



## **SUCCESS FACTORS IN FIVE HIGH-QUALITY, LOW-COST HEALTH PLANS**

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**ABSTRACT:** In this report, the authors conducted case studies of five health plans that received high scores on quality and resource utilization, using data collected by the National Committee for Quality Assurance. The focus of this study was to understand how health plans with delivery systems that include a significant network of independent, community physicians achieve high performance. Plan leaders identified several factors they believe contribute to being a high-performing plan: building a physician–plan partnership, establishing the plan as a resource for physician practices, providing physician quality and cost data on performance, and emphasizing a local area orientation. Because employers are primarily responsible for arranging the health insurance coverage for their employees, there is market pressure for health plans to work with broader networks than they would otherwise want, which in turn interferes with the factors that lead to high performance.

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This study was based on publicly available information and self-reported data provided by the institutions studied. The Commonwealth Fund is not an accreditor of health plans or health care organizations or systems, and the inclusion of an organization in a Fund case study or report is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund–sponsored studies of this type is to identify organizations that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other organizations to draw lessons from the subjects' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.

## EXECUTIVE SUMMARY

There has long been interest in establishing ways in which health plans add value to the services physicians, hospitals, and other providers offer to patients. An earlier series of papers used quantitative methods to identify the organizational and operational characteristics associated with high-performing health plans while controlling for other factors that are outside plans' control. To supplement those findings, the authors of this report identified five plans in the top-performance tier in terms of both quality and cost, and asked senior executives at each about the factors that contribute to their organization's effectiveness and to identify best practices used to improve performance.

The authors examined health plans with delivery systems that included a significant network of independent physicians. They focused interviews on the approach the plans had taken to work with community physicians and hospitals that were not in exclusive relationships. For plans that had both group or staff model components and networks of independent physicians—known as “mixed models”—the authors examined the interactions among the mixed components and focused on whether plans were able to influence independent physicians using approaches adopted in the core group or staff component of the plan's delivery system.

### **Study Findings**

Plan leaders identified several factors that they believe contribute to high performance. While some were idiosyncratic to the individual plans or environments in which they operate, there were several factors that were identified by all or most of the study plans (Exhibit ES-1).

## Exhibit ES-1

Success Factors	
<b>Build a Physician–Plan Partnership</b>	Forging and maintaining a strong relationship with physicians was consistently identified by plan leaders as a major factor in being a top performer. Consistent with this attitude, the plans were less likely to use common utilization management approaches used by many other plans.
<b>Health Plan as a Resource for Physicians</b>	Senior leaders believe the health plan should provide expertise to support physician practice. One respondent characterized the plan’s role as fostering and facilitating the physician–patient relationship and giving them what they need to do their jobs.
<b>Providing Physicians Quality and Cost Data</b>	Providing physicians with information is an important way for plans to provide support. Several of the plans, for example, conduct physician profiling and have found it can be a valuable tool to help improve quality and lower costs. As one interviewee said, “Docs don’t want to be outliers, so they do pay attention to reporting.”
<b>Plans Display a Local Area Orientation</b>	While there was considerable variation among the five study plans in market size and health plan reach, all emphasized the virtues of “being local” to facilitate relationships with both local providers and the members they serve. Local presence not only permits plans to build tighter provider partnerships but also allows them to influence plan members to take advantage of specialized programs and be more receptive to advice about patient self-care opportunities.
<b>Other Factors</b>	<ul style="list-style-type: none"> <li>• <b>Infrastructure support.</b> While none of the study plans provided direct capital investment to their physicians, a few have made available financial support to providers on a short-term basis or sent plan personnel to help a practice or group organize their claims system or to provide management advice.</li> <li>• <b>Face time.</b> Plans believe their participation in community health care efforts—for example, a local health care collaborative or a grassroots initiative to reduce lead poisoning in the community—is another way they provide support to physicians. Plan leaders believe that such “provider-facing” endeavors help raise their visibility and credibility with physicians and medical groups.</li> <li>• <b>Not “what” but “how.”</b> Plan leaders recognize that simply providing information or other support to physicians does not distinguish them from their competitors. Instead, many plan leaders felt that the way they executed different utilization, disease management programs, or data-sharing efforts made them high performers. This factor is strongly tied to building relationships and credibility with doctors.</li> </ul>

### Additional Findings

#### Marketplace forces challenge health plan success

While the virtues of being local were endorsed by all the respondents, the smaller local plans acknowledged that being a regional plan and either provider-owned or provider-affiliated means they cannot easily compete for national business, particularly with self-insured employers with employees dispersed throughout the country. Respondents pointed to the growing interest among self-insured, national employers in simplifying their contracting by seeking to give their entire book of business to a single insurer who can assemble a national delivery system.

### **Efforts to extend excellence to the broader physician network**

The group or staff model HMOs have the tightest alignment between health plan and providers. Among mixed-model plans, those that have a relatively large share of care provided in a closely affiliated medical group may have an advantage over the pure network model plans. In this situation, the “core” medical groups have an interest in the health plan faring well in their market competition, and therefore may not drive as hard a bargain on prices or compensation as do unaffiliated physicians and hospitals. Closely affiliated provider groups also may be more likely to work with the plan on guidelines, protocols, and quality improvement programs, which help the plan in achieving quality and other targets. At the same time, the plans fully recognize and respect established relationships between patients and network physicians and the increased service volume that the network wrap-around of the core group provides. For such an approach to be successful, the community physician is required to have values in keeping with the plan. This is a challenge, plan leaders concede.

### **Conclusion**

Senior health plan managers emphasized that the underlying quality of physician practice in the plan’s delivery system is an important factor contributing to the high performance accorded to the plan. There is no “magic formula” health plans can apply to providers to improve performance.

The underlying reality that health plans can affect performance mostly at the margins, but nevertheless in meaningful ways, seems to have produced a more cautious attitude among these plans about the role of aggressive “managed care.” The health plans interviewed all indicated that they tended not to do as much “policing” of their network physicians as many of their health plan competitors, preferring to find opportunities to collaborate with their network physicians.

As long as employers remain primarily responsible for arranging the health insurance coverage their employees receive, the pressure for health plans to work with broader networks, rather than more effective select networks grounded in staff and group model delivery, will continue. However, the nature of employer-sponsored coverage may change substantially after the implementation of the Affordable Care Act. If employers view the new health insurance exchanges as attractive—with their wider risk-pooling, relatively low administrative costs, and expanded choices—the number of workers offered coverage may increase significantly. Such a change would make the more collaborative model of health plans working in partnership with specific provider organizations more viable.



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## **INTRODUCTION**

There has long been interest in establishing ways in which health plans add value to the services physicians, hospitals, and other providers offer to patients. An earlier series of papers used quantitative methods to identify the organizational and operational characteristics associated with high-performing health plans.<sup>1</sup> To supplement those findings, the authors of this report identified five plans in the top-performance tier in terms of both quality and cost, and asked senior executives at each about the factors that contribute to their organization's effectiveness and to identify best practices used to improve performance.

The authors examined health plans with delivery systems that included a significant network of independent physicians. They focused interviews on the approach the plans had taken to work with community physicians and hospitals that were not in exclusive relationships.<sup>2</sup> For plans that had both group or staff model components and networks of independent physicians—known as “mixed models”—the authors examined the interactions among the mixed components and focused on whether plans were able to influence independent physicians using approaches adopted in the core group or staff component of the plan's delivery system.<sup>3</sup>

As discussed in the Methods (see [Appendix](#)), the group and staff model HMOs continue to perform at higher levels on quality and cost, which has limited the objective of seeking to emphasize network–model plans in this case study. Nevertheless, all of the plans interviewed had some network components and offered insights about how health plans can influence network providers' performance.

## **OVERVIEW OF STUDY PLANS**

The plans profiled in this report range from small, local, nonprofit plans to a large nationally affiliated, for-profit plan (Exhibit 1).

**Exhibit 1. Selected Characteristics of Study Plans**

	Capital Health Plan, Inc.	Excellus BlueCross BlueShield	Health Net of California	Kaiser Foundation Health Plan of Colorado	Network Health Plan
<b>State</b>	Florida	New York	California	Colorado	Wisconsin
<b>Headquarters</b>	Tallahassee	Rochester	Woodland Hills	Denver	Appleton
<b>Census Region</b>	South	Northeast	West	West	Midwest
<b>Plan Type</b>	HMO	HMO/POS	HMO/POS	HMO	HMO
<b>Years in Business</b>	26	23	29	39	27
<b>Model</b>	Staff/Network	Network	Network	Group/Network	Staff/Network
<b>Enrollment</b>	106,000	220,000	1,179,000	408,000	105,000
<b>Profit Status</b>	Non-profit	Non-profit	For profit	Non-profit	For profit
<b>Practice Size</b>					
Share of primary care physicians in network in large practices (50+)	Few or none	Few or none	Mixed	All or most	Some
Share of specialists in network in large practices (50+)	Few or none	Few or none	Mixed	All or most	Few or none
<b>Physician Payment Method</b>					
Predominant payment method for primary care physicians	Capitation	Fee-for-service	Capitation to medical groups/IPAs*	Salary	Fee-for-service
Predominant payment method for specialists	Fee-for-service	Fee-for-service	Capitation to medical groups/IPAs*	Salary	Fee-for-service
<b>PCP Incentives</b>					
Share of primary care physicians offered bonus incentives	Some	Few or none	All or most	All or most	Few or none

Source: NCQA's 2008 Quality and Resource Use Health Plan Survey and Case Study Findings

\* While Health Net pays a capitated rate to medical groups and IPA, how medical groups and IPAs reimburse individual physicians varies widely, ranging from paying physicians a fixed salary to fee for service.

