



**VALUE-DRIVEN HEALTH CARE PURCHASING:
CASE STUDY OF THE
MASSACHUSETTS GROUP INSURANCE COMMISSION**

Tanya Alteras and Sharon Silow-Carroll
Health Management Associates

August 2007

ABSTRACT: The Massachusetts Group Insurance Commission (GIC) is the state’s largest purchaser of health care after Medicaid, covering more than 267,000 state employees, retirees, and their dependents. In 2003, the GIC launched the Clinical Performance Improvement initiative, focused on improving provider performance and quality of care. CPI requires health plans under contract with the GIC to incorporate provider “tiering”—differential payments based on value—into their GIC product. After early data delays, group tiering began in the third year of the contract, and individual physician tiering began in the fourth year. The challenges involved in statewide tiering of providers are formidable, but stakeholders view the GIC as the only body in the state that could successfully push for such a quality improvement measure and succeed. The GIC’s lead in value-driven purchasing has informed the state’s recently enacted health care reform legislation.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This report and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund’s Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1053.

CONTENTS

About the Authors	iv
Acknowledgments	iv
Background	1
Clinical Performance Improvement Initiative	1
The Clinical Performance Improvement Initiative Aggregated Database	3
Making Quality and Value a Priority in the Massachusetts Health Care Reform Bill	9
Key Ingredients and Lessons	9
Challenges	11
Conclusion	12
For More Information	13
Notes	14

ABOUT THE AUTHORS

Tanya Alteras, M.P.P., is a senior consultant at Health Management Associates (HMA). Formerly a senior policy analyst at ESRI, she has more than six years experience examining issues related to health care financing, expanding coverage for uninsured populations, and developing cost-effective private–public coverage options. At ESRI, Alteras conducted research on a number of topics, including health coverage for adults without children, health coverage tax credits, oral health, and state- and community-based strategies for covering the uninsured. Her focus was on strategies involving the leveraging of scarce public resources with private sector funds.

Sharon Silow-Carroll, M.B.A., M.S.W., is a health policy analyst with nearly 20 years experience in health policy research. She has specialized in researching health system reforms at the local, state, and national levels; strategies by hospitals to improve quality and patient-centered care; public–private partnerships to improve the performance of the health care system; and efforts to meet the needs of underserved populations. Prior to joining HMA as a principal, she was senior vice president at the Economic and Social Research Institute (ESRI), where she directed and conducted research studies and authored numerous reports and articles on a range of health care issues.

★ ★ ★ ★ ★

Health Management Associates (<http://www.healthmanagement.com>) is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985 in Lansing, Michigan, HMA provides leadership, experience, and technical expertise to local, state, and federal governmental agencies; regional and national foundations; multi-state health system organizations; single-site health care providers; and employers and other purchasers in the public and private sectors.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of The Commonwealth Fund for funding this research. They also thank the following individuals who generously offered their time and insights for this case study: Robert Carey, director of planning and development, Commonwealth Health Insurance Connector Authority; Susan Connolly and Shawna Oliver, senior associates, Mercer Human Resource Consulting; Amy Lischko, commissioner, Division of Health Care Finance and Policy, MassHealth; Richard Lynch, vice president of network management and operations, Qi Zhou, director of clinical quality measurement, and Marisa Fusco of Tufts Health Plan; Dolores Mitchell, executive director, Group Insurance Commission; Charles Slavin, provider relations, UniCare; and Rick Weisblatt, vice president of network services, Harvard Pilgrim.

**VALUE-DRIVEN HEALTH CARE PURCHASING:
CASE STUDY OF THE
MASSACHUSETTS GROUP INSURANCE COMMISSION**

BACKGROUND

In 1956, the Massachusetts legislature established the Group Insurance Commission (GIC) to oversee the provision of health insurance for employees and retirees of the commonwealth, as well as their dependents and survivors.¹ The GIC offers members a number of health coverage choices, with models ranging from indemnity to health maintenance organizations (HMOs) to preferred provider organizations (PPOs).

