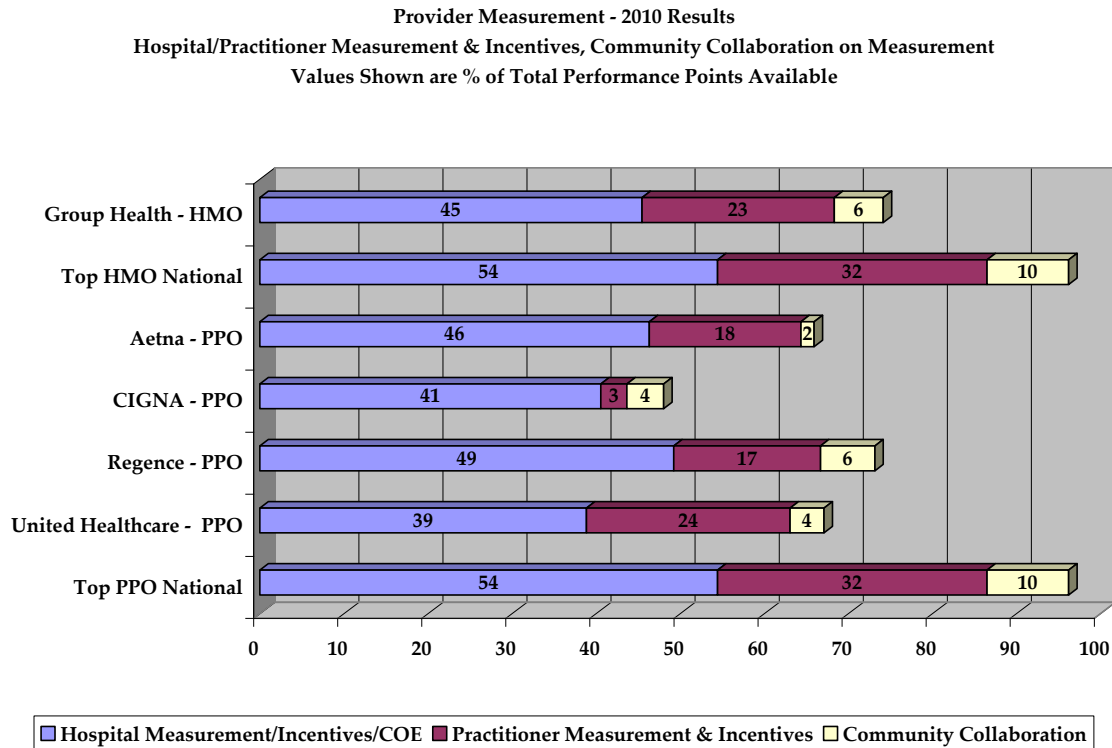
CAHPS – Satisfaction with Handling Claims

This graph shows the percentage of CAHPS respondents who indicated that their health plan always or usually handled their claim correctly. Results were reported in 2010 and reflect consumer experience in 2009.

How often did your health plan handle your claims correctly? (% Always, Usually)



Provider Measurement



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plans routinely interact with physicians and other practitioners in clinics, hospitals and other health care settings. This module considers health plan actions to: work with others in the community to measure and improve physician and hospital performance (e.g., the *Community Checkup* report); use clinical measures to differentiate among providers; and, use incentives to promote high performing providers.

What is Being Measured in Each Color Segment in the Chart?

Hospital Measurement, Incentives and Centers of Excellence (COE)

This section asks about the ways in which the health plan differentiates among hospitals using various measures (clinical, patient experience, utilization, efficiency and use of health information technology) and payment strategies to motivate the avoidance of serious events and health care associated infections. This section examines how the health plan uses incentives, benefit design and information to promote high-performing hospitals and other health care facilities. Also of interest in this section is how health plans promote high-performing facilities – or centers of excellence – that focus on complex services for cardiac, transplant, neonatal and bariatric surgery.

