



**PBGH**

Pacific Business  
Group on Health

221 Main Street  
Suite 1500  
San Francisco  
CA 94105

[www.pbgh.org](http://www.pbgh.org)  
[www.healthscope.org](http://www.healthscope.org)

Tel: 415.281.8660  
Fax: 415.281.0960

**Statement of Emma Hoo, Pacific Business Group on Health  
Little Hoover Commission  
State of California**

**Leveraging Public and Private Purchasing  
For Health Care Transformation  
January 25, 2007**

The Pacific Business Group on Health is a nonprofit association of many of the nation's largest purchasers of health care, covering over 2.5 million Californians. The members of PBGH include large public purchasers and private employers in a variety of industries, who share a common goal of improving the quality and accessibility of health care while moderating costs. For nearly twenty years, PBGH has been a catalyst promoting performance measurement and public reporting at every level of the health care system to improve performance and to help consumers to make better choices.

Purchasers and consumers of health care are grappling with significant health benefit decisions in the face of unabated cost increases and persistent gaps in quality of care. We must become more discriminating buyers of health care and apply more targeted approaches to drive improvement. Collaboration among purchasers, consumers, health plans and providers is essential to improving data and tools to support better informed health care decisions, and ultimately improving health care value.

PBGH members have adopted innovative approaches to health care purchasing and benefit design with goals of moderating health care costs, improving quality and creating incentives for health improvement and consumer engagement. Examples of ways purchasers reinforce their expectations for health care value include: 1) using the eValue8™ common health plan RFI, 2) promoting the US Department of Health & Human Services Transparency Initiative, and 3) incorporating standard metrics such as NCQA Quality Plus accreditation.<sup>1</sup> What follows below is an overview of the framework PBGH uses to promote health care transformation through value purchasing, with a focus on our use of the eValue8 Health Plan RFI to support data-driven decision-making.

***PBGH Purchasing Elements for Value Breakthrough***

PBGH and many of its Members take a multi-step approach to strategic purchasing. These steps can lead to financial savings and lay the groundwork for supporting desperately needed re-engineering of how health care is delivered in America. Key elements of this "breakthrough" strategy in the graphic below are as follows:

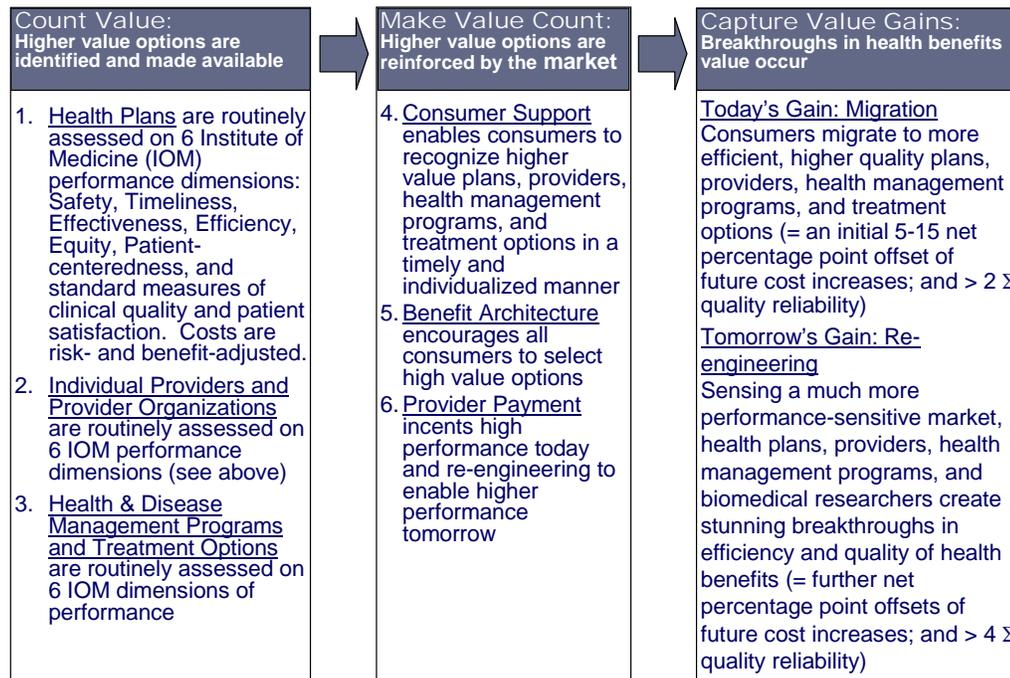
- **Count Value** (first column) at every level of delivery. Assess how effectively our health plans not only deliver care based on the Institute of Medicine's six performance dimensions, but also on how health plans in turn count value at the level of hospitals, providers and care management.
- **Make Value Count** (second column) reflects the three key ways purchasers can leverage the information on quality and cost-effectiveness to generate savings and promote improvements:

