

THE · TIERING · OF MINNESOTA PHYSICIANS

An examination of the goals, strategies, potential, and risks of Minnesota tiered-physician products.



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Note: Much of the information contained in this document represents information provided by the above-identified Minnesota health plans, the Minnesota Department of Employee Relations, and/or obtained from public Web sites. While the information is correct to the best of our knowledge, it is possible that updates or changes to the products described within this document have been made since initial research began; therefore, such changes may not be reflected in this document and we regret any unintentional omissions or inaccuracies.

INTRODUCTION

The stratification or “tiering” of hospitals and medical groups into two or more tiers or levels is an effort by health plans to define differences in cost and sometimes quality among their contracted network of providers. Patients pay lower premiums or reduced levels of cost-sharing (i.e., co-payments or deductibles) if they go to a provider in the low-cost or “preferred” tier. Although tiered-provider networks are not new in Minnesota, they currently are expanding in geographic reach and potential enrollment. The purpose of this document is to describe provider tiering, identify the opportunities and risks associated with their use, and to critically examine the key features of such products in Minnesota.¹ More information about tiered-physician products in Minnesota, as well as specific documentation, is available online at www.MMAonline.net (click on Featured Links).

The Goals of Tiering

Generally, tiered-provider networks represent a response by health plans to employers’ requests for new strategies to address rising health care costs. Tiered-provider networks are a benefit design model that provides an alternative to traditional managed care plans, where access to providers is controlled and out-of-pocket costs are somewhat limited, and consumer-directed plans, such as health savings accounts (HSAs), where access to providers is essentially unrestricted and higher out-of-pocket costs abound (in the form of high deductibles). There has been a patient backlash against the rigid controls and limited choice of providers under managed care, and many contend that currently available information about the comparative costs and quality of health care services is insufficient to ensure successful use of HSAs. Offering another option, tiered networks are designed to identify specific cost and quality differences, while transferring limited decision-making to patients. At a minimum, tiered networks are intended to allow patients, instead of health plans, to make cost-based decisions about their choice of providers.

The Potential of Tiered Networks

As a cost-containment strategy, tiered networks have the potential to mitigate costs by creating financial incentives for patients, usually in the form of differential co-payments and/or deductibles, to choose providers who are deemed by the health plan to be lower-cost.² The financial incentives associated with tiered networks could also generate competition among providers and thereby lead to more efficient use of health care resources. In some situations, tiered networks may provide health plans with greater leverage to renegotiate payment rates with some provider groups so those groups can secure preferred tier placement. Tiered networks also have the potential to expand the level of transparency in the health care system by bridging the gap in information that currently is available to patients regarding the cost and quality of health care services.

The Risks of Tiered Networks

The risks associated with tiered networks, which are very real and demand attention, depend primarily on whether the information used to differentiate providers is accurate. Biased or unreliable tiering data could disrupt patients’ relationships with their physicians, undermine the quality of care, threaten the economic survival of physician groups, and damage professional reputations. Patients may incorrectly interpret tier differentials to mean that providers in lower tiers are systematically of poor quality or wasteful. Critical attention to the methods used by health plans to create tiered-physician networks is, therefore, understandable and warranted. The MMA will aggressively challenge tiered networks based on faulty data and flawed methodologies.



¹ While most tiered networks also include hospitals, this document is limited to a discussion about physician tiering.

² Some evidence suggests that a difference of \$200 in annual out-of-pocket costs may be sufficient to compel patients to switch physicians (Meltzer D. Effects of Hospitalist Physicians on an Academic General Medicine Service: Results of a Randomized Trial, as reported in Rostenthal M, Hsuan C, Milstein A. A Report Card on the Freshman Class of Consumer-Directed Health Plans. Health Affairs. 2005; 24(6): 1592-1600).

TIERED-PHYSICIAN NETWORKS IN MINNESOTA

All three of Minnesota's largest health plans – Blue Cross and Blue Shield of Minnesota, HealthPartners, and Medica – have created tiered-physician networks.³ In addition, the state of Minnesota uses a tiered network, Minnesota Advantage, as part of its health benefit program for all state employees. All of Minnesota's tiered-physician products tier at the medical group, health system, or care system level. There are currently no products in Minnesota that tier individual physicians.

