



Collaborating for Impact:
eValue8™ 2020 Summary Report
August 2021

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eValue8 Purchaser Sponsors

- Association of Washington Cities
- Bloodworks Northwest
- Bill and Melinda Gates Foundation
- City of Kirkland
- City of Seattle
- Davis Wright Tremaine LLP
- King County
- Pacific Health Coalition
- Point B
- Port of Seattle
- Puget Sound Energy
- Seattle Chamber of Commerce
- SEIU 775 Health Benefits Trust
- Sound Health & Wellness Trust
- Sound Transit
- Starbucks Coffee Company
- The Boeing Company
- Washington Health Benefit Exchange
- Washington State Health Care Authority
- Washington Teamsters Welfare Trust

eValue8 Health Plan Participants



The Washington Health Alliance (Alliance) brings together those who give, get, and pay for health care to advance a high quality, affordable health care system for the people of Washington state. A key focus of the Alliance is improving transparency through performance measurement and reporting. Our public reporting is done at the state, county, Accountable Community of Health, medical group, clinic, and health plan levels. We focus on value improvement opportunities that include the following:

- **Reducing underuse of effective care.** When individuals receive evidence-based care at the right time, it increases the likelihood that preventable conditions will be identified earlier and chronic conditions will be better managed, both of which reduce the potential for avoidable complications that lead to higher cost services, such as inpatient admissions and emergency department visits.
- **Reducing overuse of ineffective care.** More care isn't always better care. Unnecessary tests and procedures contribute to waste in the system, add considerably to cost, and increase the risk of physical, emotional, and financial harm to the individuals receiving them.
- **Reducing price.** Overall high cost and unwarranted variation in pricing contribute to making our current health system unsustainable. The more transparency we have in pricing, the better we can identify and address these issues.

To measure health plan performance, the Alliance uses the national eValue8™ (eValue8) Request for Information (RFI). This process was originally developed in the late 1990s by several business coalitions and large employers, including Ford Motor Company, General Motors, and Marriott International. Today, the National Alliance of Healthcare Purchaser Coalitions, of which the Alliance is a member, administers eValue8.

The eValue8 RFI asks health plans for a wide range of information; including how they control health care costs, reduce and eliminate waste, ensure patient health and safety, close gaps in care, and generally improve health and health care for their members.

This report provides the eValue8 results for each of the participating health plans and summarizes the rich discussions that occurred during eValue8 health plan and purchaser meetings, highlighting the opportunities for continued collaboration between purchasers and health plans (see Collaborating for Action on page 2).

Why eValue8?

The Alliance has facilitated the eValue8 process in Washington state since 2008 with these primary aims:

- Generate a consistent, transparent health plan market assessment.
- Improve health plan performance.
- Inform health insurance purchasing decisions by plan sponsors, including public and private employers, union trusts, and multi-employer plans.
- Enable purchaser and plan collaboration around value improvement strategies.

The success of eValue8 is powered by the collective voice of Alliance purchaser members, the transparency of performance results, and the strength of the collaboration between purchasers and health plans. Participating health plans and purchasers receive detailed responses to facilitate collaboration. The results shared publicly in this report enable all purchasers and consumers to compare each health plan against others in Washington state and against national benchmarks for best performance.

Through their participation, health plans provide details on how they educate, engage, and incentivize members as health care consumers to promote optimal health from receiving recommended preventive services to ensuring evidence-based management of chronic illness. Health plans also provide information on how they measure provider and hospital performance, including the use of various payment models and approaches to partnering with contracted providers to improve the quality and affordability of care on behalf of their members. Results from the eValue8 RFI are scored nationally and disseminated regionally.

The purchasers participating in the eValue8 process collectively met with each plan to discuss the confidential results and engage in an active dialogue around improvement opportunities. This year, all meetings were held remotely, though in the past they were held in-person. The meeting summaries (pages 20 to 24) summarize the discussions that occurred during these group meetings. In the spirit of collaboration with all who seek to improve health and health care, we share the highlights from these discussions, including common strengths, obstacles, and opportunities for ongoing collaboration.

Collaborating for Action

A critical component of the eValue8 process is the interaction between participating purchasers and health plans. Working with the Alliance, the purchasers together develop the questions that they want the health plans to answer. During focused meetings with each health plan, results were reviewed, and the purchasers engaged directly with health plan leaders on topics they identified as most important. During the 2020 eValue8 discussions, the purchasers prioritized five issues and led discussions with the health plans around these topics:

- Addressing health inequities and social determinants of health.
- Strengthening the accessibility and impact of primary care.
- Improving behavioral health access through its integration with primary care.
- Sustaining virtual and telehealth advances made during the COVID-19 pandemic.
- Addressing the rising cost of medications with a focus on medical benefit coverage.

Voluntary participation by commercial health plans has been strong throughout the Alliance’s history. In 2020, five of the largest health plans participated in eValue8, representing more than two million fully insured lives. These health plans also administer programs for self-insured employers representing approximately 2 million additional covered lives in Washington state.

Participation is a testament to each plan’s willingness to be transparent about its activities and results with its current employer and union trust customers as well as potential customers. This speaks volumes about their commitment to the Washington market and the strength of their local leadership. We understand the significant effort it takes for plans to respond to the eValue8 RFI and are grateful for the participation and collaboration of the plans included in the table below.

| Plan | Commercial Lives in WA | WA Lives as % of Total Plan Nationwide |
|----------------------------------|------------------------|--|
| Aetna | 370,984 | 0.5% |
| CIGNA | 148,970 | 1.2% |
| Kaiser Permanente Washington HMO | 350,915 | 4.6% |
| Kaiser Permanente Washington PPO | 120,027 | 1.6% |
| Premera Blue Cross | 736,027 | 57.0% |
| Regence BlueShield | 686,814 | 44.8% |

The health plans’ eValue8 scores are determined based on information submitted directly by each health plan based on their programs and initiatives. After initial scoring, health plans are given the opportunity to correct or modify information to ensure that scoring accurately reflects their capabilities.

The 2020 eValue8 RFI includes seven modules. Questions within each module are weighted differently based on evidence, consensus standards, and input from national health care purchasers and health plans from across the country. The total number of points awarded in each module depends on the weight attributed to each question.

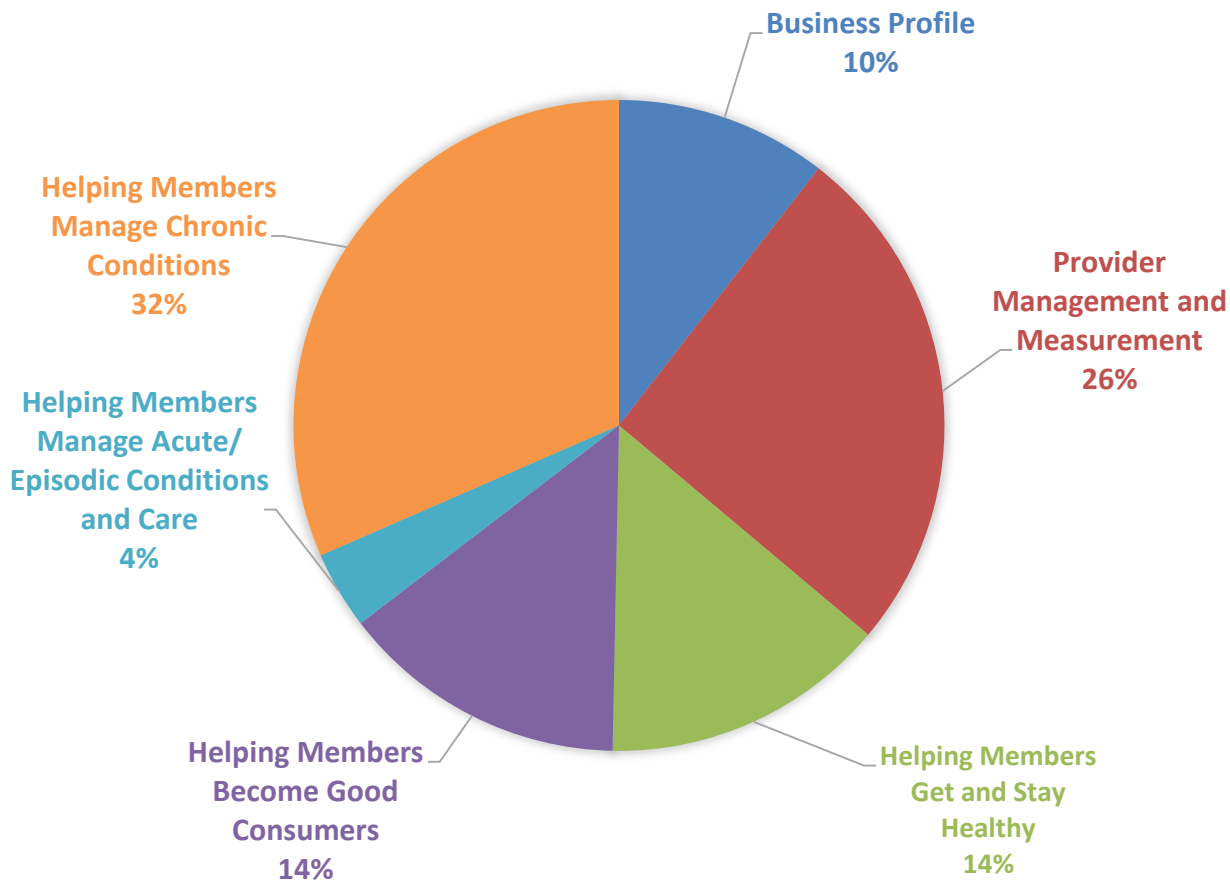
The RFI is updated annually to reflect current evidence, changes in the health care landscape, and shifts in purchaser priorities. For example, the 2020 RFI incorporated questions relating to issues of health inequities, disparities, and social determinants of health along with new questions focused on how health plans are supporting advanced primary care models.

The available points are distributed across seven modules as shown in this chart below. More than half of the total points (64%) are earned based on how well each health plan provides support directly to its members. The Provider Management and Measurement module which evaluates the plan’s provider contracting, engagement, and support strategies is next at 26% followed by the Business Profile module at 10%.

