VALUE-DRIVEN HEALTH CARE PURCHASING: CASE STUDY OF MINNESOTA'S SMART BUY ALLIANCE

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August 2007

ABSTRACT: The Smart Buy Alliance is a group of public and private health care purchasers in Minnesota working together in hopes of driving greater quality and value in the market. Its members—including the state agencies overseeing Medicaid and public employee health benefits, along with coalitions of businesses and labor unions—represent about 60 percent of state residents. The Alliance's members agree on common purchasing principles and share strategies for promoting and rewarding higher value. Strategies adopted by members include: a common set of quality standards to demand from health plans and providers; a tool that compares quality measures among health plans; a pay-for-performance program for physician practices; and evaluation and designation of certain health providers as "best in class." Looking ahead, there will be challenges associated with managing and sustaining such a broad alliance of members, getting employers to consider quality in addition to cost, and educating consumers.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This report and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1054.

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

ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of The Commonwealth Fund for funding this research. They also thank the following individuals who generously offered their time and insights for this case study: Julie Brunner, executive director, Minnesota Council of Health Plans; David Haugen, director Center for Health Care Purchasing Improvement, Minnesota Department of Employee Relations; J. B. "Sean" Kenney, president/CEO, Labor/Management Health Care Coalition of the Upper Midwest; Kathryn Kmit, director of policy and government affairs, Minnesota Council of Health Plans; Cal Ludeman, commissioner, Minnesota Department of Human Services; Susan McDonald, director, State of Minnesota Governor's Health Cabinet; Martha McDonell, administrator, Labor/Management Health Care Coalition of the Upper Midwest; Brian Osberg, assistant commissioner of health care, Minnesota Department of Human Services; Carolyn Pare, CEO, Buyers Health Care Action Group; and Frank Romero, vice president/COO, Labor/Management Health Care Coalition of the Upper Midwest.

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BACKGROUND

A Legacy of Marketplace Activity

The Minnesota health care market reflects a long legacy of innovation and collaboration by and among various stakeholders. The public sector has been at the forefront of extending coverage to the uninsured, primarily through MinnesotaCare, the state's public coverage program.[1] In recent years, Minnesota had the lowest rate of uninsurance among all states, at 8.5 percent versus a 15.5 percent national average.[2] In the private sector, different groups of purchasers (large businesses, unions, and management groups) as well as suppliers (health plans, hospitals, and physicians) have been forming coalitions in order to more efficiently effect changes in the health care market. For example:

- The Buyer's Heath Care Action Group (BHCAG), representing large self-insured employers in the state such as General Mills and 3M, has pursued value-driven purchasing strategies since 1988;
- The Institute for Clinical Systems Improvement (ICSI) was created in 1993 to develop quality-based clinical guidelines for ChoicePlus, a PPO developed by BHCAG in which participating providers were required to adopt quality guidelines. When ChoicePlus became a direct contracting model (whereby employers contract directly with health *systems*) in 1997, ICSI evolved into a health plan-supported organization and continues to develop health care guidelines based on the best available evidence, produces technology assessment reports that provide clinicians with scientific appraisals of the safety and efficacy of emerging medical technology, and supports clinical improvements among members;[3]
- The health plan-initiated MN Community Measurement program broke new ground by reporting statewide results of health care quality measures across medical groups in 2004. Using ICSI guidelines and data supplied by health plans, Community Measurement continues to measure, compare, and report quality standards for over 700 provider groups and clinics across the state.[4]

Formation of the Smart Buy Alliance

Despite their early efforts, many Minnesota purchasers perceived that their health care market continued to be "supply-dominated"—that is, primarily influenced by the suppliers (health plans and medical providers), rather than consumers or employers. Businesses identified great variation in health plan and provider quality, yet they realized that most

employers and consumers continued to focus on health care costs rather than quality when selecting plans, hospitals, and physicians. They also acknowledged that multiple and confusing demands on plans and providers for performance measures were slowing down any movement toward purchasing based on value. Finally, they understood that none of the various public or private purchasers alone had adequate market power to demand true accountability from suppliers.

