

# A Guide to Tennessee Health Plan Performance

eValue8 2010

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The Tennessee eValue8™ 2010 *A Guide to Tennessee Health Plan Performance* is published and presented by:  
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Memphis Business Group on Health (MBGH) and HealthCare 21 (HC21) are pleased to publish our annual Tennessee health plan performance report based on the nationally recognized eValue8™ tool developed through the National Business Coalition on Health. This report shows how much progress Tennessee health plans have made in meeting employer purchaser expectations in such critical areas as prevention & health promotion, chronic disease management, consumer engagement, pharmacy management, behavioral health and provider measurement.

eValue8™ is not just about the scores health plans received, but also about the experience health plans, coalitions, and employer purchasers have participating in the process. In eValue8™:

- Health plans answer a rigorous survey and provide evidence about the cost and quality of care delivered to their members.
- Certified eValue8™ scorers at MBGH and HC21 review and score health plan performance to verify that the health plans' information is accurate and comparable.
- Extensive feedback is given to plans in a face-to-face meeting with each health plan's leaders, the coalitions, and employer purchasers.
- Health plans are asked to collaborate with employer purchasers, coalitions and each other to use this information for community-wide health improvement.

MBGH's primary reason for asking health plans to participate in eValue8™ has been to establish a structure for on-going dialogue with plans around how to improve the quality of care, engage consumers, and increase efficiencies. Through this structure we work with health plans to bring effective strategies they have been implemented in other markets to Memphis so that we too can benefit from the improvements in cost and quality; we hold health plans accountable for the services they provide and establish goals for improvement; and we identify cost and quality issues that affect all health plans and employers in Memphis and ways we can work together for sustainable change.

In 2010, three statewide health plans participated in eValue8™:

- BlueCross BlueShield of Tennessee PPO
- CIGNA Healthcare of Tennessee PPO
- UnitedHealthcare of Tennessee PPO

Although they were asked to participate, two statewide health plans declined in 2010

- Aetna of Tennessee PPO
- Humana PPO

This year we took a look backward to see whether or not Tennessee health plans have made actual progress in meeting MBGH member expectations. We are pleased that for three eValue8™ modules, all three plans have shown improvement since 2008:

- Consumer Engagement, from all three plans scoring a 76% in 2008 to a range of 78%-84% in 2010.
- Provider Measurement, from a range of 58%-65% in 2008, to a range of 71%-83% in 2010.
- Chronic Disease Management: from a range of 57%-61% in 2008, to a range of 68% to 80% in 2010.

Keep in mind that purchaser expectations actually increased over this time period and, therefore, plans not only improved on basic expectations, but were also able to meet the increasing demands placed on them by purchasers.

We also looked at plan-specific progress from 2008 to 2010. We found that:

- BlueCross BlueShield of Tennessee improved in all 7 modules and by 2010 was the highest performing plan in 5 of the 7 modules.
- UnitedHealthcare improved in 5 of the 7 modules and was the highest performing plan in 2 of the 7 modules.
- CIGNA Healthcare improved in 4 of the 7 modules.

Although there has been much improvement over the past three years in overall module performance, very little improvement, especially as compared to the rest of the U.S., has been achieved in raising HEDIS scores by Tennessee health plans. MBGH considers HEDIS scores to be the “outcomes” measures for overall plan performance. Expectations outlined in each module really are expectations around plan programs and activities that should drive improvement in health as measured through HEDIS.

HEDIS scores are considered in the scores assigned in each module and HEDIS performance is, therefore, not transparent in this report. For the past 3 years, MBGH has produced a separate HEDIS analysis for each plan and used that report to engage the plans in discussions around specific opportunities.

This year, MBGH addressed the eValue8™ site visit with each plan differently. We focused on those portions of eValue8™ that are evidence-based “drivers” of health status and cost. These “drivers” are spread throughout the modules, much like HEDIS measures, and, therefore, don’t lend themselves to a module-level analysis or report. MBGH will provide the participating health plans, our Members, Partners, and Patrons a copy of the special eValue8™ report on Tennessee health plan performance on these critical drivers.

