MINNESOTA TIERED-PHYSICIAN NETWORKS: A DETAILED COMPARISON

KEY ISSUES	Blue Cross and Blue Shield of Minnesota: Blue Precision Perform & Blue Precision Achieve	HealthPartners: Distinctions Benefit Option	Medica		State of Minnesota: Minnesota Advantage Health Plan
			Patient Choice *(self-funded product)*	**Patient Choice Insights** *(fully insured and self-funded product)*	
Description	Unveiled in 2006, the Blue Precision product 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 offered in 31 markets in 26 states. Two different Blue Precision network options will be available – *Perform* and *Achieve* (note that a third, more restricted option that was under consideration for implementation sometime after 1/1/07 is no longer being pursued). Blue Precision *Perform* will have more clinics/systems in Tier	HealthPartners, through its *Distinctions* plan, was among the first Minnesota health plans to offer a tiered-physician product. The product is based on an open-access network model, which allows patients a broad choice of providers.	Originally created for the Buyers' Health Care Action Group (BHCAG) and known as Choice Plus, Patient Choice is now a Medica-owned product that is offered to large (51+), self-funded employers. Enrollees are required to select a care system and all care is provided through that system. The product is administered by Wausau and CBSA.	The Insights product was created in July 2005 and is available to all employers. It is a point-of-service product, which means that enrollees can choose any provider at the point of care and are not locked into a particular care system.	Minnesota Advantage Health Plan is the health plan offered 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 is coordinated by the PCC via referrals. The plan is administered by three health plans – Blue Cross and Blue Shield of Minnesota, HealthPartners, and PreferredOne. Family members may elect different PCCs, but all must enroll in the same health plan.

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	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. For 2007, neither tiered option will be used for patients enrolled in Blue Cross fully insured small group or individual products, Medicare products, or state public programs.				
Which physician groups are tiered?	Physician groups in 17 specialties (family practice, internal medicine, general practice, pediatrics, OB/GYN, dermatology, cardiology, general surgery, orthopedics,	Primary care clinics, cardiology, orthopedics, ENT, and OB/GYN specialty clinics.	Care systems	Primary care groups, multi-specialty groups, and the following specialty groups: allergy/asthma/immunology, cardiology, dermatology, endocrinology, gastroenterology, hematology/oncology, infectious disease, internal	Care systems/provider groups For independent clinics that are either not affiliated with a care system and/or are too small to allow reliable measurement (i.e., limited number of providers and/or limited numbers of state employees), geographic/regional aggregations of such clinics are created and cost level/tier

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	geriatrics, oncology/hematology, otolaryngology, pulmonology, rheumatology, allergy/immunology, preventive medicine, ophthalmology) are placed in one of two tiers based on cost and quality data. Physician groups in 8 specialties (endocrinology, gastroenterology, nephrology, neurosurgery, neurology, plastic surgery, urology, podiatry) are placed in tiers based on cost alone (*note that pediatric cardiology was struck from this group after initially being included*). Groups in the following sub-specialties will be			medicine, nephrology, neurology, neonatology, OB/GYN, occupational medicine, ophthalmology, orthopedic surgery, otolaryngology, pain management, pediatrics, perinatology, physiatry, podiatry, pulmonary care services, radiation oncology, radiology (imaging), rehabilitation services, rheumatology, PT/OT/ST, surgery, urgent care, urology, wound care.	assignments are made for the group.

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	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, pediatric critical care, and psychiatry. Multi-specialty clinics will be placed in tiers based on a composite score using cost and quality data.				
How many tiers are used?	2	2-3 The 3-tier model is always offered, but the 2-tier option remains the most popular choice.	3	3	4 (3 tiers were used from 2002-2003)