The “Helping Members” categories generally include elements such as:

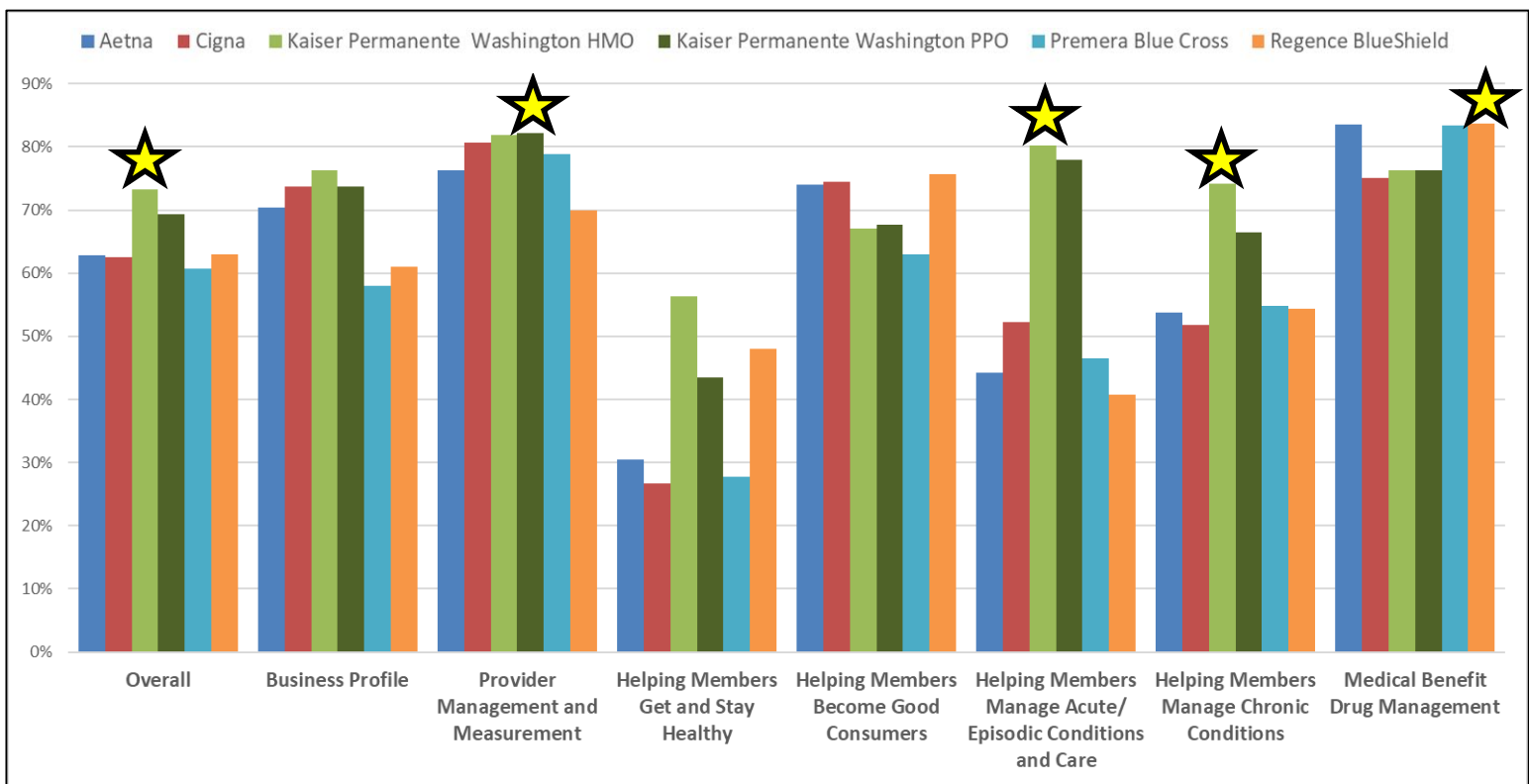
- member screening and reminders to help individuals get and stay healthy;
- transparent information on price and quality of physicians and hospitals to help members identify higher value providers (i.e., higher quality at a lower price); and
- availability of unbiased and evidence-based tools to enable members to evaluate the risks and benefits of treatment options and participate in shared decision-making.

All of the modules and the scores earned by each plan are described in this report.



Overall Performance

This chart summarizes performance for each participating plan overall and for each module. Each health plan's results are compared to the others in the same region as well as to the top performing plan nationally, overall and for each module. While all Washington state plans fared well in overall scoring, Kaiser Permanente Washington achieved the highest overall score in the nation based on its HMO performance as noted by the yellow star. The chart also identifies the top score for the Washington plans that were the highest rated nationally, which included Kaiser Permanente Washington in three modules and Regence BlueShield in one module. The individual module results that follow compare plan performance for each category.



 Best Performance Nationally by Washington Health Plans

Module 1 – Business Profile, 9.5% (58.5 out of 616 points)

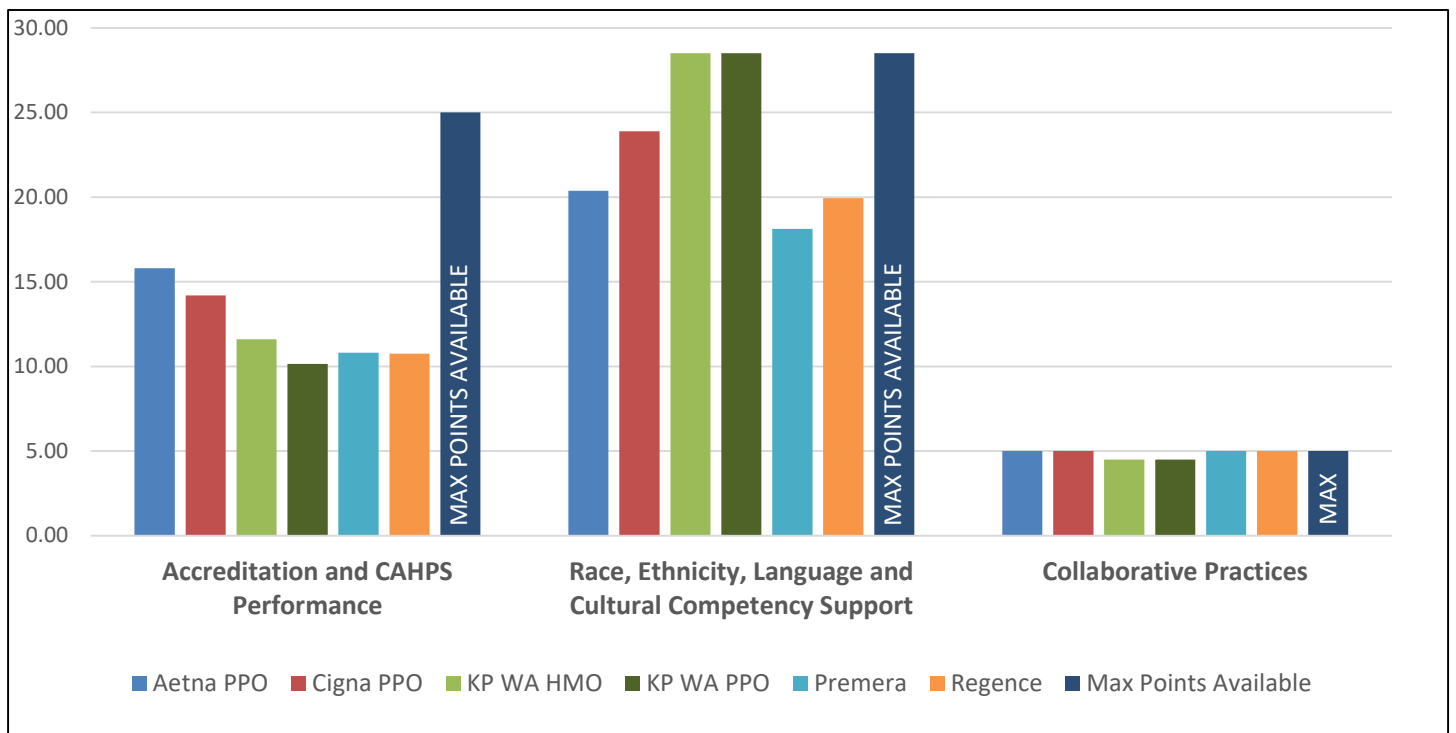
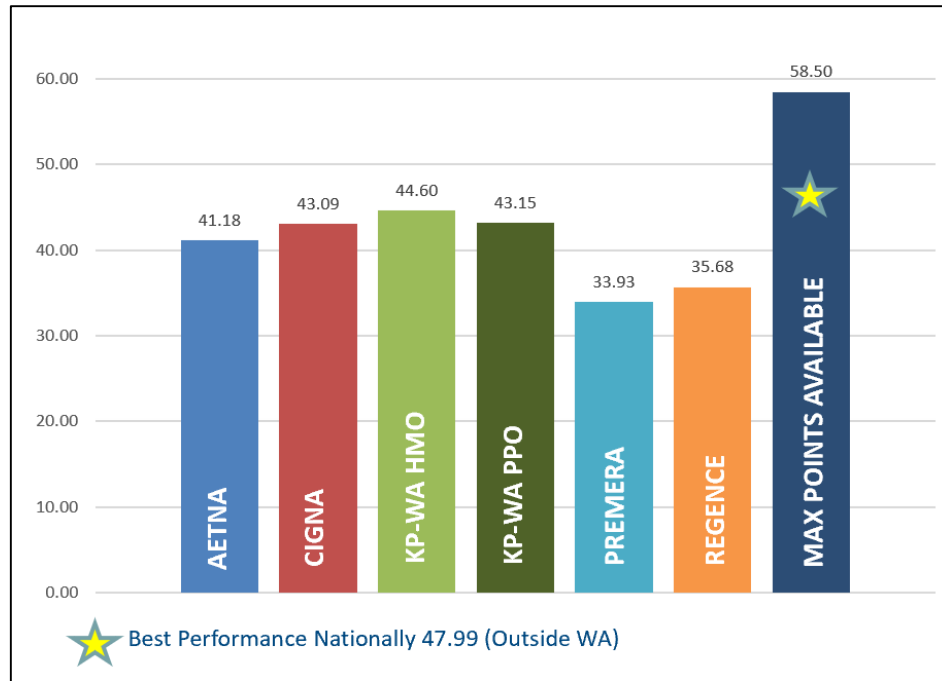
This module provides an overview of the health plan’s business practices and results.