### **Capital Health Plan**

Capital Health Plan (CHP) is a nonprofit, managed care organization that has been providing commercial health maintenance organization (HMO) services for more than 25 years. The plan is headquartered in Tallahassee, Florida, and serves the four counties surrounding the city. It is the one remaining local health plan serving the area; all other health plans are national plans such as United HealthCare and Aetna. CHP is affiliated with Blue Cross Blue Shield of Florida, which allows it to access Blue Cross's negotiated rates for enrollees going out of the local service area for care. CHP, however, operates independently and commands about 50 percent of the region's commercial market. As of late 2008, the plan's commercial HMO enrollment was about 106,000 individuals, drawing from over 2,300 area businesses.<sup>4</sup>

CHP provides multiple HMO plan options for small and large employers. In addition, it offers several Medicare plans, including Medicare Advantage direct-pay plans and Medicare retiree employer plans. CHP, however, does not participate in other public insurance programs like Medicaid or the Children's Health Insurance Program.

CHP is a mixed-model HMO, with both staff and network physicians. It began with an employed staff working in its own health center in Tallahassee and currently employs about 20 physicians (almost exclusively primary care doctors) and other health professionals who work at CHP's two health center complexes, both located in Tallahassee. In terms of network physicians, CHP contracts with more than 300 doctors and specialists across the region, including more than 100 primary care physicians. Almost all network doctors, both primary care and specialists, are in small practices. CHP uses different approaches to pay its physicians. Staff doctors are salaried, network primary care doctors are capitated, and network specialists are paid on a fee-for-service basis. In addition, CHP provides incentive payments to staff and network primary care physicians.

### **Excellus Blue Cross Blue Shield**

Excellus Blue Cross Blue Shield (BCBS) is a nonprofit, nationally affiliated, managed care plan headquartered in Rochester, New York. The plan is part of a \$5 billion family of companies that provides a wide range of health care products and services, including HMO, preferred provider organization (PPO), and third-party administrator services to about 1.7 million people in upstate New York. Excellus BCBS serves a wide range of populations, including Medicaid, Medicare, and commercial patients.

The commercial HMO product (the focus of this study), is primarily based in Rochester and is a network model plan. Excellus BCBS is by far the dominant HMO in the area, covering about two-thirds of the commercial market. As of 2008, there were about 220,000 individuals enrolled in the HMO. Most physicians in the network are in small-group or solo practices, but increasingly Excellus BCBS is entering into relationships with large-group practices. Excellus BCBS pays almost all its doctors on a fee-for-service basis and uses few incentives payments.

Fee-for-service is a recent development for Excellus BCBS. Until the mid-2000s, the plan had a contract with Rochester Individual Physician Association (RIPA) in which it paid a capitated rate for physicians' professional services. Like most of the nation, the HMO market began to shrink during the 2000s and, as expected, sicker enrollees tended to remain while healthier individuals left the plan, according to Excellus BCBS leaders. When this happened, Excellus BCBS sought to compel RIPA to assume more risk, but RIPA declined to do so. As a result, Excellus BCBS transitioned to directly contracting with physicians using a fee-for-service method. Although Excellus BCBS no longer contracts with RIPA, plan leaders believe that the individual physician association helped to develop a cohesive medical community in Rochester.

### **Health Net of California**

Health Net of California is a for-profit, nationally affiliated managed care plan based in Woodland Hills, near Los Angeles. It has been operating a commercial HMO plan in California for about 30 years. The plan's parent organization, Health Net, Inc., offers services to approximately 6.7 million individuals in 27 states and the District of Columbia. In California, Health Net has more than 2.2 million members in group and individual plans, Medicare Advantage and Medicare supplement plans, and public plans, including Medicaid and Children's Health Insurance Program plans. It offers PPO, HMO, point-of-service (POS), and other products.

Health Net's commercial HMO product in California is a network-only model plan that serves enrollees in the most populous regions of the state: southern California, the San Francisco Bay area, and Sacramento. With enrollment of nearly 1.2 million individuals, Health Net is by far the largest HMO included in the study and the only for-profit plan. For its HMO product, Health Net contracts with about 260 hospitals across the state and 220 medical groups. Virtually all of Health Net's competitors have the same provider network, a feature that plan officials acknowledge makes it challenging for the plan to distinguish itself to employers, consumers, and providers.

In contrast with the other study plans, Health Net uses a delegated capitation model. Almost without exception, all professional services for physicians are capitated to the medical groups and IPAs. Selected medical groups (i.e., very large ones) are also capitated for some institutional services, especially hospitalization. Unlike Excellus BCBS, which recently moved away from using a capitated payment approach for its physicians, Health Net is highly dedicated to the delegated capitation model, which makes it unique in the California managed care market. Indeed, Health Net leaders believe that their strong support of the delegated capitation model helps to set them apart from their competitors, particularly national health plans such as United and Anthem, which are not as invested in this payment approach.

Health Net contracts mainly with large medical groups and IPAs—there are about 40,000 physicians across the roughly 220 contract groups. However, individual physician practices run from boutique size to super size, with some having more than 100 doctors. Also, although Health Net capitates the medical groups and IPAs with which they contract, reimbursement arrangements for individual physicians vary and include salary, fee-for-service, and capitation.

Health Net participates in the Integrated Healthcare Association (IHA), a nonprofit association that includes plans, providers, and employers who collaborate on health care issues. Among its various activities, IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in 235 physician groups. The plans themselves are responsible for determining and administering any pay-for-performance payments.<sup>5</sup> Health Net has been retreating on its use of incentive payments as it is not convinced of the effectiveness of such payments in influencing physician group behavior.

### **Kaiser Foundation Health Plan of Colorado**

Kaiser Foundation Health Plan of Colorado (Kaiser Colorado) is a nonprofit, nationally-affiliated managed care plan based in Denver. It has been offering commercial HMO products in the state for 39 years. It is affiliated with Kaiser Permanente, the nation's largest integrated managed care organization, with 8.6 million members in eight regions across the United States. Kaiser Permanente is comprised of three entities: Kaiser Foundation Health Plan and its regional operating subsidiaries, Kaiser Foundation Hospitals, and the autonomous Colorado Permanente Medical Group. Kaiser Colorado is a regional operating subsidiary that serves enrollees in two primary regions across a 17-county area, which includes the Denver/Boulder region and the southern Colorado region surrounding Colorado Springs. Kaiser Foundation Hospitals do not own or operate any

hospitals in Colorado; the Colorado Permanente Medical Group is a group of more than 800 multispecialty physicians organized to provide medical services to plan enrollees.

As of late 2008, Kaiser Colorado had approximately 408,000 commercial HMO members. Kaiser Colorado offers HMO, POS, and PPO plans. It also runs a successful Medicare Advantage plan currently serving about 70,000 Medicare beneficiaries. It offers a mixed-model HMO, with both staff and network physicians. However, more than 90 percent of members are cared for by Permanente physicians in 18 Kaiser-owned medical office facilities throughout the Denver/Boulder metropolitan area.

Because employers based in Denver had employees living in Colorado Springs and Pueblo, more than a decade ago Kaiser expanded its delivery system capabilities to those two markets by building physician networks. Indeed, although it is labeled a mixed-model HMO, Kaiser Colorado's only major network activity is in the Southern Colorado area. Recently, Kaiser has established two Kaiser centers staffed with Permanente personnel in Colorado Springs and Pueblo.

### **Network Health Plan**

Network Health Plan (NHP) is a local, nonprofit HMO serving northeastern Wisconsin. It is owned by Affinity Health System, a regional integrated health care delivery system. NHP is a mixed-model HMO and has been in operation for 23 years. It is headquartered in Menasha, Wisconsin, and its service area includes 17 surrounding counties.

NHP has the smallest commercially enrolled population of all the plans in this study, with 59,700 members. It does not offer individual and family coverage product lines, but does have several employer and group products, including HMO, POS, PPO, and high-deductible health savings account (HSA) products. NHP also offers several Medicare Advantage plans, including a Special Needs Plan (SNP) for individuals who are dually eligible for Medicare and Medicaid. NHP only began contracting with the Centers for Medicare and Medicaid Services (CMS) in 2005, after the passage of Medicare Modernization Act, which raised payment levels for Medicare Advantage plans and created the category of SNPs.

At the time of this study, NHP had about 32,000 Medicare beneficiaries in its Medicare Advantage plan and nearly 1,000 in its dual-eligible SNP plan. NHP has a Medicaid contract, which is administered through Managed Health Services in Milwaukee. NHP contracts with a network of approximately 1,600 local and area health care providers. It has a mixed-model delivery system which includes the Affinity Health

System and independent physicians and hospitals. Affinity Health System provides NHP with more than 200 physicians, 22 clinics, three hospitals, and specialty health care centers. About half of NHP service dollars are paid to Affinity providers.

