

# “ALIGNING FORCES FOR QUALITY”

## EVALUATION

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## Using Community-Level Quality Measurement to Promote Value in Health Benefit Design : The Experience of Maine’s State Employees Health Insurance Program

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## Introduction

It has been well established that care for chronic disease in the United States is not optimal, and a variety of interventions have been proposed across the ideological spectrum to improve that care. There has been a growing interest in quality improvement interventions targeted at patients and consumers—a “consumer focused” strategy. One particular intervention which is garnering considerable attention is the concept of “tiering and steering.” Tiering has been defined as: “the classification of health care providers (e.g., hospitals or physicians) or treatments (e.g., pharmaceuticals, durable medical equipment, physical therapy) into different groups or ‘tiers’ based on objective or subjective criteria such as measures of cost, quality, safety or value.”<sup>1</sup> Employers or health plans may provide financial incentives to consumers in an effort to “steer” them to high quality or low cost providers, based on these tiers, through reduced deductibles or copayments. Tiering has been applied extensively to prescription drug benefits.<sup>2</sup> While not as extensive, tiering of physician and hospital services is growing.<sup>1</sup>

The Maine Health Management Coalition (MHMC), an alliance of employers, hospitals, health plans, and physicians, and an Aligning Forces for Quality (AF4Q) grantee, provides a useful example of how provider tiering and steering programs can be executed in the real world.<sup>3</sup> A pillar of AF4Q in the State of Maine is the development and public reporting of physician quality measures. The MHMC has worked with its employer, physician, and health plan members to develop widely supported public reporting of physician practice quality based on National Committee for Quality Assurance (NCQA) and Bridges to Excellence (BTE) metrics. The State Employee Health

### Aligning Forces for Quality

The Robert Wood Johnson Foundation (RWJF) is investing in efforts to improve health systems in 15 communities across the nation.

Called Alligning Forces for Quality (AF4Q), the initiative brings a commitment of resources, expertise and training to turn promising practices into real results at the community level. AF4Q asks the people who get care, give care and pay for care to work together toward common fundamental objectives to lead to better care.

The initiative aims to lift the overall quality of health care, reduce racial and ethnic disparities and provide models for national reform. It advances three interrelated reforms that experts believe are essential to improving health care quality:

- **Performance measurement and public reporting**
- **Consumer engagement**
- **Quality improvement**

For more information about AF4Q, please visit

<http://www.rwjf.org/quality/quality/af4q/about.jsp>

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Commission, which manages the health benefit plan for state employees, used the MHMC quality measurement initiative to tier providers and hospitals; the Commission also has worked with its health plan to provide incentives to consumers to seek care from high quality physician practices and hospitals. In this Research Summary, we describe the key features of the program in Maine and discuss the lessons learned through this initiative.