- **Race, Ethnicity, Language (REL) and Cultural Competency Support (28.5 points)**
 - Does the plan track and use REL data to address the unique needs of its members?
 - Are activities in place to ensure delivery of culturally sensitive care across the plan’s network?
- **Accreditation and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Results (25 points)**
 - What types of accreditation does the plan have, e.g., Health Plan, Case Management, Physician Hospital Quality, and Multicultural Healthcare?
 - Does the plan support CAHPS and are results reported publicly?
- **Collaborative Practices (5 points)**
 - Does the plan engage in national efforts to improve care quality, e.g., Leapfrog?
 - Does the plan engage in regional efforts to improve care, e.g., Multi-Payer Primary Care Model?

Common Health Plan Themes

- There are strong collaborative practices across all plans.
- There are opportunities for most to improve in the collection and use of Race, Ethnicity, and Language data to improve culturally sensitive support to members.
- All could do better in accreditation and CAHPS results.

Module 1 Performance



Module 2 – Provider Measurement and Management, 23.1% (142.5 out of 616 points)

This module assesses how the health plan measures, differentiates and rewards provider (physician and hospital) performance and the degree to which the plan uses nationally standardized measures.

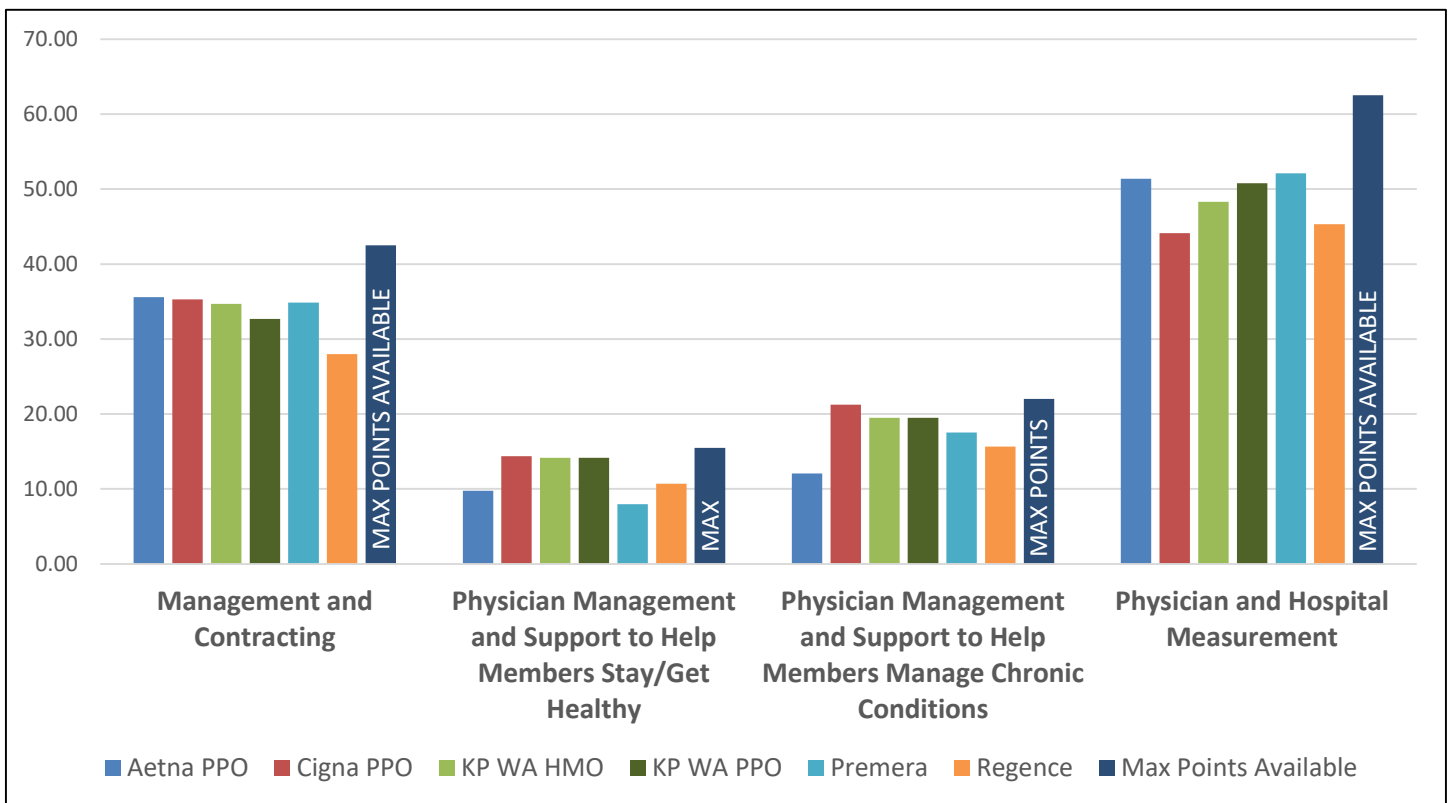
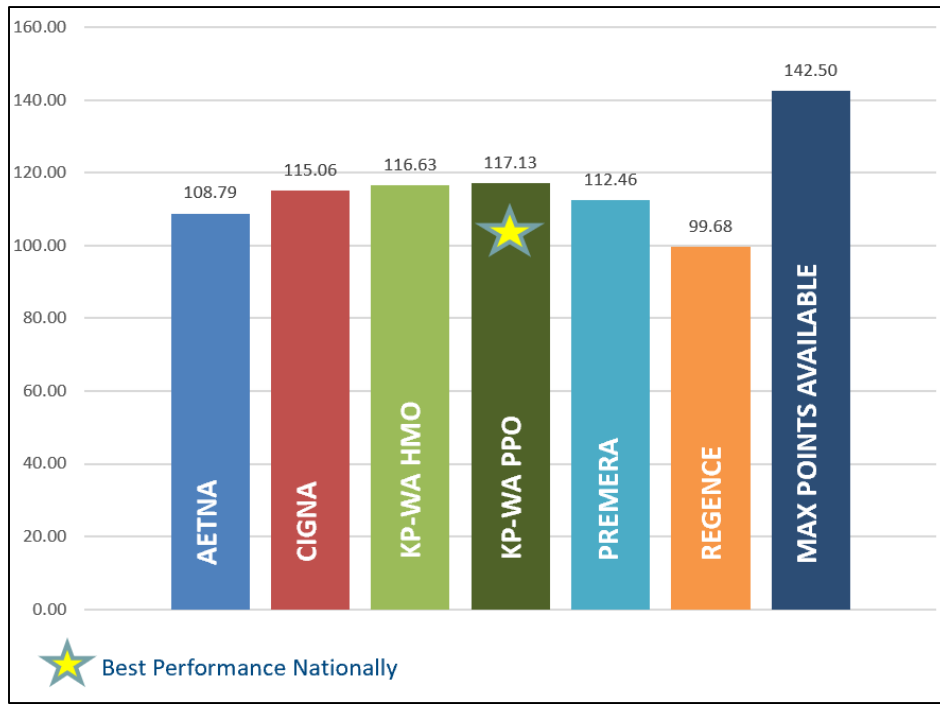
Kaiser Permanente Washington PPO was recognized for having the highest performance nationally for this module with a score of 117.13.

- **Physician and Hospital Measurement (62.5 points)**
 - Are the metrics used in provider performance evaluation and feedback meaningful?
 - Do measures align with regional and national efforts, e.g., National Committee for Quality Assurance, Leapfrog, Centers for Medicare & Medicaid Services?
- **Physician and Hospital Network Management and Contracting (42.5 points)**
 - How well is the plan implementing value-based payments?
 - Does the plan adequately protect members from surprise billing, i.e., when they receive care from a provider without a negotiated contract?
- **Physician Management/Support to Help Members Manage Chronic Conditions (22.5 points)**
 - How well does the plan support clinicians in identifying and managing members who are high risk or have complex health care needs?
 - Does the plan monitor appropriate prescribing of antidepressants and pain medications?
- **Physician Management and Support to Help Members Get and Stay Healthy (15.5 points)**
 - How well does the plan support providers' efforts to address tobacco cessation and obesity?
 - How well does the plan monitor providers' use of recommended screenings, such as depression, diabetes, and alcohol use?

Common Health Plan Themes

- All plans are focused on value-based innovation, but increased investment in non-fee-for-service payment models is needed, especially for primary care.
- Plans can better support providers' efforts to meet patients' preventive care and health improvement needs, including tobacco cessation and weight reduction.
- There are opportunities to further align measurement across payers with a focus on behavioral health measures.

Module 2 Performance



Module 3 – Helping Members Get and Stay Healthy, 12.8% (79 out of 616 points)