The need to address rising health care costs and quality concerns has long been on the GIC's agenda. In FY 2001, faced with the prospect of a 12–15 percent annual increase in GIC health care costs, as well as looming statewide budget cuts, it decided to increase copayments for pharmaceuticals and inpatient care. The GIC also increased premium contributions around this time for new employees, from 15 percent to 20 percent. When these changes did not accomplish significant reductions in costs to the state due to premium growth, however, the GIC opposed any strategies that would further shift the rising costs onto employees, many of whom had very little room in their budgets for extra discretionary spending. GIC Executive Director Dolores Mitchell began to look for ways to “wring efficiencies from the system,” focusing on the issues discussed in the 2001 Institute of Medicine report “Crossing the Quality Chasm: A New Health System for the 21st Century.”² In 2003, Arnold Milstein of Mercer Human Resource Consulting approached Mitchell with a proposal to work together to create an aggregated database that would allow GIC participating health plans to rank the efficiency of their providers.

CLINICAL PERFORMANCE IMPROVEMENT INITIATIVE

Working closely with Mercer, the GIC launched the Clinical Performance Improvement (CPI) initiative. Under this initiative, GIC-contracting health plans are required to create a “Select and Save” product, which offers savings through variable copays when members choose either physicians or hospitals in a tier that reflects greater efficiency.

The GIC negotiates three-year contracts (with the option of two-year extensions) with each participating plan. The Request for Responses (RFR) that the GIC issued for the FY 2005–2007 contract period described its new CPI initiative as a tool to measure the performance of doctors and hospitals and to recognize “doctor and hospital excellence via performance-based payments and/or plan redesigns that encourage selection of better performing providers.” Implementing this vision would require a quality-based system

of care that integrated “data, performance measures, plan design, technology and consumer information.”

The health plans developed tiered products by combining efficiency data with quality data. As described in more detail later in this report, the data are run through Episode Treatment Group (ETG) software, which identifies and classifies an entire episode of care for each patient, including inpatient, ambulatory, outpatient, and pharmacy claims. Mercer provides efficiency scores to the plans. Resolution Health, Inc. (RHI)³ provides quality indicator information to the plans. The plans then combine the information in an appropriate way they see fit to tier doctors. The first round of efficiency data that were analyzed by Mercer was provided to the plans in the early spring of 2005, and the first round of quality data analyzed by RHI was provided to the plans in the fall of that year. Due to this gap in timing, initial tiers were based mainly on efficiency (and other internal plan quality measures). By July 2007, all plans are expected to use both the quality measures from RHI and efficiency data from Mercer.

For the FY 2005–2007 contract period, the plans were given a great deal of flexibility in terms of what level or entity to tier, how they would develop the product, and at what point within the contract period the tiering would begin. Mitchell wanted to encourage the plans to be creative, and “let 1,000 flowers bloom.” Facing methodological and technical challenges, as well as some opposition from providers, most plans did not put tiering into effect until the FY 2007 enrollment period, beginning in July 2006. Only one plan, UniCare, began with tiering at the individual provider level. Effective July 1, 2007, however, all of the health plans are required to have some form of individual provider tiering incorporated into their GIC product, meaning that all GIC members who are not in a Medicare plan will not have a choice between a tiered or a non-tiered product. The GIC intends to require a more advanced level of individual tiering for FY 2009, a prospect that concerns both plans and providers.

According to Mitchell, the short-term goal of the CPI initiative is not to reduce costs of the program, but rather to motivate providers to examine their own practices. The hope is that providers who are placed consistently in a lower-performing tier will address the issues that led to that placement, whether or not they see a significant decrease in patients. Mitchell hopes that in the long term, this strategy will “lift all boats” to a higher level of quality and efficiency, which will ultimately result in savings to the system. The GIC also hopes that the CPI initiative will aid the health plans by developing and providing robust and meaningful data to educate consumers about provider quality and efficiency, although those interviewed admit that consumers are far from engaged on the

subject. Finally, the GIC would like to see the initiative aid in furthering discussions between health plans and their providers.