Until 2010, NHP had a relationship with Affinity in which Affinity did not have other health plan contracts and NHP did not contract with other providers in the core service area in which Affinity is located. Indeed, the HMO market in this part of Wisconsin was initially characterized by competition between two provider/plan systems (Affinity/Network Health Plan and ThedaCare/Touchpoint). Both NHP and Touchpoint consistently scored high marks on NCQA quality ratings.<sup>6</sup> At the time of the authors' site visit in January 2010, NHP was in the process of altering its exclusive relationship with Affinity. Affinity, while continuing to own NHP, would be free to enter into other health plan contracts with other health plans and NHP would be free to contract with other providers in the service area.

#### **HIGH-PERFORMING PLANS NATIONALLY**

The five study plans were selected from a pool of 118 plans (Exhibit 2).

**Exhibit 2. Selected Characteristics of Plans by Performance Level**

	<b>All (N=118)</b>	<b>Met high- performing criteria (N=22)</b>	<b>Did not meet high- performing criteria (N=96)</b>
	%	%	%
<b>Census</b>			
Northeast	33.9	52.2	29.5
South	27.1	8.7	31.6
West	16.1	21.7	14.7
Midwest	22.9	17.4	24.2
<b>Model Type</b>			
Network	27.1	30.4	26.3
Group	3.4	4.3	3.2
IPA	35.6	8.7	42.1
Mixed Model	33.8	56.5	28.5
<b>Commercial HMO Enrollment</b>			
< 100,000	55.1	52.2	55.8
100,000 - 199,999	18.6	17.4	18.9
200,000 - 499,999	17.8	13.0	18.9
500,000 or more	6.8	13.0	5.3
Other/Unknown	1.7	4.3	1.1
<b>Tax Status</b>			
For Profit	74.6	52.2	55.8
Non-profit	24.6	47.8	18.9
Other/Unknown	0.8	0.0	1.1
<b>Years in Business</b>			
0-10	5.9	4.3	6.3
10-20	18.6	17.4	18.9
20 or more	72.9	69.6	73.7
Other/Unknown	2.5	8.7	1.1

Source: NCQA HEDIS and RRU data, 2007-2009

On balance, the study plans share characteristics with other high-performing plans nationally. In particular, high-performing plans overall tend to be network or mixed-model plans, which is similar to the study plans.<sup>7</sup>

Also, as with the study plans, high-performing plans tend to be smaller. More than two-thirds (68.2 percent) have fewer than 200,000 enrollees; three of the five study plans had enrollment of less than 220,000. Finally, both the high-performers and the study plans tend to be older plans (i.e., in business more than 20 years).

There is some divergence between study plans and high-performing plans in terms of profit status. Four of the five study plans were nonprofit, while overall high-performing plans were split evenly on profit status.<sup>8</sup>



## FACTORS THAT CONTRIBUTE TO HIGH PERFORMANCE

Plan leaders identified several factors they believe contribute to high performance. Although some were idiosyncratic to the individual plans or the environments in which they operate, there were several factors identified by all or most of the study plans (Exhibit 3). These individual factors are often linked, working in tandem to produce high-performance results for the plan.

**Exhibit 3**

<b>Success Factors</b>	
<b>Build a Physician–Plan Partnership</b>	Forging and maintaining a strong relationship with physicians was consistently identified by plan leaders as a major factor in being a top performer. Consistent with this attitude, the plans were less likely to use common utilization management approaches used by many other plans. <sup>9</sup>
<b>Health Plan as a Resource for Physicians</b>	Senior leaders believe the health plan should provide expertise to support physician practice. One respondent characterized the plan’s role as fostering and facilitating the physician–patient relationship and giving them what they need to do their jobs.
<b>Providing Physicians Quality and Cost Data</b>	Providing physicians with information is an important way for plans to provide support. Several of the plans, for example, conduct physician profiling and have found it can be a valuable tool to help improve quality and lower costs. As one interviewee said, “Docs don’t want to be outliers, so they do pay attention to reporting.”
<b>Plans Display a Local Area Orientation</b>	While there was considerable variation among the five study plans in market size and health plan reach, all emphasized the virtues of “being local” to facilitate relationships with both local providers and the members they serve. Local presence not only permits plans to build tighter provider partnerships but also allows them to influence plan members to take advantage of specialized programs and be more receptive to advice about patient self-care opportunities.
<b>Other Factors</b>	<ul style="list-style-type: none"> <li>• <b>Infrastructure support.</b> While none of the study plans provided direct capital investment to their physicians, a few have made available financial support to providers on a short-term basis or sent plan personnel to help a practice or group organize their claims system or to provide management advice.</li> <li>• <b>Face time.</b> Plans believe their participation in community health care efforts—for example, a local health care collaborative or a grassroots initiative to reduce lead poisoning in the community—is another way they provide support to physicians. Plan leaders believe that such “provider-facing” endeavors help raise their visibility and credibility with physicians and medical groups.</li> <li>• <b>Not “what” but “how.”</b> Plan leaders recognize that simply providing information or other support to physicians does not distinguish them from their competitors. Instead, many plan leaders felt that the way they executed different utilization, disease management programs, or data-sharing efforts made them high performers. This factor is strongly tied to building relationships and credibility with doctors.</li> </ul>

### **Success Factor #1: Build a Physician–Plan Partnership**

Forging and maintaining a strong relationship with physicians was consistently identified by plan leaders as being a major factor in high performance. Most of the plans with mixed models for at least some of their service area consider the staff or group to be more effective in achieving quality and cost goals than the broader network of independent physicians. The staff and group tend to have a closer, dedicated health plan relationship; however, the plans also contract with the more diffuse network of independent physicians to provide additional plan reach and marketability to potential subscribers who do not want to give up their established relationships with independent physicians.

Nevertheless, even with network physicians, effective plans demonstrated sensitivity to the culture of independent practitioners when developing approaches to engaging physicians in improving performance. Plan leaders used various terms to describe the link they have tried to develop with physicians, including “partners,” “collaborators,” and “a personal touch.” Senior plan management readily acknowledged that establishing and maintaining such a relationship with network physicians is an ongoing challenge. There is an inherent tension between plans and physicians, who want to practice independent of plan supervision. According to plan leaders, physicians want control over their patients and practices. Senior leaders respect these feelings and have sought to allow physicians their clinical autonomy while also trying to meet the needs and standards of the plan.

For example, Excellus BCBS recently implemented a radiology management program, which caused considerable negative reaction among community physicians. Shortly thereafter, Excellus BCBS decided to implement a comparable program for cardiology services. In this instance, rather than contracting with an outside vendor, the plan approached local cardiologists and asked if they would like to design the management program. The response from physicians was an enthusiastic “yes.” For the past two years, Excellus BCBS and community cardiologists have worked together to build utilization reports using the American College of Cardiology’s clinical guidelines. With these guidelines, the plan does educational outreach to physicians who are assessed as utilization outliers.

Consistent with this attitude, the plans were less likely to use common utilization management approaches used by many other plans.<sup>10</sup> For example, Health Net of California does not make pay-for-performance a high priority, even though it participates in the California integrated health care association. Instead, Health Net sees its role as providing supportive tools to help groups, feeling that the delegated capitation model

already achieves much of what pay-for-performance attempts to achieve. Similarly, Excellus BCBS had a history of using pay-for-performance, but is no longer actively using the approach for physicians at this time.

Neither Capital Health Plan nor Network Health Plan rely heavily on managed care oversight for their network physicians. Excellus BCBS, which now relies totally on network-paid fee-for-service, is trying to rely more on collaborative approaches to engaging physicians rather than what a plan representative labeled as managed care–style “policing.” As a network model plan, it still uses most of the utilization management approaches available, such as prior authorization, but in recent years it has developed a more targeted approach, reducing the number of reviews and utilization management staff substantially. Excellus BCBS has had some success with a vendor-based disease management approach, through a contract with Health Dialog. However, it is now working to move chronic care management activities closer to the physicians, to allow for greater potential for engaging members in behavior change. Kaiser Colorado is working on an approach to bring some elements of the Permanente delivery system to network physicians, rather than aggressively using the utilization management techniques that are applied to independent physician networks.

### **Success Factor #2: Health Plan as a Resource for Physicians**

Senior leaders believe that health plans should provide expertise in specific areas to support physician practice. In one executive’s words, the plan is a “community resource” for the doctors. Many respondents thought that contracting with above-average physicians with a legacy of providing cost-effective, high-quality care was the main reason behind their high performance. That is, even without the health plan’s influence, the care would be good. As one provider-relations manager explained, much of the reason for high health plan ratings on cost and quality derives from the intrinsic performance of the network. An Excellus BCBS executive noted that Rochester was unique in having a community-oriented medical school that instilled a prudent approach to use of resources, a culture of collaboration among providers, and tight delivery systems.

One respondent characterized the plan’s role as “fostering and facilitating the physician–patient relationship” and giving providers what they need to do their jobs. In one executive’s words, plan managers do not have a “special sauce.” Without the doctors’ active participation in reinforcing the plan’s initiatives, nothing will happen.