The formation of the Smart Buy Alliance in November 2004 resulted from this environment and two parallel developments. First, a group of purchaser coalitions—primarily private but including the Department of Employee Relations (DOER), the state agency managing public employee benefits—were meeting informally for about 18 months to discuss some of the issues and obstacles described above. Though together they represented a large share of the market, their influence was limited without Medicaid, the largest state purchaser.

Second, the Minnesota Citizens Forum on Health Care Costs, led by former U.S. Senator David Durenburger and appointed by Governor Pawlenty, recommended in February 2004 the formation of an alliance of public and private purchasers to work together to enhance quality and efficiency using innovative purchasing strategies. Eight months later, the Governor announced the creation of the Smart Buy Alliance, a melding of the existing, informal purchaser group with state agencies including the Department of Human Services which oversees Medicaid.[5]

COALITION OF COALITIONS: STRUCTURE AND GOALS

The Smart Buy Alliance is a "coalition of coalitions" intended to drive quality and value in the health care market. Representing about three-fifths of the state's residents, the Alliance includes the following entities:

- The state of Minnesota Departments of Employee Relations (state employees) and Human Services (Medicaid, SCHIP, and MinnesotaCare)
- Buyer's Health Care Action Group (large private and public employers)
- Labor/Management Health Care Coalition of the Upper Midwest (union and management groups)
- Minnesota Business Partnership (large employers)
- Minnesota Chamber of Commerce (primarily small to mid-size employers)
- Minnesota Association of Professional Employees

- Employers Association
- CEO Roundtable

The Alliance's co-chairs are the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. There are monthly meetings, staffed by a coordinator employed by the state. BHCAG is the fiscal agent, though as of Fall 2006 there are no dues.

According to Carolyn Pare, CEO of BHCAG, the philosophy of the Alliance is "about moving the needle. . . . It's about influence more than direct or joint purchasing. We want everyone buying on value, not just volume or shifting costs to others, which is not sustainable. We're trying to optimize 'signal strength.'"

The Alliance's first task was to develop common principles. From there it is up to each member to develop a specific initiative and share the results with other members. Because member groups are "starting from different places," with a range of political views and constituencies, it was important to allow each member coalition to decide which tools and strategies to adopt. Similarly, each member coalition encourages and facilitates adoption of certain tools or strategies, but leaves it up to their own individual members (e.g., businesses, labor union funds) to decide which strategy, if any, to implement.

The Alliance developed and agreed upon the following Common Principles:

- Identify and reward "best in class" providers;
- Adopt uniform measures of quality and results;
- Empower consumers with easy access to information; and
- Accelerate use of latest Health Information Technology (HIT).

The Alliance's plan is to match these principles with actions that change purchaser behaviors. Though the group is relatively young, several of its members have been developing value-driven purchasing strategies for some time, and were already primed to share and adopt new strategies.

THE MAIN PLAYERS AND THEIR INITIATIVES

The State

When the governor-appointed Citizen's Forum on Health Care Costs recommended formation of an alliance of public and private purchasers, the state viewed BHCAG as a natural choice for a partner. It approached BHCAG, which was very willing to join forces and become a core member of the new Alliance. Other purchaser groups followed suit. The state's formalizing of the existing informal collaborative (including BHCAG and other groups) helped focus the purchasers' objectives. The governor's public announcement of the Alliance alone served as a catalyst by catching the attention of the public and health industry, and spurring the purchasers to take a more action-oriented approach to value-driven purchasing.

State officials cite three main benefits to joining the Smart Buy Alliance. First, just as the private groups needed Medicaid to strengthen their purchasing power, the state saw the need to join private purchasers in order make a real impact on the market. Second, inclusion of the private sector helps to avoid a perception of "government takeover" as the state begins changing its purchasing practices. And third, the Alliance gives the state entrée into new forums—addressing challenges at the technical, system level, as well as through direct conversations with health plans and providers.