THE CLINICAL PERFORMANCE IMPROVEMENT INITIATIVE AGGREGATED DATABASE

Mercer Human Resources Consulting has been an integral player in the GIC's push toward value-driven purchasing, public reporting, and tiering under its CPI program. Working collaboratively, Mercer's goal has been to collect and aggregate various elements of data, including commercial book of business (BOB) data, from each of the GIC's health plans. This aggregated data would generate relative efficiency scores for health care providers, and the scores would provide GIC health plans with information that could be used to develop tiered networks. In September 2003, Mercer held an open meeting with all health plans operating in the state—whether or not they contracted with the GIC—to discuss their vision for improving efficiency and quality via data support, and the effect that individual tiering could have on the system as whole. Not surprisingly, some health plans were wary and did not want to provide Mercer or the GIC with their data. In order to avoid having to negotiate individually with each plan, the GIC added a requirement that any plan receiving a GIC contract must submit its data to Mercer. Cleaning and sorting through the data was a difficult, resource-consuming process, described in more detail later in this report (see "[Challenges](#)" section).

Beginning in FY 2005, Mercer collected statewide BOB claims data, provider files, and member files from each of the six contracted health plans. The plans provided, and Mercer aggregated, three years of data (CY 2002, 2003 and 2004) for the first analysis, which focused on efficiency measures. In subsequent years, recognizing that quality is an essential element to the equation, the participating CPI entities agreed to partner with RHI to aid in assessing quality. RHI received the same aggregated database to provide the quality analysis as Mercer used to conduct the efficiency analysis. RHI selected quality measures in concert with the specific provider types analyzed in the efficiency analysis. Currently, 79 quality measures, all based on nationally accepted guidelines, are involved in the analysis.

One of the methodological challenges Mercer and the health plans currently face is how to attribute episodes to specific providers, given the interdisciplinary nature of care for chronic conditions. They understand that patients are likely to see multiple physicians over the course of an episode, so they came up with a solution to assign the episode and its attendant costs to the physician responsible for 25 percent or more of the episode's physician costs.

Working with GIC Plans

Mercer uses the commercial BOB data collected from the GIC health plans to create a large database that includes all physicians in the plans.⁴ The claims data are then run through the Symmetry⁵ software grouper in order to group the claims into complete episodes for the members. The episodes allow the analytic team to review an entire set of treatments for a condition, as opposed to individual treatments. The episode costs are then re-priced to remove specific contract differences from the equation, allowing analysis to be conducted on relative *resource* utilization (as opposed to price). The episodes are then attributed to a specific physician.

Finally, an Efficiency Index is created. The index reflects the relationship between actual and average costs for a provider. It is important to note that providers are compared to their peers—thus, like providers are compared to like providers. Physicians who score higher than 1.0 are below average in cost efficiency, while those who score lower than 1.0 are above average in cost efficiency. Costs are broken down into a number of different services, such as management, surgery, facility, pharmacy, etc., depending on the specialty.

The physicians' scores are sent back to the health plans along with their detail claims file. Under the GIC contract, plans agreed to share their detail claims files with each other, since many physicians are in more than one network. Plans are also sent the RHI data on quality, but were not required to incorporate those scores into their tiering methodology until now (2007).

Ultimately, Mercer would like to see the CPI initiative and public reporting expand statewide and into the private sector, leading to a re-engineering of the state's health care system into one that prioritizes high quality and cost efficiency over price.

How Health Plans Are Taking the CPI Initiative from Concept to Action

Harvard Pilgrim Health Care. In July 2006, Harvard Pilgrim Health Care (HPHC) began GIC member enrollment in its tiered product. Member copays vary according to the efficiency-based tier to which providers are assigned. In order to develop its tiers, HPHC examined spending in the GIC (BOB) and identified the largest cost drivers and areas displaying greatest variation in practice patterns. Allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, neurologists, ophthalmologists, orthopedic specialists, and otolaryngologists were identified in this process for either group or individual tiering.⁶

HPHC bases its tiers on the contract group/care unit, which is composed of one or more physician group practices. Using the Mercer analysis of the data aggregated from

all six GIC plans as a base, HPHC created two indices to further assess the care units/groups:

- peer index: looks at tests ordered by similar specialists;
- total index: looks at total cost of treating an episode of care; at least 15 percent of that cost is redistributed among as many as four physicians and two specialists within the unit.