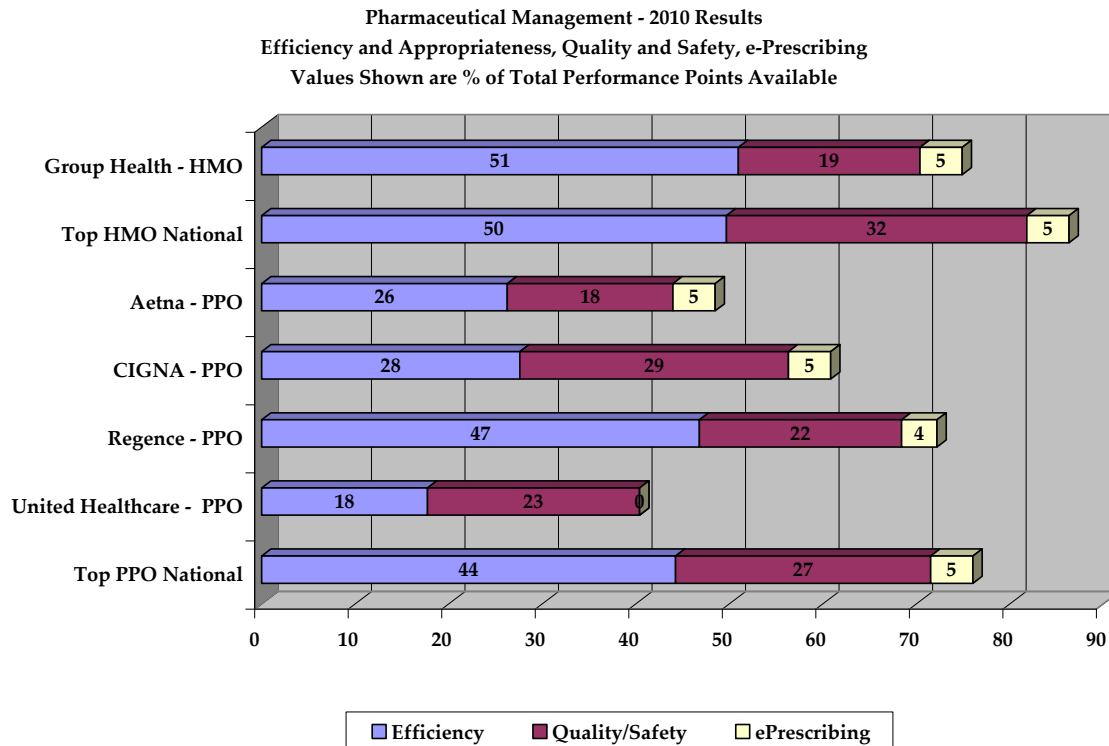
Practitioner Measurement and Incentives

Health plans are asked about the ways in which they support physicians and other practitioners by providing tools to identify members with needed services or potential gaps in care. An important element is the promotion of shareable electronic health information and adoption of health information technology. This section asks about the performance measures the health plan uses to track physicians and physician groups. The measures eValue8 asks about include those for quality, utilization, and efficiency. Health plans are also asked about whether they measure the patient's experience with physicians and physician use of health information technology. Health plans disclose the ways in which they use incentives, benefit design, and information to promote and reward high-performing providers.

Community Collaboration

This section evaluates health plans on their collaboration with other health plans in the market to measure and improve medical group (provider) and hospital performance. This includes whether the health plan pools data with others for provider benchmarking, reporting and rewards. Regionally this includes participation in the Puget Sound Health Alliance's *Community Checkup*.

Pharmaceutical Management



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plan benefits and services focus on prescription drugs because it is an increasingly important part of health care today. This module considers health plan actions to (1) promote greater use of generic drugs when appropriate; (2) monitor and influence cost-effective use of pharmaceuticals; (3) use information under the health plan's control to promote patient health and safety; (4) understand and support providers' e-prescribing capabilities; and, (5) address cost and appropriate utilization of specialty pharmaceuticals.

What is Being Measured in Each Color Segment in the Chart?

Efficiency

Health plans are asked how they promote the use of generic instead of brand-name pharmaceuticals, and whether they demonstrate high rates of prescriptions being filled with generics. Health plans describe how they monitor and influence the cost-effective use of pharmaceuticals. Health plans are assessed in terms of programs to address the cost and appropriate utilization of specialty pharmaceuticals, which are typically very expensive and for which there is no generic substitution.