As always, we thank health plans for the significant time and effort it takes to participate in eValue8™. The process is long, taking at least 7 months from health plans getting the survey to the face-to-face feedback meeting. It is challenging because employer purchasers have high expectations. It is transformational with health plan leaders, coalitions and employer purchasers collaborating on how to change the way health care is delivered in Tennessee.

We see now that the hard work of the Tennessee health plans is beginning to benefit purchasers and their employees and families. We still have much work to do and will begin to measure health plan progress in performance on these critical drivers of health status and cost.

We trust employer purchasers and others will find the eValue8™ process a powerful and useful tool that creates a structure for improving health and health care in Memphis.

Cristie Upshaw Travis  
Chief Executive Officer  
Memphis Business Group on Health

## Descriptions and Definitions

### eValue8™

The eValue8™ tool uses a standard annual request for information (RFI) survey to gather benchmarks in critical areas of the health plan operation such as health information technology, member and provider communication, disease management, prevention/health promotion programs and administration, provider performance, patient safety, pharmacy management, behavioral health and financial stability. Standardized performance results are reported for HMO and PPO products.

### Product Description

Commercial health plans may offer more than one product type – Health Maintenance Organization (HMO), Health Maintenance Organization/Open Access Product (HMO/OAP) or Preferred Provider Organization (PPO). The performance results in this report are presented by product type defined below.

- ❑ **PPO** - A health care benefit arrangement that provides incentives to use designated health care practitioners (who contract with the PPO), while also providing coverage for services rendered by health care providers who are not part of the PPO network.

### Data

- ❑ **HEDIS** (Healthcare Effectiveness Data and Information Set) data reports on performance measurement from each health plan for calendar year 2008. Data apply to commercial products. NCQA is a not-for-profit organization committed to evaluating and publicly reporting on the quality of managed health plans. HEDIS, developed by NCQA, is a set of standardized performance measures designed to ensure that purchasers and consumers can reliably compare plans.
- ❑ **CAHPS** (Consumer Assessment of Healthcare Providers and Systems) program is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to support the assessment of consumers' experiences with health care. The goals of the CAHPS program is to develop standardized patient questionnaires that can be used to compare results across sponsors and over time and to generate tools and resources that sponsors can use to produce understandable and usable comparative information for both consumers and health care providers.
- ❑ **National Benchmark** represents the best health plan with the highest performance score nationally for PPO products.

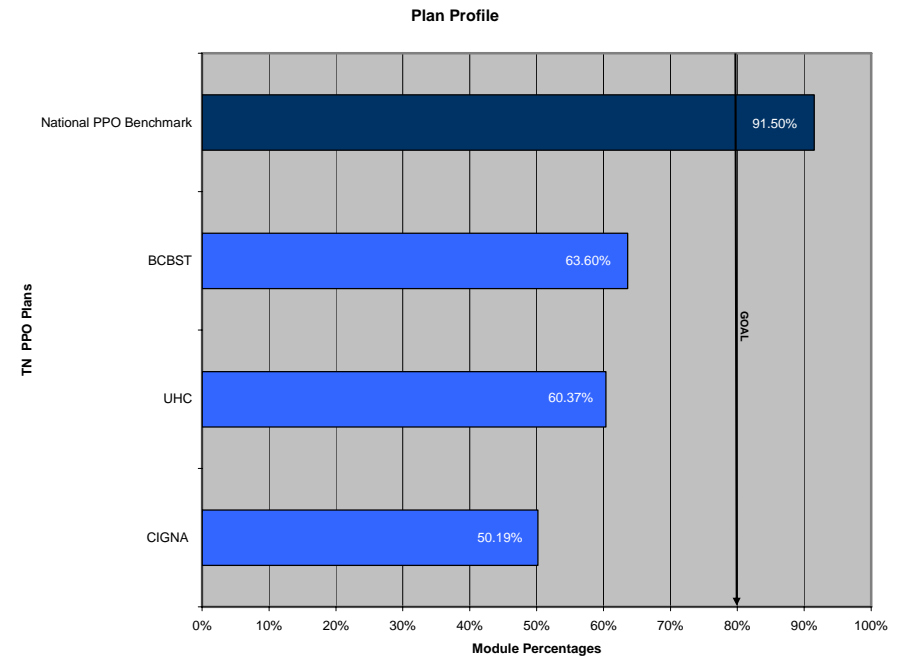
### How to Read the Graphs

The information tabulated is based on the responses to the eValue8™ 2010 RFI performance tool by the Tennessee health plans. For comparison purposes each graph demonstrates the performance in critical areas of the health plan operation of the Tennessee health plans compared to each other and to national benchmarks for PPO products.