The state plays a major role in the Alliance. The Department of Employee Relations (DOER) purchases health care for about 120,000 state employees and their families through the Minnesota Advantage health benefits plan. DOER is ahead of most health care purchasers in using value-driven purchasing mechanisms. For example, Minnesota Advantage includes the following:

- A tiered structure whereby primary care clinics are placed into four tiers based on risk-adjusted costs, and members have financial incentives (lower copays, deductibles and coinsurance) to select lower-cost providers;
- Reduced office visit copays if a member participates in a health assessment;
- Disease management programs that work to inform members how to prevent or better manage chronic health conditions.
- Access to information on the quality of health clinics through MN Community Measurement reports;
- A physician pay-for-performance program called Bridges to Excellence (BTE), described below;

- A tool (eValue8) that compares health plans along a range of quality-based indicators, described below;
- A Centers of Excellence-type program called Best in Class that will begin in early 2007 (also described below);
- Advantage Health Advisors to help members work through questions about treatment options, provider selection, and health benefits.

DOER's efforts have paid off. Minnesota Advantage had a zero percent premium increase for 2006, and about $20 million in savings is being returned to the state employees through a "premium holiday." Members who pay a health care premium will save about 4.4 percent of their total annual premium, or about $53 per employee with dependent coverage. The savings result from lower-than-expected claims attributed to the range of incentives and health promotion strategies listed above.

The Department of Human Services (DHS) is the purchaser of health care for MinnesotaCare, the Medicaid/SCHIP and state-funded coverage programs, serving over 600,000 beneficiaries. The Commissioner of DHS has a leadership role as a co-chair of the Alliance. And as noted above, the Alliance's coordinator is employed by the state.

DHS has implemented the Bridges to Excellence (BTE) model of physician pay-for-performance for clients enrolled in managed care and seen by medical groups participating in MN Community Measurement. It also has built Alliance-developed common reporting requirements into its contracts with health plans for 2006 and 2007.

Yet DHS has been limited in its ability to adopt some of the strategies developed by Alliance members. Purchasing on behalf of Medicaid is constrained by federal managed care regulations that, according to DHS Commissioner Cal Ludeman, are "focused on quality assurance rather than quality *improvement*." These extensive regulations provide for strict state oversight of health plan compliance to process and administrative provisions, making it difficult and cumbersome to subject the health plans to other, additional measurement tools. State officials are talking with the Centers for Medicare and Medicaid Services (CMS) about a possible accommodation that would allow Minnesota Medicaid to modify its reporting demands to enable it to use eValue8, a program that compares health plans on numerous quality indicators (described further below). They are also discussing potential involvement of *Medicare* in value-driven purchasing strategies. Ultimately, the state hopes to include eValue8 as a tool to measure health plan value in both Medicaid and Medicare.

To further build momentum in the state's value-driven purchasing, the Governor announced the *QCare: Quality Care and Rewarding Excellence* initiative in July 2006 (see text box below). The Smart Buy Alliance will encourage private and public purchasers and providers to adopt QCare standards.

QCare: Quality Care and Reward Excellence

Launched by Governor Pawlenty in July 2006, QCare is a plan to accelerate state health care spending based on provider performance, use of common performance measures, and public reporting of performance indicators.

The state will lead by example, through its purchasing for MinnesotaCare, Medicaid, and Minnesota Advantage. All contracts with health plans and providers will include significant new incentives and requirements for greater reporting of costs and quality, meeting targets and goals, improvements in key areas, and greater overall accountability.

QCare will initially set standards in four areas:

- diabetes
- hospital stays
- preventive care
- cardiac care

Financial incentives are already in place to promote incremental improvements, and long term goals are being developed. For example, providers who, by 2010, have at least 80 percent of diabetes patients receiving optimal care including daily aspirin and blood sugar less than 8 percent, will receive financial rewards. The state estimates that meeting these QCare standards will result in $66 million savings per year and a 31% reduced risk of complications.

Buyers Health Care Action Group

BHCAG was formed by several business leaders in 1988 to address escalating health care costs.[6] Their mission is to move "the health care marketplace toward value-driven purchasing so consumers can get the care they need in the right place, at the right time and at the right price."[7] BHCAG, whose membership now includes large, self-insured businesses in Minnesota, has been one of the most active and best-known business coalitions in the nation.[8]

BHCAG was the key organizer of the informal group of purchasers that was a precursor to the Smart Buy Alliance. It continues to play a major role, with BHCAG's CEO serving as one of the three Alliance co-chairs. Its primary initiatives, which it is promoting among both its own members and other Alliance participants, are the eValue8 tool and Bridges to Excellence.

eValue8. eValue8 is a tool that uses common specifications and criteria to collect data from health plans that choose to participate, and compares them based on cost, quality, and value. In Minnesota, BHCAG is using the program to provide member

employer groups with comparative charts, analysis of each plan's strengths, and opportunities for improvement.

eValue8

Sponsored by the National Business Coalition on Health and Watson Wyatt Worldwide, eValue8 is a Web-based tool that allows health care purchasers to assess and compare health plans on a local, regional, or national basis.