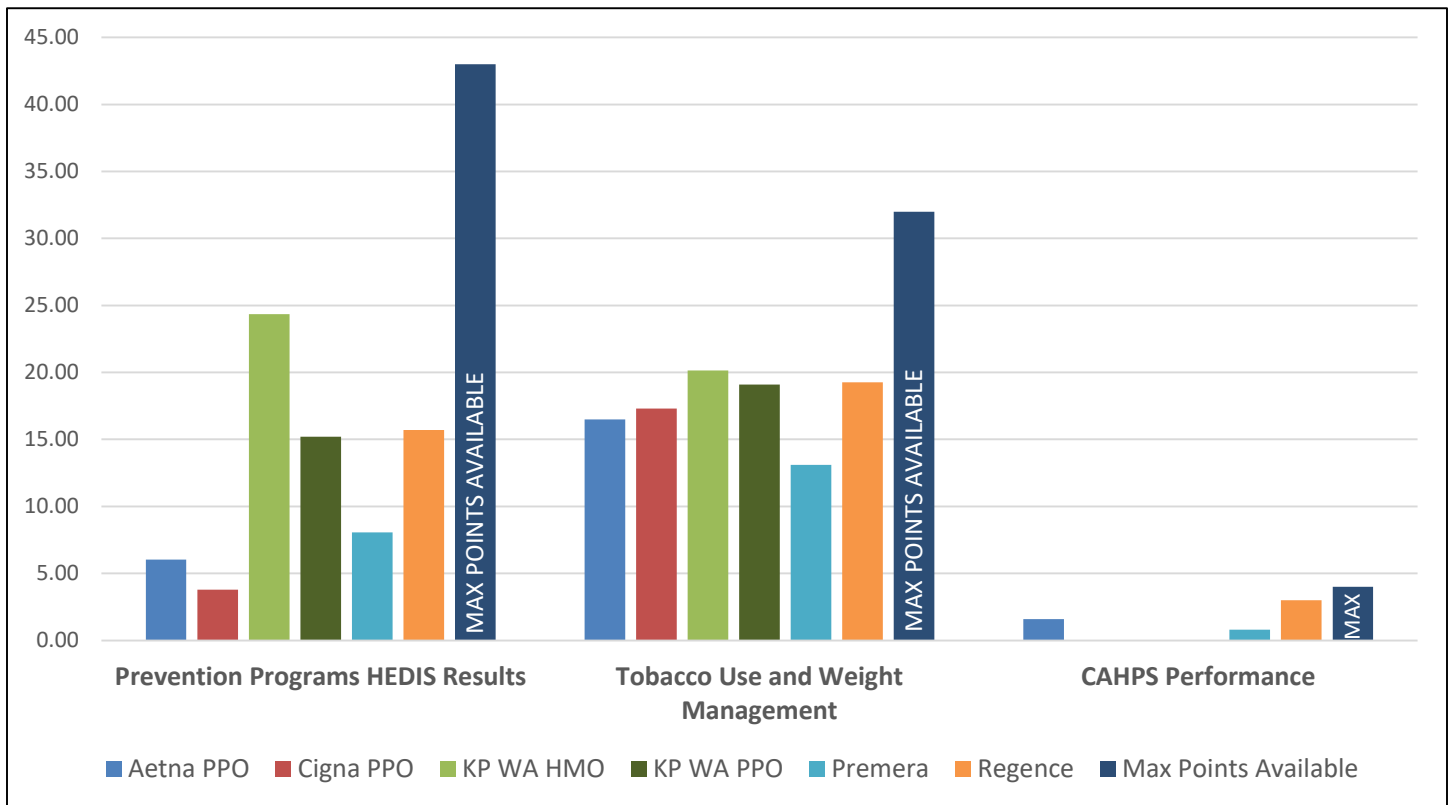
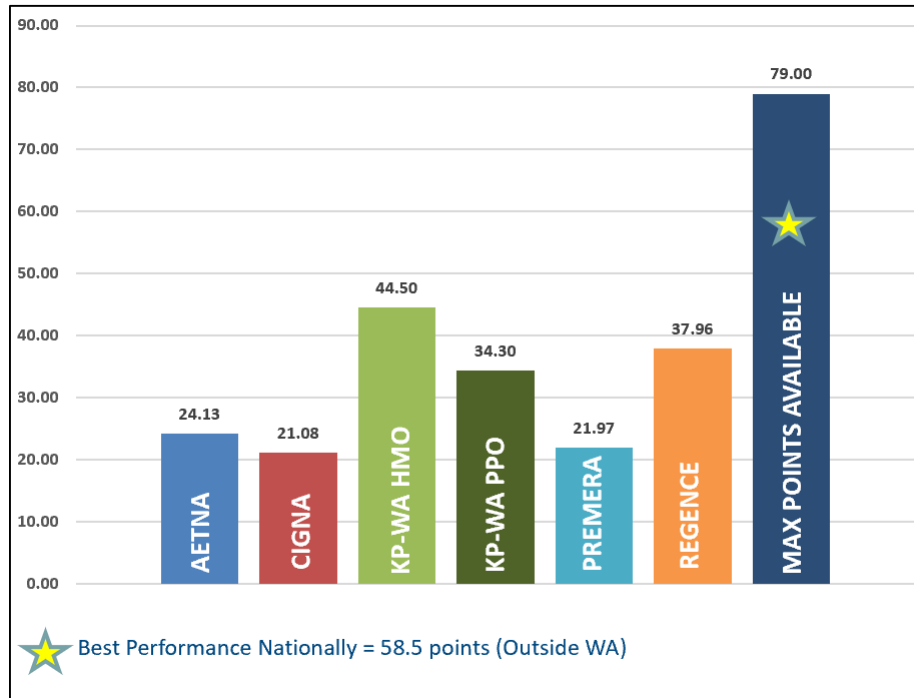
This module evaluates how well health plans directly support members to prevent illness and maintain good health by promoting healthy behaviors and recommended screenings.

- **Prevention Programs, Healthcare Effectiveness Data Information Set (HEDIS) Results (43 points)**
 - How well does the plan ensure its members receive recommended breast, cervical, and colorectal cancer screenings?
 - How well does the plan ensure its members receive appropriate well care for babies, children, and adolescents?
- **Tobacco Use and Weight Management, HEDIS Results (32 points)**
 - Does the plan effectively identify and engage members in tobacco cessation and weight management programs?
 - Does the plan perform well on tobacco and weight-related HEDIS measures?
- **Member Communication – CAHPS Performance (4 points)**
 - How effective is the plan’s health promotion and education with members as indicated by the Health Promotion and Education composite measure in CAHPS?

Common Health Plan Themes

- While Washington is significantly behind national best practices, two plans had slightly stronger performance on tobacco cessation and weight management.
- There are improvement opportunities for all in preventive services such as screenings and wellness visits.
- Insufficient data or low performance on provider communication with patients resulted in low CAHPS ratings.

Module 3 Performance



Module 4 – Helping Members Become Good Consumers, 12.9% (79.5 out of 616 points)

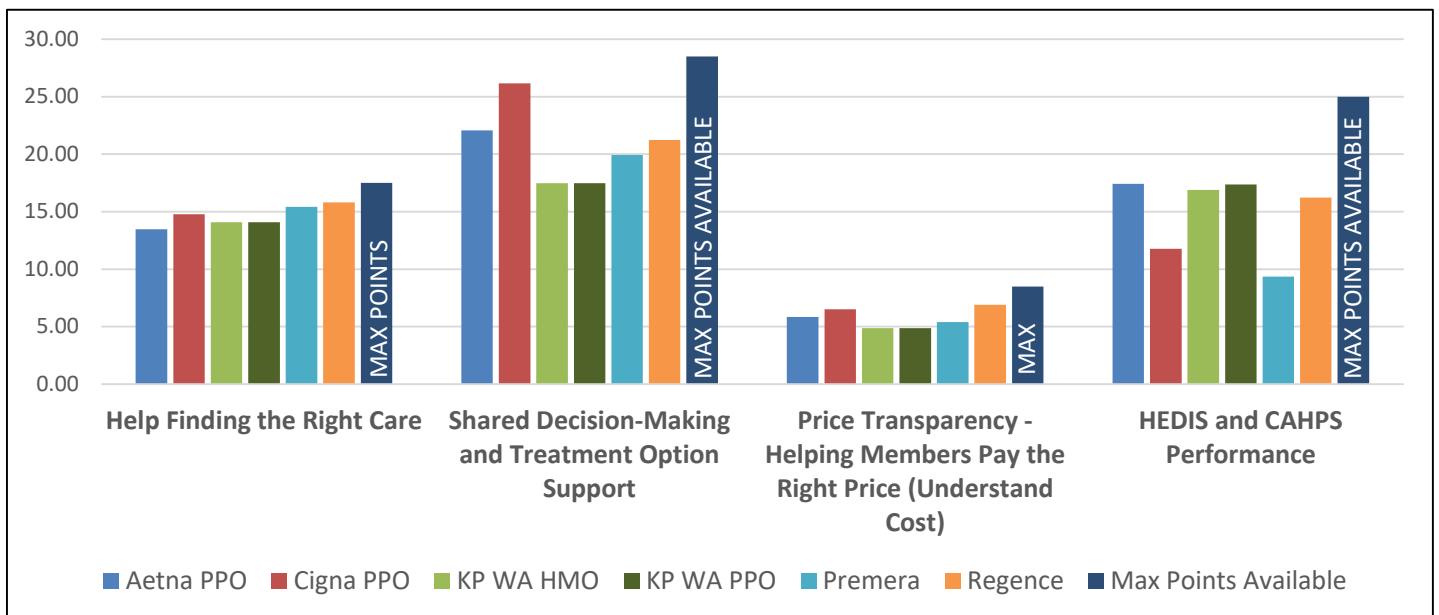
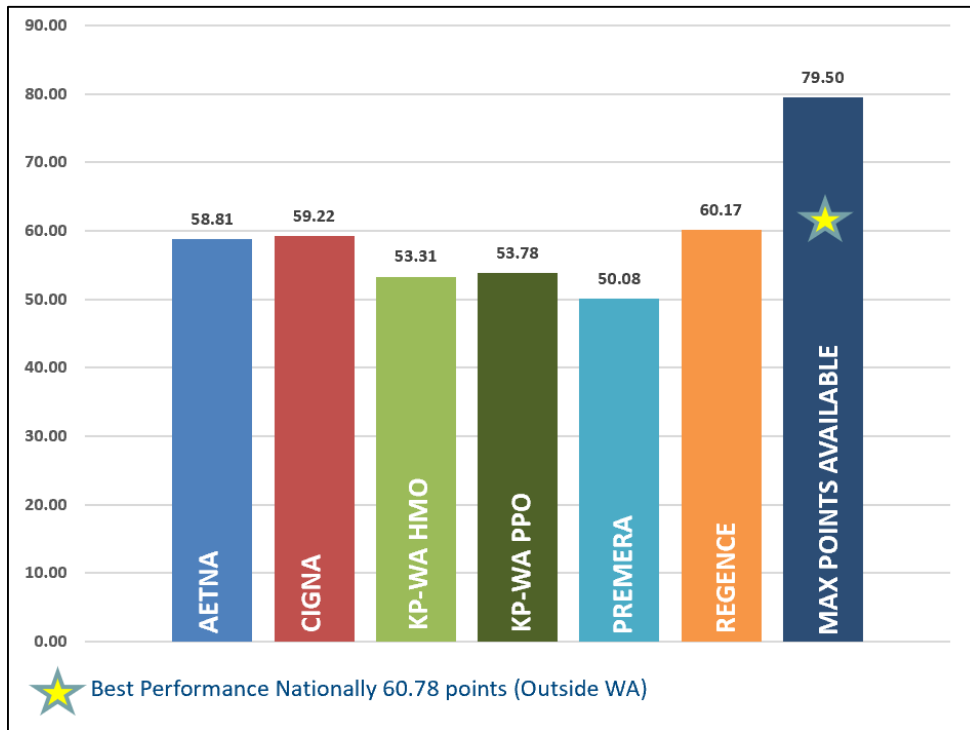
This module evaluates how well the health plan supports and engages members with tools and education to help them make informed health care decisions.