It may help for plans to have size and scale in order to be a resource and provide support to physicians. Kaiser Colorado can draw on the national expertise and resources of a very large and experienced health plan and medical group. It is broadly accepted that in many areas of clinical care management, Kaiser Permanente is an industry leader; Kaiser Colorado surely benefits from residing inside such a cutting-edge organization.

As network model plans, Health Net and Excellus BCBS have not developed delivery system expertise comparable to Kaiser, but they have developed internal capacity to provide practice support to network physicians and can provide value-added programs to the delivery systems. NHP and CHP, the two smaller, mixed-model regional plans, have found they can access resources provided by specialized vendors that give them parity with larger plans, especially in the area of data analysis. Indeed, often the larger plans use the same vendors for their specialized expertise; thus, it is not clear that plans with larger size and capacity have inherent advantages. As will be discussed in more detail, being local and having a collaborative relationship with important physician groups may outweigh size, scope, and financial resources.

### **Success Factor #3: Provide Physicians Quality and Cost Data**

All plans said they support physicians by providing them with information. In some instances, plans give data on the physician's or medical group's performance. Plans provide this information in many different ways. Several of the plans have emphasized the importance of educating physicians about their individual performance. Following a switch in its claims payment system in 2005, NHP, for example, began profiling its physicians along several dimensions. Using this profiling information, plan staff members meet with doctors and review their cost and risk indexes.

Health Net conducts similar profiling with contracted medical groups. Specifically, regional Health Net medical directors will bring performance data, including member relationship, appeals, and grievance data, as well as hospital bed days, readmission rates, and emergency room use, to their contracted medical groups. Often these meetings are conducted in person at the group's office. Plan leaders state that physicians are generally receptive to such information.

CHP has also implemented physician profiling. CHP plan leaders said they found distributing clinical guidelines was not very effective in changing behavior among doctors. After receiving input from doctors on what clinical criteria should be used, CHP shifted to profiling, which has proved to be a useful education tool. As one CHP interviewee said, "Docs don't want to be outliers, so they do pay attention to reporting."

Recently, Health Net and NHP instituted “gap” reporting or management. The plan culls its claims data and identifies failures to meet clinical guidelines. For example, gap reporting can be used to assess whether preventive services have been provided—for example, flu shots, colonoscopies, and mammograms. It also can be used to manage enrollees’ chronic diseases such as diabetes or coronary artery disease. Interviewees readily acknowledged that a major shortcoming of gap reporting is that it relies on claims, which often have a substantial time lag. Ideally they would like to move to real-time provision of gaps, which could be directly embedded in a patient’s electronic medical record.

In another example, Excellus BCBS launched its own pharmacy management program which is housed in the same department as medical management—linking together case management, disease management, and pharmacy. A major component of the pharmacy management program is working with patients with chronic health conditions to take their medications and to use lower-cost generic drugs that are at least equally effective as brand-name drugs. As part of this effort, the plan processes its claims data to inform doctors as to whether patients filled their prescriptions. Excellus BCBS also uses its in-house clinical pharmacists to help educate physicians about medications, including the use of generic drugs.

Kaiser Colorado also relies heavily on clinical pharmacists, not only to work directly with physicians, nurses, and other health professionals on the teams providing primary care to plan members, but also to directly manage specialized programs involving patient care services. For example, clinical pharmacists function essentially as the “disease managers” for patients with coronary heart disease and high cardiac risk, directly interacting with patients between physician office visits, much as nurses in vendor-based disease management programs do. In this case, however, the doctors of pharmacy are part of the health care team, ensuring communication within the responsible primary care team.<sup>11</sup> Kaiser is extending clinical pharmacy services support beyond its own centers to network physicians, as well.

#### **Success Factor #4: Plans Display a Local Area Orientation**

Two of the health plans—CHP and NHP—are locally based and serve a significant proportion of members within a small geographic area. Excellus BCBS serves a much larger area, but nevertheless maintains a very visible presence in the Rochester, New York area. Although Kaiser Colorado’s main service area is Denver/Boulder, this report focuses on its network-based activities in the smaller southern Colorado markets where it does not have a major market share. Health Net California serves virtually all of

California and has a moderate share in many competitive markets. The plans serve very different numbers of members.

Despite this variation in market size and health plan reach, all the plans emphasized the virtues of “being local” to facilitate relationships with local providers and the members they serve. CHP employs physicians in its core health centers and has extensive ties throughout the local community in Tallahassee. Affinity Health System (a provider organization, also based in Appleton, Wisconsin) is the owner of NHP. This relationship has produced close collaboration between the health plan and the core provider organization in its delivery system.

Respondents thought the various approaches the five plans have adopted to “act locally” differentiate them from national health plans administered through state- or regionally affiliated plans. Local presence not only permits plans to build tighter provider partnerships but also to influence plan members to take advantage of specialized programs offered by the health plans and to be more receptive about patient self-care opportunities. NHP and CHP respondents said they have much greater receptivity from members who receive written or telephone communication from the local plan, rather than the same communication from a national insurer, regardless of whether the actual communication comes from a local office of the national company.

There are alternative ways of achieving strong local presence. For the three relatively small local plans interviewed (CHP, NHP and Excellus BCBS), administrative offices are in the heart of the service area. These plans have relations with closely affiliated providers and with network physicians. Further, having administration centrally located in the community served facilitates communication across the health plan organization, purportedly producing improved management consistency and a better ability to problem-solve. Although a network model plan, Excellus BCBS highlights its community orientation but emphasizes that plans need critical mass to be able to gain attention among the network providers. Such a significant presence permits the plan to pull stakeholders together and “compel rather than command” improvement.

The other two organizations—Kaiser Colorado and Health Net—are much larger and have parent organizations that also support plans in other states. As with all nationally focused insurers, state-based health plans (which hold the state-issued HMO licenses) can develop a locally oriented culture to interact collaboratively with local providers and to engage members in various ways. Nevertheless, both Health Net (with national headquarters in California) and Kaiser Colorado felt that in comparison with

other national plans, they have more autonomy to develop local solutions, rather than having to follow national policy.

For example, Kaiser Colorado recently initiated a unique strategy for developing delivery system capacity in southern Colorado, which reflects both the traditional Permanente delivery system and independent, network physicians. Referred to as a “collaborative model,” Kaiser plan members may select either Permanente primary care physicians located in Kaiser centers or community physicians in the broader network with no gatekeeper signup requirement. In addition, Permanente physicians refer to network specialists within the community rather than to Permanente physicians elsewhere, as part of the collaborative approach. In short, the Permanente physicians are expected to develop extensive relationships within the local medical community, rather than remain in a separate Permanente enclave.

Starting with six Permanente physicians and about 700 community physicians in Colorado Springs and Pueblo, health plan and Permanente group managers envision a tripling of the Permanente group and a reduction to about 500 network physicians. The broad goal is to work with physicians who embody the “values, methods, and model” that Kaiser exemplifies. Even in Denver and Boulder, where Kaiser relies largely on Permanente physicians for most care, it has had the experience of working with a non-Permanente cardiac surgery group to good effect, according to plan leaders.

Health Net maintains a local flavor in part because of its regional network of medical directors that works with the various medical groups and IPAs that receive capitated payments. This distinguishes it from the national plans that may have once been based in California but have moved important decision-making that affects local delivery out of the state.

### **Other Success Factors to Support Practices**

**Infrastructure support.** While none of the study plans emphasize providing direct capital investment to support their network physicians, in a few instances plans have made available financial support to providers on a short-term basis or sent plan personnel to help a practice or group organize their claims system or to provide management advice. In essence, in these and other situations the plan acts as a “cushion” for their providers.

**Face time.** Plans see their participation in community health care efforts as another way to provide support to physicians. Health Net leaders, for example, felt their

involvement in local health care collaboratives has helped raise visibility and credibility with physicians. One initiative cited was the California Quality Collaborative (CQC), formed by the Pacific Business Group on Health. The collaborative includes employers, health plans, and medical groups, and has a mission to identify best practices in managing costs and quality and to introduce those practices back in the member organizations. Health Net is heavily involved with the CQC and believes that its participation provides important face time with medical groups and also demonstrates its commitment to working with them on quality and cost issues.

Excellus BCBS's leaders noted the plan's participation in several local, provider-facing efforts. For example, the plan has been involved with and helped finance a grassroots effort to reduce lead poisoning in the community. More recently, it participated in an effort to reduce obesity. These endeavors have involved a range of stakeholders, including doctors. Additionally, in response to the local provider community, Excellus BCBS was among the first plans to increase its reimbursement rate for neurosurgery services in an effort to keep these services in the local area.

**Not “what” but “how.”** Plan leaders recognize that simply providing information or other support to physicians does not distinguish them from their competitors. All plans can generate information and share it with physicians, according to respondents. Instead, many plan leaders felt that the way they executed different utilization, disease management programs, or data-sharing efforts made them high performers. This factor is strongly tied to building relationships and credibility with doctors. At the same time, respondents concede that other factors, such as having a significant market share or covering a large portion of a practice's patients, help with getting physicians to pay attention to them and their programs and initiatives.