HPHC removes outlier patients and outlier episodes in its calculations. In order to be placed into Tier 1, a group must score in the top 45 percent of the peer index and the top 60 percent of the total index. The remaining groups are placed in Tier 2. Patients are charged a \$15 copayment for Tier 1 doctors and a \$25 copayment for Tier 2. HPHC includes tier composition and performance comparisons in their member benefits handbook. At this time, quality data are not factored into the tiering, due to the lack of quality measures that could be applied across all units. But HPHC does disclose to members quality information, including hospital quality measures, for which it uses data from the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services, and the Leapfrog group.

In the first year of their Select and Save product, approximately 35 percent of the 100,000 specialists subject to tiering were placed in Tier 1; the rest were categorized as Tier 2. HPHC staff have met with provider groups that expressed concern over their placement in Tier 2 and reviewed their ETG data in detail. According to one interviewee, “Many doctors are pushed into Tier 2 because of their pharmacy costs, which push the cost for managing certain conditions way above average.”

Because HPHC’s product is so new, data are not yet available on whether the tiering has led to enrollee switching among physician groups. As of late fall 2006, HPHC had not received complaints from physicians. Staff do meet annually with primary care provider (PCP) medical directors and plan to query them about whether their patients are asking specifically for referrals to Tier 1 specialists. While HPHC has no plans to develop tiered products for its non-GIC members, it is publishing quality data on hospitals and primary care providers in its provider directories across all of its products. This data will include cost comparisons across certain specialties at various hospitals.

Tufts Navigator Health Plan. This plan began enrollment in July 2004, and focuses its tiering efforts on three specific hospital inpatient departments: adult medical surgery, obstetrics, and pediatrics. Navigator has three tiers based on a cost and quality index, with

each weighted equally. Cost-efficiency data were based on all commercial admissions, which were risk-adjusted for case mix and severity. For cardiology, quality measures were drawn from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) measures on cardiac care, pneumonia, and smoking cessation, as well as case-mix adjusted mortality rates and Leapfrog data on intensive care, computerized physician order entry, and electronic medical records (EMR).

To develop these measures, Tufts senior staff convened an expert panel of both hospital clinicians and non-clinician experts in the quality and efficiency fields. Similar measures were developed for obstetrics⁷ and pediatrics. Staff admit that they have issues with the timeliness of the JCAHO and Leapfrog data, and that while hospitals are not happy in general with the tiering, they do think the panel did a good job in developing the methodology.

Members face copayments of \$150, \$300, and \$500 for services designated as Tier 1, Tier 2, and Tier 3, respectively. There are two exceptions: all pediatrics services are designated Tier 1 and automatically require only a \$200 copayment.

As with the Harvard Pilgrim plan, Navigator is still relatively new, and at this point staff have not seen a dramatic shift in patients from Tier 2 or 3 hospitals to Tier 1. Some shift has been seen in obstetrics, a slight shift in adult surgery, and no changes in pediatrics. Interestingly, while the FY 2005 enrollment period did see these shifts to higher ranked hospitals, FY 2006 saw a number of members returning to their lower ranked institutions. One explanation for this may be that the health care market is very “hospital centric,” i.e., many people base their choices on the hospital name rather than the providers and quality-of-care data.

While the Navigator product has yet to change consumer behavior in any significant way, it has had an effect on providers. Anecdotal evidence suggests that specialists in the surgical, obstetrics, and pediatrics fields are talking to their patients much more about quality. Some hospitals have even called Navigator staff to find out what measures they plan to focus on next year so they can get a head start on addressing any issues. Given that 35 percent of state residents’ admissions are to tertiary care hospitals (vs. the national average of 15 percent), Navigator believes that transparency associated with tiering at the hospital level can have an impact not only on quality, but also on long-term costs to the system.