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota (BCBS) recently unveiled its new tiered-physician network, which builds on its hospital-tiered network introduced in 2005. The product, Blue Precision, is being marketed to large (51+ employees), self-insured employers and will become effective January 1, 2007. The product is part of a larger national network offered by other Blue Cross plans that will be available in 31 markets in 26 states. The Blue Precision product comes approximately one year after BCBS withdrew an earlier tiered-physician product from the market in response to significant negative physician reaction to the design, which would have tiered physician groups based exclusively on their hospital referral patterns and the hospital's underlying cost structure.

Among the distinguishing characteristics of the BCBS Blue Precision product are the following:

- Two different Blue Precision network options (Perform and Achieve) that will provide varying levels of costs savings and patient choice.⁴
 - Blue Precision Perform will have more clinics/systems in Tier 1 (highest benefit level/lowest patient out-of-pocket costs) than the Blue Precision Achieve option. As a result, Perform likely will yield lower savings for employers, but create less disruption for patients and physicians.
- Targeted enrollment/marketing
 - For 2007, neither of the Blue Precision options will be available to patients enrolled in BCBS fully insured small group or individual products, Medicare products, or state public programs.
- With 31 quality metrics across 17 specialties, the Blue Precision product uses the greatest absolute number of clinical quality measures among Minnesota tiered products.⁵
- Blue Precision will tier physician groups in 26 different specialties – beyond the number of specialty groups consistently tiered by other Minnesota health plans.⁶

3 PreferredOne also has a small tiered network in place, but given its current size and scope it was not included in this analysis.

4 According to BCBS, a third, more restricted network option is also in development, and would be effective sometime after 1/1/07.

5 A complete listing of the quality metrics used by BCBS can be found on the MMA Web site at www.MMAonline.net (click on Featured Links).

6 Physician groups in 17 specialties (family practice, internal medicine, general practice, pediatrics, OB/GYN, dermatology, cardiology, general surgery, orthopedics, geriatrics, oncology/hematology, otolaryngology, pulmonology, rheumatology, allergy/immunology, preventive medicine,

HealthPartners

HealthPartners, through its Distinctions plan, was among the first Minnesota health plans to offer a tiered-physician and tiered-hospital product. An open-access model, the Distinctions plan tiers primary care practices as well as cardiology, ear, nose, and throat (ENT), orthopedics, and obstetrics and gynecology (Ob/Gyn) practices.

Among the distinguishing characteristics of the HealthPartners Distinctions product are the following:

- Use of the broadest definition of "quality" in the tiering process
 - For primary care clinics, five "domains" of quality are assessed – access (measured via a patient satisfaction survey); care/communication (measured via a patient satisfaction survey); chronic condition care (optimal coronary artery disease care, optimal depression care, optimal diabetes care, and optimal asthma care as measured by Minnesota Community Measurement Project data); acute/preventive care (healthy lifestyle advice for adults/children; preventive services for adults/children; immunizations for children; pharyngitis care for children; appropriate use of antibiotics for URI for children; appropriate low back pain imaging for adults; tobacco – assess and assist for adults; tobacco – secondhand exposure for children); and use of generics.⁷
- Equal balance of cost and quality criteria in tiering placement determinations
 - For placement in the highest benefit tier, HealthPartners requires that clinics (compared to peers) exceed the mean in quality, and score below the mean in cost.
- Targeted geographic scope
 - Distinctions, with a market presence limited to the 7-county Twin Cities metropolitan area and Rochester, has the narrowest geographic scope of Minnesota's tiered-physician products. HealthPartners has indicated that further geographic expansion of its tiered product is dependent upon sufficient data to allow for both cost and quality measurement.
- Easily accessible cost and quality rankings
 - Comparative information (at the clinic level) about costs and quality, with options that can be customized, are readily accessible on the HealthPartners Web site.

ophthalmology) are placed in one of two tiers based on cost and quality data. Physician groups in nine specialties (endocrinology, gastroenterology, nephrology, neurosurgery, neurology, pediatric cardiology, plastic surgery, urology, podiatry) are placed in tiers based on cost alone. Multi-specialty clinics are placed in tiers based on a composite score using cost and quality data. All other specialty clinics will be paid at the tier 1 (highest benefit) level. As this document went to press, BCBS indicated that the following sub-specialties will be excluded from specialty tiering and will be paid at the tier 1 level: spinal surgeons, epilepsy/seizure care, reproductive endocrinology, hand surgeons, reconstructive surgery, pediatric cardiology, and pediatric critical care.

7 Information about the quality data used by HealthPartners to tier specialty clinics is available on the MMA Web site at www.MMAonline.net (click on Featured Links).