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<sup>1</sup> Website references: 1) <http://www.evaluate8.org/> 2) <http://www.hhs.gov/transparency/> 3) [http://www.ncqa.org/communications/news/quality\\_plus.htm](http://www.ncqa.org/communications/news/quality_plus.htm)

- **Provide consumers with tools to make better choices**, by providing health plan chooser tools, hospital choice tools, cost calculators, and treatment decision-support.
- **Build better value choice into benefit design** by linking information with financial incentives for the consumer, such as through tiered products and differential contributions.
- **Change payments to differentially reward providers** for high performance rather than paying more for bad care and unnecessary procedures.
- **Capture Value Gains** by implementing value purchasing is the end goal. Because of the huge variation in cost and quality of health care, changing where consumers get care can show near-term 5% to 15% reductions of future cost increases. At the same time value purchasing should also pay off in a quality reliability increase from the current rate of about 50% likelihood of getting the right care, to greater than “2 Sigma” (70% likelihood).

Tomorrow’s gains from this purchasing and payment strategy are huge – they hold the promise of supporting true breakthroughs in quality and efficiency because those elements are rewarded and they focus providers on continually re-engineering and moving to “4 Sigma” (getting the right care about 99% of the time).



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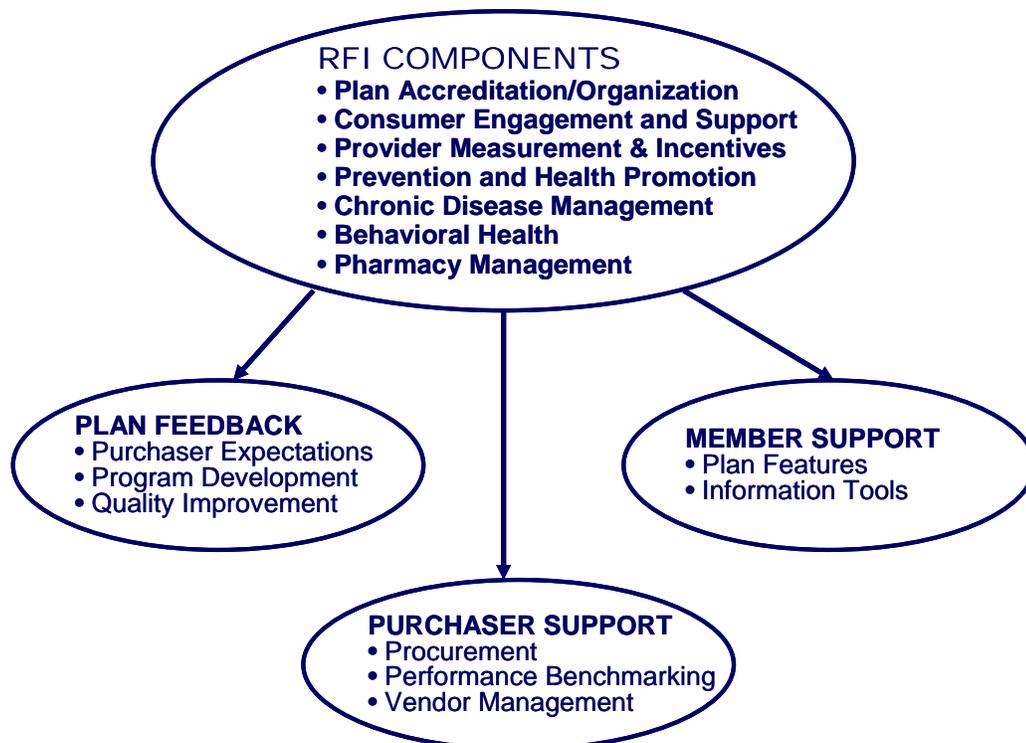
The eValue8 Health Plan RFI is a powerful health plan quality measurement and comparison tool developed by purchasers, Pacific Business Group on Health, and other health care coalitions around the country. Administered by the National Business Coalition on Health (NBCH), the tool simplifies the evaluation process for both employers and plans by consolidating requests for information into a single streamlined online survey. Local purchaser coalitions validate the self-reported quality data from over 100 health plans and track performance over time, allowing purchasers to compare plans based on value, and not just cost. EValue8 is used by national purchasers such as General Motors and Pitney