It uses standardized requests for information to collect vendor-specific data from health plans and then analyzes the data using automated scoring based on best practice standards. Comparative reports cover several key areas of health plan performance, including:

- Adoption of health information technology
- Member and provider communication
- Disease management
- Program administration
- Provider performance
- Patient safety
- Pharmacy benefit management
- Behavioral health
- Financial stability

To learn more about eValue8, visit: http://www.eValue8.org/eValue8/about/overview.cfm

Member employers can use information from the tool to negotiate pricing with health plans, set employee premiums, and stimulate market-wide improvements. While there is no way to measure or quantify the impact of eValue8 in Minnesota at this point, Pare asserts that it has led to more discussions between employers and health plans over quality issues, especially areas in need of improvement. As noted above, the State Medicaid program is trying to adopt eValue8, but needs federal approval to modify data collection requirements so as not to overburden the health plans.

The five large health plans in Minnesota, representing the majority of insured residents, participate in eValue8 (as do more than 100 plans nationwide). Reportedly, there was some initial "griping" by the health plans about the large data demands related to participation (according to one interviewee, the process takes approximately 1,000 hours and $100,000 to complete). But over time, the larger health plans got on board and are cooperating. These health plans now view the program as a way to reduce reporting redundancies, with potential to save themselves money. Also, the program has sharpened focus on some quality measures, and "raised the competitive juices among health plans." Health plan representatives acknowledge that the tool helps inform employers' decisions by narrowing choices, and that health plans are paying attention to the results. The smaller

health plans, however, declined participation in eValue8 due to the intensity and cost of the data requirements.

Bridges to Excellence. Bridges to Excellence (BTE) is an employer-led pay-for-performance (P4P) program whose mission is to improve health care through rewards at the physician level. In Minnesota, it has been adopted by BHCAG members including 3M, GE, Honeywell, Carlson Company, and Wells Fargo—self-insured employers that contract directly with providers and care systems. And as noted above, the state's DOER has adopted BTE for state employee coverage, and DHS is beginning to bring BTE pay-for-performance into their coverage programs as well. In fact, BTE has arranged for all major payers in the MN market—including the large health plans—to use the same metric on diabetes for their P4P programs (every health plan has its own form of P4P for its participating providers). In this way, BTE is pursuing the Smart-Buy Alliance goal of creating common performance measures—reducing confusion around reporting and quality standards. In 2007, Minnesota BTE will expand to include cardiovascular disease (health and stroke).

BTE rewards still comprise a very small portion of total P4P payments to providers. But it does indicate that employers are recognizing the value of using financial incentives to reward good provider performance.

Minnesota Bridges to Excellence (BTE)

BTE is a national program that was started in 2003 by multi-state employers including General Electric and Ford Motor Company. It has grown to become a broad coalition operating in twelve states. Participants include large employers, health plans, the National Committee for Quality Assurance, the American Board of Internal Medicine, and several Quality Improvement Organizations. As of June 2006, it had recognized 3,500 physicians and 250 practices, and paid nearly $4.8 million in bonuses nationwide (For more information, see http://www.bridgestoexcellence.org/bte/)

In Minnesota, BHCAG operates a modified version of BTE. The Minnesota BTE builds on existing, local infrastructure, using clinical measures developed by the Minnesota-based Institute for Clinical Systems Improvement (ICSI), and data collected by health plans through the MN Community Measurement initiative. About 90 percent of patients in MN are seeing physicians that are in the Community Measurement data set.