## Provider Tiering in Maine

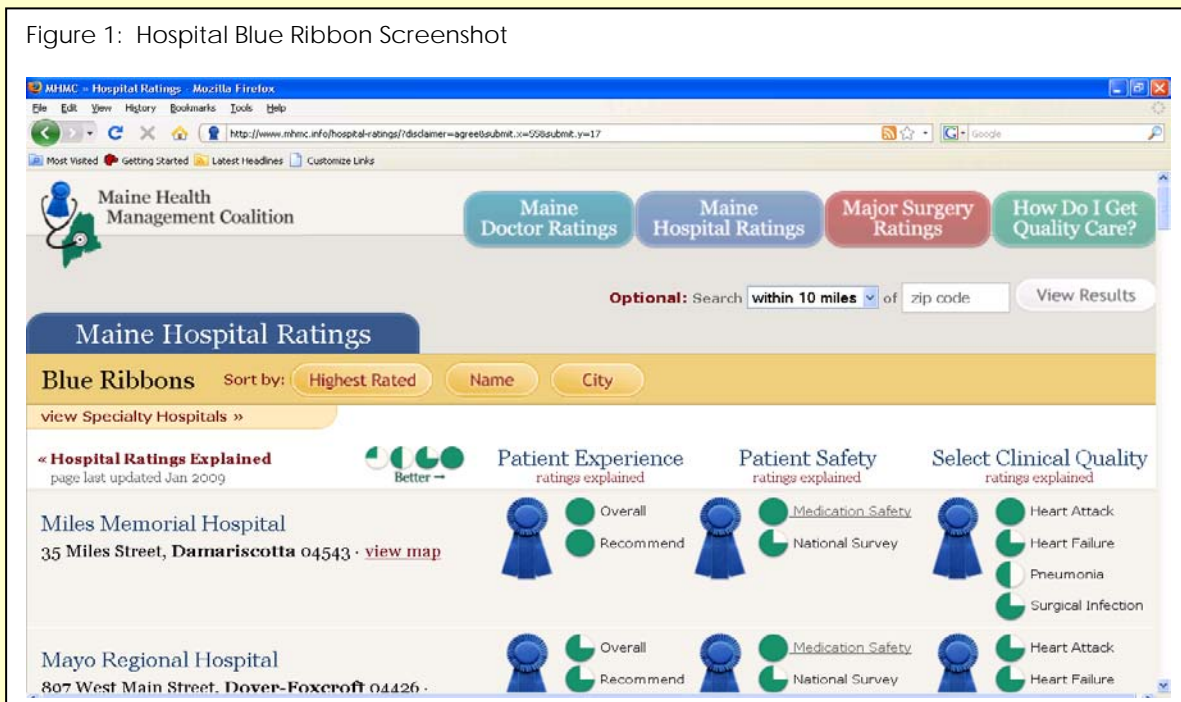
### *MHMC's Blue Ribbon Program*

In an effort to promote transparency across the state, the Maine Health Management Coalition (MHMC) has embarked on an expansive effort to publicly report the quality of care provided by physicians and hospitals. MHMC rates each hospital and primary care practice in the state on a number of quality domains.

**Hospitals:** Hospitals are measured on patient satisfaction, patient safety, and quality of clinical care for heart attacks, heart failure, pneumonia, and surgical site infections.<sup>4</sup> MHMC collects hospital quality data from a variety of sources. Patient satisfaction scores come from the new Hospital Consumer Assessment of Health Plans Survey (HCAHPS) ratings on the U.S. Department of Health & Human Services (HHS) Hospital Compare website ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)). Hospital safety is measured using a composite safety score from the Leapfrog Group as well as MHMC's annual Medication Spotlight Survey. This survey rates hospitals on the systems in place to double check medications, record medication administration, store medications appropriately, verify medications at the bedside, and track pharmaceutical management of patients with renal failure. MHMC developed the Medication Spotlight Survey several years ago when it was concerned that the Leapfrog computerized physician order entry (CPOE) ratings would not be applicable to many small Maine hospitals. Clinical quality performance for heart attacks, heart failure, pneumonia, and surgical site

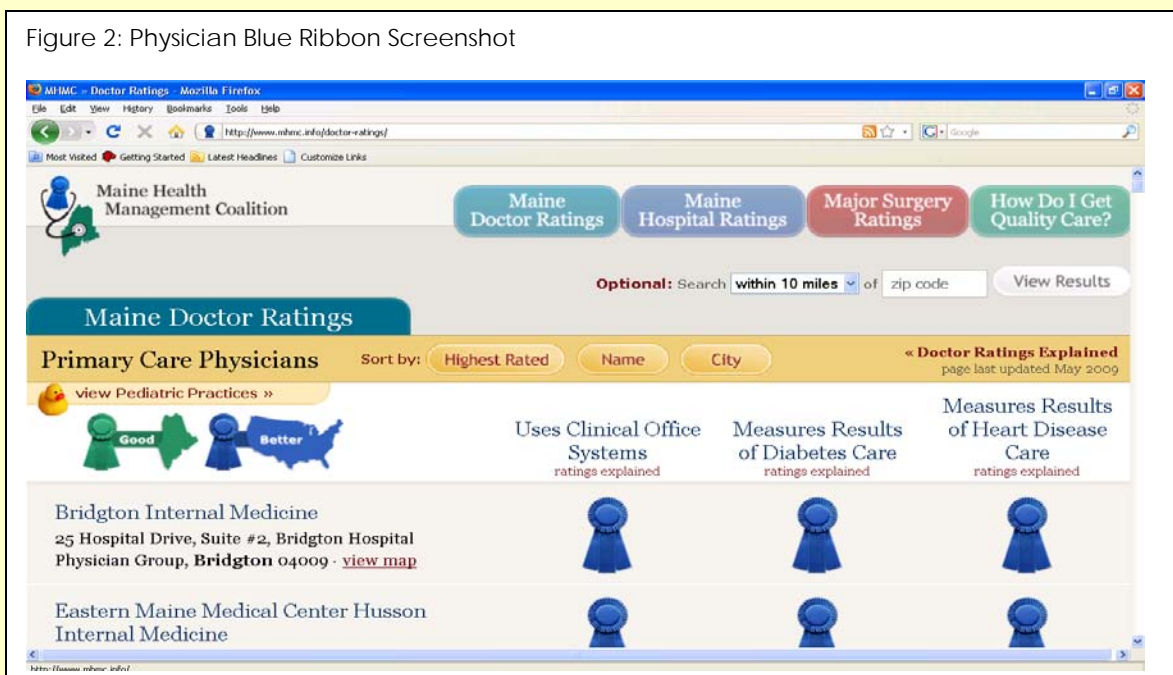
infections is based on data collected by HHS and made publicly available on its Hospital Compare website. Hospitals can receive up to three blue ribbons, one for each of three categories (see Figure 1).