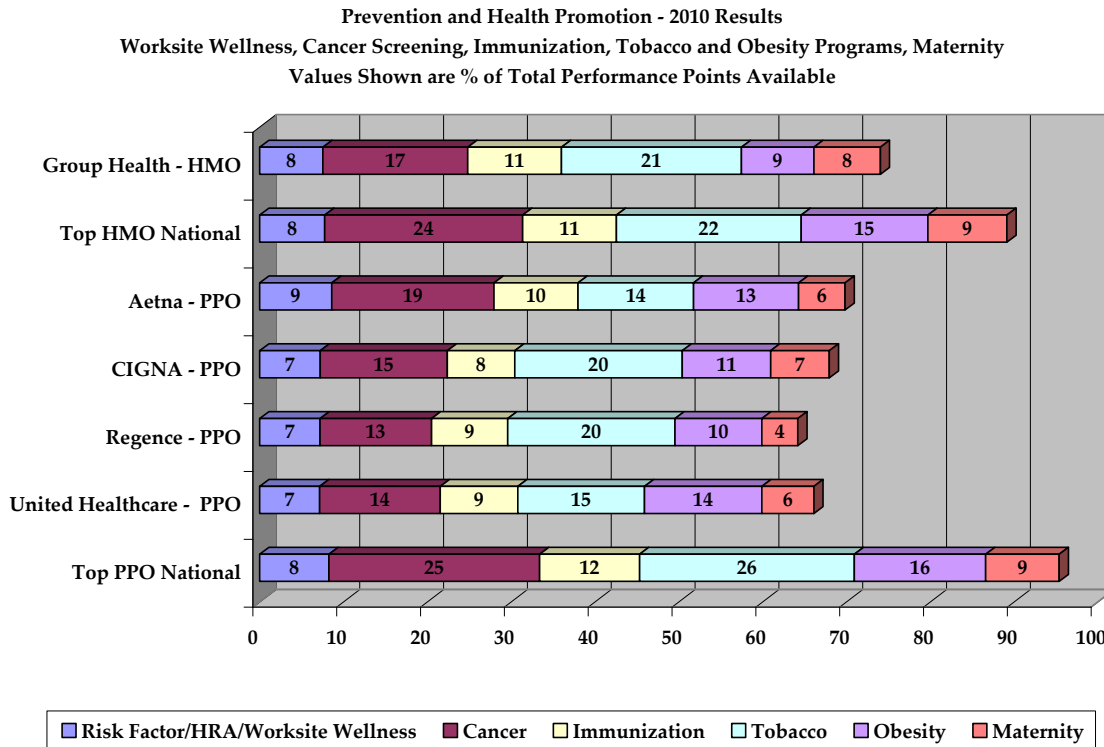
Quality and Safety

Health plans are expected to measure and report HEDIS and other pharmaceutical indicators and to use information under the health plan's control to promote patient safety and support patients staying on medications as prescribed. Nationally, the number of important pharmaceutical measures is growing, including those that reveal the extent to which there are gaps in care or safety problems.

e-Prescribing

Health plans describe whether and how they know the e-Prescribing capabilities of their contracted network, as electronic prescribing has been found to increase the efficiency and safety of prescribing pharmaceuticals. Health plans are also expected to comply with the national health data management standards that support information system interoperability.

Prevention and Health Promotion



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plans provide benefits and services that influence health care decisions made by members, including actions that affect an individual's current and future health. This module considers health plan actions to: partner with employers on worksite health promotion and education about risk factors associated with chronic diseases; provide and promote the use of health risk assessments; and offer programs to address cancer screening, immunizations, tobacco use, obesity and high-risk pregnancy.

What is Being Measured in Each Color Segment in the Chart?

Risk Factors, Health Risk Assessments (HRA), Worksite Wellness

This assesses a health plan's capabilities and history in offering employers on-site health promotion programs such as health fairs, customized printed materials, on-site health screenings and presentations on health topics, with emphasis on follow-up for health plan members needing assistance with things like tobacco cessation and management of chronic conditions. eValue8 assesses whether health plans offer a health risk assessment (HRA) to members and the health plan's strategies to motivate and maximize members to complete and use the HRA. Health plans are expected to educate their members on chronic disease risk factors such as family history, diet, physical inactivity, weight, cholesterol levels and tobacco use. There is a particular interest in education for children and their caregivers about the risk factors associated with developing chronic disease.