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How are physician payments impacted by tier placement?	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. Patients will pay more of the total payment amount if they elect to receive care from a medical group in Tier 2.	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. Patients will pay more of the total payment amount if they elect to receive care from a medical group in Tier 2 or 3.	Regardless of tier placement, total allowable physician payment is the same. Patients will pay more in premium contribution if they select a care system in Tier 2 or 3.	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. Patients will pay more of the total payment amount if they elect to receive care from a medical group in Tier 2 or 3.	Regardless of tier placement, total allowable physician payment is the same (subject to the negotiation between the physician group and the specific plan administrator[s]). The proportion of the payment amount that is paid by the patient differs depending on the patient's choice of primary care clinic and that clinic's designated tier. Patients will pay more of the total payment amount if they elect to receive care from a care system in Tiers 2-4.
What are the cost differentials between tiers?	Employer-defined	Employer-defined	Employer-defined, but intended to provide lower premiums for enrollment in a	Employer-defined, but intended to provide lower employee copays and/or lower coinsurance for selection of providers in lower cost tiers.	[A]Deductible (single/family): Cost Level 1: $30/60; Cost level 2: $100/200; Cost Level 3: $280/560; Cost Level 4: $500/1000 Office Visit for illness/injury[B]: Cost Level 1: $20; Cost level 2: $25; Cost Level 3: $25; Cost Level 4: $35

[A] For the Minnesota Advantage product, the cost-sharing differences that enrollees pay are intended to help illustrate (but do not fully reflect) the actual cost differences between cost levels/tiers.
[B] For 2006-2007, the cited office copays 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.

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				care system in a lower cost tier.		Inpatient hospital copay: Cost Level 1: $50; Cost level 2: $150; Cost Level 3: $400; Cost Level 4: 25% coinsurance Lab/Pathology/X-ray: Cost Level 1: 0% coinsurance; Cost level 2: 0% coinsurance; Cost Level 3: 10% coinsurance; Cost Level 4: 30% coinsurance Prescription drugs: $15 formulary/$30 non-formulary for all Cost Levels. (See http://www.doer.state.mn.us/ei-segip/pdf/currentrates/SummaryOfBenefits.pdf for a more comprehensive listing of benefits)
Distribution of patients/enrollees across tier levels		Information not available yet – product takes effect 1/1/07	Approximately 52-54% of enrollees use Tier 1 providers.	Approximately 68-70% of enrollees choose a care system from Tier 1	Data not yet available for Insights.	In selecting a primary care clinic: 10% of enrollees chose one from Tier 1 73% of enrollees chose one from Tier 2 16% of enrollees chose one from Tier 3 1% of enrollees chose one from Tier 4
Is cost data a factor in tiering placement?		Yes	Yes	Yes	Yes	Yes
What is cost method-ology?	**Data source** **Age of data** **Frequency of updates**	Administrative claims data for Minnesota commercial lines of business. December 2003-November	Administrative claims data for commercial lines of business. Calendar year 2002, 2003 and 2004 data determine 2006 tiering placement.	Administrative claims data for Patient Choice enrollees. Calendar year 2004 claims data	*For primary care and multi-specialty clinics:* The data source is administrative claims data for Patient Choice enrollees.	State employee administrative claims data, aggregated from all three participating health plans. Calendar year 2004 data determine 2006 tiering placement.

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		2005 claims data is used to identify Episode Treatment Groups (ETGs) that end in the most recent year of this period. These ETGs are grouped together into Super ETGs (SETGs), risk-adjusted, and used to determine 2007 tiering placement. Updates to tiering placement expected on an annual basis.	Updates to tiering placement conducted on an annual basis.	determine 2006 tiering placement. Updates to tiering placement conducted on an annual basis	Calendar year 2004 claims data determine 2006 tiering placement. Updates to tiering placement conducted on an annual basis. *For specialty clinics:* The data used are reimbursement level, survey responses regarding infrastructure and care processes, and (as applicable) mix of facilities used for procedures. Current data (2006-accepted reimbursement level) and 2005 survey responses are used to determine 2006 tiering placement for specialty clinics. Updates to tiering placement conducted on an annual basis.	Updates to tiering placement conducted on an annual basis (consistent with collective bargaining agreement timelines).