## Plan Profile

### Plans are expected to:

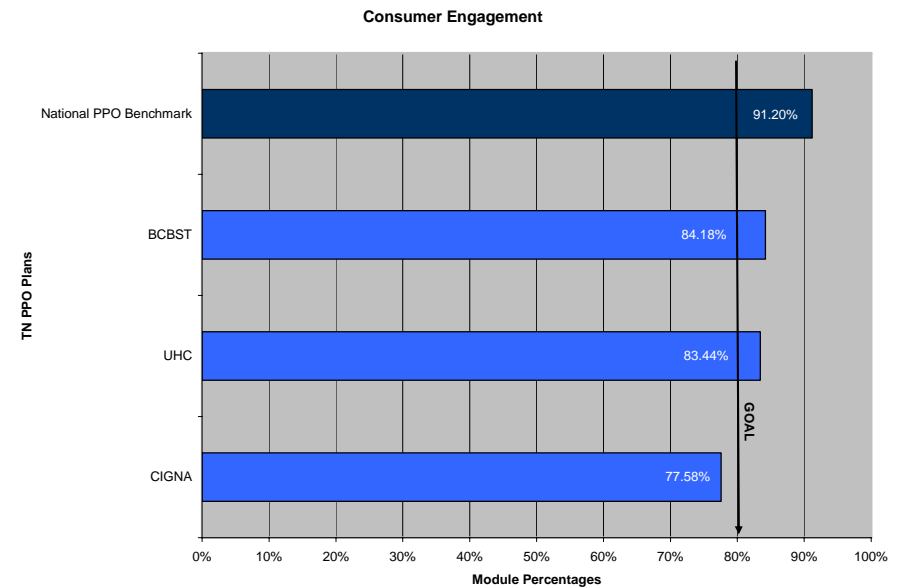
- Have external review and oversight of operations by: Joint Commission, NCQA (National Committee for Quality Assurance) and/or URAC. Highest credit awarded for NCQA Excellent accreditation
- Participate in the NCQA Quality Plus program
- Report HEDIS and CAHPS results for public reporting at state/local market level
- Offer plan designs with emphasis on reduction of financial barriers to essential services (e.g., medication compliance; preventive care services)
- Provide flexible reporting support to purchasers that reveal opportunities for improved health management and plan design
- Keep medical inflation below national averages
- Manage networks & contract renewals; Require board certification/accreditation of network providers
- Monitor and report utilization rates of procedures identified as “overused” and take steps to reduce preventable admissions
- Use and promote interoperability of standards-based information technology
- Participate in or help form multi-stakeholder community collaboratives
- Provide diverse approaches to meeting the racial, cultural and language needs of its members