Minnesota BTE rewards physicians for optimal care for chronic illness. The program focused on diabetes care in 2006. Physicians at nine out of 53 medical groups were rewarded with $100 bonuses for each diabetic patient that met five specific clinical measures: blood sugar count under control, LDL cholesterol under 100, blood pressure less than 130 over 80, no smoking, and daily aspirin for patients over age 40. Minnesota BTE plans to add heart disease care in 2007.

Labor Management Health Care Coalition

The Labor Management Health Care Coalition of the Upper Midwest (LMC) was formed in 2001 to provide its members better health care through value-driven purchasing options.[9] LMC has more than 38 members, primarily self-insured Taft Hartley Health and Welfare Funds and public sector unions including state employees and school district members. With joint labor and management governance, LMC represents about 400,000 covered lives including about 175,000 active workers. Its CEO is a co-chair in the Smart Buy Alliance.

LMC's major initiative, and its main contribution to Smart Buy Alliance to date, is the Patient Advocacy-Best in Class Program (PA-BIC), described in the text box below. First implemented by one LMC union fund in 2004, it has been adopted by about 25 percent of LMC's member lives as of Fall 2006.

Illustrating the connections among Alliance members, DOER implemented PA-BIC in September 2006 for all 123,000 state workers and their families. While using a slightly different approach and a different vendor, the state has learned from the LMC experience. Also, DHS Commissioner Cal Ludeman will serve as public sector management representative on the LMC Executive Committee and will help coordinate state efforts with those of the LMC.

Patient Advocacy-Best in Class Program (PA-BIC)

PA-BIC is intended to address the facts that about 15 percent of health claims consume more than 85 percent of total costs, and that better outcomes are associated with providers who treat more patients for specific conditions or procedures. A national vendor—Health Systems Management—was chosen to assess and compare providers willing to participate, focusing on volume of patients and performance. It includes a thorough assessment of program structure, processes, and clinical outcomes for high-cost specialty care such as heart care, cancer, high risk pregnancies, organ transplants, orthopedic problems, and neurological conditions. Certain medical practices and hospitals are then certified as "best in class" for specific procedures.

The second piece of the program is the Patient Advocacy Support System, or "PASS." PASS provides 24 hour/day telephone assistance with specialty care referral and scheduling. Patient advocates give information to consumers about Best in Class providers, but let them decide where to go based on their own needs and priorities. There are no financial incentives tied to using the certified providers, but some member groups are considering increased copays/deductibles if individuals do not *access the information*, regardless of whether/how they use the information in their provider decision. PA-BIC currently costs less than $2 per member per month.

PA-BIC appears to be proving LMC's contention that "good quality costs less." According to LMC President Sean Kenney, the first LMC group to implement the program has estimated a 2.5 to 1 return on investment. This reflected a savings to the group of about $400k its first year, representing between 2 percent and 3 percent of its health expenditures. Total savings for the group are now reported to be up to $1 million per year. This does not include some less easily quantified benefits related to greater productivity—e.g., reduced risk of dying; full recovery and functioning.

Nevertheless, there are challenges to expanding PA-BIC. One major heart center with high market share refused to participate by providing data. Other providers decline to participate, presumably due to indifference or fear that they would not be certified. Also, not all Smart Buy Alliance groups are promoting the program to their members.

Meanwhile, LMC is supportive of other Smart Buy Alliance initiatives, but is not pushing them among its members because it is concentrating on PA-BIC. According to Kenney, "There's a learning curve, and we can't do all of these things at once."

RESULTS AND NEXT STEPS

In addition to the early achievements of the individual initiatives noted above, or perhaps stemming from the cumulative impact of the various efforts under the Alliance umbrella, the public–private purchasing coalition appears to be starting to have an impact on the market as a whole. It has begun the process of aligning purchasers both in terms of principles and demands on providers and health plans. By speaking as one voice (albeit not in terms of actual purchasing), the Alliance has caught health plans' and providers' attention. As one state official put it, the Alliance is having a "cascading effect." It appears to be expediting a process already in motion, creating pressures on providers to solve performance problems. When the Alliance hosted a press conference announcing the second annual Community Measurement report card, there was major press coverage on the 6pm news. Although it is too early to measure the impact of the Alliance in a quantifiable way, purchasers expressed that they are seeing a change in provider culture.