## **ADDITIONAL FINDINGS**

### **Experiences with Delegated Capitation**

Health Net believes another way it achieves a local presence is its strong belief in the way health plans in California pay their physicians. As mentioned previously, most plans in California rely on delegated capitation contracting, which shifts the locus of management for health care delivery and some health plan functions to local provider organizations. That is, under delegated capitation, many of the management and care delivery functions that are generally performed by the health plan are shifted to the delivery system—the medical groups and IPAs—which take on many health plan responsibilities.



By design, the delegated capitation model inherently relies on being local. Even though Health Net has a “network” delivery model, because it neither employs nor has an exclusive relationship with a particular group, its approach is similar to a group-model HMO. The approach gives the intermediary organizations—medical groups and IPAs—authority to make decisions on how to practice, how to compensate their constituent members, and how to achieve quality and spending targets, with the health plan relegated to a more supportive role.

Health Net executives acknowledge that all major California health plans use the delegated capitation approach, so this does not set them apart from their competitors. What does, according to leaders, is their commitment and support of the approach, which they do not see in the national health plans.

These experiences demonstrate the ways in which the delegated capitation approach can shift authority for cost control to the physician groups. Under the delegated capitation model of HMO contracting, multispecialty group practices and IPAs take over primary responsibility for managing quality and costs. Health Net serves a supportive role in care delivery and is responsible for the more traditional health insurer functions like underwriting, marketing, and regulation compliance.

In contrast, Excellus BCBS determined that the delegated capitation model did not permit them to achieve cost targets, even though they had incorporated local decision-making and collaboration with providers, with physicians assuming central roles on quality and cost management. In Health Net’s experience in California, the groups and IPAs were responsible for most health care spending—concerted action by physicians could reduce spending by reducing inpatient stays in hospitals. In contrast, the Rochester IPA was only responsible for professional services and could actually do better by increasing the share of care provided by hospitals.

Interestingly, while the local plans (i.e., Capital Health Plan and Network Health Plan) developed special relationships with closely aligned groups and were known to the broader community of physicians that made up the network, Excellus BCBS, having given up its unique relationship with RIPA, felt it maintains credibility with the provider community by acting in a collaborative manner and having large market share. While all the plans in the study felt having a strong local presence was important, there was agreement that plans must have enough market presence to make it worth providers’ effort to engage with the plans.

### **Marketplace Forces Challenge Health Plan Success**

The smaller, local plans acknowledged that being a regional plan and either provider-owned or provider-affiliated means they cannot easily compete for national business, especially with self-insured employers with employees dispersed throughout the country. Respondents pointed out that many such employers have simplified their contracting by giving their entire book of business to a single insurer who can assemble a national delivery system. This trend produces a move away from HMOs toward PPOs with broad provider networks, rather than concentrated, effective delivery systems. This shift thus limits the ability of local HMOs (such as CHP or NHP) to compete for this large business segment. A shift from HMOs to PPOs also threatens the delegated capitation model used in California HMOs because PPOs are not allowed to shift financial risk to providers under capitation arrangements.

Another factor working against the small, regionally based plans is the lack of size and market leverage with providers outside the local market and with national vendors of pharmaceuticals and medical devices.<sup>12</sup> Further, small plans may lack access to capital to upgrade operations to compete effectively in competitive environments.

Indeed, Kaiser Colorado points to its advantages, due to both significant size and a tightly aligned delivery system. The plan can build its own ambulatory surgery centers and purchase its own advanced imaging equipment, such as MRI and CT scanners. Marketplace prices for these profitable services far exceed the costs that Kaiser incurs by owning the facilities and equipment. Kaiser's MRIs are typically in operation from 7 a.m. to 11 p.m., thereby reducing the unit cost of an MRI scan.<sup>13</sup>

### **Efforts to Extend Excellence to the Broader Physician Network**

A close alignment between plan and physicians was cited as important in achieving high performance on quality and resource use. The tightest alignment lies in the group- or staff-model HMO. Among mixed-model plans, those that have a relatively large share of care provided in a closely affiliated medical group may have an advantage over the pure network-model plans. The "core" medical groups have an interest in the health plan faring well in terms of market competition, and therefore may not drive as hard a bargain on prices or compensation as do unaffiliated physicians and hospitals.

Closely affiliated provider groups may also be more likely to work with the plan on guidelines, protocols, and quality improvement programs, which all help the plan in achieving targets. In many cases, the core group has a direct interest in developing initiatives to achieve quality and resource-use objectives. Indeed, plan leaders from the

mixed models in this study indicated they would prefer that more patients be seen by the core providers but recognize and respect established patient–network physician relationships and the increased service volume provided by the network wraparound of the core group.

Among the study plans, CHP was the “purest” mixed-model plan. CHP has a core group of salaried staff physicians who see mostly CHP patients, as well as a broader physician network. CHP leaders have found the plan attains better results from its core staff physicians, which it considers “the engine that drives the system,” especially for chronic care patients. When possible, CHP tries to channel complex, high-cost patients to the staff physicians. At the same time, CHP also tries to be an important presence with its network physicians. It seeks to provide at least 100 members to each primary care physician so they will be willing to engage with CHP in collaborative improvement initiatives. In addition, larger numbers per physician can better support the primary care capitation payment model from an actuarial perspective. NHP leadership has recognized the market imperative to alter its collaborative relationship with the Affinity-based delivery system to a larger, more decentralized network. However, it is concerned this will involve taking on more oversight responsibilities over physician performance.

Kaiser Colorado managers emphasized that making a mixed model work well is challenging. The plan has a marketplace requirement to offer services in southern Colorado cities because Denver-based employers wanted to select health plans able to provide services throughout the entire Denver metropolitan area. However, it had never attempted to aggressively develop its network in the southern Colorado market. Until recently, Kaiser never invested much in influencing the care provided by the local physician network and did not try to build business in this area by marketing directly to individuals and employers in these markets.

Because many Colorado Springs physicians are not accepting new Medicare patients, Kaiser acted opportunistically in 2009 to implement a Medicare Advantage model. This model builds on Kaiser’s strength: the ability to provide high-level chronic care management and coordination to patients with long-term, chronic conditions such as diabetes, chronic obstructive pulmonary disease, and congestive heart failure. Given the lack of interest in the local physician community in serving these patients, Kaiser has been able to bring in its own core model: Permanente primary care physicians working in a Kaiser center supported by Kaiser information technology, chronic care management programs, clinical pharmacy systems, and other support services.

Similarly, Kaiser entered Pueblo with its own Kaiser-based center with Permanente physicians, nurses, and pharmacists in 2009, based on a finding that an increasing shortage of community primary care physicians was leading to access problems for the entire population. Now in both Colorado Springs and Pueblo, plan members have the choice between seeing a Permanente physician in a Kaiser site or a community physician in his or her own practice.

Kaiser Colorado's entry into the Medicare market in Colorado Springs through its group practice approach filled a gap in care resulting from decisions by community physicians to deemphasize traditional Medicare patients. Now with a stronger presence in the community, Kaiser is trying to develop more collaborative relationships with community physicians in their network, by trying to "wrap around" the network physician's care with Kaiser's successful approaches at chronic care management.

One particular interest is improving the quality of transitions from inpatient hospital to homes and post-acute care facilities, and thereby reducing avoidable hospital readmissions. Kaiser is trying to identify physicians in the community who share its values, especially the ability to function as part of a team in an integrated care approach. Identifying and engaging these physicians remains a challenge for Kaiser.

At the same time, Kaiser does not want to "cannibalize" its core delivery model in the Permanente group, so it is approaching this "side-by-side" delivery approach cautiously. In the meantime, by acting opportunistically it now has two operational Kaiser Health Plan centers in southern Colorado, which provides a base on which to build a collaborative model.

#### **QUALITY IMPROVEMENT AND SPENDING REDUCTION INITIATIVES**

The health plans in this study had implemented innovative strategies designed to address cost or quality problems (Exhibit 4). Sometimes these strategies were custom-made by the individual plan. Indeed, several of the study plans indicated they have backed away from purchasing prepackaged vendor programs or "bolt-on solutions," as one interviewee described them. Instead, they have often found home-grown strategies to be better solutions.

