



## **VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE**

### **OVERVIEW**

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August 2007

**ABSTRACT:** Health care purchasers, suppliers, and consumers are rallying for better-quality health care. In response, several states are pursuing value-based purchasing (VBP) initiatives that emphasize collection of quality-of-care data, transparency of quality and cost information, and incentives. In this overview of public-private VBP efforts in Massachusetts, Minnesota, Washington, and Wisconsin, the authors find that tiered premiums, pay-for-performance measures, and the designation of high-performance providers as “centers of excellence” are paying off. Minnesota, for example, has used incentives to achieve about \$20 million in savings in 2006. Similarly, Wisconsin’s Department of Employee Trust Funds has announced premium rate increases in the single digits for the third straight year. More research is necessary to determine the true impact of VBP, but health plans and providers are paying attention to and learning from these current efforts. (Note: Accompanying the overview report are four separate state case studies, available at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=515778](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778).)

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](http://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. 1052.



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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 of this overview report and the accompanying case study reports gratefully acknowledge the support of The Commonwealth Fund for funding this research. We also thank the planners and administrators of the programs we highlight in the case studies, as well as numerous stakeholders who were so generous with their time and willingness to share information about strategies and challenges, and to review drafts of the case study reports. We thank them not only for their assistance, but for their long-term commitment and effort to create a value-based health care system. These individuals are named in each case study report.

## EXECUTIVE SUMMARY

In an August 2006 executive order, President George Bush outlined his administration's Value-Driven Health Care Initiative. This initiative calls on employers to use four cornerstones when they purchase health insurance: interoperable health care information technology, reporting of quality-of-care measures, reporting of health care price information, and incentives for high-quality, cost-effective care. By committing to these goals, according to the administration, "Public and private employers and other stakeholders in the health care system can help bring about uniform approaches for measuring quality and cost and providing this information to consumers to help them make informed health care choices."

This emphasis on data collection, transparency, and incentives in health care purchasing is not new. It grows out of more than a decade of efforts to develop and implement "value-based purchasing" (VBP)—purchasing practices that are geared toward improving the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients.

In this report, the authors examine the current and potential role of state and local governments, as well as public-private coalitions, in promoting value-driven health care. It summarizes an analysis of four major initiatives aimed at pursuing value in the health care system that are led by, or include, state agencies. (These initiatives in [Massachusetts](#), [Minnesota](#), [Washington](#), and [Wisconsin](#) are examined in greater depth in four separate case studies, also published by The Commonwealth Fund.)

The **Massachusetts Group Insurance Commission (GIC)**, a state entity that provides and administers health insurance and other benefits to the commonwealth's employees, retirees, and their dependents and survivors, is trying to improve provider performance through "tiering." GIC assigns its health plan members to a particular tier, based on quality and efficiency, and requires these plans to offer their members different levels of cost sharing, depending on which tier their chosen hospital or provider is designated.

The **Minnesota Smart Buy Alliance** is a group of public and private health care purchasers, including the state agencies overseeing Medicaid and public employee health benefits, along with coalitions of businesses and labor unions. The alliance is developing common value-driven principles, and its members are sharing VBP strategies.

Washington State's **Puget Sound Health Alliance**, a broad group of public and private health care purchasers, providers, payers (health plans), and consumers, is working to develop public performance reports on health care providers and evidence-based clinical guidelines.

The **Wisconsin Department of Employee Trust Funds (ETF)**, the state agency that administers health benefits for state and local government employees, is pursuing value through a variety of purchasing strategies. ETF is also becoming involved in public-private collaboratives such as a statewide health data repository.

### **THREE MODELS OF VALUE-BASED PURCHASING**

An exploration of the more advanced VBP efforts involving states, including the four selected for case study analysis, reveals three basic models, each with strengths and weaknesses.

**Model 1—Single Large Purchaser:** involves a large purchaser working actively and cooperatively with suppliers while using its market power to make demands. Such purchasers working alone are limited in influence but can move quickly and be pioneers.