- **Shared Decision-Making and Treatment Option Support (28.5 points)**
 - How effective is the plan’s use of social media, digital tools and/or telephone support to engage consumers in decision-making?
 - How well does the plan proactively identify members who would benefit from decision support?
 - How well does the plan allow members to incorporate individual preferences when evaluating treatment options?
- **Making Informed Health Care Choices (25 points)**
 - How well does the plan perform on HEDIS measures related to overuse of care?
 - How well does the plan perform on CAHPS composite measures: getting needed care, getting care quickly, customer service, and shared decision-making?
- **Help Finding the Right Care (17.5 points)**
 - Does the plan consider members’ language and health literacy needs in member engagement activities to address health literacy?
 - How robust are the plan’s interactive tools that help members choose a physician?
 - How well does the plan support use of technology in physician-member consultations?
- **Price Transparency (8.5 points)**
 - Are the plan’s cost calculator tools accessible and easy for members to use?
 - How well does the plan perform on CAHPS measures that assess members’ ability to find out how much a health service costs before receiving it?

Common Health Plan Themes

- Most plans offer a robust online cost calculator, but these tools lack integration with treatment support and shared-decision-making tools.
- Inconsistencies in reimbursement for telehealth and tele-behavioral health make it challenging for providers to understand how to adapt to virtual modalities.
- All plans can improve the integration of quality and cost of care components in their provider selection tools.

Module 4 Performance



Module 5 – Helping Members Manage Acute/Episodic Conditions and Care, 3.5% (21.5 out of 616 points)

This module addresses how the health plan supports members in management of acute/episodic care, including the use and alignment of benefit design. There is particular focus on obstetrics, maternity care, and childbirth.

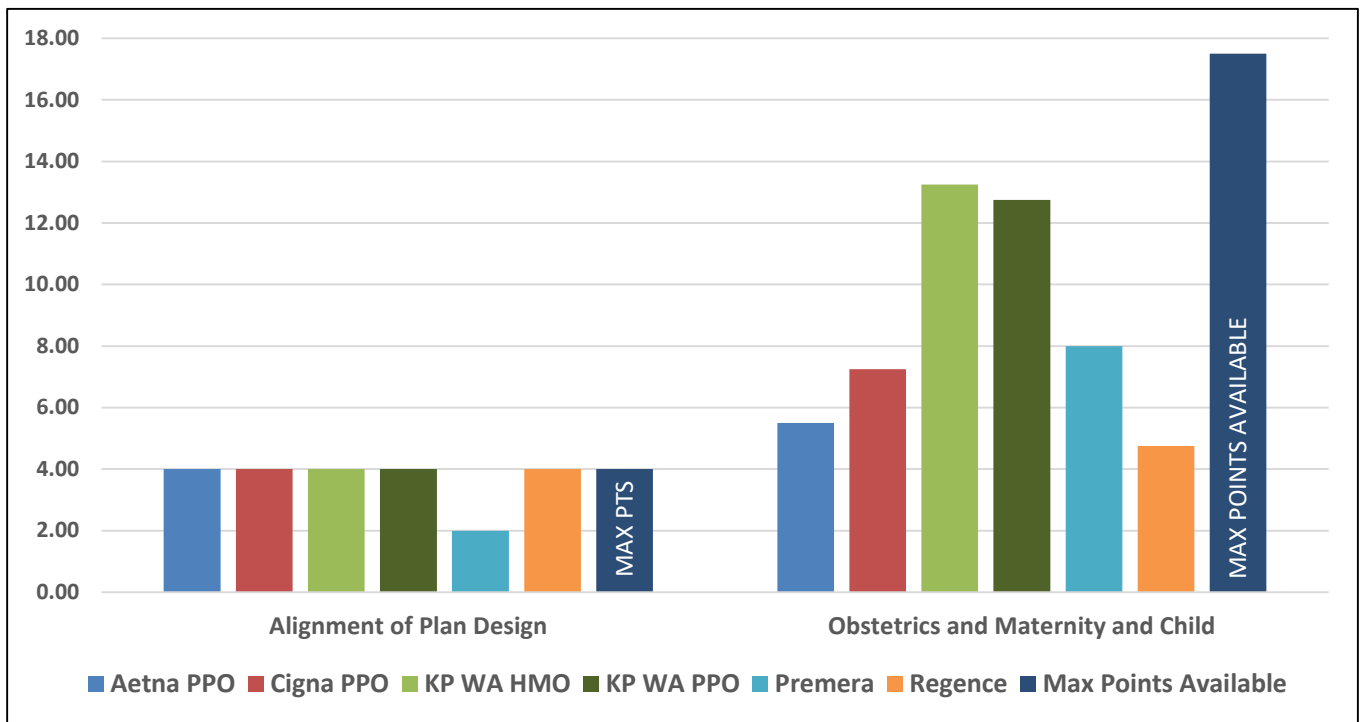
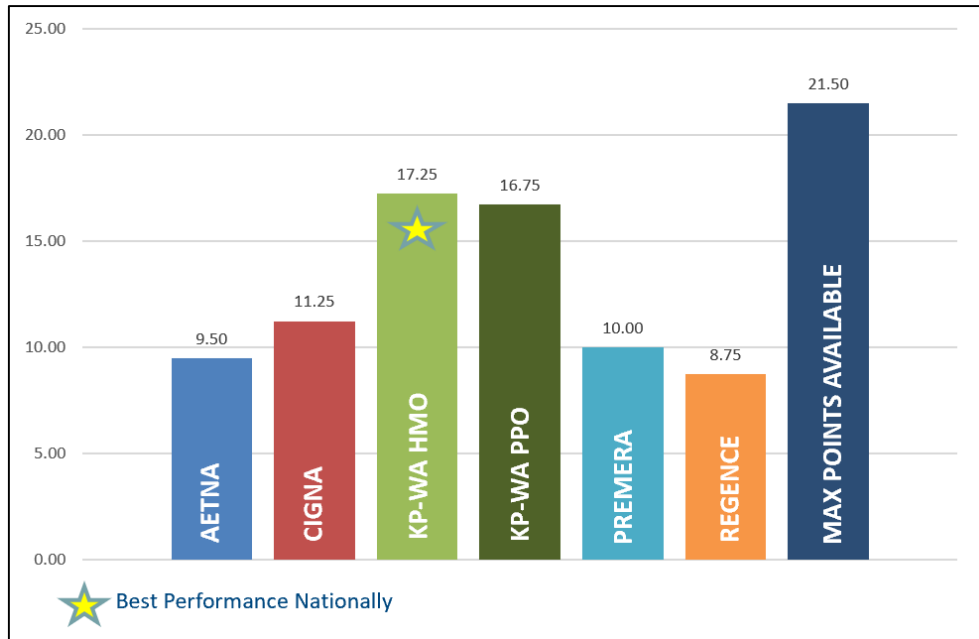
Kaiser Permanente Washington HMO ranked the highest in the nation in this module with 17.25 points.

- **Obstetrics/Maternity and Child (17.5 points)**
 - How well does the plan promote and support activities directly linked to healthier birth outcomes?
 - How well does the plan perform on C-section, vaginal birth after cesarean (VBAC), elective delivery rates, as well as HEDIS results on chlamydia screening and prenatal/postpartum care?
- **Alignment of Plan Design with Shared Decision-Making/Acute Care (4 points)**
 - Do plan designs promote member participation in shared decision-making?

Common Health Plan Themes

- All plans have robust policies for normal labor and delivery.
- Most plans need to increase reporting on early elective deliveries and VBAC.
- Most plans can improve results for chlamydia screening and prenatal care.

Module 5 Performance



Module 6 – Helping Members Manage Chronic Conditions, 28.5% (175.5 out of 616 points)

This module focuses on disease management of coronary artery disease (CAD), diabetes, depression, and alcohol and other substance use disorders.