Looking ahead, Alliance leaders are developing a business plan with concrete 'deliverables.' The upcoming focus will be a large-scale Public Awareness Campaign, to educate consumers about the principles of value-driven health care—e.g., the need to become informed, active decision makers regarding their family's health care. Part of this drive will involve seeking ways to make information available and accessible to consumers, in order to overcome past barriers to consumer report cards that have not been very effective.

Also, to be self-sustaining, the Alliance plans to charge dues from members. This will allow it to fund the education campaign, hire staff to coordinate initiatives, and hire consultants who offer additional expertise.

CHALLENGES

Despite early progress and enthusiasm, the Smart Buy Alliance is facing some difficult challenges that it will need to overcome in order to effect lasting change in the market. Alliance leaders acknowledge these challenges, which include the following:

- Moving beyond talking to real action;
- Getting Alliance members to adopt other members' initiatives, given that they are starting from different places and have different priorities;
- Moving stakeholders beyond the "not invented here" mentality to accept best practices without having to reinvent the wheel;
- Getting employers, especially smaller businesses, to focus on quality and not just cost; leaders admit that there is no evidence yet that private purchasers are shifting their employees from one health plan or provider to another based on quality; according to one interviewee, "The Alliance is not there yet";
- Helping individual employees and consumers in general to become smarter purchasers; this will involve making data understandable to consumers, and educating them to use the information that is available to make health care decisions;
- Getting providers and purchasers out of their silos to work together toward enhanced transparency and accountability for quality and value;
- Bringing together a diverse group to work on policies with bipartisan support (an existing conflict is that some members want to avoid talk of public policy, while others feel the need for the Alliance to move in that direction);
- Measuring progress and success to show a business case for value-driven health care;
- Getting Alliance members to contribute financially, in order to sustain the coalition's efforts.

The state is facing additional challenges, including the following:

- Dealing with timing issues; moving toward value-driven health care is a slow process, yet the state departments are run by a legislative schedule, and must show results in the short term in order to retain support;

- Working within federal and state rules and regulations that constrain Medicaid purchasing strategies; as noted above, Medicaid needs—but is not assured—a federal waiver to adopt some of the Alliance initiatives; the lengthy waiver application process exacerbates the timing issue noted above;
- Anticipating additional federal cutbacks in Medicaid, which will place greater pressures on Medicaid to make short-term cuts rather than long-term solutions;
- Moving toward involving Medicare as a purchaser that could be aligned with Alliance principles and strategies; and
- Addressing the conflict whereby it is critical for the Governor to be a champion for the Alliance efforts, but the movement must keep above politics to retain the wide range of participants; also, stakeholders did not want to risk losing state involvement and support if there were a change in Administration.

LESSONS LEARNED

Though the Smart Buy Alliance is relatively young, it has already learned some lessons that can help inform other stakeholders interested in pursuing value-driven purchasing initiatives through broad purchaser collaboratives. They include the following:

- It is difficult to buy on 'value,' in part because different purchasers place varying weight on price and different aspects of quality; a way to address this is to push for transparency, make the information available and user-friendly, and allow individual purchasers (employers, consumers, etc.) to define value their own way and make decisions accordingly;
- A successful public–private coalition requires strong leadership; in Minnesota, public 'champions' of health purchasing reform include both the Governor and the Commissioner of Human Services, a co-chair of the Alliance; the other Alliance co-chairs, representing private sector, are also viewed as very knowledgeable, committed, and strong 'movers';
- A purchaser collaborative should include nearly all purchasers—both public and private—to avoid cost shift from some purchasers to others;
- Other states that don't have the history of Minnesota can still replicate the Smart Buy Alliance model if there is political will, though it may take a little longer to get up to speed;
- It is important to keep the collaborative "above" politics, in order to attract and retain individuals and groups with a range of political leanings around the table, and

also to sustain the effort if the political climate changes; however, Alliance leaders believe that if a new state Administration favored a strong regulatory approach over a market approach, this would not be a good fit with Alliance philosophy;

- It is important to limit the focus of coalition-based market reform efforts, keep priorities to a reasonable number, and zero in on things that are most important to members; that is, keep goals specific and do-able;
- To influence and get unions and smaller businesses on board, it is helpful to conduct regional meetings, and allow individuals to hear from their peers.