UniCare. UniCare is GIC's only indemnity plan; 93 percent of its business is made up of GIC members.⁸ It is also the only GIC plan that implemented individual physician tiering in 2006, prior to the July 1, 2007 deadline. UniCare used only Mercer's CPI data in its first year, and added RHI quality data into its methodology for year two. Their process involves first scoring the physician based on an efficiency threshold.⁹ If the physician passes, he or she is then assessed based on quality. Physicians that meet the efficiency and quality thresholds are placed into Tier 1, and their patients are subject to a \$10 copayment. Those who either do not pass the efficiency threshold, or do pass it but then do not pass the quality threshold, are placed in Tier 2, subjecting their patients to a \$20 copayment.

In reviewing physicians' quality scores, UniCare executives were surprised and concerned by the low level of compliance with certain quality measures across the board. Since the benchmark used is based on comparisons among peers in the local area or state, and not against national averages, providers can score highly on the quality threshold even if their overall compliance is low. This low compliance raised some questions that UniCare, Mercer, and GIC staff are considering, including the efficacy of comparing doctors to their local peers for the purpose of tiering.

At this time, UniCare has not seen a significant amount of switching providers among members related to the tiering, although it has seen some issues with pediatricians dropping out of the plan's network (see below). UniCare expects that in the next contract period, the GIC will require an evaluation component to quantify membership movement.

UniCare and the GIC were careful to not spring the tiering program on physicians. They held meetings with physicians and the Massachusetts Medical Society leadership, where they explained the tiering methodology. UniCare also prepared issue papers and other educational materials. Despite these efforts, some physicians have complained about the program; for example, some providers argue that assigning different tiers to physicians within a single group practice creates an administrative burden. UniCare's response is that practices are already set up to accept varied copayments from the different health plans.

Fallon Community Health Plan. The Fallon Community Health Plan called Select Care had tiers for its PCPs and specialists at the individual level beginning July 1, 2007. It also offers the Direct Care plan, which is a selective network.

Neighborhood Health Plan. The Neighborhood Health Plan (NHP) program began individual tiering on July 1, 2007. On that date, they merged their two products—the Neighborhood Health Plan HMO and Neighborhood Health Plan Community Care—into one, which incorporates components of individual physician tiering. For example, members pay lower office visit copays when they use physicians with higher quality and cost-effectiveness scores. NHP tiers all PCPs as well as cardiologists, endocrinologists, and obstetrician/gynecologists.

Health New England (HNE). Health New England operates an HMO, which began individual tiering on July 1, 2007. This plan is unique within the GIC as it is the only plan that offers three tiers for PCPs, with copays of either \$10, \$15, or \$20. Specialists, including cardiologists, dermatologists, gastroenterologists, orthopedic specialists, and otolaryngologists are divided into two tiers.

Reaching the Ultimate Goal: Individual Physician Tiering

Staff at several health plans have expressed reservations about the GIC's push toward tiering physicians at the individual level. Some disagreement has occurred over whether the appropriate data are available. Most of the 76 quality measures developed by Mercer and RHI are based on PCP practices. Yet when asked about tiering PCPs, Tufts Health Plan's expert panel felt that the data were not there to support it, and instead identified the top 25 percent of PCPs based on a different cost/quality/value index. Tufts had a particular challenge since it began at the hospital level; concerns have been voiced that moving to individual physician tiering would likely result in at least some lower-ranked physicians practicing at Tier 1 hospitals, which would then lead to confusion. Others have argued that individual tiering would make physicians uncomfortable with their colleagues, and that taking that step in order to improve quality and efficiency is not necessary.

The plans are also concerned with the administrative difficulties that individual tiering presents. However, others make the argument that physicians' offices deal with differing copays on a daily basis as they see patients with varying levels of insurance, thus making the administrative complexity argument difficult to maintain. The Massachusetts Medical Society's leadership has come out strongly against individual tiering on the grounds that such sensitive data should be shared only among physicians and not the public. They contend that if public reporting is necessary, it should be done at the large group level, not the individual one.