## Consumer Engagement

### Plan is expected to:

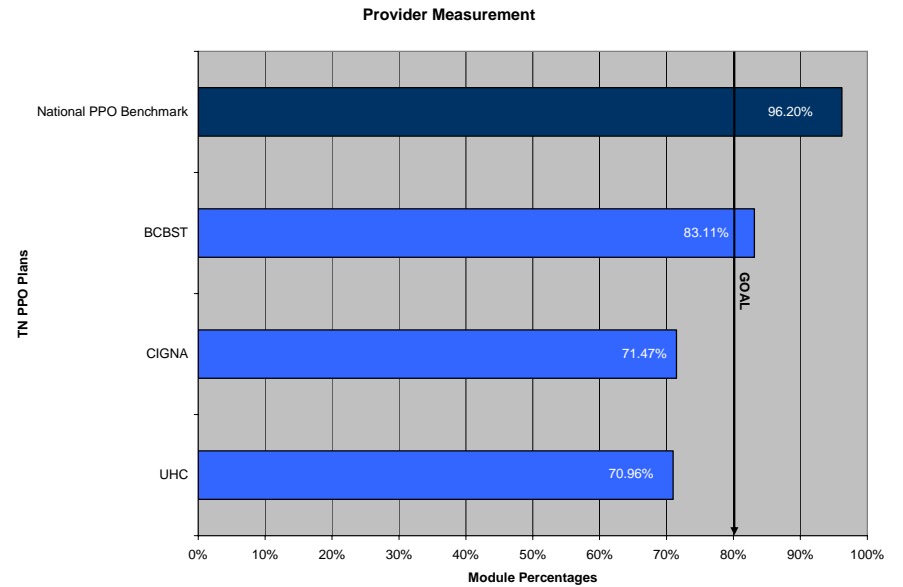
- Provide searchable directory contents and navigability/customization features inclusive of elements related to quality and patient experience
- Provide facility performance information to include clinical quality and patient safety metrics.
- Provide well-researched and objective resources to support members in making critical treatment decisions incorporating benefit coverage and network specific cost information
- Provide electronic personal health record as a significant aid to consumer engagement and personal health management; PHR should have the capability to initiate outbound messages and reminders
- Assist members in becoming more involved in the financial aspects of managing their healthcare
- Provide cost comparison tools and information about alternative choices to help members manage their pharmacy benefit
- Field the CAHPS survey and report results publicly



## Provider Measurement

### Plans are expected to:

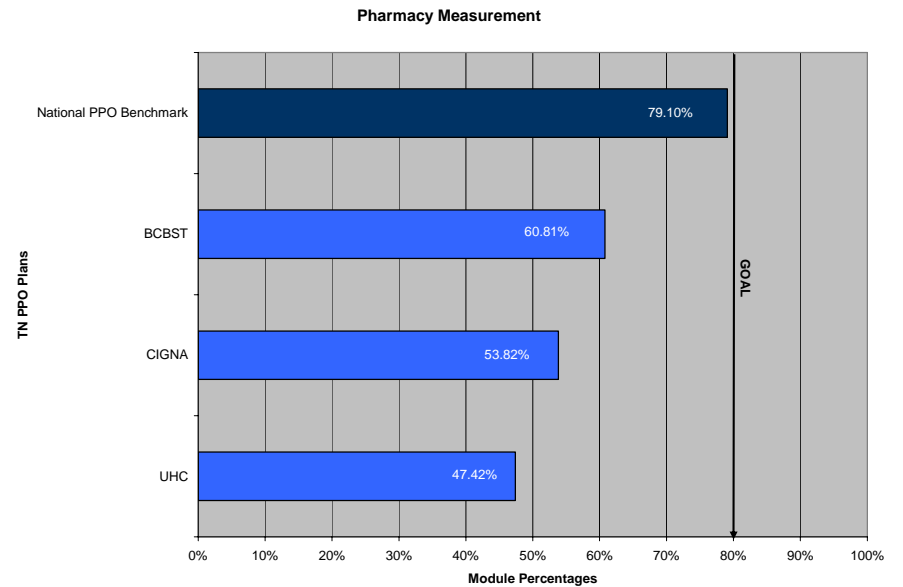
- Engage in community collaborations on implementation of physician and hospital performance-related activities with emphasis on standardized measures and data pooling
- Provide information and tools to support referrals and steerage to higher performing providers
- Promote adoption of interoperable health information technology (HIT) and encourage provider to use certified electronic health records
- Provide incentives to providers to promote utilization of standards-based interoperable HIT tools for improving quality and outcomes of patient care
- Use a robust set of clinical process and outcomes measures reflecting nationally recognized standards to promote transparency and differentiate performance among providers and hospitals
- Recognize provider and hospital performance through financial incentives
- Undertake initiatives to promote patient use of higher-performing facilities to optimize clinical outcomes and value