Bowes, as well as public purchasers such as the Minnesota Departments of Employee Relations and Human Services through the Smart Buy Alliance.

More than just a measurement tool, eValue8 fosters communication between health care purchasers and health plans, and helps both groups articulate shared incentives and goals. Health plans also benefit from the tool's valuable updates on service and quality benchmarks, as well as its timely assessment of plans' strengths and opportunities vis-à-vis their competitors. Armed with evidence-based and verified performance data points, purchasers encourage plans to engage providers in the quality improvement process and, ultimately, create a cascade effect that raises the quality bar through common standards and expectations in the industry as a whole. Exhibit 1 is a sample of one plan's Strengths and Opportunities summary for the Consumer Engagement and Support module.

One of eValue8's key assets is that it can be implemented in local markets by employer coalitions and large purchasers. In California, Pacific Business Group on Health (PBGH) works with 10 health plans and 50 employer members to assess plans along key dimensions. PBGH then uses these results along with rate information and national benchmarks to appraise overall plan value. The final product – detailed reports tailored to each employer – provides benefit managers with a rich, informative snapshot of specific plan performance which can be used to guide health care purchasing decisions. Exhibit 2 is a sample of how benchmarking information is presented to employers. Exhibit 3 is a sample of how an individual employer can use data to support member choice of health plan and access to plan-based health management services.

The eValue8 tool focuses on consensus-driven, nationally recognized guidelines in a number of key clinical and administrative areas. The questionnaire is evidence-based, with input from federal agencies (e.g., Centers of Disease Control, Agency for Healthcare Research and Quality (AHRQ), accreditors, academic experts, and other stakeholders such as the Leapfrog Group and the eHealthInitiative. The RFI components and uses include:



Each dimension evaluates operational practices that serve as accurate proxy measures of quality. For example, adoption of Health Information Technology (HIT) tools is known to reduce errors and improve clinical decision making. EValue8 assesses health plans' commitment to HIT by gathering data on their use of outpatient electronic prescribing systems, provider administrative and clinical support tools, and electronic personal health records, among other parameters. Consumer Support questions include racial, cultural and language competency to address disparities in care.

### ***Collaboration Opportunities to Improve Quality***

Purchasers expect plans to promote quality improvement through adoption of standardized performance metrics to produce comparable quality information. EValue8 recognizes plans that work collaboratively with other plans and public agencies to improve quality in local communities.

Plans and purchasers need to work together to advance a business case for quality. Advancing quality requires common action by both plans and purchasers to:

- Collaborate with other plans and private/public purchasers in joint initiatives to engage providers (such as the PBGH/CCHRI Breakthroughs in Chronic Care Program);
- Assure that quality information is used to develop high performance networks or Centers of Excellence;
- Align incentives across multiple payment streams to reward quality and efficiency; and
- Educate consumers to use performance information to support health care decisions.