### Exhibit 4

Health Plan	Quality Improvement and Spending Reduction Initiatives
<p><b>Excellus Blue Cross Blue Shield</b></p>	<p><b>Nurse navigator program.</b> An internal resource for providers and members that can respond to different issues to help improve care and lower costs for complex patients. Staffed by nurses who are employees of Excellus BCBS, care elements and capabilities are brought together, including case management, utilization management, contracting, and pharmacy.</p> <p><b>Hospital performance incentive program.</b> Rewards hospitals for improving quality of care for meeting particular standards. Between 1 percent and 3 percent of hospitals' contracting fees are incented under the program, with each year's incentives built into the base the following year. Hospitals select measures on which incentives are based, including hospital readmissions, number of complications, and number of hospital days. Up to about 25 percent of the measures can be for maintaining already-high performance, and the balance is for improving performance on metrics.</p>
<p><b>Capital Health Plan</b></p>	<p><b>Colorectal cancer screening program.</b> Launched in 2002 and championed by CHP's medical director, the plan mined data and sent out letters to high-risk individuals, encouraging them to get screened.</p> <p><b>Center for Chronic Care.</b> CHP's sickest 1 percent of patients are invited to participate in this initiative, staffed by a CHP internal medicine physician with a significantly reduced panel of patients.</p> <p><b>Selective prior authorizations.</b> CHP loosened preauthorization requirements for many items. Authorizations are no longer required for routine initial visits to specialists or inpatient hospital care, except for elective procedures.</p>
<p><b>Kaiser Permanente Colorado</b></p>	<p><b>Collaborative model development.</b> Kaiser Colorado is using "score cards" to provide feedback to network physicians using common quality metrics, such as performance on achieving targets of HbA1c levels in diabetics.</p> <p><b>Improving care transitions.</b> Kaiser is providing hospitalists working in the contracted community hospitals with additional resources to hire case managers to assist them in facilitating early and smooth discharges.</p>
<p><b>Network Health Plan</b></p>	<p><b>The COURAGE clinic.</b> NHP's COURAGE clinic (modeled after a Mayo Clinic program) relies on nurses and health coaches to work with patients on diet, cholesterol management, blood pressure control, lifestyle alteration, and patient self-management skills.</p> <p><b>Living well with chronic disease.</b> NHP offers a six-week workshop free to members to help individuals with chronic illnesses deal with common issues such as pain management, stress, and coping skills.</p>
<p><b>Health Net</b></p>	<p><b>Disease management coaching.</b> Members can call and speak with a health coach to help them understand their health and conditions, as well as treatment options. The plan has integrated this coaching program into other parts of its delivery system by educating physician groups about it to help make appropriate and timely member referrals and ways to use behavior change messages and techniques with their patients.</p> <p><b>Shared-risk arrangements.</b> Efficiency-based payments are written into medical groups' contracts and designed to reward providers for using services at the most appropriate location at the most appropriate level of care. Health Net provides incentives on hospital readmission rates, hospital bed days, ambulatory surgery versus hospital-based surgery, use of emergency rooms, and generic drug use, among other factors.</p> <p><b>Alternative provider network.</b> Health Net launched its Silver Network product, a lower-cost product that offers members a narrower network than its HMO.</p>

A consistent theme that emerged across plans was a streamlining of utilization management programs. Some plans reported that many of the preauthorization techniques they used in the past did not work and have shifted to focus on selected problem areas such as reducing particular types of imaging, promoting generic prescription drugs, or offering alternatives to surgery to manage lower back pain.

For example, Excellus BCBS recently examined its prior authorization processes. For each prior authorization requirement, the plan examined approval rate, clinical risk, and financial risk, along with other factors. Ultimately, Excellus BCBS reduced the number of reviews per month by more than one-third. According to plan leaders, it was a win-win undertaking. Providers in general are happier, and the plan achieved a higher percentage of cases in which it modified the requested service because the reviews were more targeted to likely problem cases. In the process, Excellus BCBS also reduced its medical management costs by 30 percent.

## **Excellus BCBS**

**Nurse navigator program.** In response to an exceptionally high-cost, complicated patient, Excellus BCBS started its nurse navigator program in 2009. The idea was to create an internal resource for both providers and members that could handle and respond to a full range of different issues to help improve care and lower costs. In the program, which is staffed by nurses who are employees of Excellus BCBS, a wide range of care elements and capabilities are brought together, including case management, utilization management, contracting, and pharmacy.

**Hospital performance incentive program.** To help promote quality in hospitals, Excellus BCBS developed its hospital performance incentive program (HPIP), which rewards hospitals for improving quality of care and meeting standards. All the plan's hospitals, with the exception of a few, small rural hospitals, participate in HPIP. Between 1 percent and 3 percent of participating hospitals' contracting fees are paid under the incentive program. The incentive is compounding; if a hospital gets its full incentive, it is built into the hospital's base the following year. Hospitals are able to select from a list the particular measures on which their incentive is based. Metrics include hospital readmissions, number of complications, and number of hospital days. Up to about 25 percent of the measures can be for maintaining already-high performance, and the balance is for improving performance on metrics. Apart from improving care for Excellus BCBS's members, plan leaders believe that the HPIP improves the overall quality of the community's hospital care. That is, when hospitals are providing care, they do not look to make improvements only for Excellus BCBS patients but for all their patients.

## **Capital Health Plan**

**Colorectal cancer screening program.** Starting in 2002, CHP set out to improve its colorectal cancer screening rates, which were low by both national and Florida standards. The motivation to improve rates was further driven by the fact that 25 percent of CHP's enrollees are African American, a high-risk population. Launched in 2002 and championed by CHP's medical director, the plan mined its data and sent out letters to high-risk individuals, encouraging them to get screened. In 2009, CHP was ranked number two for colorectal cancer screening among commercial HMOs in a survey by *U.S. News & World Report*.<sup>14</sup>

**Center for Chronic Care.** The Center for Chronic Care initiative was designed to take care of the plan's sickest 1 percent of patients, defined as those who have a risk score about seven times that of the average CHP patient. About 300 patients are in the initiative. Prospective patients are invited to join the initiative, which is staffed by a CHP internal medicine physician with a significantly reduced patient panel (about one-fifth of the average CHP physician) so he or she can carefully focus on these complicated individuals.

**Selective prior authorizations.** In years past, CHP, like many health plans, required preauthorizations for many items but found it was an administrative burden and not particularly successful—they rarely denied a requested service. About two years ago, the plan made a concerted effort to scale back medical management to focus on particular items. According to plan leaders, the idea was to make referrals a transaction between physicians and remove CHP from the middle. Loosening prior authorization can also help patients make informed decisions and participate in health care decision-making. Authorizations, for example, are no longer required for routine initial visits to specialists or for inpatient hospital care, except for elective procedures.

## **Kaiser Permanente Colorado**

**Collaborative model development.** Kaiser Colorado did not adopt many of the approaches used by network model plans to influence its relatively large cohort of community physicians, partly because of its relatively small market share (and small percentage of any practice's patients) in that service area. Yet, with a network in place for over 10 years, it has developed relationships and is currently using "score cards" that provide feedback on network physicians' performance using common quality metrics, like achieving targets of HbA1c levels in diabetics. Other programs include: diabetes care management, a specialized anticoagulation clinic for patients taking a blood thinner to prevent vascular occlusion, and clinical pharmacy services support. Kaiser is also

working to provide information technology integration support and disease registry capabilities for its network physicians.

**Improving care transitions.** Kaiser is providing hospitalists working in the contracted community hospitals with additional resources to hire case managers to assist them in facilitating early and successful discharges, with attention to smooth transitions. By negotiating case rates with the hospitalists to align the incentives between the hospitalist and health plan, Kaiser believes that the hospitalists are more likely to take full advantage of the case manager's presence.

### **Network Health Plan**

**The COURAGE clinic.** NHP has recently implemented a program modeled after the COURAGE (Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) trial. Although findings remain controversial in the cardiology and epidemiological research communities, the COURAGE clinical trial found that percutaneous coronary intervention, using stent placement in partially blocked coronary arteries, does not decrease mortality or risk of heart attack when added to optimal medical therapy in patients with chronic, stable coronary artery disease.<sup>15</sup>

NHP and Affinity are devoting significant effort to developing practical medical and lifestyle treatment approaches to noninterventional therapy. NHP calls the program the COURAGE clinic, located at Affinity but available to all NHP members. Modeled after a program adopted by the Mayo Clinic, the COURAGE clinic relies on nurses and health coaches to work with patients on diet, cholesterol management, blood pressure control, lifestyle alteration, and patient self-management skills. As needed, referral is made to exercise physiologists, dietitians, endocrinologists, and others, while under the general supervision of cardiologists and lipid specialists.

**Living well with chronic disease.** NHP has recently implemented a program called Living Well with Chronic Disease. This program, also known as the chronic disease self-management program, has demonstrated effectiveness and has been developed and refined over the past 20 years by Professor Kate Lorig of Stanford University.<sup>16</sup> The program recognizes the need for individuals with chronic illnesses to deal with common issues such as pain management, stress, and coping skills to promote their own well-being and to gain greater independence and confidence in dealing with the physical and emotional challenges of a long-term illness or combination of chronic conditions. It is administered as a workshop with sessions held over a six-week period. Participation of NHP members is free; a couple thousand members have participated to date.



## **Health Net**

**Shared-risk arrangements.** In addition to traditional pay-for-performance incentive payments, Health Net has made a deliberate shift to reward providers for controlling cost. Called shared-risk arrangement programs, these efficiency-based payments are an effort to interest providers in controlling costs. The payments, which are written into medical groups' contracts, are designed to reward providers for using services at the most appropriate location and at the most appropriate level of care. Health Net provides incentives for hospital readmission rates, hospital bed days, ambulatory surgery versus hospital-based surgery, use of emergency rooms, and generic drug use. Shared-risk payments account for only 2 percent to 3 percent of overall payments made to physicians, but management would like to see them increase.