## Pharmacy Management

### Plans are expected to:

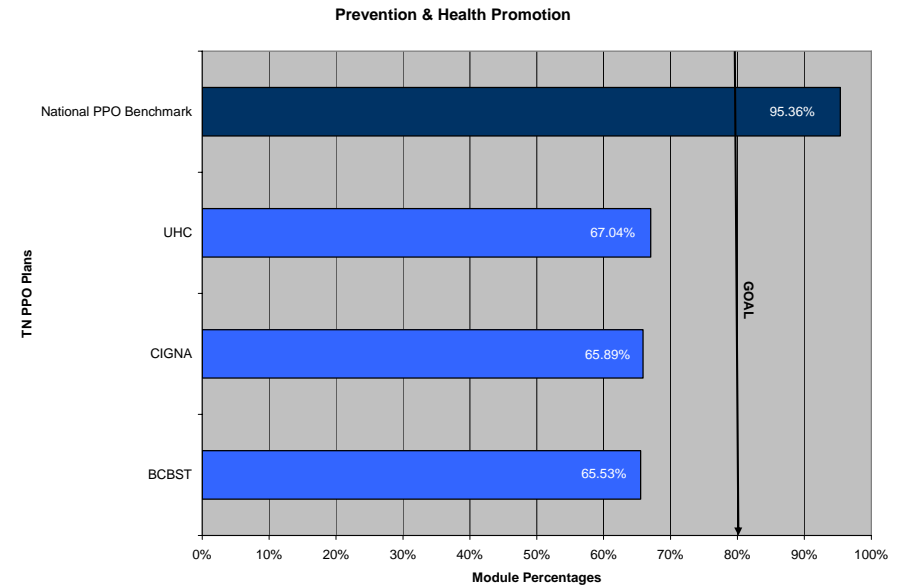
- Promote use of generic drugs and demonstrate a high proportion of generic use; Have an education program in place for members and practitioners on availability of new generic drugs and applicable conversion programs; Monitor generic dispensing rates
- Engage in a variety of strategies addressing costs and utilization of pharmaceuticals (e.g., step therapy)
- Emphasize use of e-prescribing technology among contracted physicians to increase efficiency and safety of drug prescribing
- Have a specialty pharmacy program
- Measure and report HEDIS and other related indicators and to use the information to influence patient safety, medication compliance and gaps in care
- Participate in community collaborative programs related to encouraging generic drug use, antibiotic prescribing, e-prescribing and outpatient pharmacy safety



## Prevention/Health Promotion

### Plans are expected to:

- Emphasize activities providing meaningful information that can be integrated with health plan programs to members
- Provide targeted proactive outreach regarding risk factors for children
- Provide a comprehensive, automated, actionable Health Risk Assessment that demonstrates strategies to maximize completion rates
- Have comprehensive cancer screening programs and report HEDIS outcomes for breast, cervical and colorectal cancer
- Address child, adolescent, and adult immunizations and report HEDIS outcomes
- Provide member-specific reminders based on screening status for cancer and immunizations
- Have a comprehensive tobacco use program addressing prevention and treatment with emphasis on member-specific reminders and comparative reports to physicians; Track and report CAHPS and other outcomes
- Have a comprehensive weight management program addressing health risks and treatment benefits, member identification/support. Track results of program efforts
- Offer a maternity and high risk pregnancy program that promotes and support activities directly linked to healthier birth outcomes
- Report HEDIS measures for Women and Children