**Model 2—Purchaser Coalition:** involves a group of public and private purchasers (or purchaser coalitions) working together to standardize demands on suppliers and share value-driven strategies. Reaching agreement among purchasers with different priorities can be challenging, but coalitions can leverage greater market share and wield more influence with suppliers.

**Model 3—Mixed Coalition:** involves a group of health care purchasers and suppliers working cooperatively to promote transparency and incentives. Reaching consensus is very difficult and time consuming, and leads to watered down strategies, but multi-stakeholder initiatives have the potential to make the most significant impact on the market.

## Four State Initiatives to Improve Value in Health Care Purchasing

Value-Driven Initiative	Model	Scale
Massachusetts Group Insurance Commission (GIC)	Model 1: Single Large Purchaser	GIC is the largest employer purchaser in the state, covering more than 286,000 state employees, retirees, and their dependents.*
Minnesota Smart Buy Alliance	Model 2: Purchaser Coalition	Public and private purchaser members collectively represent almost 60 percent of state residents.
Washington State Puget Sound Health Alliance	Model 3: Mixed Coalition	This coalition includes more than 140 participating organizations, including public and private employers; health plans; physicians and other health professionals; hospitals; community groups; and individual consumers. This coalition represents more than a million covered lives, or about a third of the population in five counties: King, Kitsap, Pierce, Snohomish, and Thurston.
Wisconsin Department of Employee Trust Funds (ETF)	Model 1: Single Large Purchaser	ETF is the largest employer purchaser in the state, covering more than 250,000 active state and local employees and 115,000 retirees and their dependents.**

\* <http://www.mass.gov/gic/>.

\*\* [http://www.pophealth.wisc.edu/UWPHI/education/conference/health\\_colloquium\\_2005\\_02\\_07/etf.ppt#330.3.Value-based Purchasing Managing thru Cost AND Quality](http://www.pophealth.wisc.edu/UWPHI/education/conference/health_colloquium_2005_02_07/etf.ppt#330.3.Value-based Purchasing Managing thru Cost AND Quality).

### STRATEGIES

Depending on the model, the sites examined for this study employed a variety of strategies that can be grouped into three main categories.

**Uniform Quality Measures and Reporting Requirements.** This strategy involves multiple purchasers joining together to establish standard quality measures, which are translated into standard data requirements for health plans or providers. The intent is to reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation); reduce confusion to employers and consumers when purchasing health care; and allow providers to focus on improving quality measures that reflect evidence-based medicine.

**Transparency and Public Reporting.** Transparency of quality and cost information is deemed a critical component of VBP across all of the programs examined. The initiatives involved collecting data from providers and health plans, and applying quality, efficiency, and “value” measures (a combination of quality and cost) to present comparative information. Individual purchasers (Model 1) are concerned with reporting this information to their individual employee members, which is common among large

corporations. Coalitions (Models 2 and 3) are working to build more universal repositories of data that would be available to and used by the wider public and all employer/purchasers.

**Direct Incentive-Based Strategies.** The third and ultimate strategy that defines VBP is the use of direct incentives—financial or non-financial rewards and penalties—to change the behavior of consumers, employers, and providers in ways that promote better quality of care, greater value for dollars spent, and improved health outcomes.

Mechanisms include:

- *Tiered Premiums or Copayments.* Researchers are beginning to see variable premiums or copayments tied to the quality and performance of physician group practices, individual physicians, and hospitals.
- *Pay-for-Performance.* Programs to give extra payments (“carrots”) to reward health plans or physician practices for quality improvement and patient-focused high-value care are growing, and one major purchaser is considering penalties related to poor performance (“stick”) approaches.
- *Centers of Excellence.* This tactic takes public reporting one step further by selecting the best performers and giving them special designations. The expectation is that patients are more likely to select the publicly recognized hospitals and physician practices, which should result in improved health outcomes. This strategy also gives incentives to providers to improve their performance in seeking the designation. A member group of the Labor Management Coalition, a Smart Buy Alliance member, has estimated a 2.5 to 1 return on investment from its “Best in Class” program.