### ***Consumer Engagement and Support***

Recognizing that engaging consumers in health care decisions is integral to quality improvement, eValue8 asks if and how plans provide support and incentives for member involvement in the decision-making process. One approach scored in this category is implementation of consumer education and financial management tools such as online provider directories and claims self management. Better consumer choice begins with performance information for every point on the health care continuum – plan, hospital, doctor, etc. Benefit design (consumer incentives) can build upon performance data and promote use of quality and value information. Differential provider payment can promote re-engineering and transformation. To help put consumers in the driver's seat, purchasers expect plans to:

- Increase use of customized consumer tools and decision support: offer and promote use of provider choice, treatment option support and shared decision making, personal care and disease management, and cost calculators;
- Promote consumers' use of tools through incentives: customized health content and preventive care reminders are "pushed" to members based on risk and psychographic profile;
- Support consumer self-care and information: promote use of portable personal health records with self-reported information that integrate medical and Rx claims data and self-care; and
- Document health plans' impact: measure and report level of consumer engagement, use of tools, or "activation" opportunities and financial/health quality impacts.

### ***Provider Performance Transparency and Accountability***

Benchmarking and performance feedback can augment provider efforts to improve quality and reduce variation in care. The eValue8 Provider Measurement module of the survey gauges plans' adoption of programs designed to drive physician and hospital quality improvement. Plans score well if they offer high performance physician networks, physician referral support for members, and hospital performance measurement, for example. Such tools are designed to benefit both consumers and providers by rewarding plans that help physicians and hospitals track and improve their quality, service, and efficiency.

Purchasers also expect plans to engage members through actionable information such as care reminders for needed services. Purchasers expect health plans to:

- Increase provider performance transparency and foster accountability;
- Use nationally standardized provider metrics – hospital, medical group and physician;
- Publicly report provider performance to consumers for informed choice and to providers for quality improvement;
- Document savings and quality impacts from using performance-based networks and incentives;
- Demonstrate how savings reward higher performing providers and are passed through to purchasers and consumers; and
- Affirm that the movement of dollars to pay-for-performance be budget-neutral and not additive to current costs.

Health plan and purchaser incentives must be aligned to achieve common goals:

- Steer consumers to higher performing providers, including through network design; and
- Reward higher performing providers.

### ***Fostering Health Status Improvement and Risk Reduction***

Because quality of life for patients with chronic disease can be markedly improved if their conditions are well-managed, eValue8 assesses plans' use of chronic disease management programs for asthma, coronary artery disease and diabetes. Health plans score well if they effectively identify members with chronic disease, support their care with appropriate interventions, assist physicians with clinical decision-making tools, and integrate such disease management efforts into overall care.

Purchasers expect health plans to:

- Identify and target those at-risk or in need of care coordination: demonstrate how use of claims, health risk appraisals or other self-reported data results in complete active enrollment in appropriate programs (from wellness to chronic care to high-cost care management);
- Engage enrollees in appropriate programs: demonstrate active enrollment and use of triage, behavior change and risk reduction (whether through coaching or online tools); assure members are targeted based on psychological profiling, cultural, ethnic and other appropriate characteristics;
- Provide incentives for consumer engagement: support benefit designs and programs that promote member engagement in health management and preventive care;
- Measure and report to purchasers: quantify and report the purchaser-specific net ROI, premium and quality impacts;

Equally important are purchaser efforts to help low-risk individuals maintain their health and moderate-risk individuals to lower their risk status. Promoting health and wellness requires the joint efforts of both plans and purchasers to:

- Support worksite health promotion and education programs;
- Invest in appropriate data exchange to promote early identification and risk reduction;  
and
- Assure that benefit design supports access to preventive care and compliance with evidence-based medicine.

The eValue8 process has the potential to catalyze health system change by fostering market sensitivity to a basic value equation and by creating an effective way to reward plans and providers that meet quality, as well as cost, expectations. Collaboration among purchasers to communicate common expectations and use standard RFI tools can help stakeholders focus resources. The eValue8 health plan RFI is an important element among other purchasing tools such as benefit design and contribution strategy to improve performance and promote transformation opportunities.