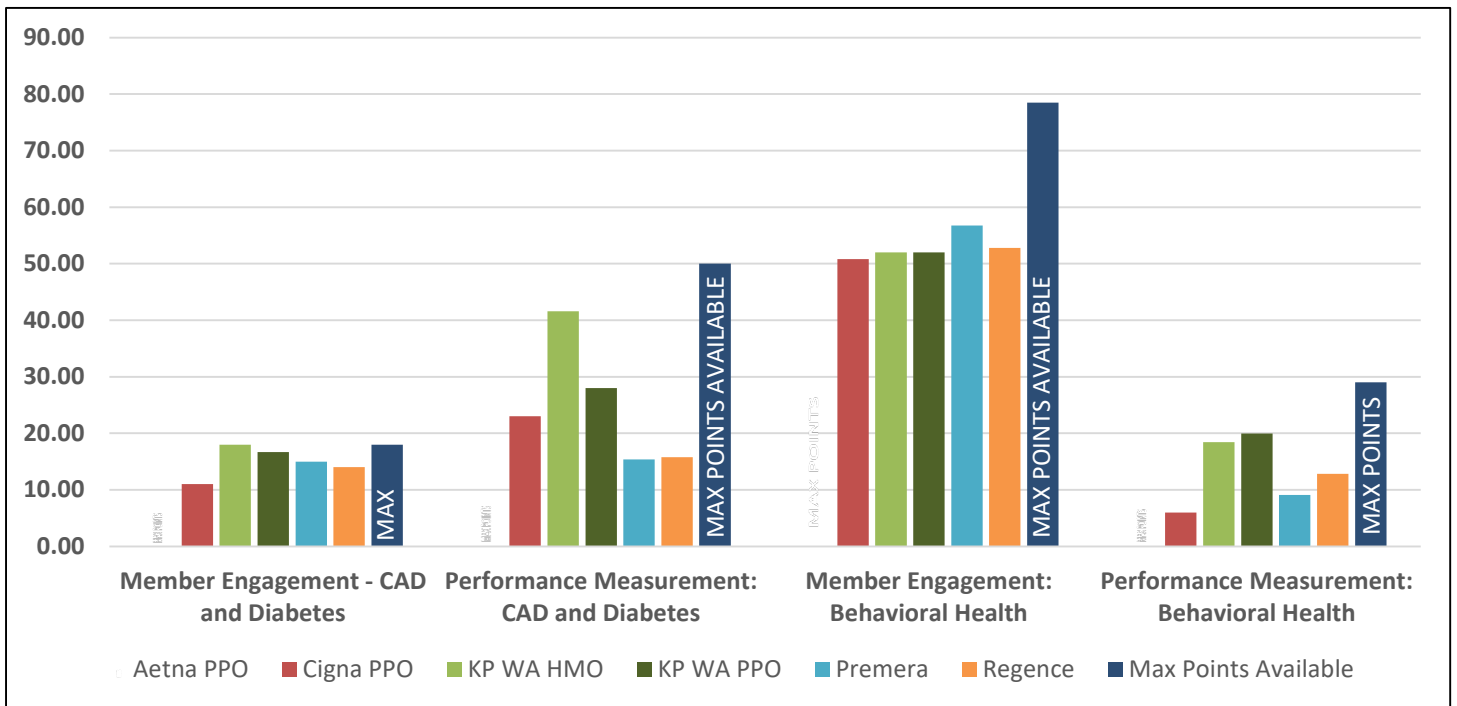
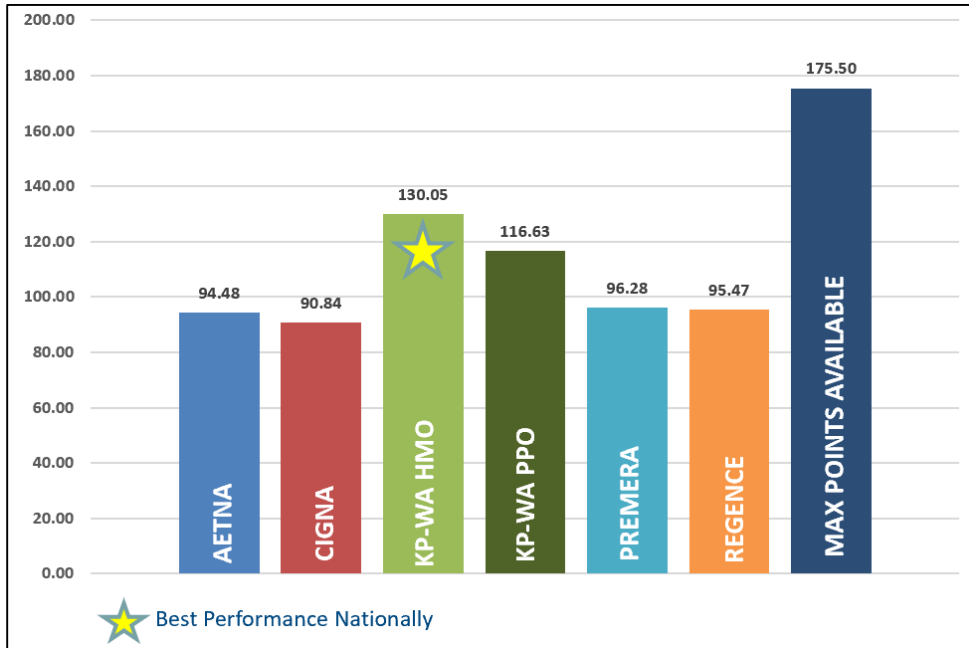
Kaiser Permanente Washington HMO had the highest national score in this module, 130.05 points.

- **Member Engagement: Behavioral Health (78.5 points)**
 - How well does the plan identify and engage members with depression or substance use disorders?
 - How well is the plan’s network meeting members’ mental health needs?
- **Performance Measurement: CAD and Diabetes – HEDIS Results (50 points)**
 - How well does the plan perform on HEDIS measures related to heart disease and diabetes?
- **Performance Measurement: Behavioral Health – HEDIS Results (29 points)**
 - How well does the plan perform on HEDIS measures related to behavioral health?
- **Member Engagement: CAD and Diabetes (18 points)**
 - How well does the plan identify and engage members with CAD or diabetes?
 - How well does the plan perform on Pharmacy Quality Alliance measures related to medication adherence for CAD and diabetes?

Common Health Plan Themes

- All plans provide appropriate access to pharmaceutical treatment for members identified with substance use disorder.
- All plans can improve member engagement efforts targeting behavioral health improvements.
- Most plans have low levels of attention on the measurement and reporting of behavioral health services related to wait times, integration, and network adequacy.

Module 6 Performance



Module 7 Medical Benefit Drug Management, 9.7% (59.5 out of 616 points)

This module identifies how the health plan organizes, administers, and manages its pharmaceutical program administered through its Medical Benefits.

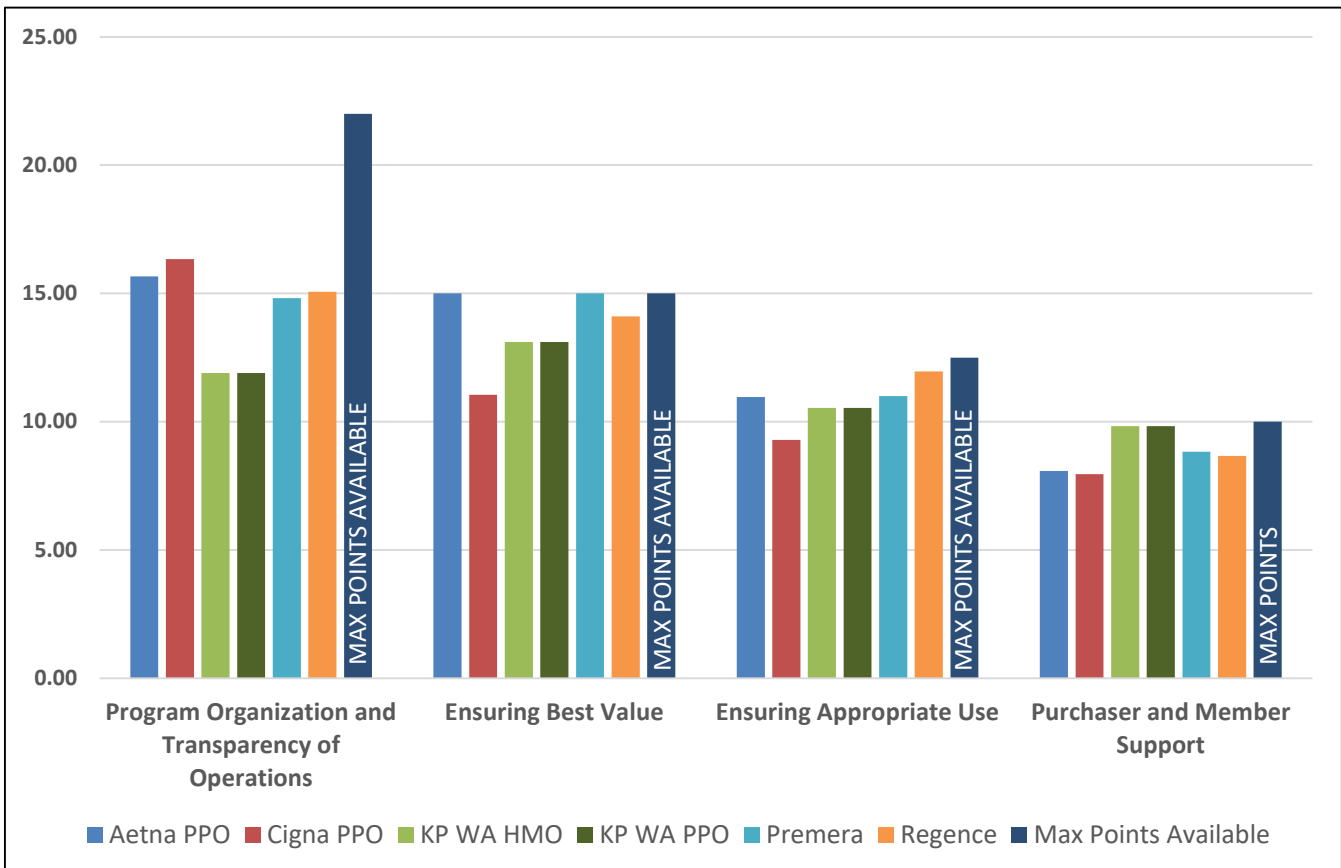
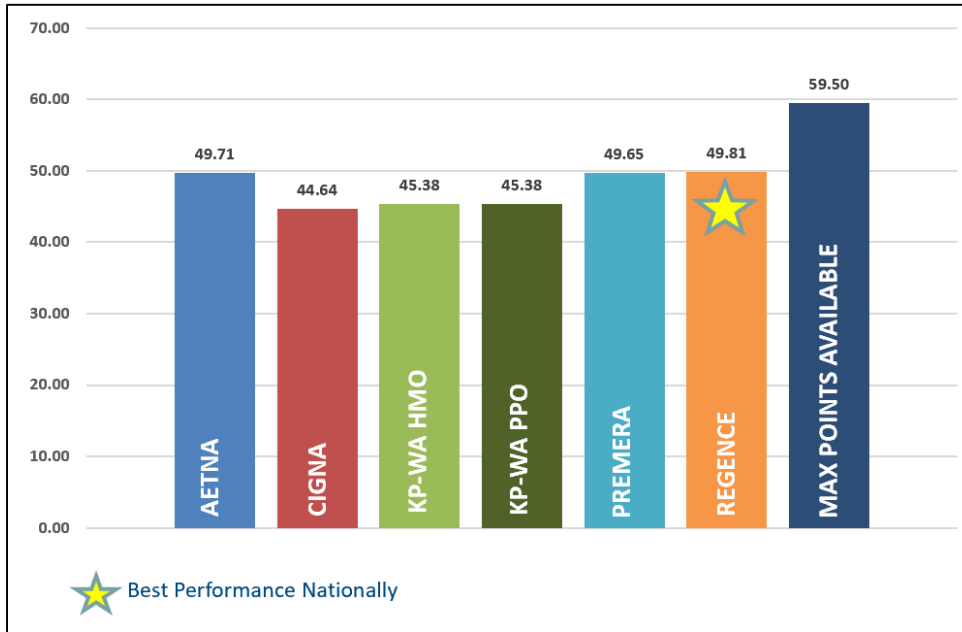
Regence BlueShield was the highest performing plan nationally with 49.81 points.