Medica

Medica offers two different tiered products – Patient Choice and Patient Choice Insights. Patient Choice, which was originally created for the Buyers’ Health Care Action Group (BHCAG) and known as Choice Plus, is now a Medica-owned product that is offered exclusively to large, self-insured employers. Patient Choice relies on a care system model and all care is provided through the patient’s selected care system. Patient Choice tiers exclusively at the care system level. The Patient Choice Insights product was created in July 2005 and is available to self-insured and fully-insured employers. It is a point-of-service product; enrollees have a broad choice of providers and they are neither locked into a particular care system nor required to select a primary care clinic. Patient Choice Insights tiers primary care clinics, multi-specialty clinics, and select specialty clinics.

Among the distinguishing characteristics of the Medica Patient Choice and Patient Choice Insights products are the following:⁸

- Voluntary submission of quality information
 - Under its “quality credit” approach, care systems (Patient Choice) and primary care and multi-specialty clinics (Insights) that choose to submit Medica-specified quality data have the potential to “buy-down” their cost-of-care result and thereby move to a more preferential tier.⁹
- Incorporation of bidding process
 - Under a unique “bidding” system, Medica provides care systems (Patient Choice) and primary care and multi-specialty clinics (Insights) with their specific cost and utilization data and quality “credit” (as applicable) in order to allow the submission of a payment/reimbursement “bid” that is used in outlining tier placements (final tier decisions are made annually with employer input).
- Diversity in use of financial incentives
 - Premiums paid by patients/enrollees vary among tiers in the Patient Choice product. The Insights product, like all the other tiered plans, varies patient co-pay/deductible amounts.
- Separately negotiated contract terms and conditions
 - For both products, Medica has created a separate contracting mechanism with participating care systems/clinics. The other tiered-physician products generally are built upon the existing contractual relationships between the health plans and their network of physicians and providers, with the tiered product offered as simply an additional benefit design option.

State of Minnesota

Minnesota Advantage Health Plan is the tiered network plan provided to Minnesota state employees. The plan is built on a care system model and enrollees are required to select a primary care clinic (PCC) with the expectation that most care will be coordinated by the clinic via referrals. The plan is administered by three health plans – BCBS, HealthPartners, and PreferredOne. Medical group participation and tier assignment can vary based on the plan administrator.

Among the distinguishing characteristics of the Minnesota Advantage Health Plan are the following:

- Only comprehensive statewide product – most other tiered products are limited to communities where some level of competition among health care providers is presumed to occur.
 - State employees, who live and work in nearly all areas of the state, have access to the same health care benefit design regardless of where they live.
- Tiering of unaffiliated clinics
 - In certain geographic areas of the state where individual, clinic-level tiering is not possible due to data limitations (i.e., limited number of providers and/or limited numbers of state employees), Minnesota Advantage will aggregate unaffiliated clinics (who are sometimes “competitors”) as a single “group” in order to create tiering options.
- Exclusively cost-based tiering
 - Minnesota Advantage is the only Minnesota, tiered product to be based exclusively on cost-of-care information; no quality information is incorporated in the tiering design, although the state does make available to employees information about the Minnesota Community Measurement Project.
- As part of union collective bargaining processes, as well as state-defined geographic access standards, some physician clinics may be moved to a more preferential tier independent of their tier placement defined analytically.
 - Clinics may also renegotiate or “buy down” their reimbursement rates with the plan administrator (BCBS, HealthPartners, or PreferredOne) as a way to obtain a more preferential tier placement.

⁸ More information about the Insights tiering process for specialty clinics can be found on the MMA Web Site at www.MMAonline.net (click on Featured Links).

⁹ In 2006, Medica reports that about 60% of care systems applied for the quality credit by reporting the necessary data. Therefore, many of the Patient Choice care systems were tiered on cost information alone.

THE MEASUREMENT PROCESS



Tiered networks are based on the measurement of differences among physician groups in cost and sometimes quality. Such measurement, however, is technically difficult and far from fully mature. Because of the strong influence of cost on the establishment of tiers, however, some understanding of the methods employed is essential.¹⁰

At this time, there are no local or national cost or quality measurement standards; therefore, decisions about how to measure, what to measure, who to measure and how to use the results are determined by individual health plans. As a result, it should not be surprising that physician groups may be placed in different tiers depending on the standards and rules established by each health plan. Among the consequences of these variable approaches are confusion and lack of trust among patients and employers, and the lack of a consistent message and incentives for physicians.