The difficulties in tiering individual physicians in a market where some physicians are in group practices are demonstrated by the backlash that occurred among pediatricians

in UniCare's network. Prior to July 2007, UniCare was the only GIC-contracted health plan that implemented individual tiering. In the process, some pediatricians working in the same group were placed into different tiers, which angered many of them. As a result, several pediatric practices dropped out of the network, leaving members without a provider.¹⁰

To minimize disruption to the physician-member relationship, the GIC allowed UniCare members to switch to other GIC plans if they wished to continue to see their pediatrician under their health insurance. Following this experience, most of the GIC plans are not tiering pediatricians individually. Also, as mentioned above, concerns have been raised as to how NHP, which operates primarily through a local clinic-based system, would apply individual tiering given that members do not always have a choice of physician. Their cost sharing would be based on whoever is available to see them at their visit, rather than an informed decision based on comparative provider performance.

MAKING QUALITY AND VALUE A PRIORITY IN THE MASSACHUSETTS HEALTH CARE REFORM BILL

When the Massachusetts legislation that paved the way toward universal coverage was passed in April 2006, many of the value-based purchasing priorities and lessons learned by the GIC were taken into account. The health care reform bill created a Healthcare Cost and Quality Council, charged with developing standardized performance measures for providers, and ultimately for Pay-for-Performance (P4P) programs. According to Amy Lischko, former Commissioner for the Division of Health Care Finance and Policy, the legislature wholeheartedly supported the council and agreed that issues related to quality and value must be central to any reform plan.

GIC's Mitchell is helping to integrate value and quality into the reform efforts. She sits on both the Cost and Quality Council and on the board of the Commonwealth Health Insurance Connector, a state agency created to administer Commonwealth Care, a subsidized coverage program for individuals living at up to 300 percent of the Federal Poverty Line (FPL). The connector also administers Commonwealth Choice, the new mandatory health insurance program for those living above 300 percent of the FPL who do not have insurance through an employer.¹¹

KEY INGREDIENTS AND LESSONS

A number of ingredients made the GIC's push for transparency, public reporting, and tiering possible. First among these was strong leadership. All interviewees described the vision and courage displayed by Mitchell in implementing the CPI initiative and pushing for an overhaul of the system, rather than continuing to let consumers take on additional

financial burden. Several people described a health care system in which employer purchasers are not motivated to work together to demand public reporting, leaving the GIC and possibly Blue Cross Blue Shield insurance carrier as the only entities large enough to demand change. The GIC took on the role as an innovator and has become *the* voice in the market, developing standards and advocating for consumers to have access to consistent, easily understood information. The fact that the GIC is a semi-autonomous agency able to exercise a certain degree of independence (as long as its commissioners agree), has helped create an environment where it can be an innovative force, although it does have to stay aware of the possible ripple effects its actions might have on the rest of the health care system.

Another key factor behind the GIC's progress was the way in which the CPI's initial RFR was worded, in that it allowed plans to ease into tiering slowly over the course of a three-year contract period. According to Mitchell, this gradual process was done intentionally to give plans flexibility and to foster a sense that moving toward tiered networks was a feasible goal. The GIC was also interested in seeing what the plans would come up with when given the freedom to be creative. Also important was a requirement that participating health plans provide claims data for their entire BOB to Mercer so that a robust database could be built. Without this requirement, the researchers would not have had sufficient data on which to develop tiering.

Given the controversial nature of tiering, particularly at the individual physician level, many stated that it was vitally important to involve stakeholders—including health plans and the Medical Society leadership—early on in the process. Others noted the importance of health plans feeling a sense of ownership in the process, which the GIC achieved via its flexibility. In return, the plans were cooperative about sharing data with each other.¹²

On the whole, the health plans have moved slowly and methodically toward tiering, which many considered a positive thing. Some expressed concern that implementation of any “radical” program that created wide differentials in cost sharing for members would probably be subject to a backlash from consumers, as well as the legislature and the governor. So far, relatively small copayment differentials have been used.

Finally, a key ingredient is recognizing that data do not have to be perfect, but rather just “good enough” to be used responsibly. Many agreed that perfect efficiency and quality measures do not exist, or that measures for primary care providers and specialists were lacking in certain areas. However, costs are continuing to rise and consumers are

continuing to get squeezed, making it impossible for purchasers to wait for the perfect measures and data.