Cancer

Health plans are asked to describe their comprehensive cancer screening program, if any, and the screening rates for breast, cervical and colorectal cancer; health plans are expected to report this as part of the national HEDIS survey.

Immunization

Health plans are assessed as to how they address child, adolescent and adult immunizations, with emphasis on member-specific interventions such as reminders when specific immunization services are needed. Health plans are expected to report this as part of the national HEDIS survey.

Tobacco

Health plans are expected to offer a comprehensive program to address prevention and treatment of tobacco use. This includes identifying members, offering a variety of intervention opportunities, and measuring member participation.

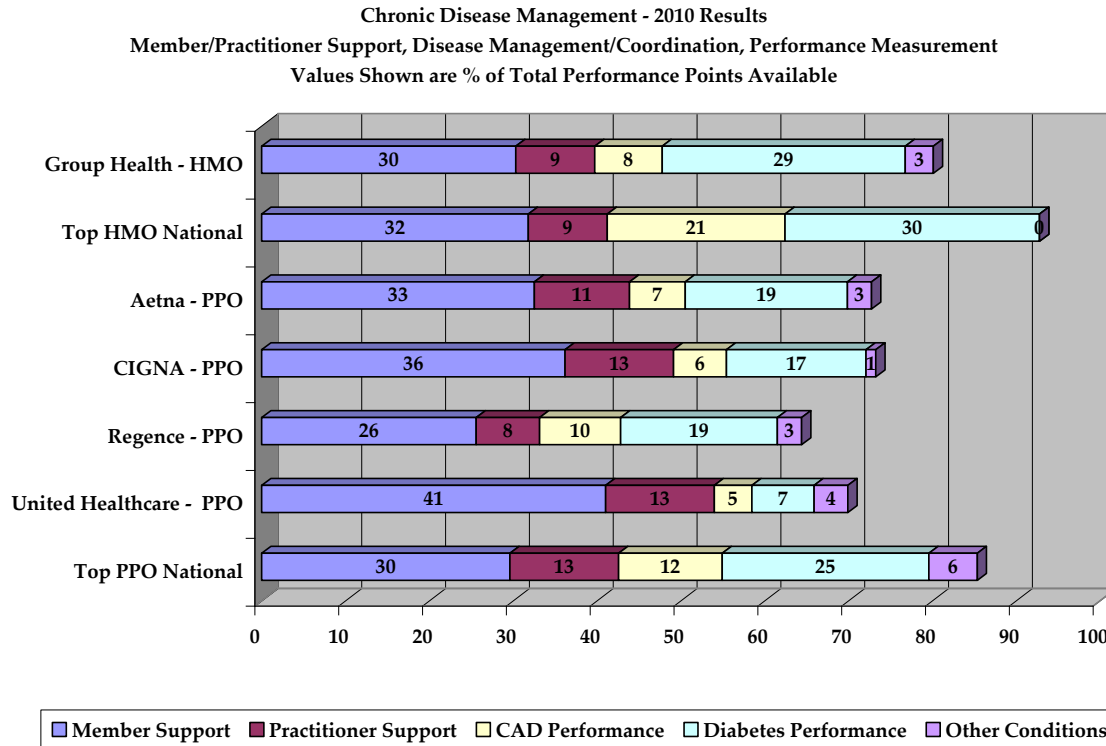
Obesity

Health plans are expected to educate their members on the health risks of obesity. This includes identifying and targeting members who can benefit from treatment and tracking results from obesity-related programs.

Maternity

Health plans are expected to promote pre-conception counseling and track high-risk pregnancies and interventions. This includes encouraging providers to screen pregnant women for alcohol and for tobacco use.

Chronic Disease Management



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plan services focus on preventing and managing the impact of chronic disease, because it is one of the largest cost drivers in health care. This module considers health plan actions to: provide disease management programs that enable coordination of care across multiple health conditions while addressing depression, alcohol and tobacco use and prescription drugs; use interventions that involve direct contact with members to address the member's specific needs, including staying on needed medication; and proactively engage providers in the health plan's disease management program to support effective patient care.

What is Being Measured in Each Color Segment in the Chart?