Cost-of-Care

Cost-of-care or cost “efficiency” measurement is the principal means used by health plans to differentiate physician groups. For purposes of tiered-physician networks in Minnesota, cost measurement involves analyzing the relative costs/resource-use among physicians for a set of services. It is important to note that the cost measurements are not outcomes-based – that is, the cost data are not linked to particular clinical outcomes, which would be the more traditional definition of efficiency and the one commonly accepted by economists.¹¹ As such, it is important to emphasize that the cost measurements used in tiered products reflect the relative costs of resources utilized by patients, rather than a medical group’s comparative cost efficiency in treating specific patient conditions or in improving patients’ health.

Relying on data found in the health care claims databases of health plans, most cost-of-care analyses (“economic profiling”) involve a comparison of actual costs to expected costs. While the comparison of actual costs to expected costs is quite common, the unit of analysis can differ. For the development of tiered-physician networks in Minnesota, two different units of analysis and underlying profiling methodologies are in use – Episode Treatment Groups (ETGs) and Adjusted Clinical Groups (ACGs). The ETG system uses episodes of care as the unit of analysis, while the ACG system uses total per-person costs as the unit of analysis.

The Episode Treatment Group (ETG) methodology is patented by Symmetry Health Data Systems.¹² It is a case-mix adjustment and episode-building system that aggregates inpatient, outpatient, professional, pharmacy, and ancillary claims from a patient to create approximately 600 clinically homogenous episode groups.¹³ Used in Minnesota by BCBS and HealthPartners, ETGs is the industry-leading episode grouper methodology and, according to Symmetry, is “currently used by over 400 managed health plans across the United States representing nearly 200 million individuals.”¹⁴

The ETG system analyzes each line from a health care claim and links procedure codes and diagnosis codes to a particular episode group. Among the nearly 600 different episodes are acute bronchitis, congestive heart failure, and viral meningitis. An actual episode cost is calculated by adding together the allowed payment amounts for all claims included in a specific episode (e.g., hospital, physician, pharmacy, etc.). An expected or average cost of an episode is then calculated based on the average actual cost of all episodes of the same type. The resulting ratio of actual episode cost to expected/average episode cost is used to determine relative cost efficiency for physicians/clinics within a peer/specialty group.

Developed by researchers at Johns Hopkins University, Adjusted Clinical Groups (ACGs), previously known as Ambulatory Care Groups, “measure the morbidity burden of patient populations based on disease patterns, age, and gender by relying on the diagnostic code information found in professional and hospital insurance claims or other computerized records.”¹⁵ Created originally for research and management purposes, including as a risk-adjustment tool, ACGs have many applications and are used in cost-of-care tiering calculations by Medica and the state of Minnesota (Minnesota Advantage Plan).

The ACG system analyzes health care claims and assigns individual patients into one of 93 discrete ACG categories, which reflect a patient’s diagnoses, age and gender.¹⁵ Based on ACG category, total per-patient costs are calculated. Expected costs per patient (risk-adjusted) are calculated based on the average cost for all patients with the same ACG assignment. The resulting ratio of actual per-patient cost to expected/average per-patient cost is used to determine relative cost efficiency for physicians/clinics within a peer/specialty group.

10 While this document identifies some of the methodological concerns associated with measurement used in tiering, it is not intended as a comprehensive critique.

11 Thomas, JW. Economic Profiling of Physicians: What is it? How is it done? What are the Issues? American Medical Association, 2006.

12 Symmetry Health is an Ingenix Company – part of UnitedHealth Group.

13 Forthman, Dove, Wooster. Top Health Inform Manage, 2000, 21(2), 51-61.

14 Symmetry Health Web site (www.symmetry-health.com), August 2006.

15 Johns Hopkins University, ACG Web site (www.acg.jhsph.edu), April 2006.

What about Quality?

While cost-of-care information is a consistent factor used in the development of tiered-physician products, the incorporation of quality information is much more variable. Minnesota health plans have taken vastly different approaches to using quality metrics as a factor in creating tiered-physician products. At one extreme, the Minnesota Advantage Health Plan incorporates no quality information. At the other extreme, BCBS uses 31 clinical quality metrics across 17 different physician specialties. HealthPartners has adopted a broad definition of quality that reflects both clinical as well as patient satisfaction measures. Medica, while using a definition of quality similar to that of HealthPartners, incorporates such measures on only a voluntary basis when its care systems/clinics choose to submit the information.¹⁶

As a quality-improvement strategy, current tiered networks may have minimal impact. The expectations for quality improvement embedded in tiered network strategies are inconsistent and quite diverse. In addition, reliable quality-of-care measurement likely is at an even earlier stage of sophistication than that of cost-of-care measurement. There is little reason to doubt health plans' commitment to incorporating more rigorous quality measurements into their tiering products. Currently, however, it arguably is safe to say that Minnesota's tiered-physician networks only offer patients and employers limited or modest quality-based information.