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	Underlying methodology	Episode Treatment Group (ETG) methodology[C] (via Blue Cross contract with Health Benchmarks). Symmetry version 5.2	Episode Treatment Group (ETG) methodology[C] For 2006, version 4.0 was used and for 2007, version 5.02 was used.	Adjusted Clinical Groups (ACG) methodology[D] Version 7.1	Primary care and multi-specialty clinics: Adjusted Clinical Groups (ACG) methodology[D] Version 7.1	Adjusted Clinical Groups (ACG) methodology[D] (via contract with Deloitte). Version 7.1
	Calculation of costs	The ETG system analyzes each line from a health care claim and links procedure codes and diagnosis codes to a particular episode group (e.g., acute bronchitis, congestive heart failure, viral meningitis). An actual episode cost is calculated by adding together the allowed payment amounts for all claims included in a specific	The ETG system analyzes each line from a health care claim and links procedure codes and diagnosis codes to a particular episode group (e.g., acute bronchitis, congestive heart failure, 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.).	Each member is assigned an ACG score based on their age and gender, as well as diagnostic information from their incurred claims. Total actual costs per member are then calculated. Based on ACG assignment, a	*For primary care and multi-specialty clinics:* Each member is assigned an ACG score based on their age and gender, as well as diagnostic information from their incurred claims. Total actual costs per member are then calculated. Based on ACG assignment, a total *expected* cost for each member is calculated based on average total (statewide) costs for members within the same ACG category.	Each member is assigned an ACG score based on their age and gender, as well as diagnostic information from their incurred claims. Total actual costs for all members with the same ACG are calculated. All members with the same ACG score are assumed to incur similar costs. Based on ACG assignment, a total *expected* cost for each member is calculated based on average total (statewide) costs for members within the same ACG category. An aggregate "illness burden" score is calculated to assess each care system's relative mix of risk/health status.

[C] The Episode Treatment Group (ETG) methodology is patented by Symmetry Health Data Systems (an Ingenix company, which is part of UnitedHealth Group). It is a case-mix adjustment and episode-building system that uses routinely collected inpatient and ambulatory claims data to create approximately 600 clinically homogenous groups (Forthman, Dove, Wooster. Top Health Inform Manage, 2000, 21(2), 51-61).
[D] 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" (JHU, ACG Web site, April 2006).

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		episode (e.g., hospital, physician, pharmacy, etc.). Risk-adjusted statistical modeling is used to create the expected cost of each SETG. The difference between the actual and observed episode cost is divided by a statistical measure of variation to create a standardized cost efficiency measure for physicians/clinics within a peer/specialty group.	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.	total *expected* cost for each member is calculated based on average total (statewide) costs for members within the same ACG category. An "illness burden" score is calculated to assess each care system's relative mix of risk/health status. The illness burden score is applied to calculate risk-adjusted per member costs.	An "illness burden" score is calculated to assess each primary care clinic's relative mix of risk/health status. The illness burden score is applied to calculate risk-adjusted per member costs. *For specialty clinics:* Costs are based on reimbursement level, survey responses regarding infrastructure and care processes, and (as applicable) mix of facilities used for procedures. Groups that are willing to accept a "community average fee schedule" (developed for Medica by an outside consulting firm) are placed in Tier 2. Groups are then offered the opportunity to complete an online "specialty survey" – information collected includes patient tracking and follow-up processes,	The illness burden score is used to calculate risk-adjusted per member costs.

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					implementation of clinical guidelines, implementation and use of electronic medical records and electronic prescribing, and external recognition (e.g., certification, accreditation, awards). Practices that score high enough may move to Tier 1 (i.e., information re-evaluated annually and is linked to cost data so that the highest cost practices need to score higher in order to move down). Groups that are unwilling to accept the "community average fee schedule" are placed in Tier 3, but can earn placement into Tier 2 based on their results to the "specialty survey." Groups that move to a more preferential tier based on survey results are subject to an audit to validate responses. No specialty groups can be placed in Tier 1 without	

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				completion of the "specialty survey."	
Attribution of costs	Costs are attributed to the medical group with the majority (greater than **50%**) of the professional service costs for that 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 attribution, total costs are standardized to control for differences in payment rates across groups.	Total per-member actual and expected costs (risk-adjusted) are attributed to the enrollee's selected care system.	For primary care and multi-specialty clinics – total per-member actual and expected costs (risk-adjusted) are attributed to the patient's primary care clinic.	Total per-member actual and expected costs (risk-adjusted) are attributed to the patient's selected primary care clinic.
Sample size threshold used in constructing profile – (i.e., minimum number of episodes [Blue Cross, HealthPartners] or patient lives [Medica, State of MN] used in calculations)	A provider can get any 30 episodes spread across any included "Super ETGs" (SETGs) and be included for a cost score, but if they have fewer than 30 episodes attributed to them, they will not get a cost score.	100 episodes is the minimum number used in constructing a profile.	65,000 lives	Currently calculated using care system data.	The target threshold is 10,000 member months. This can vary depending on the variability of the data and number and size of catastrophic cases. Occasionally fewer member months are used when there are multiple years of claim data available and the results appear consistent.
Exclusions/Exceptions	Some incomplete episodes; high and low cost outliers, and	Outliers are excluded based on standard ETG grouper methodology; an	Initial analyses are based on standardized	Initial analyses are based on standardized prices (i.e., independent of payment	Catastrophic claims are adjusted when assessing the appropriate tier for a particular care system.