## Health Plan Feedback: Strengths & Opportunities

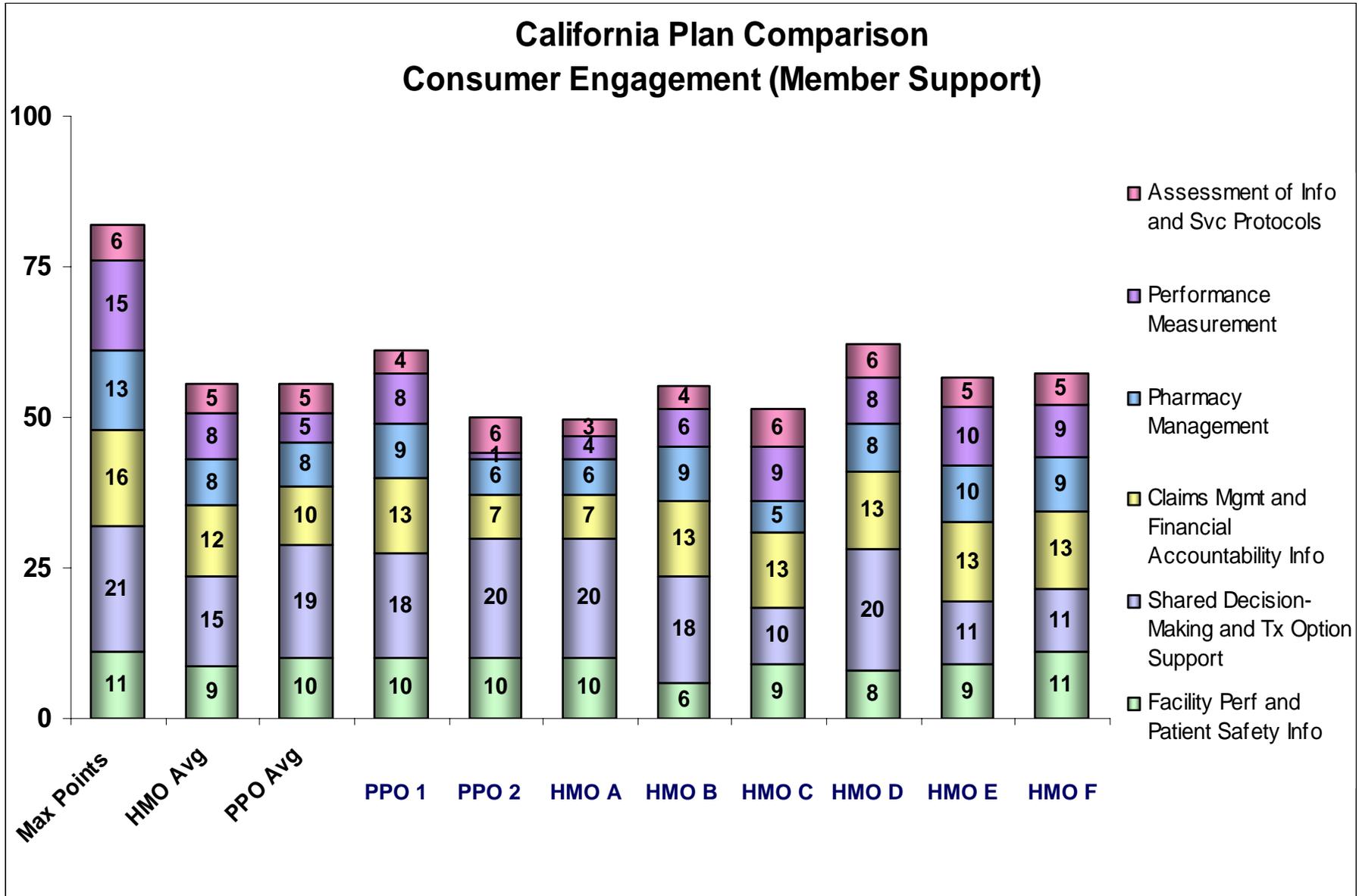
<b>HMO Plan A - Consumer Engagement</b>					
<b>2006 NBCH eValue8 RFI Strengths &amp; Opportunities</b>					
Section Name	Scoring Description	Max Points	Plan Score	%	Comments
<b>Consumer Engagement</b>	This module specifically addresses how the Plan provides consumers with support and what mechanisms are used to foster a high level of consumer engagement by the use of tools, interventions, and strategies that purchasers believe should be widely and routinely available.	100	73	73%	
Practitioner Information	Although most Plans make a web-based practitioner directory available to members, the credibility and depth of the data varies tremendously. To support greater consistency and accuracy, the Plan is encouraged to work closely with the recommendations of the NCQA consensus panel on electronic physician directories. Maximum directory credit is awarded for information that is searchable, detailed, well-explained and audited. Another important component of access is the availability of practitioner performance information. Maximum credit is provided for performance information provided on the Plan's website or by direct link to a subcontractor's website. Lesser credit is available for information provided in print format. In aggregate, credit is roughly split between directory information and practitioner performance information provided to members.	18	10.75	60%	Plan's directory offers most of the typical elements. Note: practitioner board certification, facility privileges, weekend/evening hours availability are display only. The directory does not offer disciplinary information, medical training information, years in practice, or quality metrics. Plan does not inform users about how often information is updated or whether information is audited. Plan provides medical group level performance data (consumer assessment and HEDIS) on its website.
Facility Performance and Patient Safety Information	This section emphasizes the importance of providing patient safety and facility performance information to members. The Plan is also encouraged to provide incentives to members to act upon the quality information being provided to them. Maximum credit is awarded for web-based information, with minimal recognition provided for the availability of print information.	11	8	73%	All hospital-specific performance data is available on Plan's website. However, education about leapfrog standards and which hospitals meet these standards is the only method used to encourage members to choose Leapfrog hospitals.
Shared Decision-Making and Treatment Option Support	Efforts to engage members more actively in managing their own care focus on two central areas: proactive personalized information sent to the member and comprehensive interactive decision support when a member is making treatment decisions. Maximum credit is awarded for sophisticated and ongoing efforts to proactively send members information based on knowledge gained via an HRA, PHR, medical management program, or claims data. Interactive decision support is most effective the more personalized it becomes and when it is made available directly on the Plan's website.	21	20	95%	24/7 advice nurse, evidence-based guidelines, information about community resources, and "ask the expert" email option are available to all Plan members. Plan also offers a decision support tool, an online interactive resource for members to correspond with health coaches. Members that could benefit from these services are proactively identified through several sources. The health coaches can be accessed by phone or via interactive online session. The Bookmark section is an opportunity for health coaches to post information about a member's condition and tx options. Health coaches focus on decision support and educational content in addition to symptoms. The plan has a survey of members' experience with the hospital comparison tool and evaluates these results, but there does not appear to be an indicator of how many members access web-based consumer tool.
Claims Management and Financial Accountability	Plans are expected to help consumers become more involved in the financial aspects of managing their healthcare. Information provided to the member should be specific, inter-active and actionable. Searchable information is more valued than display only information. Credit is provided to Plans whose members have no claims. Description must be provided.	16	13	81%	Plan reports that members can track their deductibles, OOP max, and benefit limits via telephone but not online. Hospital data re: cost per services and clinical performance is available online, as well as physician clinical performance data.