Methodological Limitations

Several methodological questions arise with all comparative cost-of-care and/or quality analyses that merit review by those subject to such analysis. Among the questions or limitations of note are the following:

- Risk adjustment. Does the profiling method control for differences in the severity, complexity, and demographic characteristics among patients? All Minnesota plans incorporate some degree of risk adjustment, but the approaches vary.
- Attribution. How is responsibility for costs determined and assigned? How are patients assigned and responsibility for care processes and outcomes determined?
 - ♦ Cost attribution is a sensitive issue among physicians, particularly among those primary care physicians who are held accountable (and tiered) based upon a patient's total cost of care. Cost attribution should bear some resemblance to the level of "control" that the physician/group has over the patient's resource consumption. In "open access" health plan products (e.g., BCBS, HealthPartners, Medica Patient Choice Insights), physicians have little control or even awareness about a patient's total health care utilization so determining responsibility for costs is challenging.

In more controlled or referral-based health plan products in which physicians are expected to have greater control over resource use (e.g., Medica Patient Choice and Minnesota Advantage Plan), responsibility for costs may be theoretically easier, but many physicians lack the necessary information about the comparative costs of care for particular services and, in fact, disclosure about such information is often restricted under health plan contract terms.

- Relationship between cost-of-care and quality performance. There is some question as to whether or not cost-of-care measures distinguish between care that is provided consistent with evidence-based guidelines and care that is inconsistent with such guidelines, particularly because cost-of-care calculations are not linked to patient outcomes. For example, if an evidence-based guideline calls for several procedures, tests, and visits, will a physician who appropriately adheres to the guideline be evaluated as "cost inefficient" (i.e., expensive) relative to the "efficient" (i.e., less expensive) physician who fails to follow the guideline? In fact, there is no research available on this issue. The lack of evidence in this regard is a source of frustration to many who believe that the use of economic profiling data should be severely limited until evidence exists that cost-of-care measures are not confounded by quality performance.¹¹
- Sample size. Currently available research suggests that the factor that has the single greatest effect on cost profiling reliability and validity is the size of the sample – either covered lives or episodes.¹⁷ While it is not yet possible to define the specific "appropriate" sample size, approaches available to health plans to maximize the accuracy of their analyses include using a longer claims time period (e.g., 1-2 years), analyzing at the physician group level rather than individual physician level, and pooling data across health plans.¹¹



¹⁷ Thomas, JW. Sample size considerations in economic profiling of specialty physicians. Portland, ME: Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, 2005.

¹⁶ A complete listing of the quality metrics used in Minnesota tiering products can be found on the MMA Web site at www.MMAonline.net (click on Featured Links).

KEY DIFFERENCES AMONG MINNESOTA TIERED-PHYSICIAN NETWORKS



Given the fact that individual health plans define their own standards and rules for creating tiered networks, it should not be surprising that there are significant differences among the Minnesota tiered-physician networks. The table below outlines the key differences; additional, detailed information on each of these items, as well as several others, is available on the MMA Web site at www.MMAonline.net (click on Featured Links).

