Introducing Tiered Networks:
An Overview from BCBSMA

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Presented at:
NIHCM Foundation
Driving Value Webinar Series
27 May 2014
Aligning Provider and Member Incentives to Make Quality Health Care Affordable

A multi-faceted strategy

- Reduced administrative spending
- Member Engagement through product design and data-informed decision-making
- Provider Engagement through payment reform

Lower cost trend
Advancing Quality, Outcomes and Affordability:
Aligning Member and Provider Engagement Strategies

- Wherever possible, our measures should be drawn from nationally accepted standard measure sets.

- The measure must reflect something that is broadly accepted as clinically important.

- There must be empirical evidence that the measure provides stable and reliable information at the level at which it will be reported (i.e. individual, site, group, or institution) with available sample sizes and data sources.

- There must be sufficient variability on the measure across providers (or at the level at which data will be reported) to merit attention.

- The must be empirical evidence that the level of the system that will be held accountable (clinician, site, group, institution) accounts for substantial system-level variance in the measure.

- Providers should be exposed to information about the development and validation of the measures and given the opportunity to view their own performance, ideally for one measurement cycle, before the data are used for “high stakes” purposes.
**Network Based**

Provider selection engagement through benefit tiers, cost and quality transparency

**CDHP**

Financial engagement through deductibles and spending accounts

**Value Based**

Medical treatment utilization engagement through evidence-based benefit changes

**Shared Supports**
- Personal Health Assessment
- Biometric Screenings
- Disease Management
- Health Management
- Utilization Management
- Pharmacy Management
- Transparency
- Wellness Programming
- Decision-Support Tools
- Member Services
- Employee Education
- Informatics Reporting

**Healthy Behaviors**

Health-focused behavior engagement through incentives, tools and resources
Growth in Tiered Products Over Time

- Membership in tiered products has grown substantially over the past decade
- Blue Cross Blue Shield of MA offers two forms of value-based network products
- Combined, these two products cover more than 230,000 members
Guiding Principles in Establishing the Empirical Basis for Tiering

Vision
To advance the system toward safe, effective, affordable, patient-centered care by offering members both information and financial incentives to choose providers that have demonstrated high performance on quality and favorable cost relative to their peers.

Principles
- No new measures. Wherever possible, measures used for tiering will be drawn from nationally accepted and widely used performance metrics. In all cases, measures will be familiar to physicians, and physicians will have seen results from at least one measurement cycle—ideally through BCBSMA incentive and/or reporting programs, but where necessary, through state or national reporting programs.
- Performance measures used to tier physicians or hospitals will reflect as broad a spectrum as possible of the care provided by that specialty or institution.
- The methodology for financial measures will afford meaningful cost differentiation for members and employers.
- For a measure to be included in the tiering of a physician, practice, or institution, available sample sizes must be sufficient to meet thresholds for measure reliability and stability.
- Where insufficient data exist to tier a physician, practice, or institution on either the cost/efficiency or quality domain, the tiering assignment will be made such that the entity is placed in a “neutral tier” for that domain.
# Quality Measures for Hospital Tiering

<table>
<thead>
<tr>
<th>AMI Care</th>
<th>Surgical Care Improvement Project (SCIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin at Discharge</td>
<td>Perioperative beta-blocker</td>
</tr>
<tr>
<td><strong>Health Failure Care</strong></td>
<td>Urinary catheter removal</td>
</tr>
<tr>
<td>ACEI/ARB for LVSD</td>
<td>Appropriate VTE prophylaxis received</td>
</tr>
<tr>
<td>LVS function evaluation</td>
<td>VTE prophylaxis ordered</td>
</tr>
<tr>
<td>Discharge instructions</td>
<td>Antibiotic received</td>
</tr>
<tr>
<td><strong>Community-Acquired Pneumonia Care</strong></td>
<td>Antibiotic discontinued</td>
</tr>
<tr>
<td>Blood Culture</td>
<td>Received appropriate preventive antibiotic(s)</td>
</tr>
<tr>
<td>Antibiotic selection</td>
<td><strong>Outcomes (AHRQ)</strong></td>
</tr>
<tr>
<td><strong>Outpatient Surgical Care</strong></td>
<td>Post-operative Respiratory Failure</td>
</tr>
<tr>
<td>Prophylactic antibiotic selection</td>
<td>Post-operative PE/DVT</td>
</tr>
<tr>
<td>Timing of antibiotic prophylaxis</td>
<td>Accidental puncture or laceration</td>
</tr>
<tr>
<td><strong>Patient Experience (HCAHPS)</strong></td>
<td>Iatrogenic pneumothorax</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>Obstetrics trauma--vaginal with instrument</td>
</tr>
<tr>
<td>Responsiveness of Staff</td>
<td>Obstetrics trauma--vaginal w/o instrument</td>
</tr>
<tr>
<td>Communication, doctors</td>
<td>Central venous catheter associated blood stream infections</td>
</tr>
<tr>
<td>Communication, nurses</td>
<td></td>
</tr>
</tbody>
</table>

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Blue Cross Blue Shield of Massachusetts
### Tiering Placement by Performance Categories

<table>
<thead>
<tr>
<th>Tier</th>
<th>Primary Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quality</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Pass overall quality threshold</td>
</tr>
<tr>
<td>Standard$^1$</td>
<td>Pass overall quality or insufficient data</td>
</tr>
<tr>
<td>Basic</td>
<td>Did not pass overall quality threshold</td>
</tr>
</tbody>
</table>

**Notes**

1. In limited circumstances, to provide adequate geographic access for members, the Standard Tier includes certain providers whose scores would put them in the Basic Tier.
## Member Cost by Tiering Placement

<table>
<thead>
<tr>
<th>Tier</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>PPO</strong></td>
<td><strong>HMO Blue Deductible</strong></td>
<td><strong>HMO Blue Deductible</strong></td>
</tr>
<tr>
<td></td>
<td><strong>PCP Visit</strong></td>
<td><strong>Imaging at Hospital</strong></td>
<td><strong>Outpatient Day Surgery</strong></td>
</tr>
<tr>
<td>Enhanced</td>
<td>$15</td>
<td>$75</td>
<td>$250</td>
</tr>
<tr>
<td>Standard</td>
<td>$25</td>
<td>$150</td>
<td>$500</td>
</tr>
<tr>
<td>Basic</td>
<td>$45</td>
<td>$250</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Notes
1. In limited circumstances, to provide adequate geographic access for members, the Standard Tier includes certain providers whose scores would put them in the Basic Tier.
2. Cost figures refer to PPO in-network coverage.
3. Figures reflect the HMO Blue New England Options Deductible product, for care within Massachusetts. The benefit content displayed above applies to the small group segment for 2014. The cost share amounts are different in the 51–99 and large group markets. Deductible figures assume an individual, not family, policy.
4. Preventive care is exempt from copays.
A blend of member-facing and provider-facing initiatives is valuable to the goals of improving quality, outcomes, and affordability.

Tiered product designs are an approach that allows access to the full network while beginning to expose members to differences in provider cost and quality.

A rigorous measurement approach and methodology is critical both for provider engagement and to ensure that member steerage to preferred providers will have the desired effects.

Since the introduction of tiered product designs about a decade ago, uptake has grown steadily and is currently about 230,000 members.

A forthcoming evaluation of hospital choice for elective care demonstrates significant impact.
For More Information

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