Member Support

Health plans are assessed on their performance in providing assistance to members who have chronic health conditions. For instance, health plans are scored on whether they offer reminders to diabetic patients to schedule routine visits and lab tests. Health plans are also asked if they provide follow-up reminders to patients who have missed appointments or tests, or are not filling or re-filling prescriptions for needed medications. Other services looked for include one-to-one counseling, outbound phone calls to members and programs that facilitate coordination of care beyond the specific individual disease. This might include depression, alcohol and tobacco screening for members and pharmacy expertise to address medication compliance.

Practitioner Support

Health plans are evaluated regarding whether they provide physicians and other health care practitioners with patient-specific reports on adherence to clinical guidelines appropriate to the patient's condition and reports that compare practitioners' results with their peers. Health plans are expected to proactively engage providers in disease management programs.

Coronary Artery Disease (CAD) Performance

Health plans are assessed regarding the breadth of the disease management programs offered to members suffering from coronary artery disease (CAD). It is expected that such disease management programs also facilitate coordination of care *across* chronic conditions and include depression, alcohol and tobacco screening. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

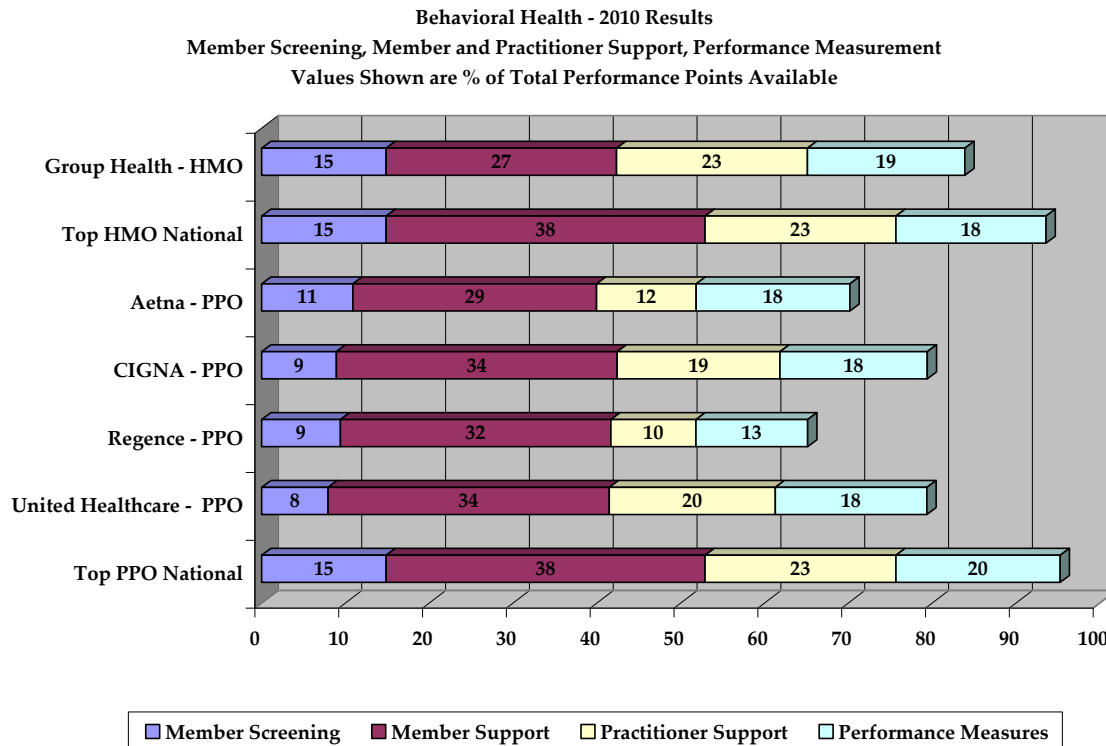
Diabetes Performance

Health plans are assessed regarding the breadth of the disease management programs offered to members who have diabetes. It is expected that such disease management programs also facilitate coordination of care across chronic conditions and include depression, alcohol and tobacco screening. This also looks at whether the health plan measures outcomes of its chronic disease program in addition to employee absenteeism, productivity, program return on investment and patient experience with the program. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

Other Conditions

Health plans are assessed regarding the breadth of the disease management programs offered to members suffering from chronic obstructive pulmonary disease. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

Behavioral Health



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2010.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Health plan programs to address depression management and alcohol treatment are essential to promoting health and health care value. This module considers health plan actions to cover behavioral health in an accredited program for all members; identify, track and support members who need treatment for alcohol use and/or depression; provide and monitor physician use of patient screening tools for alcohol use and depression; and, use related clinical guidelines and patient-specific reports.