	BLUE CROSS AND BLUE SHIELD OF MINNESOTA: BLUE PRECISION	HEALTHPARTNERS: DISTINCTIONS BENEFIT OPTION
WHO IS TIERED	Physician groups in 26 specialties. (see footnote no. 6)	Primary care clinics and cardiology, orthopedic, ENT, and Ob/Gyn specialty clinics.
NUMBER OF TIERS	2 (see footnote no. 4)	2 or 3 (The 3-tier model is always offered, but the 2-tier option remains the most popular choice)
GEOGRAPHIC SCOPE	11-county Twin Cities' metropolitan area; Duluth; Fargo/Moorhead; Mankato; Rochester; St. Cloud; and, Sioux Falls.	7-county Twin Cities' metropolitan area and Rochester
COVERED LIVES	Unknown – enrollment data will be available after product effective date of 1/1/07	Approximately 160,000 (out of about 650,000 total HealthPartners enrollees)
COST DIFFERENTIALS BETWEEN TIERS	Regardless of tier placement, total allowable physician payment is the same. The proportion of the payment amount that is paid by the patient differs depending on the patient's choice of medical group and that group's designated tier. Actual cost differences are employer-defined.	Regardless of tier placement, total allowable physician payment is the same. The proportion of the payment amount that is paid by the patient differs depending on the patient's choice of medical group and that group's designated tier. Actual cost differences are employer-defined.
COST-OF-CARE METHODOLOGY	Unit of analysis is episode of care; actual and expected costs calculated using Episode Treatment Groups (ETGs) methodology.	Unit of analysis is episode of care; actual and expected costs calculated using Episode Treatment Groups (ETGs) methodology.
ATTRIBUTION OF COSTS	Episode costs are attributed to the medical group with the majority (> 50%) of the professional service costs for an episode.	Episode costs are attributed to the medical group that accounts for at least 25% of the management and surgery resources associated with that episode's total cost. In determining which medical group is responsible for at least 25% of the professional costs, HealthPartners standardizes costs to control for differences in payment rates across groups.
TIER DEFINITIONS/ ASSIGNMENTS	Medical groups are arrayed based on the average combined cost and quality results. BCBS makes final determination of tier positions.	For the 2-tier product, tier 1 clinics must score below the mean in costs and above the mean on quality.
QUALITY DATA INCORPORATED?	Yes – BCBS incorporates 31 quality metrics into the tiering methodology for 17 specialties.	Yes – HealthPartners incorporates measures of access, care/communication, chronic condition care, acute/preventive care, and generic use in its tiering methodology.

18 The Minnesota Advantage Plan also tiers independent clinics that either are not affiliated with a care system and/or are too small to allow reliable measurement. Such clinics are grouped into geographic/regional aggregations and cost level/tier assignments are determined for the group.

19 For the Minnesota Advantage product, the cost-sharing differences that enrollees pay are intended to help illustrate the actual cost differences between cost levels/tiers.

MEDICA: PATIENT CHOICE	MEDICA: PATIENT CHOICE INSIGHTS	STATE OF MINNESOTA: MINNESOTA ADVANTAGE HEALTH PLAN
Care systems	Primary care and multi-specialty clinics and many specialty clinics. ⁸	Care systems ¹⁸
3	3	4 (3 tiers were used from 2002-2003)
Much of Minnesota, eastern North and South Dakota, and western Wisconsin	11-county Twin Cities' metropolitan area	Entire state
Approximately 70,000	Approximately 150 employer groups; 7,500 covered lives	Approximately 115,000
<p>Regardless of tier placement, total allowable physician payment is the same.</p> <p>An employee's premium contribution is subject to variation based on care system enrollment.</p>	<p>Regardless of tier placement, total allowable physician payment is the same. The proportion of the payment amount that is paid by the patient differs depending on the patient's choice of medical group and that group's designated tier.</p> <p>Actual cost differences are employer-defined.</p>	<p>¹⁹Deductible (single/family): Cost Level 1: \$30/60; Cost level 2: \$100/200; Cost Level 3: \$280/560; Cost Level 4: \$500/1000</p> <p>Office Visit for illness/injury²⁰: Cost Level 1: \$20; Cost level 2: \$25; Cost Level 3: \$25; Cost Level 4: \$35</p> <p>Lab/Pathology/X-ray: Cost Level 1: 0% coinsurance; Cost level 2: 0% coinsurance; Cost Level 3: 10% coinsurance; Cost Level 4: 30% coinsurance</p>
Unit of analysis is total per-member costs of care. Actual and expected costs are calculated for each enrollee and risk adjusted using Adjusted Clinic Group (ACG) methodology.	Unit of analysis is total per-member costs of care. Actual and expected costs are calculated for each enrollee and risk adjusted using Adjusted Clinic Group (ACG) methodology.	Unit of analysis is total per-member costs of care. Actual and expected costs are calculated for each enrollee and risk adjusted using Adjusted Clinic Group (ACG) methodology.
Total per-member, risk-adjusted costs are attributed to the enrollee's selected care system.	Total per-member, risk-adjusted costs are attributed to the patient's primary care clinic.	Total per-member, risk-adjusted costs are attributed to the patient's selected primary care clinic.
<p>Care systems are arrayed based on their submitted bid, costs and, if reported, quality credit.</p> <p>Employers review placements and determine final tier positions.</p>	<p>Primary care and multi-specialty clinics are arrayed based on submitted bid, their costs and, if reported, quality credit.</p> <p>Employers review placements and determine final tier positions.</p>	<p>Primary care clinics are distributed into one of four cost levels. Initial tier placement is then reviewed as part of the collective bargaining process. Minnesota Department of Health HMO access standards (HMO administrative rules) of 30 minutes/30 miles are used to determine required access to at least tier 2 clinics. To meet these access standards, clinics may be moved from their initial placement.</p>
Voluntary – Medica provides for a quality “credit” for those care systems that voluntarily report performance for diabetes, coronary artery disease, asthma, and preventive services.	Voluntary – Medica provides for a quality “credit” for those primary care and multi-specialty clinics that voluntarily report performance for diabetes, coronary artery disease, asthma, and preventive services. (see footnote no. 9)	No