Combination strategies incorporate various elements of the above strategies. For example, Wisconsin’s ETF centralized its pharmacy benefit into a newly developed Pharmacy Benefit Manager (PBM), using value-driven principles of transparency and incentives. ETF helped create a PBM that would have no “secret” deals with pharmaceutical manufacturers and all rebates would flow to the state. Further, the PBM would receive a bonus if the state saved money; thus, the two organizations’ incentives are aligned. The PBM also developed a three-tier, evidence-based formulary and other quality/efficiency-based initiatives. The result of these pharmacy initiatives was savings estimated at \$160 million across three years.

Minnesota’s Department of Employee Relations (DOER), a member of the Smart Buy Alliance, purchases health care for about 120,000 public employees and their families,



and it has implemented many of the value-driven strategies described in this report. Its coverage program had a 0 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. DOER attributes the savings to lower-than-expected claims related to value-driven incentives and health promotion strategies.

## **CHALLENGES**

While value-driven health care purchasing poses a number of exciting opportunities for reshaping the health care system into one that is more efficient and provides higher quality care, these efforts are not without significant challenges.

Many of these challenges involve achieving the critical mass to change the system. Representing a large enough portion of purchasers to maximize influence and minimize cost shifting is necessary but raises challenges of reaching agreement among disparate purchasers with different priorities. Each of the programs examined in these reports noted the difficulty of getting employers to look beyond cost and incorporate quality in their health purchasing decisions. Further, getting Medicaid on board and past federal purchasing constraints has been a difficult struggle. And all of the sites noted the ongoing challenge of getting consumers engaged, though they are trying through public awareness, education, incentives, and user-friendly tools.

Another set of challenges involves facing difficult tradeoffs and striking delicate balances. For example, the programs had to find the most effective balance between cooperating with suppliers of health care and taking a more aggressive stance. The program planners also needed to obtain support from top political leadership, but, at the same time, stay above politics to remain non-partisan. They wanted to balance the need to address multiple technological and political challenges with the need to display to their supporters results and present a business case for value-driven health care. In addition, they wanted to avoid “reinventing the wheel” by using existing national quality and efficiency standards, but they needed to add a local spin to promote buy-in. And they needed to balance academic rigor in their methodology with the need to avoid “making perfect the enemy of the good” and getting nowhere.

Finally, the value movement leaders faced challenges trying to get multiple, local initiatives to build on and support rather than duplicate each other. Other communities without histories of collaboration among stakeholders that were evident in Minnesota, Puget Sound, and Wisconsin may face additional challenges in replicating value-driven models.

Changing purchaser and supplier behavior through value-oriented strategies is a slow process, and therefore value-driven health care should be viewed as one element in a broader, comprehensive effort to improve the performance of the health care system. A few of the initiatives highlighted in this report are beginning to show results—primarily but not exclusively at an anecdotal level—in terms of reducing costs and grabbing the attention of health care providers. If these and other value-oriented initiatives around the United States can successfully overcome the obstacles so that they influence providers to enhance quality and efficiency of care, then the potential to “raise all boats” is truly there—that is, for all users of the health care system, not just the current participants of the VBP initiatives. Conducting objective, empirical evaluations of the kinds of efforts highlighted in this report is critical to fully understanding the impact of such efforts on quality of care, health outcomes, and costs. Such results will help determine whether the value-driven initiatives will spread beyond the few states that are now pursuing these efforts.

# **VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE**

## **OVERVIEW**

### **INTRODUCTION**

Growing concerns about the quality of health care and continued escalation of costs has prompted certain purchasers of health care to take a more active role in seeking value for their health care dollar. Earlier reviews of “value-based purchasing” (VBP) found a limited number of leaders, mainly among large employers and business coalitions.<sup>1</sup> But even large businesses are finding that their influence in promoting quality and value among health care suppliers is limited without the influence of the very largest purchasers: state or county employee benefit agencies and Medicaid.

At the same time, factors such as cost escalation, growing numbers of uninsured people, mounting evidence of substandard care, and lack of a strong national directive for health reform are pressuring states and counties to seek both efficiencies and improved quality in their health care systems. While several states have increased cost sharing for public employees, cut Medicaid eligibility and benefits, or imposed caps on spending, others are digging beneath the spending aggregates. They are trying to determine the outcomes they are getting for the money spent; the way purchasing of services could be redesigned to lower costs, reduce inappropriate care, and improve outcomes; how various services inside and outside the traditional health programs can be coordinated; and how patients with chronic illness and disability can be better served.