**Alternative provider networks.** In response to demands from small employers, Health Net recently launched its Silver Network product, a lower-cost product that offers members a narrower network than its regular HMO network. In picking medical groups to be in the Silver Network, Health Net first looked at medical groups from a quality and cost perspective, and then at geography to ensure good access. Health Net also offers Salud! Started about 10 years ago in San Diego and Tijuana, Salud! began as a cross-border health plan but has since evolved into a product serving California's large and growing Hispanic population. Salud! is a restricted network of medical groups that have been selected for their linguistic and cultural competencies and sensitivity to the needs of the Latino population.

**Health coaching.** Beginning around 2005, Health Net introduced health coaching through the vendor Health Dialog. Under the initiative, members can call a coach who can help them better understand their physician's advice and counsel. The coach can also help the member formulate questions to ask the physician. According to plan staff, the coach's role is not to tell the patient what to do but rather to talk through the different options available to them. What Health Net staff believe is unique to the program is the considerable effort made to involve physicians, asking them to make referrals into the coaching program. In supporting that activity, Health Net developed a packet called "smart registry," in which the plan gives doctors six months of data showing any clinical gaps physicians may have in treating their patients for selected diseases, such as diabetes and asthma. The smart registry also provides feedback to physicians on "preference-sensitive conditions," such as chronic back pain, for which there are alternative, acceptable treatment options. The plan provides the data to their different contracted medical groups and to individual physicians' offices with the goal of bringing them into the program, and not simply keeping the information at the plan level. According to plan

officials, members have been very responsive to the coaching initiative and believe it helps them make better, informed decisions.

## **CONCLUSION**

Senior health plan managers emphasized that the underlying quality of physician practice in the plan's delivery system is an important factor contributing to the high performance accorded to the plan. There is no "magic formula" that health plans can apply to providers to improve performance.

The case studies confirm the importance of a core physician group that fully collaborates with a health plan in a special relationship. The prototype for this kind of relationship is Kaiser Permanente. The positive attributes of that collaboration were confirmed in interviews with Kaiser Permanente Colorado officials, who struggle to export the culture and values embodied in the medical group to the network physicians. The same issue arises at the smaller, regional plans—Network Health Plan and Capitol Health Plan—which have mixed models, yet rely on a core group with a unique relationship to the plan.

Executives at all three of the mixed-model plans emphasize that the performance of the core group generally was superior to that of the network, although they also agreed that the generally high performance of the independent physicians in their broader network complemented the core group, producing overall high ratings. When possible, Network Health Plan, Capitol Health Plan, and Kaiser Colorado attempt to channel patients with complex, chronic conditions to physicians in the core group, with whom the plan has closer relationships. When this is not possible, the plans attempt to supplement the care—or, in the words of one respondent, "wrap around" physician services with complementary activities provided by additional health professionals, often based within the core group enterprise.

The findings have implications for the development of accountable care organizations (ACOs). The core provider groups are the prototypes of organizations that are being proposed as ACOs—direct contractors to CMS under the traditional Medicare program. Yet, these groups already have access to Medicare beneficiaries through participation with their partner health plans in Medicare Advantage (MA).

Provider-sponsored organizations (PSOs) were created under the Balanced Budget Act of 1997 as provider entities enabled to contract with CMS without an insurance license as part of the program that was the predecessor to Medicare Advantage.

Yet, since passage, there have only been a few PSOs in the program, with only one currently operating. Some experts speculate that organizations capable of becoming standalone MA plans as PSOs have not wanted to jeopardize their relationships with the health plans with which they contract. The health plans not only provide access to Medicare beneficiaries but also to individuals in commercially insured and self-funded insurance products, as well as Medicaid patients. The health plan–provider relationships described in these case studies are particularly tight. For example, given the close relationship between Kaiser Health Plans and the Permanente Medical Group, it is unlikely that Permanente would choose to enter the Medicare Advantage as a standalone PSO when it had the opportunity to participate with Kaiser as an integrated MA plan.

Would these provider organizations view the ACO opportunity differently? In contrast to PSOs in the MA program, ACO contractors in the traditional Medicare program would not take full financial risk. Indeed, in the basic, shared savings payment approach defined in the Affordable Care Act, ACOs would not take any financial risk for exceeding spending targets. Further, in the ACO program in traditional Medicare, beneficiaries’ freedom to choose a provider at the point of service would not be restricted in any way. As a result, these groups would not need to be regulated to the same extent as insurance companies—or PSOs—receiving capitated payments for all services in Medicare Advantage. Perhaps, then, the medical groups that are in close partnership with the health plans in this study might welcome the opportunity to continue in traditional Medicare as ACOs, while also participating in Medicare Advantage as subcontractors to health plans. Such groups might provide fertile ground for testing the ACO concept.

The basic reality that health plans can affect performance mostly at the margins, but nevertheless in meaningful ways, seems to have produced a more cautious attitude among these plans about the role of aggressive “managed care.” The health plans interviewed all indicated that they tended not to do as much managing of their network physicians as do many of their health plan competitors, preferring to find opportunities to collaborate with their network physicians.

Yet, the underlying performance of the provider networks may give the plans in this study the luxury of adopting less intrusive, more collaborative approaches. Health plans with delivery systems performing at a lower level may have fewer opportunities to collaborate and thus adopt more a more aggressive managed care posture. In short, it is not clear whether higher performance produces collaboration or whether collaboration produces higher performance.

It is notable that the two wholly network plans in this study have had long experiences working with the delegated capitation model, in which medical groups and IPAs have major responsibility for quality and cost, partly taking over the traditional health plan role. Health Net of California seems committed to this approach of working with intermediary organizations and essentially holding physician-led organizations accountable for quality and cost management (as a prototype of an accountable care organization). However, Excellus BCBS has abandoned the delegated capitation approach, finding that the large intermediary physician organization was not able or willing to take on sufficient financial risk for the services provided to make continued reliance on this approach viable. Nevertheless, the experience with the model has influenced its approach to dealing directly with network physicians and has produced a generally collaborative attitude toward working with them.

From a national perspective, however, despite the fact that most of the high-performing health plans are drawn from the relatively small number of plans that are tightly aligned with particular physician groups, the marketplace trend is moving in the opposite direction. The focus of this study was on high-performing HMO plans. The HMO model is more compatible with approaches the plans in this study have taken to improve quality and reduce resource use. With HMO product designs, it is easier to direct patients to higher-performing providers, to share risk with providers using payment approaches other than fee-for-service, and to collaborate with health professionals to improve care. But with a continuing rise in employer self-insurance, there is accompanying growth in PPO products that feature broad provider networks, fee-for-service reimbursement, increased patient cost-sharing, and more distant health plan-provider relationships.

Across the board, plans need to construct and maintain broader networks to appeal to local and national employers seeking broad provider choice for their employees. Plans also need to appeal to national employers who did not wish to deal separately with locally based health plans, regardless of the demonstrated superiority of their performances compared to alternative insurers. Thus, even highly successful collaborations—such as the one between Affinity Health System and Network Health Plan—are being threatened as both parties will now increase contracting opportunities in an attempt to expand market share.

As long as employers remain primarily responsible for arranging the health insurance coverage their employees receive, the pressure for health plans to work with broader networks rather than more-effective, select networks grounded in staff- and

group-model delivery will continue. However, as a recent *New England Journal of Medicine* article concluded, if employers view the exchanges as attractive, “the nature of employer-sponsored coverage may change substantially after the implementation of the Affordable Care Act, with an increase in the number of workers offered coverage through the health insurance exchanges,” owing to wider risk-pooling, relatively low administrative costs, and expanded choices.<sup>17</sup> Such a change would make the more collaborative model of health plans working in partnership with specific provider organizations more viable. Nevertheless, despite the challenges of working with a network of independent physicians, the health plans in this study all acted opportunistically to introduce specific programs available to patients of network physicians that seek to extend the reach of the health plan influence, while respecting the culture of private practice.

## APPENDIX

### METHODS

This study was based on a sample of five health plans:

- Capital Health Plan;
- Excellus Blue Cross/Blue Shield of New York;
- Health Net of California;
- Kaiser Foundation Health Plan of Colorado; and
- Network Health Plan.

As noted, we extended the 2000 Mathematica Policy Research study (which examined mostly group- and staff-model HMOs) and focused on understanding what factors contribute to making network-model health plans high-performing in terms of quality and cost.

### SELECTION OF PLANS

In picking health plans for the case studies, we relied on several data sources. The primary one was the NCQA-supported Healthcare Effectiveness Data and Information Set (HEDIS) quality data and NCQA's measure of relative resource use (RRU) for 2007–2009 for commercial HMO members with diabetes.<sup>18</sup> Using these HEDIS data, we estimated the overall quality of diabetes care provided by each plan based on a composite measure of diabetes that looks across seven diabetes quality measures.<sup>19</sup> We then indexed each plan's composite rate against the mean composite rate for HMO commercial plans across the nation. This index quality measure was constructed for each commercial HMO plan for each of three data years, 2007 to 2009.

To ascertain resource use, we relied on NCQA's RRU measure for diabetes for 2007–2009. In brief, the RRU measure tracks individual plan resource use along the continuum of care (inpatient, surgery, ambulatory, and pharmacy) for total annual resources for selected chronic conditions including diabetes. For our selected condition (diabetes), a RRU was calculated for each plan that is the ratio of the plan's observed total per member per month (PMPM) resource use compared to the plan's expected PMPM resource use, which is estimated by NCQA.<sup>20</sup> Then an RRU index was calculated which, in simplest terms, relates the plan's raw observed-to-expected resource use ratio to the average observed-to-expected resource use ratio across all commercial HMOs in the nation. Plans that did not have complete HEDIS data or RRU data, submitted data for fewer than 400 members with diabetes, or had extreme values for RRU measures were excluded from consideration for the study.