**HMO Plan A - Consumer Engagement**

**2006 NBCH eValue8 RFI Strengths & Opportunities**

Section Name	Scoring Description	Max Points	Plan Score	%	Comments
Pharmacy Management	The Plan is expected to provide information and tools to help members manage their pharmacy benefit. Roughly equal credit is given for providing in-depth, member-specific information regarding specific pharmaceutical options (e.g. generic versus name brand, benefits/risks of a drug) and cost management information (e.g. cost calculators, pill splitting options). Maximum credit is awarded for web-based information with partial credit for information provided in other formats (e.g. paper).	13	8	62%	Plan offers almost all standard pharmacy information via website, paper format or phone. However, drug cost management data is unavailable. Plan provides a drug dictionary and drug calculator, but this calculator does not include a few features, such as OTC alternatives and pill splitting options.
Performance Measurement	The Plan is expected to meet CAHPS expectations, as well as provide strong customer service with respect to call timeliness and claims payment.	15	7.75	52%	Plan scored above the 90th %ile on the CAHPS health plan assessment and quality of care measures. On the remaining CAHPS questions, Plan was far below all national percentiles. Plan's HEDIS scores regarding claims and call systems were very high, but the percentage of these claims that are processed in the first pass is extremely low.
Assessment of Information and Service Protocols	Purchasers expect plans to maintain the validity of the material provided to members by conducting a regular assessment of both accuracy and usability. Plans are also expected to establish and track response standards for web-based inquiries.	6	5.5	92%	Plan's Medical Advisory Council reviews all medical information on its information tools annually. Vendors are also required to evaluate content. Plan tests the usability of information tools but does not consider education level of content or cultural competency. Regarding timely response to member inquiries, Plan has protocols to evaluate turnaround times and can link phone and email inquiries back to member. However, Plan does not have protocols to evaluate email responses.
Other Information	While this section is not individually scored, the Plan is asked to provide information regarding consumer support and engagement practices or strategies that they were not able to describe within the context of this RFI but are relevant to specific sections, i.e. Member Support, and may warrant credit. Responses may be used to edit scores in other sections of this module as deemed applicable by the reviewer.	0			