CHALLENGES

As with any innovative idea, the GIC's CIP is beset by a number of challenges:

Consumer engagement. At this stage, the GIC admits that getting consumers involved is not the highest priority, given that public reporting of provider performance has yet to be implemented. The GIC does, however, hope that consumers will contribute to what it is trying to accomplish by asking their physicians why they are in one tier as opposed to another, and also by requesting referrals to Tier 1 specialists when necessary.

Building a "clean" database. One of the biggest challenges for Mercer and the participating health plans has been cleaning up the claims data for the CPI database. Because many physicians had more than one identification number associated with them, Mercer had to create new "Master IDs" for physicians. The creation of these IDs allowed a provider to be connected across each of the health plans. The aggregating of data, and linking of providers across all of the plans, is essential to create a credible database to conduct this analysis. Another data-related challenge is the fact that several local plans do not use ICD-9 codes, but rather "home grown" codes. These issues are continually being addressed through a technical advisory committee that includes representatives from each of the GIC plans, as well as daily contact among Mercer, RHI, the GIC, and the plans.

Getting plans on board with individual tiering. While the GIC has made clear that individual tiering will occur on July 1, 2007, a lot of resistance from the plans, providers, and the Massachusetts Medical Society has occurred. Some argue that individual tiering should not be rushed when there are not adequate data to support it. The Medical Society has also come out in strong opposition to individual tiering and has proposed that at the very least, providers that are in several networks should be assigned the same tier across all plans with which they contract.

Building private-sector purchaser interest. Some interviewees noted that purchasers in the private sector were showing interest in a number of quality- and value-oriented strategies, including P4P, weight management, and smoking cessation programs. Others said that the purchaser market has not been aggressive in pursuing VBP strategies and is content to let the health plans develop new models. Health plans reported that their private purchasers were not pushing for tiered networks, believing that tiering was not a money-saving strategy. It remains to be seen whether the private sector will take

advantage of the path that the GIC has begun paving. If tiering becomes a trend in the Commonwealth Care program, it possibly will begin to spread slowly beyond the public sector into the private.

Dealing with low-performing providers. Currently, no direct penalties exist for providers who score poorly on the efficiency and quality scales, though the higher copayments serve as indirect penalties, giving consumers incentives to go elsewhere. The GIC has no plans at this point to develop a P4P program (which offers more direct rewards or penalties), so other than the potential loss of patients, no penalties for poor performance “sticks” are in place to motivate physicians to improve performance on the measures being used. According to Mitchell, “The hope is that physicians who merit low scores will become self-motivated to improve their performance for both their own financial sake as well as to help their patients.” But she does not foresee health plans dropping poorly performing providers from their networks unless they receive poor marks consistently while making no attempts at improvement.

Evaluating the effect of tiered networks. The GIC, Mercer, and the health plans are eager to evaluate whether tiering at any level is having an impact on consumer behavior. None of the participating plans is currently conducting its own research, but the GIC is hoping to put an evaluation requirement in the next RFR.

CONCLUSION

Almost all interviewees agreed the GIC, the largest “employer” purchaser and with a strong champion at its helm, was the only entity in Massachusetts that could take on a challenge like creating quality- and efficiency-based tiering for providers. Mercer researchers and others greatly hope the CPI will lead to changes that will ultimately affect the GIC’s spending on health care. In an environment where private purchasers are not very aggressive with health care suppliers, the GIC is a groundbreaking force. According to Mercer executives, what the GIC is doing amounts to “publicly recognizing that providers’ cost and quality data will be the biggest driver of change, not higher cost sharing.”

Interviewees generally agreed that in order to “move the needle,” public reporting and making providers more accountable for their inefficient practices were the right strategies. Some expressed concerns that in response to the directives set forth by the GIC, plans might try to stay competitive by implementing more “blunt” instruments than tiering, such as narrow networks and higher deductibles. But the general consensus is that even if this tiering experiment does not survive, the GIC’s push for greater transparency will leave a legacy with a significant effect on the market as a whole.