- **Program Organization and Transparency of Operations (22 points)**
 - How robust are contract requirements including the use of National Drug Codes and contract terms such as pass-back of manufacturer rebates, and outcomes-based measurement?
 - How transparent is the program to plan sponsors, including audit capabilities?
- **Ensuring Best Value (15 points)**
 - To what degree does the plan rely on third-party analysis, such as the Institute for Clinical and Economic Review, in determining value?
 - How does the plan encourage the use of cost-efficient medication options, including biosimilars (drugs derived from living organisms) that can act as a less expensive alternative in many instances, and site-of-care incentives?
- **Ensuring Appropriate Use (12.5 points)**
 - How well does the plan ensure the appropriate use of high-cost, high-value services such as genetic testing, and minimize waste?
- **Purchaser and Member Support (10 points)**
 - How well does the plan support member adherence to needed medications, including financial, emotional, psycho-social, and other supports?
 - To what degree is the plan reporting actionable information to plan sponsors?

Common Health Plan Themes

- Most plans are consistently using third-party resources to support their negotiating position on drug costs.
- Prior authorization, step therapy, and plan design are used by most plans to direct usage to high-value biosimilars and cost-efficient sites-of-care.
- Only one plan is sharing a substantial percentage of drug rebates with plan sponsors.

Module 7 Performance



Health Inequity & Social Determinants of Health

The importance of addressing social determinants of health and racial and ethnic disparities in health and health care have long been recognized in the U.S. and across the globe. The COVID-19 pandemic has exposed, in no uncertain terms, the significant disparities that continue to persist. The well-established [County Health Rankings Model](#) developed by the University of Wisconsin illustrates the many factors that contribute to health and health outcomes (Figure 1). Alliance purchasers are very committed to addressing the many factors that contribute to the persistent issues that create health disparities and ask that health plans and other partners join them in this effort.

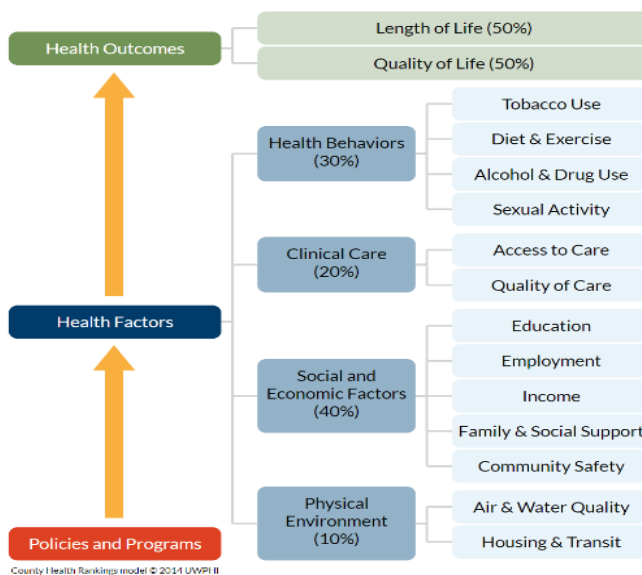


Figure 1: University of Wisconsin Population Health Institute, County Health Rankings Model.

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| <p>Opportunities We Can Address Together</p> | <ul style="list-style-type: none"> • In the absence of reliable, standardized Race, Ethnicity, and Language (REL) data, we need to work together to identify and leverage existing data sources that can augment health care data (claims or clinical) to illuminate actionable opportunities for improvement and measure progress. • Include the measurement of sub-populations in all efforts to evaluate care delivery, including cost, quality, value, and experience. |
| <p>Purchaser Perspective</p> | <ul style="list-style-type: none"> • Addressing health disparities and inequities is imperative. • There is a need for better data collection to inform the impact that REL and other social determinants of health have on the health of populations. • Regular assessments of unmet social needs are important foundational elements that must be in place to inform actions that address root causes. • Collective solutions are required for improvements. |
| <p>Common Strengths</p> | <ul style="list-style-type: none"> • There is strong shared awareness that REL and social determinants of health are significant impediments to individuals receiving needed care and achieving their best health. • There is interest in working collaboratively to address health inequities and social determinants of health, including identifying mechanisms for securing more complete REL data. • There is agreement on the value of making culturally competent care readily available, including mechanisms for individuals to locate providers aligned with their cultural preferences. |
| <p>Common Obstacles</p> | <ul style="list-style-type: none"> • There are no current mechanisms that standardize collection of REL data in ways that make it readily available for analytic or operational purposes that can be used to target improvements in health equity or limit the negative impact of social determinants of health. • There is an underlying lack of diversity in the clinical workforce, particularly among physicians, which reduces an individual’s ability to obtain care consistent with their cultural preferences. |

Advancing High-Quality Primary Care

Research and evidence from the U.S. and around the world continue to validate the concept that a strong primary care foundation is essential to create and sustain a high-performing health system. The National Academies of Science and Medicine emphasize this point in its recently released report [*Implementing High Quality Primary Care: Rebuilding the Foundation*](#) (Figure 2). Alliance purchasers are committed to working with providers and health plans to ensure their plan participants have access to a high-quality primary care network.



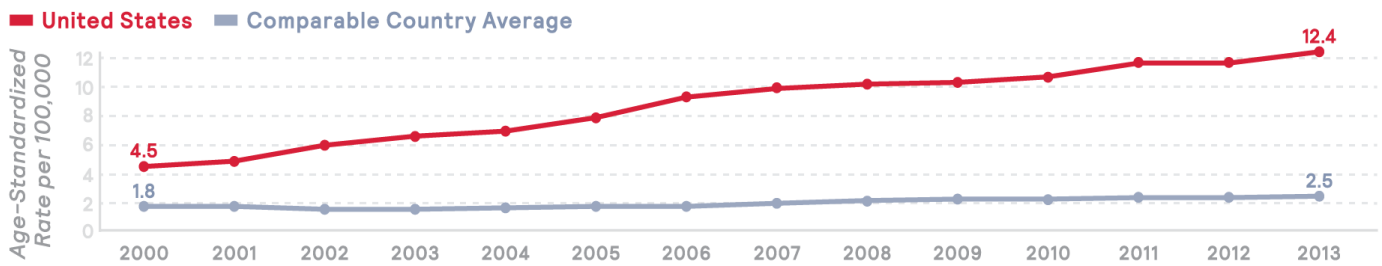
Figure 2. The National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (2021).

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| <p>Opportunities We Can Address Together</p> | <ul style="list-style-type: none"> • Health plans can improve advancement of high-quality primary care by participating in multi-payer models. Purchasers can support these advancements by working with health plans who use multi-payer strategies. • Purchasers can emphasize the importance of primary care in benefit designs by including lower out-of-pocket costs or tiered primary care networks. • Encourage individuals to identify their preferred source of primary care for prospective payment purposes – whether in an HMO or PPO plan. • Design and implement all primary care initiatives with a strong health equity focus. |
| <p>Purchaser Perspective</p> | <ul style="list-style-type: none"> • The level (% of total cost of care) and nature (fee-for service vs. prospective) of primary care spending are key indicators of investment in a high-performing health system as well as an acknowledgement that current levels are unacceptable. Health plans in Washington state report primary care spending of 5-10% of total cost of care, with 1-2% reported as being prospective on the eValue8 RFI. • There is strong support for multi-payer approaches to strengthen primary care in order to maximize investment and minimize unnecessary administrative complexity. • They are committed to plan participants having access to a robust, advanced primary care network and encourage its use through education and benefit design. |
| <p>Common Strengths</p> | <ul style="list-style-type: none"> • Health plans join purchasers in their commitment to strengthen primary care and most are open to doing so in a collaborative multi-payer approach. |
| <p>Common Obstacles</p> | <ul style="list-style-type: none"> • It is difficult to align payment approaches with existing provider capabilities and available resources. • Assigning individuals to primary care providers for the purpose of prospective payment is challenging, but doable, in a PPO environment. • Benefit designs currently provide little in terms of helping plan participants identify high quality primary care providers. |

Behavioral Health Access & Integration with Primary Care

Almost 18% of adults reported having a mental, emotional, or substance use disorder in 2015, according to a Kaiser Family Foundation [report](#) on the impact of mental health and substance use disorders in the U.S. The same report highlighted the significance of mental health and substance use disorders relative to other disease burdens as measured by Disability Adjusted Life Years (Figure 3). Strong primary care addresses the needs of the whole person, including behavioral, mental, and psychosocial needs. Integrating behavioral care for individuals can happen in a variety of ways. One example is collaborative care agreements with behavioral health specialists that allow primary care providers to meet patients’ needs without adding additional staff. Addressing the challenge of meeting members’ behavioral, mental and psychosocial needs within primary care settings was given particular attention in the eValue8 purchaser and health plan discussions.

Relative to Comparable Countries^a, the US Has Had Higher Rates of Death From Unintentional Poisonings^b



^a Based on size and wealth ^b 92% of unintentional poisonings in the US in 2013 were due to illicit or pharmaceutical drug overdoses.

Figure 3. JAMA. 2017;318(5):45. 10.1001/jama.2017.8558.

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| <p>Opportunities We Can Address Together</p> | <ul style="list-style-type: none"> • Ensure that regular assessments of an individual’s whole health are conducted, documented, and shared with the patient’s care teams, including behavioral health and other providers who are outside the primary care setting. • Accelerate the use of Collaborative Care codes by making training and technical assistance available to network providers. |
| <p>Purchaser Perspective</p> | <ul style="list-style-type: none"> • COVID-19 and social unrest over the last 12 to 18 months have taken a toll on all of us. • Ensuring plan participants receive strong whole-person primary care that addresses both physical and mental well-being concurrently is paramount. • Ensuring access to a network of readily available, high-quality care is essential for members with more severe behavioral health concerns. |
| <p>Common Strengths</p> | <ul style="list-style-type: none"> • There is agreement on the need to integrate behavioral health with primary care; many efforts currently underway place a high priority on making this happen. • There is shared commitment to increase access by expanding provider networks and facilitating virtual care options. • There is increased focus on tracking and monitoring behavioral health progress through the use of quality metrics specific to behavioral health. |
| <p>Common Obstacles</p> | <ul style="list-style-type: none"> • There is limited payment for behavioral health integration, including the uptake of new payment codes for Collaborative Care Models, which are important to support new investments that are made to meet patients’ behavioral health needs. • Finding creative solutions to address multifaceted behavioral health conditions requires structural changes that support collaborative delivery of health care services. |

Virtual Care–Telehealth and Telemedicine

The use of virtual care options to deliver care without an in-person visit has long been espoused as an effective and efficient means to manage minor acute needs and routine chronic conditions, but there was limited use of telehealth prior to March 2020. The COVID-19 pandemic lockdown showed us what is possible to achieve in a very short time span when telehealth visits increased exponentially. This is illustrated in the graph below from a CDC [report](#) showing the dramatic increase in telehealth visits during March 2020 (Figure 4).