In short, these public purchasers are looking for ways to enhance the value of the health care they purchase. They are forming partnerships with other public and private stakeholders to place greater demands on health care providers and plans by building into their contracts data collection, evidence-based medicine, performance incentives, and new information technologies.

Many states are pursuing individual elements of VBP (such as Medicaid pay-for-performance programs), but apparently only a few are taking a broader, comprehensive approach, including some that involve partnerships between public and private entities. This report summarizes an examination and analysis of four initiatives pursuing value in the health care system that are led by or include state agencies.

## **BACKGROUND**

In an August 2006 executive order, President George Bush outlined the Value-Driven Health Care Initiative. This initiative calls on employers to use four cornerstones when they purchase health insurance: interoperable health care information technology, reporting of quality-of-care measures, reporting of health care price information, and incentives for high-quality, cost-effective care. By committing to these goals, according to the administration, “Public and private employers and other stakeholders in the health care system can help bring about uniform approaches for measuring quality and cost and providing this information to consumers to help them make informed health care choices.”<sup>2</sup>

This emphasis on data collection, transparency, and incentives in health care purchasing is not new. It grows out of more than a decade of efforts to develop and implement VBP—broadly defined as “any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost.”<sup>3</sup> Researchers Meyer and colleagues further describe VBP as follows<sup>4</sup>:

The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.

An Agency for Healthcare Research and Quality (AHRQ) guide for purchasers describes two key strategies associated with VBP<sup>5</sup>:

1. Change the behavior and decisions of individuals through activities such as public reporting of provider and health plan performance, consumer information campaigns, and financial incentives (e.g., selective contracting, differential cost sharing).
2. Change the performance of health care organizations and practitioners through activities such as standardizing benefits across health plans (to facilitate comparisons); requiring accreditation and reporting of National Committee for Quality Assurance’s (NCQA’S) Health Plan Employer Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures on mortality or complication rates; encouraging adoption of

disease management programs; monitoring reports to identify potential improvement areas; and incorporating quality standards into contracts.

Previous research on VBP has found limited impact of such initiatives. Meyer et al., found a limited number of “pioneers” acting boldly on data collection, developing financial incentives, and working with providers to promote best practices. They also found a moderate number of “dabblers” who ask providers and health plans for information but rarely use it in purchasing decisions; and “do-nothings” comprising the majority of employer purchasers who do not incorporate quality considerations into their purchasing.<sup>6</sup>

Similarly, in a later review of the literature published in 2003, Maio and colleagues concluded that:<sup>7</sup>

Despite these [various] dissemination and education efforts, only a limited number of champions, particularly large employers and business coalitions, are actively involved in promoting quality through their purchasing decisions. Furthermore, experts believe that, although some purchasers have firmly committed to value-based purchasing, many purchasers, especially large companies, are losing interest in implementing value-based health plan programs. Although purchasers appear to be committed to gathering performance data about health plans and providers, it is unclear whether they are using this information to influence quality.

The degree to which the administration’s recent emphasis on value-driven health care will spark new interest and action by employers in the private sector is yet to be seen. The federal government is trying to lead the way by ensuring that all federal agencies and those who do health care business with the government incorporate the cornerstones of health care transparency in their practices.

This study examines the current and potential role of state and local governments, as well as public-private coalitions, in promoting value-driven health care. Researchers identify and study efforts that include state or county employee benefit agencies and Medicaid, often partnering with private entities. These public purchasers and broad coalitions represent a large share of the market and, thus, have the potential to make a strong impact on the health care system.