Purchaser Use of eValue8 Data for Health Plan Benchmarking



**PBGH Plan Chooser: Use of eValue8 information in Employer and Member Information Tools**

**Union Bank of California - Medical Plan Chooser**

Medical plans' features affect which doctors you can see, whether you get help to stay healthy and get care that you need. Use this page to decide which medical plans' features best fit your needs. [Read more about Medical Plan Features](#)

Rate each plan on how well its features match your needs. "Good Fit" means the plan offers features that you need. "So-So Fit" if your choice is limited in a key area. "Poor Fit" means the rules restrict you too much or that the plan does not offer services that are important to you.

*Tips: To compare the plans' features on topics that are important to you click on the underlined text.*

Plan	Rate or Remove Plan	Seeing a Doctor	Help to Stay Healthy	Medical Conditions
Kaiser HMO (California)	Good Fit	PCP selection encouraged but optional; referral required for most specialists	<a href="#">Plan has nurse advice by phone 24 hours</a> <a href="#">Plan has weight management program</a> <a href="#">Plan has stop smoking program</a> <a href="#">Plan has health risk assessment service</a>	<a href="#">Plan has diabetes program</a> <a href="#">Plan has coronary artery disease program</a> No arthritis program

Plan	Diabetes
Kaiser HMO (California)	Free program includes one-on-one counseling, help by phone, self-care and behavior change educational materials online and by mail. Fee charged for health education classes.
PacifiCare Value Network HMO Signature Value Advantage (California)	Free program includes educational information online and by mail; glucose meters and an online diabetes diary.
PacifiCare HMO Signature Value (California)	Free program includes educational information online and by mail; glucose meters and an online diabetes diary.
United PPO \$1200	Free program includes help by phone from a health professional, self-care educational materials online and by mail and reminders about getting care.

Plan	Stop Smoking
Kaiser HMO (California)	Free program includes help quit by phone counseling; online, self-directed education and discussion groups moderated by health professionals. Nicotine patches. Helpline for referrals to community resources. Fee charged for some health education classes.
PacifiCare Value Network HMO Signature Value Advantage (California)	Fee charged for stop smoking help by phone program that includes counseling, quit smoking kit and nicotine patches/other nicotine replacement prescriptions. Also, a free stop smoking program that includes online, self-directed educational information.
PacifiCare HMO Signature Value (California)	Fee charged for stop smoking help by phone program that includes counseling, quit smoking kit and nicotine patches/other nicotine replacement prescriptions. Also, a free stop smoking program that includes online, self-directed educational information.
United PPO \$1200	Free program includes online, self-directed stop smoking education. 24-hour nurseline help to find community resources and other services.

**Compare Features**

Plan	Weight Management and Fitness
Kaiser HMO (California)	Free program includes exercise and nutrition counseling with health professionals by phone; online, self-directed education and discussion groups moderated by health professionals. Discounts for Weight Watchers and fitness clubs. Fee charged for some health education classes.
PacifiCare Value Network HMO Signature Value Advantage (California)	Free program includes online self-directed behavior change tools and educational information; discounts for health clubs, Weight Watchers and DietMate programs.
PacifiCare HMO Signature Value (California)	Free program includes online self-directed behavior change tools and educational information; discounts for health clubs, Weight Watchers and DietMate programs.
United PPO \$1200	Free program includes online, self-directed weight management education and discounts for Weight Watchers and fitness center memberships. Fee charged for obesity management program.