Public policies could support Alliance-type value-driven purchasing efforts. Stakeholders suggested the following federal actions:

- Easing of mandates and requirements on Medicaid, and/or establishing a fast-track waiver so states can adopt value-driven tools and strategies; this must be balanced, however, with adequate protections to ensure that new flexibility is not abused to diminish coverage to Medicaid enrollees;
- Providing technical assistance to groups that need reliable research and information on quality; and
- Promoting disclosure of price and quality.

CONCLUSION

The Smart Buy Alliance seems to be formalizing a process that was already taking place in the marketplace. That formalization created an entity and process that is "greater than the sum of its parts." That is, there appears to be added value to have an *official* public–private purchaser effort.

The Smart Buy Alliance, as well as the many individual health initiatives promoted by its members that are intended to improve value in the health care market, rely on voluntary adoption of common (or at least compatible) practices filtering down multiple layers: first at the Alliance leadership level; second, a coalition member of the Alliance may select a program or tool to promote; third, the employer or union group in the coalition may or may not choose to adopt the practice; fourth, for programs that involve consumer actions, individual employees and family members may or may not choose to utilize that tool. With so many layers, there is risk that the value-driven strategies will not be adopted on large scale, and/or will not bring results fast enough to maintain interest and support in the Alliance or to avoid further crisis in system—such as employers dropping out of providing coverage, rising uninsurance and underinsurance, ongoing quality problems, etc.

Alliance leaders point out, however, that the decline of employer-sponsored insurance and the shift toward consumer-driven health care underscore the need to move toward the kind of consumer-level shifts in purchasing practices that the Alliance will soon be pursuing.

FOR MORE INFORMATION

For more information on the Smart Buy Alliance, contact Susan McDonald, director, State of Minnesota Governor's Health Cabinet, by e-mail at susan.mcdonald@state.mn.us, or by telephone at (651) 431-7443.

Additional information is available through the following Web sites:

- State of Minnesota Governor's Health Cabinet: www.maximumstrengthhealthcare.com
- Buyers Health Care Action Group: www.bhcag.com/
- Labor/Management Health Care Coalition of the Upper Midwest: www.labormanagementcoalition.org
- Bridges to Excellence: http://www.bridgestoexcellence.org/bte/
- Community Measurement: http://www.mnhealthcare.org/

NOTES

[1] MinnesotaCare includes Medicaid, SCHIP, and state-subsidized coverage for low-income adults without dependent children. Children, pregnant women, parents and relative caregivers are eligible if household income is no greater than 275% of the federal poverty level (FPL). Adults without dependent children are eligible if household income is not greater than 175% of FPL, they are uninsured and do not have access to employer-based coverage, and if they meet an asset limit.

[2] Using a three-year (2002–2004) average (DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-229, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* U.S. Government Printing Office, Washington, DC, 2005, Table 11).

[3] For more information about ICSI methods, reports, and accomplishments, see www.icsi.org.

[4] Founding members of Community Measurement include the Minnesota Medical Association and seven nonprofit Minnesota health plans (Blue Cross and Blue Shield of Minnesota/Blue Plus, First Plan of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne and UCare Minnesota). See http://www.mnhealthcare.org/~main.cfm.

[5] At around the same time, the Governor also created a "Health Cabinet," consisting of commissioners of six state departments, to implement many of the health care reforms recommended by the Citizen's Forum. The Minnesota Department of Health began annual public reporting of adverse health events at a facility-specific level in 2005. In 2004, the Governor's Health Cabinet created a Web site designed as a clearinghouse that connects users to a wide range of information about the cost and quality of health care in Minnesota (http://www.minnesotahealthinfo.org/).

[6] See www.bhcag.com/.

[7] *Minnesota Purchasers Health Plan Evaluation,* Buyers Health Care Action Group 2006.

[8] For example, in 1997 BHCAG launched Choice Plus, whereby employers contract directly with "care systems," provider groups made up of physicians and hospitals; employees may compare the care systems' prices and patient satisfaction results when deciding which system to select for the next year.

[9] See www.labormanagementcoalition.org.

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