## **METHODOLOGY**

To conduct this study, researchers first reviewed the literature and interviewed researchers, state officials, and others to identify VBP activities that were particularly advanced or

innovative, and that involved public entities. They chose not to focus on purely private efforts or pay-for-performance (P4P) programs to avoid duplicating other research.<sup>8</sup> They strove for diversity in models, strategies, and region. After selecting four initiatives in consultation with The Commonwealth Fund, the researchers conducted site visits during which face-to-face meetings were held with a range of stakeholders. They included representatives of the purchasers—state employee benefit managers, Medicaid, county governments, private businesses, labor/consumer groups, and various public and private coalitions. They also included suppliers of health care—physicians, hospitals, health plans, pharmacy benefit managers, and others. These visits were supplemented by telephone interviews when necessary. An interview guide was created to ensure consistency across interviews and sites, yet allowed flexibility to address the variation in initiatives and circumstances (see [Appendix](#)).

While the primary focus was on four selected value-driven initiatives, researchers discovered additional, related value-based efforts in each of the markets. The four primary initiatives are:

1. **Massachusetts’ Group Insurance Commission (GIC).** The GIC provides and administers health insurance and other benefits to the commonwealth’s employees and retirees, their dependents and survivors.<sup>9</sup> The GIC’s Clinical Performance Improvement initiative, with a focus on provider “tiering,” was launched to improve provider performance and quality of care. Health plans contracting with the GIC assign hospitals, physician groups, or individual physicians to different tiers based on quality and efficiency; the tiers are tied to varying cost-sharing requirements to encourage members to select higher quality and more efficient providers.
2. **Minnesota’s Smart Buy Alliance.** The Smart Buy Alliance comprises a group of public and private health care purchasers in Minnesota, including the state agencies overseeing Medicaid (Department of Human Services) and public employee health benefits (Department of Employee Relations, DOER). Also included are coalitions of businesses and labor unions who collectively represent almost 60 percent of state residents. Various member groups within the alliance developed purchasing principles and strategies such as P4P, public reporting, and designating centers of excellence to promote and reward higher value. These strategies are shared with the other members for potential implementation.
3. **Washington State’s Puget Sound Health Alliance.** The alliance is an organization of stakeholders in Washington State that includes payers, purchasers, providers, and consumers of health care. Its goal is to develop substantive reforms in quality, evidence-based medicine, and purchasing that will also address rising

health care costs. The group's current focus is on developing and disseminating public performance reports on health care providers across five counties. It is also developing evidence-based clinical guidelines for conditions such as diabetes, back pain, heart disease, and prescribing of pharmaceuticals.

4. **Wisconsin's Department of Employee Trust Funds (ETF).** ETF administers health and other benefits for state and local government employees and their families. ETF is pursuing value through public reporting of health plan performance; using tiered premiums as incentives to members to purchase more efficient plans; giving financial rewards to health plans displaying favorable cost and quality; developing an innovative pharmacy benefit management model emphasizing transparency; and becoming involved in public-private collaboratives with a statewide health data repository.

This overview presents a cross-cutting analysis in which common VBP models and strategies are summarized along with factors that foster or impede their progress. In addition, researchers have prepared a case study report for each of the sites that describes the strategies in greater depth, along with how the initiatives were developed, challenges addressed, and lessons learned. The case studies also briefly describe other value-oriented efforts in each market and how they relate, build on each other, or in some cases, compete with each other. (The individual case study reports for [Massachusetts](#), [Minnesota](#), [Washington](#), and [Wisconsin](#) are available from the Fund's Web site.)

While the limited sample size does not allow generalizations or conclusions about the value-driven health care movement as a whole, both this overview and the case studies can provide policymakers, purchasers, and suppliers of health care with important information about the range of models, their direction, early accomplishments, promise, and limitations of VBP in improving the performance of the health care system.

## **MODELS OF MARKET CHANGE EFFORTS**

An exploration of the more advanced value-driven health care efforts involving states, including those selected for case study analyses, reveals three basic models. Each model has strengths and weaknesses:

### **Model 1: Single Large Purchaser**

This model involves a large purchaser working actively and cooperatively with suppliers while using its market power to make demands. States as purchasers, representing either state employees or a Medicaid program, are in the best position for this role as the largest health care purchasers, but large private corporations can use this model as well. In this

study, Massachusetts' GIC, Minnesota's DOER, and Wisconsin's ETF fit this model and are ahead of most private purchasers in pursuing VBP strategies. These programs emphasize transparency and incentives to individual members, health plans, and providers.