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	episodes attributed to members not continuously enrolled are excluded from analysis.	additional facility outlier adjustment is also applied, which serves as a secondary filter to catch very large facility claims that are overlooked by the standard ETG methodology.	prices (i.e., independent of payment rates) – negotiated rates are incorporated in final analysis. Catastrophic costs (90% of costs > than $30,000 inpatient, > $10,000 outpatient, > $10,000 pharmaceuticals) are excluded from analysis.	rates) – negotiated rates are incorporated in final analysis. Catastrophic costs (90% of costs > than $30,000 inpatient, > $10,000 outpatient, > $10,000 pharmaceuticals) are excluded from analysis.	
Are costs risk adjusted to allow comparison across provider groups (i.e., is the health status of the patient population served by the medical groups adjusted for)?	Yes Health Benchmarks generates an expected cost for *each episode* a provider sees by performing regression modeling and controlling for the	Yes The ETG methodology provides for case mix adjustment based on age, complicating conditions, co-morbidities, and major surgeries.	Yes The ACG methodology provides for risk adjustment based on age, sex, and disease patterns.	Yes The ACG methodology provides for risk adjustment based on age, sex, and disease patterns. Data used in analysis are shared with clinics.	Yes The ACG methodology provides for risk adjustment based on age, sex, and disease patterns.

[E] Charlson M, Pompei P, Ales K, and MacKenzie C. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *J Chron Dis* 1987;40(5):373-83.
[F] Needham DM, Sclaes DC, Laupacis A, Pronovost PJ. A systematic review of the Charlson comorbidity index using Canadian administrative databases: a perspective on risk adjustment in critical care research. *J Crit Care* 2005;20(1):12-9.

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	following factors: • Member demographics • Presence of complications • Need for hospitalization or surgery • Co-morbidity score (Charlson index)[E,F] • Medication burden • Provider specialty • Anatomy (for orthopedics)		Data used in analysis are shared with care systems.		
Are quality data a factor in physician tiering placement?	Yes – for 17 specialties (see above) Quality data are not used for the 8 specialties of endocrinology,	Yes	Voluntary	Voluntary (for primary care clinics) Specialty groups are solicited for self-reported structure and process quality characteristics. Results are	No[G] As part of the provider group selection process, state employees are provided with information to allow them to link to the Minnesota Community Measurement Project for quality information.

[G] Representatives from the Minnesota Department of Employee Relations note the following: "Although the Advantage program does not explicitly integrate specific quality measures into the tiering structure, we believe it would be very difficult for a "low quality" provider to retain a favorable tiering status. Additionally, the State has initiated several risk-management programs, which they offer at no cost to all members with high-risk conditions. Along with these programs, the State has contractual guarantees with their plan administrators to meet several quality measurements for the employee population. Finally, the member cost differentials between tiers are not overly prohibitive, allowing members to move to a provider they view as "higher quality" without experiencing unreasonable increases in their cost sharing."

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	gastroenterology, nephrology, neurosurgery, neurology, plastic surgery, urology, and podiatry (*note that pediatric cardiology was struck from this group after initially being included*).			audited via site visits.	
What quality metrics used for physician tiering?	31 quality indicators are used across 17 specific specialties. • Radiation therapy following breast conserving surgery (applies to oncology/hematology and general surgery) • Post-op complications after cataract surgery (applies to ophthalmology) • Use of nasal steroids as a first line agent for the treatment of	For **primary care** clinics, five "domains" of quality are assessed (with 86 discrete quality measures): 1. Access – as measured via a patient satisfaction survey (represents 15% of total quality score); 2. Care/communication – as measured via a patient satisfaction survey (represents 15% of quality score); 3. Chronic condition care (represents 40% of quality score) – for primary care, these are	A quality "credit" mechanism provides for the voluntary reporting of information for each of the 4 conditions listed below. For each condition, the following 3 "dimensions" of performance are measured for each (as possible): ▪ Care management capacity accounts for	*For primary care and multi-specialty care clinics:* A quality "credit" mechanism provides for the voluntary reporting of information for each of the 4 conditions listed below. For each condition, the following 3 "dimensions" of performance are measured for each (as possible): ▪ Care management capacity accounts for 30% of total score (e.g., evening and weekend appointments, 24-hour health advice line, EMRs, e-prescribing); ▪ Clinical outcomes (using MN Community	N/A