What is Being Measured in Each Color Segment in the Chart?

Member Screening

Health plans are assessed as to whether they recommend tools to screen members for depression and alcohol overuse and to monitor the use of these tools.

Member Support

Health plans are assessed as to whether they offer behavioral health services *in an accredited program*, as a part of all of their benefit plans. Health plans are expected to provide timely clinical support 24 hours per day, 7 days per week, and 365 days per year. Similar to chronic disease management, the emphasis of this support is on the use of clinical guidelines and adherence to prescribed medications, recommendation of effective screening tools, and supporting provider use of clinical data registries. Health plans are asked how they support interventions that involve directly contacting members for specific needs, including medication compliance. The health plan is expected to identify and treat members who have behavioral health and medical conditions in a coordinated fashion.

Practitioner Support

In contrast to the Chronic Disease Management module above, for this element, health plans are asked about the support they provide to both medical practitioners such as primary care physicians and behavioral health practitioners including psychiatrists, psychologists and other professionals who provide behavioral health services. Health plans are asked which screening tools it recommends to these practitioners, whether the health plan tracks the use of those tools, and if they provide patient-specific and comparative reports for practitioners.

Performance Measures

Similar to the Chronic Disease Management module above, the health plan's HEDIS results specific to depression and alcohol use disorders are used for this score, with maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally. Health plans also disclose their use of non-HEDIS measures and are allowed to specify their own measures, for example in the areas of productivity and absenteeism.

More about eValue8

The eValue8 tool is a nationally-recognized health care quality improvement assessment process developed by the 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 standardized request for information based on national standards, eValue8 asks health plans to submit information about quality and efficiency so purchasers (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 are among those that routinely 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
- 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. At the local level, 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, 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. Today, some purchasers in the Puget Sound area are also using the information to select and contract with health plans, counting the plan's scoring on eValue8 as a significant part of their overall evaluation of health plans. In some parts of the country, purchasers are also using eValue8 results 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.

What eValue8 Means to Leaders Across the Country

eValue8 Means Transparency. “The plans that participate in eValue8 open themselves up to truly rigorous scrutiny; we see how they work, where they’re doing well, what the opportunities are for improvement. It lets us know they’re committed to being open and collaborative partners.”

-- Emma Hoo, Director of Value-Based Purchasing, Pacific Business Group on Health

eValue8 Means Collaboration. “eValue8 sets the stage and provides a forum for employers, health plans and business coalitions to begin working together on community-based solutions. That’s how we’re going to improve health care quality and value and it all starts with eValue8.”

-- Laurel Pickering, Executive Director, New York Business Group on Health

eValue8 Means Quality. “The eValue8 survey includes dozens of unique elements focusing on things like how doctors are paid, gaps in care, price transparency and community collaboration. If a plan does well on the eValue8 survey, we generally view that as a good indication that our employees are getting great care and great service.”

-- Patrice Jennings-Dixon, Senior Benefits Consultant, Pepco

eValue8 Means Value. “We’ve actually incorporated eValue8 and eValue8 results into our RFI and procurement process. Plans can’t do well on an eValue8 survey unless they are putting a heavy emphasis on value-based benefit design and we believe that comes back to us in the form of better care and lower premiums. eValue8 lets us know that our health plan partners are doing everything they can to make the most out of every health care dollar.”

-- Kerry Schaefer, Manager, Compensation & Benefits, King County, Washington

eValue8 Means Stability. “HEDIS tells you how plans are doing, but eValue8 gets behind those HEDIS results and tells you why a plan scored the way it did. It looks at the drivers of health status and cost and tells you what the issues are.”

-- Cristie Travis, Chief Executive Officer, Memphis Business Group on Health

Acknowledgements

Participating Health Plans

- Aetna (PPO)
- CIGNA HealthCare (PPO)
- Group Health Cooperative (HMO)
- Regence Blue Shield (PPO)
- United Healthcare (PPO)

Sponsoring Purchasers

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

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