- *Strengths:* A single purchaser can move more quickly; it is not slowed down by the need to reach agreement. Early successes can encourage and act as models for other purchasers.
- *Weaknesses:* This effort does not draw directly from a broader set of purchasers and presents the risk of remaining alone in the front of the pack. In addition, suppliers may cost-shift to other purchasers.

### **Model 2: Purchaser Coalition**

This model involves a group of public and private purchasers (or purchaser coalitions) working together to standardize demands on suppliers and share VBP strategies. Minnesota's Smart Buy Alliance, a "coalition of coalitions," uses primarily incentive-based strategies.

- *Strengths:* Coalitions leverage greater market share, thereby wielding more influence with suppliers. They can more forcefully present the purchaser perspective and priorities, and different members can pursue, test, and share different strategies. The more purchasers involved in an effort, the fewer suppliers will be able to shift costs to other purchasers, and the more they will be forced to become efficient.
- *Weaknesses:* Reaching agreement given different constituencies and political leanings can be difficult; the result may be somewhat watered down strategies or demands.

### **Model 3: Mixed Coalition**

This type of coalition involves a group of health care purchasers and suppliers working cooperatively to promote transparency and incentives. Washington's Puget Sound Health Alliance and the Wisconsin Health Information Organization, a non-profit collaborative of health care-related stakeholders, have made efforts that reflect this model.

- *Strengths:* If all major stakeholders can agree on goals and strategies and align incentives toward common objectives, there could be a significant impact on the health care market.
- *Weaknesses:* Groups that are traditionally in an oppositional relationship will take longer to reach consensus. Moreover, strategies that are finally agreed upon may be heavily watered down, rendering them ineffective in reaching goals of greater efficiency and quality.



## **RANGE OF STRATEGIES**

The purchasers and collaboratives in the four sites examined were engaged in a range of value-driven activities. While each was unique in detail, researchers found common themes falling into three basic categories:

1. Standardization of performance measures and data requirements;
2. Transparency and public reporting; and
3. Direct incentives, including tiered premiums, cost sharing, P4P, and center of excellence designations.

In some cases, these approaches are sequential; that is, standard data requirements and quality measures are the first step toward public reporting and comparisons of provider or health plan performance. This step, in turn, can lead to the use of incentives to select or reward the better performers. But the purchasers also viewed each of these approaches as beneficial in and of themselves. Most of the strategies are based on requirements incorporated into contracts between purchasers and suppliers of health care.

### **Uniform Quality Measures and Reporting Requirements**

This strategy involves multiple purchasers joining together to establish standard quality guidelines or measures, which are translated into standard data requirements for health plans and providers. The intent is to reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation); reduce confusion to employers and consumers when purchasing health care; and allow providers to focus improvement on quality measures that reflect evidence-based medicine. These standards are generally based on national measures and best practices, such as those developed by the National Quality Forum, the NQCA's HEDIS measures, the Joint Commission on Accreditation of Healthcare Organizations, the Hospital Quality Alliance, and the Leapfrog Group. Purchaser coalitions may then adapt these measures with the help of local expert groups to promote “buy in.” Examples include the following:

- One goal of the Smart Buy Alliance in Minnesota is to create common performance measures across public and private member organizations, representing about two-thirds of the state's population.
- The Minnesota Bridges to Excellence program has arranged for major payers in the Minnesota market—including the large health plans—to use the same standards and criteria on diabetes care for their P4P programs (every health plan has its own form of P4P for its participating providers).

- Minnesota’s Qcare initiative, endorsed by the governor, is setting standards in diabetes, hospital stays, preventive care, and cardiac care. Purchasers may then give providers financial rewards for meeting standards.
- The Puget Sound Health Alliance’s Quality Improvement Committee has formed clinical improvement teams for the purpose of developing and endorsing evidence-based treatment guidelines. So far they have completed the process for heart disease, diabetes, and pharmaceutical prescribing, and are working on protocols for the treatment of back pain and depression.