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<tr><th>Patient Choice (self-funded product)</th><th>Patient Choice Insights (fully insured and self-funded product)</th></tr>
<tr><td></td><td>moderate to severe allergic rhinitis (applies to geriatrics, otolaryngology, pulmonolgy, allergy/immunology; primary care [FP, GP, IM, Peds], and preventive medicine)
• Osteoporosis screening for patients on systemic corticosteroids (applies to geriatrics, pulmonology, rheumatology, primary care [FP, GP, IM], and preventive medicine)
• Subsequent annual screening for diabetic retinopathy (applies to geriatrics, primary</td><td><u>optimal CAD care</u> (defined as those 18-75 with: LDL<100mg/dl, BP <140/90, daily aspirin, documented non-tobacco use); <u>optimal depression care</u> (defined as, for those ≥ 18 yrs of age, as: documentation of 5 or more symptoms of major depression, documentation of symptom monitoring [i.e., treatment response], maintained on antidepressant meds for 180 days; <u>optimal diabetes care</u> (defined as: HbA1c less than or equal to 8.0%, BP < 130/85, LDL-C less than 130 mg/dl, aspirin use age 41-75, documented tobacco free); <u>optimal asthma care</u> (defined as, for</td><td>30% of total score (e.g., evening and weekend appointments, 24-hour health advice line, EMRs, e-prescribing);
▪ Clinical outcomes (using MN Community Measurement data) account for 30% of total score;
▪ Patient experience – as measured via a patient satisfaction survey – (e.g., physician-patient interaction, integration of care, would you</td><td>Measurement data) account for 30% of total score;
▪ Patient experience – as measured via a patient satisfaction survey – (e.g., physician-patient interaction, integration of care, would you recommend MD) accounts for 40% of total score.

The conditions examined, and their relative “weight” to the overall quality “credit” are as follows:
5. Diabetes (43% of total quality score)
6. CAD (22% of score)
7. Asthma (13% of score
8. Preventive services (22% of score)

Based on results of quality analysis, a clinic can earn a $3.50 “credit” that can be applied to their per-member cost calculation, which may allow for a “buy down” or change in tier placement.</td><td></td></tr>
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	[FP, GP, IM], OB/GYN, and preventive medicine) • Endoscopy or barium enema after initial diagnosis of diverticulitis and following resolution of the acute event (applies to geriatrics, general surgery, and primary care [FP, GP, IM]) • Inappropriate medication use in the elderly (applies to dermatology, geriatrics, oncology/hematol ogy, ophthalmology, otolaryngology, pulmonology, rheumatology, orthopedics, general surgery, allergy/immunolog	patients 5-56, those who are prescribed primary therapy for long-term control of asthma). 4. Acute/preventive care – for primary care, these are 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 – second hand exposure for children (represents 20% of quality score); 5. Use of generics (represents 10% of quality score).	recommend MD) accounts for 40% of total score. The conditions examined, and their relative "weight" to the overall quality "credit" are as follows: 1. Diabetes (43% of total quality score) 2. CAD (22% of score) 3. Asthma (13% of score 4. Preventive services (22% of score) Based on results of quality analysis, a clinic can earn a $3.50 "credit" that can be applied to	*For specialty clinics:* Specialty groups are give the opportunity to complete an online "specialty survey" – information collected includes patient tracking and follow-up processes, implementation of clinical guidelines, implementation and use of electronic medical records and electronic prescribing, and external recognition (e.g., certification, accreditation, awards). Practices that score high enough may move to Tier 1.	