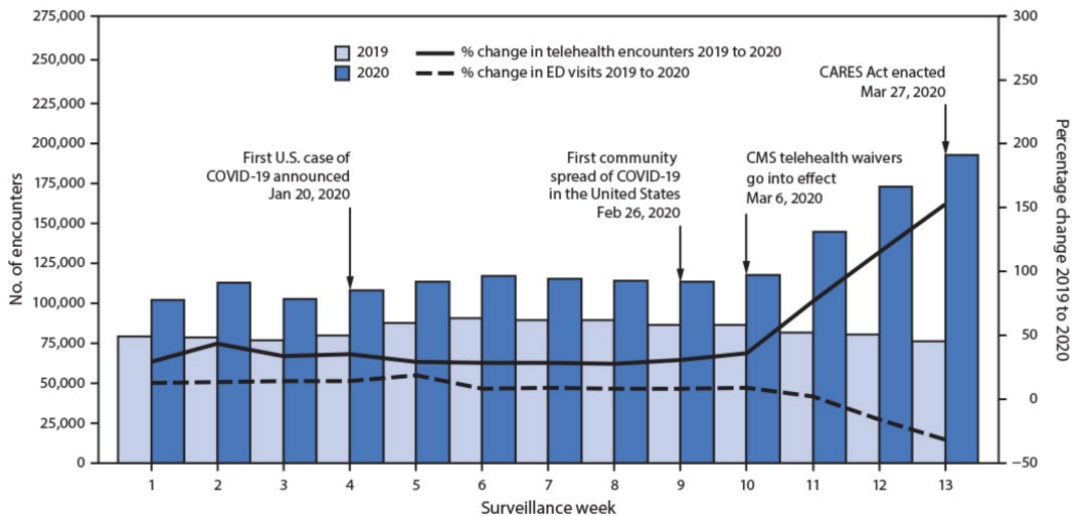
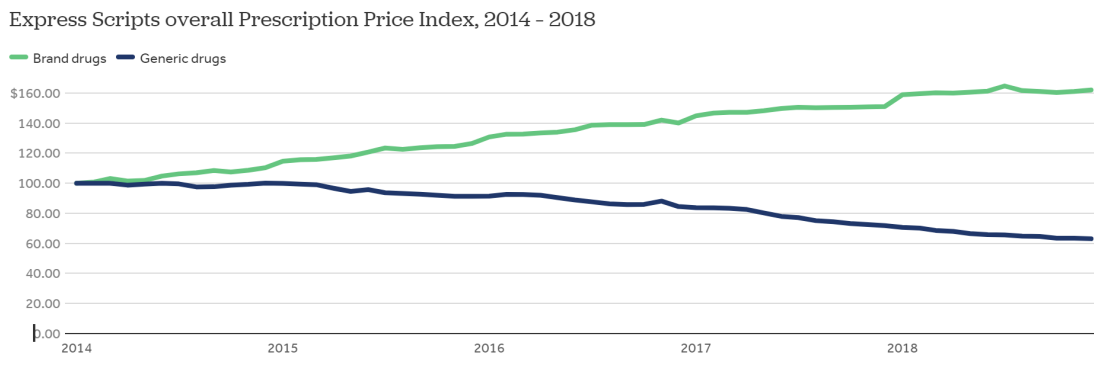


Figure 4. Koonin, LM, Hoots B, Tsang CA, et al. *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic-United States, January-March 2020*. MMWR Morb Mortal Wkly Rep 2020;69:1595-1599.

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| <p>Opportunities We Can Address Together</p> | <ul style="list-style-type: none"> • Ensure that there is patient-centric data-sharing across all modes of care, including virtual, whether offered through a traditional provider or third-party platform. • Evaluate the impact of virtual care on outcomes of interest–cost, quality, and experience–to ensure its appropriate use going forward. |
| <p>Purchaser Perspective</p> | <ul style="list-style-type: none"> • Access to convenient, affordable health care options that meet plan participant’s needs as they arise is a high priority. • Many virtual care alternatives, including telehealth, have the potential to fragment care for individuals. Supporting integrated care and the integration of patient information in a patient-centric manner is important. |
| <p>Common Strengths</p> | <ul style="list-style-type: none"> • A silver lining of COVID-19 is the increase in virtual care capabilities and use. It expanded beyond acute or urgent care to include a broad range of services, such as behavioral health and physical therapy. • Payment rules have expanded the availability of virtual care and will continue to remain in place for the foreseeable future. |
| <p>Common Obstacles</p> | <ul style="list-style-type: none"> • Virtual care platforms supported by third party vendors can lead to fragmented care for individuals. Some plans currently address this on behalf of their members; all plans have the opportunity and obligation to integrate this care option so that information is integrated into the patient record and shared across providers in a patient-centric manner. • The long-term effectiveness of virtual care is unknown, particularly for new virtual care areas, such as behavioral health and physical therapy. |

Medical Benefit Medication Cost Management

One of the most challenging aspects of managing the rising cost of medications is the lack of transparency that purchasers have into the price and utilization of prescriptions purchased by plan participants. This is true for medications purchased through a retail or mail-order pharmacy and can be even greater for medications administered directly by providers and covered under the plan sponsor’s medical benefits. Many of these medications are considered “specialty drugs” which is a designation earned based on a drug’s high cost, the complexity of the condition addressed, or the high touch required for delivery or administration of the medication, including many of which are delivered by infusion therapy. The rising cost of specialty brand drugs is highlighted in this [graph](#) provided by the Kaiser Family Foundation which shows that brand drug costs have increased 57% since from 2014 to 2018 (Figure 5).



Source: Express Scripts • Get the data • PNG

Peterson-KFF
Health System Tracker

Figure 5. Peterson-KFF Health System Tracker, Kamal R, Cox C, and McDermott D. *What are the recent and forecasted trends in prescription drug spending?* February 20, 2019.

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| <p>Opportunities We Can Address Together</p> | <ul style="list-style-type: none"> • Increase visibility of price and utilization of all services for purchasers, including medications, regardless of where they are received, or which benefit provision applies. • Continue to focus on ensuring receipt of the most efficient and effective medications. • Health plans should make the price of medications and alternatives available to individuals and plan sponsors. • Incentivize the use of biosimilars (drugs derived from living organisms) that can act as a less expensive alternative in many instances and generic drugs when available and efficacious. |
| <p>Purchaser Perspective</p> | <ul style="list-style-type: none"> • Purchasers are concerned that medication costs covered under Medical Benefits have not received enough attention and can be mitigated. • There is a lack of transparency for rebates, prices, and biosimilar alternatives that prevents purchasers from proactively addressing rising medication costs. |
| <p>Common Strengths</p> | <ul style="list-style-type: none"> • All purchasers are focused on improving transparency and addressing excess costs. • Many purchasers report focusing on, and seeing improvement in, the use of biosimilars. |
| <p>Common Obstacles</p> | <ul style="list-style-type: none"> • Many plans are working toward greater transparency but there are plenty of opportunities for improvement. • Irrational pricing strategies create the need for unnecessary interventions, such as steerage to less costly sites-of-care. |

Alliance members understand that health care improvement is best served through a collaborative process and view their participation in that process as vital. At the Alliance, we welcome all members of the health care community to engage in that process and were pleased to facilitate the 2020 eValue8 process which included the robust discussions documented in this report.

The leadership of the Alliance’s purchaser members and the collaborative approach of the health plans that elected to participate in the 2020 eValue8 process is what ensures its success. It is a significant commitment of time and resources by all of the organizations involved and demonstrates their commitment to improve health and health care in Washington state.

That commitment is evidenced by the strong results achieved by the Washington health plans presented in this report. Washington is fortunate to have several plans recognized as top performers nationally overall and in four of the seven modules. It is appropriate to take a moment to acknowledge their participation and their achievement:



- Kaiser Permanente Washington HMO for best overall, for chronic condition management, and for helping members manage acute/episodic conditions;
- Kaiser Permanente Washington PPO for provider measurement and management; and
- Regence BlueShield for medical benefit drug management.

Exceptional performance occurs through deliberate and consistent effort. We acknowledge not only those who meet that standard, but the efforts of all to reach for it, and encourage purchasers and plans to use these insights to continue to improve the health care delivered across Washington state.

About the Washington Health Alliance

The Washington Health Alliance (Alliance) is a 501(c)(3) nonprofit nonpartisan organization working collaboratively to transform Washington state’s health care system for the better. The Alliance brings together more than 185 committed member organizations to improve health and health care by offering a forum for critical conversation and aligned efforts by health plans, employers, union trusts, hospitals and hospital systems, health care professionals, start-up companies, consultants, consumers, and other health care partners. The Alliance believes strongly in transparency and offers trusted and credible reporting of progress on health care quality, value, pricing, and overall spending. The Alliance publishes its reports at WACommunityCheckup.org and provides guidance for consumers at OwnYourHealthWA.org so that individuals can make informed health care decisions.

Nancy Giunto
Executive Director
Email: ngiunto@wahealthalliance.org
Phone: 206.454.2951

Mark Pregler
Director, Data Management and Analytics
Email: mpregler@wahealthalliance.org
Phone: 206.454.2952

Karen Johnson
Director, Performance Improvement and Innovation
Email: kjohnson@wahealthalliance.org
Phone: 206.454.2953

Theresa Lampkin Tamura
Director, Membership and Business Engagement
Email: ttamura@wahealthalliance.org
Phone: 206.454.2957



For more about the Alliance:
WashingtonHealthAlliance.org

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