Figure 1: Hospital Blue Ribbon Screenshot



**Primary Care Practices:** Primary care practices are measured on three domains: (a) use of quality office systems, such as a registry and electronic prescribing; (b) measurement of care quality for diabetes; and (c) measurement of care quality for heart disease. Pediatric practices are measured on asthma care and immunization status instead of diabetes and heart disease, as well as use of quality office systems. High performing practices in each of these three domains are awarded a "blue ribbon." Adult practices can receive up to three blue ribbons, one for each domain (see Figure 2) when a threshold

Figure 2: Physician Blue Ribbon Screenshot



proportion of its physicians (as determined by a MHMC expert committee) receives recognition from NCQA or BTE physician recognition programs in that domain. Pediatric practices receive blue ribbons by submitting clinical performance and clinical systems measures directly to MHMC as national recognition programs have not been developed for pediatric practices.<sup>5</sup> Finally, some adult practices are too small or otherwise cannot qualify for NCQA or BTE designation; MHMC has made special accommodations for these practices by granting them a “green ribbon” for reporting clinical measures directly to MHMC and performing satisfactorily on MHMC’s office system survey.

The thresholds used to determine blue/green ribbon status are determined by two expert committees of MHMC, one for physician practices and one for hospitals. These committees consist of representatives from a variety of stakeholder groups including employers, physician practices, health plans, consumers, and hospitals.

### ***Tiered Health Plan Benefit Design at a Member Organization***

A wide variety of employers are members of the MHMC collaborative including Bath Iron Works, Hannaford Brothers, State of Maine, University of Maine System, and L.L. Bean. Many employer members of MHMC use the Blue Ribbon program to encourage employees to make decisions about where to access care; each employer has the freedom to decide how the ratings will be used to inform or incentivize its employees to make informed health care choices.

One particular employer, the State of Maine, uses financial incentives to steer patients in the State Employees Health Insurance Program (SEHIP) to high quality physician practices and hospitals. SEHIP covers 40,000 lives including 30,000 employees and dependents as well as 10,000 retirees and their dependents.<sup>6</sup>

Since 2006, hospitals in the SEHIP’s provider network that receive a blue ribbon in both the patient safety and quality of clinical care categories are given a “preferred” status.<sup>7</sup> Copayments and deductibles are waived for patients who receive care at preferred hospitals, but patients who visit non-preferred hospitals must pay \$100 per day (up to \$300 per year) and \$50 for outpatient surgery. A similar program was started in 2007 for primary care practices. When beneficiaries receive care from primary care practices (PCPs) with two or more blue or green ribbons, all office visit copayments are waived and any services provided by preferred PCPs are not subject to deductibles. However, beneficiaries who use a non-preferred physician practice are required to pay the copayment (\$10) and deductible (\$200). Beneficiaries can find the status of physician practices and hospitals on the health plan website or by calling a toll-free phone number provided to health plan members.<sup>8</sup>

Although the University of Southern Maine’s Muskie School of Public Service recently has received funding to investigate the effects of the Blue Ribbon program, there presently is no literature studying the impact of the Blue Ribbon program generally or SEHIP’s tiering and steering program specifically. However, there is

substantial anecdotal evidence that hospitals and physician practices are at least paying attention and responding to the Blue Ribbon program. For example, pharmacists in many hospitals have cited the Blue Ribbon status in an attempt to convince hospital leadership to invest in electronic medication order entry systems. However, it is impossible at this time to understand specific and systematic impacts of the programs or to disentangle the effect of the public reporting aspect of the Blue Ribbon program from associated benefit design changes and/or efforts providers are undertaking on their own.

## Early Lessons Learned

Individuals familiar with the Blue Ribbon program have stressed that multistakeholder input during the development of the tiering process helps to increase the buy-in of all key participants. For example, providers participating on the MHMC Blue Ribbon committees were concerned with the accuracy of administrative data and, as part of the committee, lobby for the use of self-reported clinical data. This provider participation could mitigate backlash that may come when practices or hospitals lose, or fail to attain blue ribbon status.