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	y, cardiology, primary care [FP, GP, IM], OB/GYN, and preventive medicine) • ER utilization of asthma patients (applies to pulmonology, allergy/immunology, primary care [FP, GP, IM, Peds], and preventive medicine • Use of first line antibiotics for patients with acute sinusitis (applies to geriatrics, otolaryngology, primary care [FP, GP, IM, Peds], OB/GYN, and preventive medicine) • Glycosylated hemoglobin (HbA1c) for	**Specialty Care Clinics** (4 specialty areas are assessed using 63 discrete quality measures): For **ENT**, quality is assessed based on patient experience alone – no clinical quality measures for ENT are used because HealthPartners has found little distinguishing variation in quality among ENT groups. For **cardiology** four "domains" of quality are measured – access & timeliness, communication, preventive care (healthy lifestyle advice, tobacco assess and assist), use of generics, and clinical quality as follows: JCAHO AMI optimal care; JCAHO CHF optimal care; repeat catheterization; frequency of catheterization before bypass; and, coordination	their per-member cost calculation, which may allow for a "buy down" or change in tier placement.		

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	diabetes (applies to primary care [FP, GP, IM]) • Osteoporosis screening following fractures (applies to geriatrics, rheumatology, orthopedics, primary care [FP, GP, IM], and preventive medicine) • Compliance with glaucoma medications (applies to ophthalmology) • Compliance with inhaled corticosteroids for moderate to severe asthmatics (applies to geriatrics, pulmonology, allergy/immunolog y, primary care [FP, GP, IM, Peds] and preventive	of care (based on primary care physician assessment). For **orthopedics**, four "domains" of quality are measured – access & timeliness, communication, preventive care (healthy lifestyle advice, tobacco assess and assist), use of generics, and clinical quality as follows: ACL compliance to guidelines (HP-developed guideline); orthopedic pre-surgical patient selection for meniscectomy, discectomy, carpel tunnel; total hip replacement average length of stay; total knee replacement average length of stay. For **OB/GYN,** two "domains" of quality are measured - preventive care and use of generics, and clinical quality as follows: breast cancer screening rate for OB/GYN patients,			

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	medicine) • Lack of ICS with concomitant leukotreine modifier use (applies to geriatrics, pulmonology, allergy/immunology, primary care [FP, GP, IM, Peds], and preventive medicine) • Follow-up after diagnosis of actinic keratosis (applies to dermatology, geriatrics, primary care [FP, GP, IM], and preventive medicine) • Hepatic enzyme monitoring for persons using antimycotic pharmacotherapy (applies to dermatology,	and Pap smear screening rate for OB/GYN patients.			

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	geriatrics, oncology/hematology, otolaryngology, pulmonology, primary care [FP, GP, IM], and OB/GYN) • X-ray prior to MRI or CAT scan of lower back pain (geriatrics, rheumatology, orthopedics, primary care [FP, GP, IM]) • Conservative use of imaging for low back pain (applies to geriatrics, rheumatology, orthopedics, primary care [FP, GP, IM]) • Appropriate monitoring for methotrexate use (applies to dermatology, geriatrics,				

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	oncology/hematology, rheumatology, primary care [FP, GP, IM], and preventive medicine) • Avoidance of preoperative urinalysis for patients undergoing surgery (applies to orthopedics and general surgery) • Risk-adjusted complication likelihood for surgeries (applies to general surgery) • Follow-up examination after diagnosis and treatment of skin cancers (applies to dermatology, geriatrics, primary care [FP, GP, IM], and preventive medicine)				

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	• Appropriate monitoring of tamoxifen use (applies to geriatrics, oncology/hematology, primary care [FP, GP, IM], OB/GYN, and preventive medicine • Risk-adjusted complication rates following total hip and total knee replacement (applies to orthopedics) • Inappropriate use of antibiotics for viral URI (applies to geriatrics, otolaryngology, allergy/immunology, primary care [FP, GP, IM, Peds], OB/GYN, and preventive medicine) • ACE inhibitor use				

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	in congestive heart failure (applies to geriatrics, cardiology, and primary care [FP, GP, IM]) • Treatment of coronary artery disease: beta blockers (applies to geriatrics, cardiology, and primary care [FP, GP, IM]) • Treatment of coronary artery disease: lipid lowering drugs (applies to geriatrics, cardiology, and primary care [FP, GP, IM]) • Hepatic enzyme monitoring for statin use (applies to geriatrics, cardiology, primary care [FP, GP, IM], and				