Obstacles to standard measures and demands across purchasers include difficulty obtaining sensitive data from health plans, as well as technical issues related to different information systems, risk adjustment methods, and others described further below.

Stakeholders generally agreed that seeing a significant impact from these efforts may take some time; a few sites, however, are already experiencing positive outcomes. Providers who have embraced the Puget Sound Health Alliance’s evidence-based guidelines for prescribing prescription drugs have reported lower drug costs by focusing more on generic drugs, as per the alliance’s advice. Seattle’s Everett Clinic, for example, has achieved a generic prescribing rate of 75 percent,<sup>10</sup> which lowered its costs to 15 percent—20 percent below the market baseline.

### **Transparency and Public Reporting**

Transparency of quality and cost information is deemed a critical component of value-driven health care across all of the programs examined. The initiatives involved collecting data from providers and health plans and applying quality, efficiency, and “value” measures (a combination of quality and cost) to present comparative information. Individual purchasers (Model 1) are concerned with reporting this information to their individual employee members, a practice common among large corporations. Coalitions (Models 2 and 3) are working to build more universal repositories of data that would be available to and used by the wider public and all employers/purchasers. Examples include the following:

- One of the main strategies of the Puget Sound Health Alliance is to produce publicly available reports that measure quality performance of providers in five counties comprising the Puget Sound area, and potentially across Washington State. These reports will compare the quality of care provided in local clinics, medical practices, doctors’ offices, and hospitals beginning in 2007, with subsequent quarterly updates.

- eValue8 is a tool that uses common specifications and criteria to collect data from health plans that choose to participate. It then compares the data on cost, quality, and value. In Minnesota, the business coalition Buyers Health Care Action Group (BHCAG) is using the program to provide member employer groups with comparative charts, analysis of each plan's strengths, and opportunities for improvement.
- The health plan-initiated Minnesota Community Measurement program broke new ground by reporting statewide results of health care quality measures across medical groups in 2004. Using guidelines developed by a local institute and data supplied by health plans, Community Measurement continues to measure, compare, and report quality standards on more than 700 provider groups and clinics across the state.<sup>11</sup>
- Wisconsin's Health Information Organization (WHIO) is a non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals, physicians, and state agencies.<sup>12</sup> WHIO is building a statewide, centralized health data repository based on voluntary reporting of private health insurance claims. It will be used to develop reports on the costs, and eventually, the quality of episodes of care in ambulatory settings.
- Wisconsin's Collaborative for Healthcare Quality (WCHQ), primarily physician driven, publicly reports comparative information on its member physician practices, hospitals, and health plans through an interactive [Web-based tool](#). WCHQ's CEO Chris Queram notes that, "the measures are reported in ways that allow member groups to identify variation by physician practice and target areas for improvement."<sup>13</sup>

Some impact of public reporting is already evident. Health plans report they are paying attention to the publicly available data in terms of how they compare to other health plans, and how hospitals and physicians in their network compare to others (though most health plans were already assessing their network providers in various ways). Anecdotal evidence indicates that hospitals and many physicians also pay attention to how they compare to others, and they appear to be making efforts to improve their scores. Certain businesses are also reportedly using the publicly reported measures in discussions and negotiations with health plans. But in most areas, the information (particularly quality measures) is not yet used often by employers and rarely by consumers. These and other barriers are discussed further below.

One of the biggest controversies related to public reporting concerns the unit of comparison. Managed care plan comparisons have been reported for many years, with

measures developed by NCQA (including HEDIS), which set an almost universally used standard since 1991. But reporting at the health plan level has not been very helpful for either purchasers or consumers in making quality-based decisions, given the extent to which provider networks overlap. In response, clinicians, researchers, and purchaser groups (e.g., the Leapfrog Group) have developed their own measures to compare hospitals. These measures are used primarily by employers, health plans, and hospitals.

Consumers, however, are generally concerned with selecting physicians, who then admit their patients to hospitals with which they affiliate. Current efforts focusing on physician comparisons are mainly occurring at the clinic or group practice level, including the Puget Sound Health Alliance's upcoming public reports. Still, some analysts argue that in order to engage consumers on a large scale, performance should be compared across individual physicians.