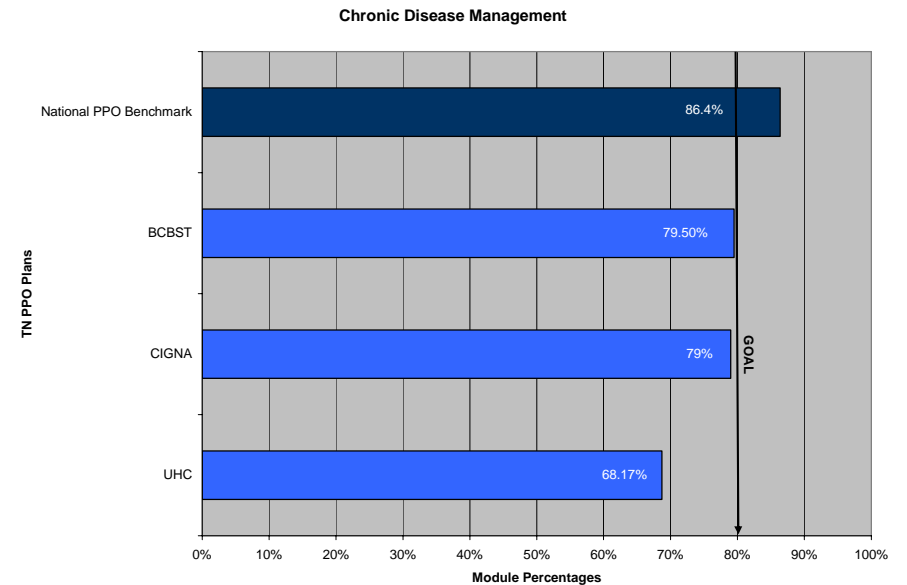


## Chronic Disease Management

(Focus on Coronary Artery Disease, Diabetes)

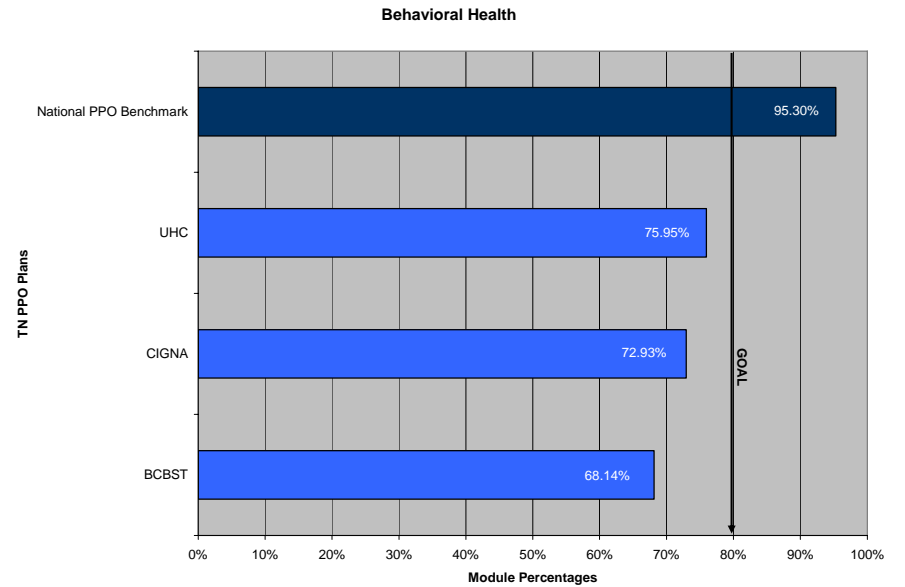
### Plans are expected to:

- Achieve accreditation for disease management programs
- Have DM programs that facilitate coordination of care across co-morbid conditions, depression, alcohol, obesity and tobacco screening with inclusion of pharmacy expertise
- Identify and track members with chronic disease
- Provide member support for self-management to include direct contact, member reminders and live outbound telephone calls.
- Address medication compliance
- Monitor clinical indicators illustrative of member-specific compliance and physician compliance with clinical guidelines
- Provide physician support inclusive of comprehensive member-specific and peer comparison reporting
- Proactively engage physicians in the disease management programs
- Report HEDIS and non-HEDIS results for coronary artery disease, diabetes and chronic obstructive pulmonary disease (COPD)



**Behavioral Health**  
**Plans are expected to:**

- Offer plan-wide accredited Behavioral Health disease management program with timely 24/7 clinical support
- Identify and track members requiring treatment for alcohol use disorders and depression; Identify and treat members' behavioral health and any additional co-morbid conditions
- Provide member support for self-management to include direct contact, member reminders and live outbound telephone calls. Address medication compliance
- Provide practitioners with tools for screening members for depression and alcohol overuse and monitor use of these tools
- Support treating providers with clinical guidelines, patient-specific and comparative performance reports for depression and with comparative reports for alcohol overuse
- Proactively engage practitioners in the Behavioral Health Disease Management program
- Track prescribing of anti-depressant medications to assure that there is an appropriate assessment
- Monitor and report HEDIS and non-HEDIS outcomes for depression and alcohol use





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