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	preventive medicine) • Annual visual field tests for glaucoma patients (applies to ophthalmology) • Visual field test for patients with suspected glaucoma (applies to ophthalmology)				
Are quality data risk adjusted to allow comparisons across provider groups (i.e., is the health status of the patient population served by the medical groups adjusted for)?	Risk adjustment is less applicable to 29 of the 31 measures that are process-of-care measures. The two outcome measures (complication likelihood for surgeries, and complication rates following total hip and total knee replacement) are risk adjusted.	Risk adjustment is less applicable to structural measures, process-of-care measures and patient satisfaction measures. The clinical outcome measures are not risk adjusted.	Risk adjustment is less applicable to structural measures, process-of-care measures and patient satisfaction measures. Outcomes measures used are not risk adjusted.	Risk adjustment is less applicable to structural measures, process-of-care measures and patient satisfaction measures. Outcomes measures used are not risk adjusted.	N/A

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How are assignments to tiers made?	Medical groups are arrayed based on the average combined cost and quality results. Blue Cross makes final determination of tier positions; quality and cost are weighed equally.	Assignment to Tier I (highest enrollee benefits/lowest enrollee out-of-pocket costs) requires a score below the mean for cost and above the mean for quality.	Based on cost methodology, submitted bid, and quality credit (as applicable), care systems are arrayed. Employers meet annually to review data and placements and determine final tier placement.	*For primary care and multi-specialty clinics:* Based on cost methodology, submitted bid, and quality credit (as applicable), clinics are arrayed. Employers meet annually to review data and placements and determine final tier placement. *For specialty clinics:* If a specialty care clinic is willing to accept the "community average fee schedule" payment level, the clinic will be placed in Tier 2. Performance on the "specialty survey" can earn a specialty clinic placement into a lower cost tier (see also "Calculation of costs" section above).	Based on the risk-adjusted per member costs, primary care clinics are distributed into one of four cost levels/tiers. Initial tier placement is then reviewed as part of 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.
Can medical groups negotiate a change in their tiering placement?	No	No	Yes/No Tiering placement can be changed based	Yes/No *For primary care and multi-specialty clinics:*	Yes A clinic may move tiers if they choose to accept reduced reimbursement – the payment reduction must be equivalent to the cost

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			on results of "quality credit." Providers submit their own pricing data in a bid process. They are provided with the utilization and quality credit information that will be used, along with a computer model that enables them to consider different pricing models. Tiering placement can not be changed based on revised payment negotiations.	Tiering placement can be changed based on results of "quality credit." Providers submit their own pricing data in a bid process. They are provided with the utilization and quality credit information that will be used, along with a computer model that enables them to consider different pricing models. Tiering placement can not be changed based on revised payment negotiations. *For specialty clinics:* Specialists are informed prospectively about how various reimbursement levels (relative to the "community average fee schedule) will impact their tier placement and they choose their reimbursement level accordingly.	differential associated with that tier.
Geographic scope	7 "competitive markets"	7-county Twin Cities' metro area and Rochester	Much of Minnesota, eastern North	11-county Twin Cites' metropolitan area.	Statewide

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	11-county Twin Cities' metro area (Hennepin, Ramsey, Scott, Dakota, Washington, Carver, Anoka, Chisago, Isanti, Wright, Sherburne); Duluth; Fargo/Moorhead; Mankato; Rochester; St. Cloud; and, Sioux Falls.		and South Dakota, and western Wisconsin.		
Separate contracting mechanism for tiered product?	No	No	Yes	Yes	Somewhat Network development and reimbursement decisions are determined by each of the health plans through their contracting processes. While physician clinics may choose to modify their tier placement by negotiating a lower reimbursement level, such adjustment is required to reflect the full differential associated with the change (i.e., it must be budget neutral to the state/employee).
Covered lives	Membership available after 1/1/07 for accounts who purchase this network product (Product effective	Approximately 160,000 (out of about 650,000 total HealthPartners enrollees)	70,000 (approx.)	Current enrollment is 150 employer group; 7,500 covered lives	115,000 (approx.)

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	1/1/07)				
Origination date	Initially announced spring 2006, tier placement notification occurred summer 2006, with product effective date of 1/1/07.	1995	1997	2005	2002

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