²⁰ For 2006-2007, the cited office co-pays are reduced by \$5 for employees who completed a health assessment. The Minnesota Department of Employee Relations (DOER) reports that 73% of eligible state employees completed the health assessment.

EVALUATION ■ ■ ■ ■ ■

The Minnesota Medical Association has adopted policy on physician tiering, which states the following:

The Minnesota Medical Association continues to support health care cost and quality transparency to foster improved decision making by patients. The MMA does not support the tiering of physicians if such tiering does not make available the methodology used to assign tiers, and does not use validated benchmarks when making quality comparisons.²¹

In addition, MMA leadership developed additional criteria that would define a fair and reasonable tiering product. The following section presents the application of those criteria to Minnesota's tiered-physician products.



VALID COST ANALYSIS

As critical as this issue is, there is no specific way to compare the relative accuracy of the various methods employed by the health plans to calculate medical groups' relative cost-of-care. Physicians are urged to request access to and critically examine the data used by the health plans, keeping in mind the methodological limitations described in this document.

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Validity of cost-of care measurement	?	?	?	?	?

TIERING METHODOLOGY TRANSPARENCY

Degree of transparency about methodology based on information available via patient and physician/provider portals on the plans' Web sites. Other plan-reported or known disclosure strategies were also incorporated in scoring.

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Provided to patients/enrollees	?*	Basic	Basic	Basic	Limited
Provided to physicians/clinics	Advanced	Advanced	Advanced	Advanced	Basic

No Transparency
 Limited
 Basic
 Advanced

*As this document went to press, BCBS had not yet determined the content or strategy for communicating with patients/consumers.

21 Physician Tiering 280.18; HD-SR300-2005 (MMA Policy Compendium).

TIERING PLACEMENT TRANSPARENCY

Degree of transparency based on disclosure of clearly-defined and understood criteria that determine physicians'/clinics' tier placement (i.e., cut-off decisions between tiers).

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Transparency of tiering placement decisions					
	Virtually None	Advanced	Limited	Basic	Advanced

ACCESS TO TIERING DATA

Level of access based on known and/or reported ease of access to physician/clinic-specific data used by health plans to determine tier placement.

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Ability for tiered physicians/clinics to review specific data/results that determined their tiering placement	?*				
	No Access Allowed	Difficult Access	Manageable Access	Easy Access	Easy Access

*As this document went to press, BCBS had not yet released its data access strategy, which is expected to provide secure, Web-based access to clinic and aggregate/system-level data.

VALUE OF COST AND QUALITY SUPPORT TOOLS PROVIDED TO PHYSICIANS/CLINICS

Value of tools based on review of known information/ products and physician reports of information availability and utility.

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Usefulness of information to support cost- and quality-conscious decisions and referrals.	?*				?* *
	No value/Nothing Provided	Limited Value	Potential Value	Significant Value	Significant Value

*The Blue Precision product takes effect 1/1/07 and, as this publication went to press, it was unknown whether or not any information or tools would be provided to physicians.

** Minnesota Advantage is administered by three different health plans, each of whom may offer tools. The MMA was unable to evaluate all potential information from each plan, but physician reports suggest minimal information and limited value.

EVALUATION (CONTINUED)



VALIDITY OF QUALITY METRICS

Validity of quality metrics based on physicians' ease of access to the underlying evidence base/data upon which the measures are based (e.g., Web-based access, access upon request, routine citation of evidence, etc.).

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Ease of physician/clinic access to evidence base/data upon which quality measures are based.					

No Quality Metrics Used
 Limited Access
 Manageable Access
 Open Access

*Strong reliance on ICSI and/or MN Community Measurement Project metrics.