We further restricted the sample to commercial HMOs that responded to a survey of health plans conducted by NCQA specifically for the study—the 2008 Quality and Resource Use Health Plan Survey. The plan survey was conducted among commercial HMOs that reported HEDIS data for 2007. The survey was fielded between October 2008 and February 2009 and collected information about innovations and administrative practices used by health plans related to improving quality and controlling costs. The survey, among other things, gathered information about plans’ physician and hospital networks, strategies to support performance improvement, and disease management and case management initiatives. Of the 260 plans that were contacted for the survey, 173 had full HEDIS and RRU information. Of those 173 plans, 118 responded to the survey.

For these 118 plans, we looked at those that were above-average in their quality score and below-average in cost. We did this grouping for the three study years, 2007–2009. Using these yearly data points, we then arrayed plans by state and identified as possible candidates for case study those plans that scored as a high-quality, low-cost plan in at least two of the three years. As final selection criteria, we sought diversity in plan attributes (e.g., profit status, type of network, and size) and geographic location.

## **SITE VISIT METHODS**

Each site visit involved a day of interviews by at least one of the principal investigators. Visits were conducted between December 2009 and March 2010. Where necessary, a few interviews were conducted by telephone. We used a series of semistructured interview protocols that permitted the research team to obtain consistent and comparable information across the five sites. At each site, researchers interviewed senior health plan leadership: the chief executive officer; chief financial officer; medical director; director of network development; and director of quality. Some site visits included other individuals who could provide additional insights, particularly related to approaches to influencing the performance of independent, network physicians. In addition to the interviews, we reviewed background information as well as documents provided by the plan.

A range of topics was covered in the interviews. Chief among them:

- background information on the plan and the local health care market environment;
- factors thought to contribute to the plan being high-performing (e.g., plan characteristics, provider policies, member policies, market characteristics);
- quality strategies that have worked for the plan and those that have not;
- cost-reducing strategies that have worked for plan and those that have not;

- details on provider polices such as payment policies, use of incentives, providing financial and other support, and physician selection and retention policies;
- details on utilization management strategies; and
- details on disease and chronic care management and wellness programs.

In addition, for the three mixed-group and network model study plans (Capital Health Plan, Kaiser Foundation Health Plan of Colorado, and Network Health Plan), a series of questions was included in which we asked about challenges the plan had in dealing with their network physicians compared with group or staff physicians, and how they addressed them. As part of this line of inquiry, we also probed whether cost and quality strategies used with their more closely aligned physicians could effectively be translated to network physicians, who typically contract with numerous health plans and may feel no particular allegiance to any one plan.

Upon completion of site visits, interviews were either transcribed or notes drafted. The principal investigators reviewed notes, identifying cross-cutting themes as well as unique plan activities or attributes identified as contributing to quality or cost performance.

## **STRENGTHS AND LIMITATIONS**

As with any research, there are strengths and weakness to our study approach. As to the strengths, the case study approach enabled us to explore in detail complicated questions that could not have been fully investigated using a standard survey approach. As illustrated in the report, major research findings were quite consistent across the five sites, suggesting that the results provide useful and timely insights into high-performing health plans.

At the same time, we acknowledge that the study approach has shortcomings. Perhaps most important is that the findings are based on a purposeful sample of five plans. Thus, study plans are not necessarily representative of high-performing plans overall and findings may not be generalizable, even though a number of consistent finding emerged from the study. Also, through this approach we were not able to directly attempt to verify the accuracy of the interviews by obtaining the views of affected providers.



## NOTES

<sup>1</sup> R. C. Saunders, M. A. Tirodkar, S. H. Scholle et al., *Factors Associated with Efficient Delivery of Health Care by Commercial HMOs in Patients with Diabetes*, (Washington, D.C.: National Committee for Quality Assurance, 2010); and S. E. Turbyville, R. C. Saunders, M. A. Tirodkar et al., *Classification of Health Plans Based on Relative Resource Use and Quality* (Washington, D.C.: National Committee for Quality Assurance, 2010).

<sup>2</sup> This report builds on a 2000 report from Mathematica Policy Research (MPR), produced with support from the National Committee for Quality Assurance. MPR conducted 10 case studies, also focused on high-performing group and staff model health maintenance organizations with highly collaborative, sometimes exclusive, relationships between physicians and the health plan, including Kaiser Foundation Health Plan (Southern California Region), Group Health Cooperative of Puget Sound, and Harvard Pilgrim Health Care. For more information about this report, see S. Felt-Lisk and L. C. Kleinman, *Effective Clinical Studies In Managed Care: Findings from Ten Case Studies* (Princeton, N.J.: Mathematica Policy Research, Nov. 2000).

<sup>3</sup> A group model HMO contracts with a single multispecialty medical group to provide care. A staff model HMO employs physicians directly. Both are examples of closed-panel HMOs in which patients can receive care only through a limited number of providers. In contrast, in a network model HMO, the HMO contracts with multiple physician groups to provide services to HMO members. Typically, the network physicians provide services to both HMO and non-HMO patients. Increasingly, as with those in this case study, HMOs based on group- or staff-model organization also have a network and are referred to as mixed-model plans.

<sup>4</sup> NCQA 2008 Quality and Resource Use Health Plan Survey.

<sup>5</sup> For more information, see <http://www.iha.org/index.html>.

<sup>6</sup> In 2004, Touchpoint sold its HMO to UnitedHealthcare, altering the tight relationship between the health system and the health plan. In part, this was done to better serve national employers that want health insurers which can put together national provider networks to more easily serve their dispersed employee base.

<sup>7</sup> Plans that are predominantly group or staff HMOs may be labeled correctly as mixed if they have any network component, but it may be a misleading label in some cases. In our sample, for example, Kaiser Health Plan is mixed although more than 90 percent of patient contacts are within the Permanente Medical Group.

<sup>8</sup> We tried to secure participation of another for-profit health plan but, citing competing demands, the plan declined to participate in the case study.

<sup>9</sup> G. P. Mays, G. Claxton, and J. White, "Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies," *Health Affairs* Web Exclusive, Aug. 11, 2004:w4-427-w4-436.

<sup>10</sup> Ibid.

<sup>11</sup> In the United States, the Pharm.D. (Doctor of Pharmacy) degree is a professional degree that prepares the graduate for pharmacy practice. It is awarded after four years of pharmacy school, including one year of practice experience.

<sup>12</sup> The NCQA process for analyzing resource use recognizes that market prices that health plans face play an important role in health spending comparisons. It therefore measures resource use, not spending, and adjusts volume of services generated by uniform pricing adjustments to eliminate the major price variations that health plans experience.

<sup>13</sup> In comparison, for the Medicare fee schedule, the Affordable Care Act makes the assumption that an MRI scanner operates 37.5 hours per week, compared with Kaiser's 80 hours. Such a conservative work use assumption produces a much higher unit cost and fee in the Medicare fee schedule. Market prices that imaging centers can charge health plans are even higher.

<sup>14</sup> Ibid.

<sup>15</sup> W. E. Boden, R. A. O'Rourke, K. K. Teo et al., "Optimal Medical Therapy with or Without PCI for Stable Coronary Disease," *New England Journal of Medicine*, April 12, 2007 356(15):1503–16.

<sup>16</sup> K. R Lorig, P. Ritter, A. L. Stewart et al., "Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes," *Medical Care*, Nov. 2001 39(11):1217–23.

<sup>17</sup> C. Eibner, P. S. Hussey, and F. Girosi, "The Effects of the Affordable Care Act on Workers' Health Insurance Coverage," *New England Journal of Medicine*, Oct. 7, 2010 363(15):1393–95.

<sup>18</sup> National Committee for Quality Assurance (NCQA). 2006. HEDIS 2007 Volume 2: Technical Specifications. NCQA: Washington, D.C.; NCQA. 2007. HEDIS 2008 Volume 2: Technical Specifications. NCQA: Washington, D.C.; NCQA. 2008. HEDIS 2009 Volume 2: Technical Specifications. NCQA: Washington, D.C.; and J. Roski, S. Turbyville, D. Dunn et al., "Resource Use and Associated Care Effectiveness Results for People with Diabetes in Managed Care Organizations," *American Journal of Medical Quality*, Sept./Oct. 2008 23(5):365–74.

<sup>19</sup> In particular, four diabetes processes measures were used (HbA1c testing; eye exam performed; LDL-C screening; and medical attention for nephropathy), and three intermediate outcomes: HbA1c, poor control (>9.0%) (inverted); LDL-C control (<100 mg/dL); and blood pressure control (<130/80 mm Hg).

<sup>20</sup> Expected per member per month resource use is calculated by NCQA based on the average estimated resource use by all commercial HMOs adjusted for the characteristics of each plan's members for particular health conditions. As mentioned, in our study we used only diabetes.