FOR MORE INFORMATION

For more information on GIC's Clinical Performance Improvement and plan design initiatives, contact Dolores Mitchell, executive director of the Massachusetts Group Insurance Commission, by e-mail at dmitchell@state.ma.us or by telephone at 617-727-2310, ext.7010. Also visit the following Web pages:

<http://www.mass.gov/gic/annualreportb.htm#accelerate>

and

<http://www.mass.gov/gic/annualreportb.htm>.

NOTES

¹ The GIC also covers Housing and Redevelopment Authority personnel; City of Springfield employees and retirees; and retired municipal employees and teachers in certain governmental units.

² The full report is available at <http://www.nap.edu/books/0309072808/html/>.

³ Resolution Health, Inc. (RHI) is a health care data analytic and intervention company that offers services in cost reduction and quality improvement to health plans, employers, and benefits managers.

⁴ To be included, a physician must have at least 30 episodes of care attributed to him/her.

⁵ Mercer works with Symmetry (now part of Ingenix) to develop Episode Treatment Groups using Symmetry's trademarked software. See <http://www.ingenix.com>.

⁶ Any specialty not represented in this group was automatically put into Tier 2, except for obstetrics and gynecology, ancillary care, and mental health practices, which were placed in Tier 1. In addition, all primary care providers were placed in Tier 1.

⁷ For obstetrics, data are reported only on deliveries.

⁸ In addition to the UniCare indemnity plan, it offers a PPO and a "Community Choice" plan, both of which incorporate individual tiering.

⁹ Efficiency data were used before RHI was introduced into the process.

¹⁰ Note that while indemnity plans do not have networks, the UniCare indemnity plan operates more like a PPO.

¹¹ The connector began enrolling individuals below 100 percent of the FPL in the no-cost subsidized program on October 1, 2006. Commonwealth Care's commercial program began enrolling individuals between 100 and 300 percent of the FPL on January 1, 2007, through a choice of private health plans.

¹² Plans were required by the RFR to share their data with Mercer, but they are not contractually obligated to share with one another.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*States in Action: A Bimonthly Look at Innovations in Health Policy*](#). Newsletter.

[*Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve*](#) (August 2007). Sharon Silow-Carroll and Tanya Alteras.

[*Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance*](#) (August 2007). Sharon Silow-Carroll and Tanya Alteras.

[*Value-Driven Health Care Purchasing: Case Study of Washington State's Puget Sound Health Alliance*](#) (August 2007). Tanya Alteras and Sharon Silow-Carroll.

[*Value-Driven Health Care Purchasing: Case Study of Wisconsin's Department of Employee Trust Funds*](#) (August 2007). Sharon Silow-Carroll and Tanya Alteras.

[*Lessons from Local Access Initiatives: Contributions and Challenges*](#) (August 2007). Karen Minyard, Deborah Chollet, Laurie Felland, Lindsey Lonergan, Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong.

[*An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part II, Quality and Efficiency*](#) (July 2007). Karen Davis, Sara R. Collins, and Jennifer L. Kriss.

[*Quality Matters: Payment Reform*](#) (July 2007). Newsletter.

[*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

[*Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*](#) (April 2007). Kathryn Kuhmerker and Thomas Hartman.

[*State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers*](#) (January 2007). Alice Burton, Isabel Friedenjohn, and Enrique Martinez-Vidal.

[*Creating Accountable Care Organizations: The Extended Hospital Medical Staff*](#) (December 5, 2006). Elliott S. Fisher, Douglas O. Staiger, Julie P. W. Bynum, and Daniel J. Gottlieb. *Health Affairs* Web Exclusive (*In the Literature* summary).

[*State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States*](#) (December 2006). Neva Kaye, Jennifer May, and Melinda Abrams.

[*Value-Based Purchasing: A Review of the Literature*](#) (May 2003). Vittorio Maio, Neil I. Goldfarb, Chureen T. Carter, and David B. Nash.

[*How Does Quality Enter into Health Care Purchasing Decisions?*](#) (May 2003). Neil I. Goldfarb, Vittorio Maio, Chureen T. Carter, Laura Pizzi, and David B. Nash.