RELEVANCE OF QUALITY METRICS

Relevance of quality metrics is based on the MMA's assessment of the relevance of the measures to primary care physicians (Note: relevance of non-primary care measures was not determined in this analysis).

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Quality metrics used in tiering are relevant to primary care physicians/clinics					

No Quality Metrics Used
 Somewhat Relevant
 Relevant
 Significantly Relevant

*Measures are only reported on a voluntary basis, so relevance is limited to reported situations.

■ A plan-by-plan summary of the evaluation can be found on p.12.

CONCLUSIONS AND RECOMMENDATIONS



Absent a local or national silver-bullet solution to the issue of rising health care costs, health plans and employers are likely to continue to pursue a variety of cost-containment strategies. Although there is no clear evidence yet available to confirm the ability of tiered networks to save costs, anecdotal information does exist. In fact, the state of Minnesota credits the Minnesota Advantage Health Plan with saving “millions” of dollars and holding down premium increases. The MMA believes that the provision of useful, valid and reliable health care cost and quality information to patients is critically important, and the MMA supports efforts to develop such information. Tiered networks may prove to be a useful mechanism to expand the availability of information, as well as to contain costs and improve quality. It is reasonable to conclude that tiered-physician networks will be a reality for Minne-

sota physicians for the foreseeable future. Given the risks associated with the use of tiered networks, however, the MMA believes it is critical that the methods and data upon which they are based be as accurate and transparent as possible.

There is significant variation in the approaches and strategies to tiered network development among the five products reviewed. While somewhat understandable from a competitive market perspective, such variation and the inherent complexity of the methodologies make it very difficult for patients, employers, physicians, and other providers to fully understand and develop trust in these products. On the criteria identified by the MMA for evaluation, none of the tiered networks received a perfect score. While each of the commercial products (BCBS, HealthPartners and Medica) had a variety of strengths, the Minnesota Advantage Health Plan

consistently under-performed compared with the other products.

The methodological limitations of tiering (e.g., risk adjustment, cost attribution, cost/quality relationship, sample size) merit ongoing review and scrutiny. The level of sophistication included in most of the approaches used in Minnesota is fairly high, but no system is without flaws. The MMA urges those physicians/clinics that have concerns about their tiering placement or underlying data to seek clarity and to insist on an open and transparent process from the health plans.

The MMA is hopeful that this document begins to shine some light on Minnesota tiering practices and provides useful information to Minnesota physicians, their patients, and the Minnesota health care marketplace.



EVALUATION PLAN-BY-PLAN SUMMARY



	BLUE CROSS AND BLUE SHIELD OF MINNESOTA: BLUE PRECISION	HEALTHPARTNERS: DISTINCTIONS BENEFIT OPTION
VALID COST ANALYSIS Validity of cost-of care measurement	?	?
TIERING METHODOLOGY TRANSPARENCY Provided to patients/enrollees	As this document went to press, BCBS had not yet determined the content or strategy for communicating with patients/consumers.	
TIERING METHODOLOGY TRANSPARENCY Provided to physicians/clinics		
TIERING PLACEMENT TRANSPARENCY Criteria used to define tier placement is provided.		
ACCESS TO TIERING DATA Ability for tiered physicians/clinics to review specific data/results that determined their tiering placement	As this document went to press, BCBS had not yet released its data access strategy, which is expected to provide secure, Web-based access to clinic- and aggregate/system-level data.	
VALUE OF COST AND QUALITY SUPPORT TOOLS PROVIDED TO PHYSICIANS/CLINICS Usefulness of information to support cost- and quality-conscious decisions and referrals.	The Blue Precision product takes effect 1/1/07 and, as this document went to press, it was unknown whether or not any information/tools would be provided to physicians.	
VALIDITY OF QUALITY METRICS Ease of physician/clinic access to evidence-base/data upon which quality measures are based.		
RELEVANCE OF QUALITY METRICS Quality metrics used in tiering are relevant to <u>primary care</u> physicians/clinics		

MEDICA: PATIENT CHOICE

MEDICA: PATIENT CHOICE INSIGHTS

STATE OF MINNESOTA: MINNESOTA ADVANTAGE HEALTH PLAN

?

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Minnesota Advantage is administered by three different health plans, each of whom may offer tools. The MMA was unable to evaluate all potential information from each plan, but physician reports suggest minimal information and limited value.



(voluntary)

(voluntary)



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