Related to this point, stakeholders in Maine also stress the importance of accurate measurement; faulty measurement can lead to the false classification of providers and their performance, potentially yielding substantial reputational, revenue, and market share consequences. As communities move from

public reporting to pay-for-performance to tiered benefits structures, the stakes for providers rise and the need for robust measures becomes increasingly important. Because identifying these robust measures can be difficult, the MHMC has relied on measures that have been extensively utilized, vetted, and/or endorsed by large, established quality measurement organizations such as the Leapfrog Group, HHS, NCQA, and the National Quality Forum (NQF).

Finally, developers of tiering and steering programs must be attuned to local market conditions; in Maine, program developers must pay special attention to the challenges posed by rurality. For example, in many parts of the state, there may only be a single physician practice for miles. These physician practices may have little competitive incentive to report their quality and patients have little choice of where to access care. In this case, the effects of tiered benefits would be limited.

Alliance stakeholders made efforts to ensure physician buy-in despite the potential absence of competitive forces. Because the steering committees that determine the ratings have substantial clinician representation, stakeholders hope that all providers will consider the reporting of the quality metrics as “the right thing to do” and use the measures to assess and improve their own performance. Moreover, alliance stakeholders have worked to ensure that the same quality metrics are used in most, if not all, pay-for-performance and tiering and steering programs in Maine. That way, if providers focus

on delivering the highest quality of care, they will maximize the rewards from all parties.

MHMC also has paid special attention to the unintended consequences of the Blue Ribbon program particularly on small physician practices that have less reporting capacity than their larger counterparts. For example, it has given smaller physician practices the option to record and submit quality scores manually, rather than electronically, and it also has developed the Green Ribbon program for these practices, which allows them to be designated even if they cannot qualify for national recognition programs. Although these specific issues may not apply to every region, local market characteristics still have important implications for tiering and steering programs everywhere.

Interest in tiering and steering programs is likely to grow. A forthcoming book by the Institute of Medicine (IOM), "Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes and Innovation," includes a chapter on tiering and steering which provides an extensive literature review as well as a discussion of the role of tiering and steering programs in the future. The IOM chapter and other publications maintain the spotlight on these tiering and steering programs. Furthermore, although evidence remains limited regarding the effectiveness of these programs, a recent publication by Scanlon, Lindrooth, and Christianson, demonstrate that tiering may have some, if limited, effect on hospital choice.<sup>9</sup>

Continued learning from the SEHIP and the AF4Q project also will provide useful information on the potential role of tiering and steering for improving value in health care.

This report was prepared by the Aligning Forces for Quality Evaluation Team at Penn State University's Center for Health Care and Policy Research which is studying the AF4Q initiative to gain insights about community-based reform that can guide health care practice and policy. The AF4Q Evaluation Team presents periodic issue briefs on key findings and policy lessons gleaned from its ongoing mixed-method evaluation of the AF4Q program.

***For more information about the AF4Q***

***Evaluation Team -***

[\(http://www.hhdev.psu.edu/CHCPR/alignforce/\)](http://www.hhdev.psu.edu/CHCPR/alignforce/)

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#### Notes

<sup>1</sup> Scanlon, D.P., & Martsof, G.R. (2009). The Role of Tiered Benefit Designs for Improving Value in Health Care. In Institute of Medicine, *Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes and Innovation*. Washington, DC: National Academies Press.

<sup>2</sup> The Kaiser Family Foundation and the Health Research & Educational Trust. (2008). *Employer Health Benefits Annual Survey*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

<sup>3</sup> MHMC is the primary grantee in Maine for the Aligning Forces for Quality project.

<sup>4</sup> As of January 2009, hospitals are also rated based on volume and performance on a number of common surgeries. However, the blue ribbon system is not used in this case and was not used for tiering hospital benefits in Maine's State Employee Health Insurance Program.

<sup>5</sup> The Maine Health Information Center (MHIC), an independent, non-profit, health care data organization collects local physician practice quality data and provides the results to MHMC.

<sup>6</sup> Foubister, V. (2009). *Case Study: State of Maine Ranks Providers Based on Quality*. NY, NY: Commonwealth Fund.

<sup>7</sup> The patient experience category has not been used historically to determine preferred status although it will be used beginning in 2010.

<sup>8</sup> The State of Maine self-funded plan is administered by Anthem Blue Cross and Blue Shield. The ratings are available on the Anthem website.

<sup>9</sup> Scanlon, D. P., Lindrooth, R. C., & Christianson, J. B. (2008). Steering Patients to Safer Hospitals? The Effect of a Tiered Hospital Network on Hospital Admissions. *Health Services Research*, 43(5 Pt 2), 1849-68.