A few recent efforts at this level have begun, but such assessments raise many challenges. Perhaps the largest is how to attribute quality measures and outcomes related to an entire episode of care and multiple providers to just one physician. Some have raised concerns that assessments will not reflect patient compliance and other factors over which a physician has little control, unfairly penalizing certain physicians. And appropriate measures must be developed for primary care physicians and various specialists. A few of the physician representatives interviewed for this study contend that until consistent measures can be agreed upon, quality reporting at the individual physician level will not be useful and might actually be harmful.

### **Incentive-Based Strategies**

The third and ultimate strategy that defines value-driven health care is the use of incentives to change the behavior of consumers, employers, and providers in ways that promote better quality of care, greater value for dollars spent, and improved health outcomes. While public reporting serves as an indirect incentive to providers to improve their performance (based on the expectation that employers and consumers will choose the better performers), incentives can be taken to the next level by providing direct financial or non-financial rewards and penalties.

Adoption of this level of value-driven health care has been very slow among private businesses, even large firms. Obstacles include reluctance to antagonize workers, union contracts that prevent such strategies, assumption that health plans are providing adequate quality control, and lack of resources or interest to invest in quality measurement activities. Also, private (and many public) purchasers have focused on cost containment—

getting discounts from suppliers or shifting costs to workers—rather than trying to use their market power to affect quality or value. Indeed, health plans themselves have been implementing P4P programs for providers within their networks. Realizing that additional pressure is needed from the demand side of the market, the pioneering public and private purchasers and coalitions highlighted in this study are pursuing similar but new, innovative incentive-based techniques. Following are specific mechanisms used.

*Tiered Premiums or Copayments.* It is not uncommon for employers to require from workers different premium contributions based on the cost or “richness” of health plans offered. Nor is it unusual for health plans to charge higher copayments for higher cost providers. The practice of tying premiums to quality or value of health plans, however, is just being tested. Similarly, variable copayments tied to the efficiency/quality of physician group practices, individual physicians, and hospitals are just beginning to be seen. These efforts involve developing a set of quality and efficiency measures, collecting and cleaning the data, setting criteria for designation into different tiers, and establishing different cost-sharing requirements for the different tiers. Patients are “incentivized” by lower cost sharing to select higher value performers. Of course, to be effective, the cost differential must be meaningful. The purchasers in the case studies that follow are not yet employing significant differentials because planners felt it would be more prudent to ease in this new concept, given that measurement is not yet perfect. In addition, they do not want to totally antagonize suppliers of health care or consumers. Examples include the following:

- Wisconsin’s ETF implemented tiered premiums for its health plans. Each health plan is assigned to one of three tiers, and member premium contributions vary according to the tier of the health plan they choose. Tier designation is based primarily on cost, though ETF is trying to shift toward greater emphasis on quality. The tiering creates incentives for state employees to choose better value health plans: after the first year, enrollment among Tier 2 plans shifted somewhat to Tier 1. Planners assert, however, that tiering is pushing the health plans to become more efficient.

<b>Tier</b>	<b>Single Rate</b>	<b>Family Rate</b>
1	\$27	\$68
2	\$60	\$150
3	\$143	\$358

- As the largest health care purchaser in Massachusetts (outside of Medicaid), the GIC has required all of the health plans with which it contracts to develop and

implement tiered cost sharing. One health plan has placed hospitals in tiers, others have developed tiers for physician group practices, and one is beginning to tier individual physicians. All of the plans are required to move to the individual physician level within three years. The challenges associated with tiering at this level are formidable and will be discussed further below. One obstacle in this market is a common consumer assumption that higher-priced providers are better; when faced with serious health problems, they may choose to spend more to get what they assume to be the “very best,” which defeats the very purpose of tiering based on quality. Careful and effective education about what determines tiers could help to counter this phenomenon.

- Minnesota’s DOER places primary care clinics into four tiers based on risk-adjusted costs. State employees pay lower copayments, deductibles, and coinsurance for lower-cost providers. They also pay lower copayments if they undergo a health assessment; in this way, DOER is using financial incentives to promote better health.

*Pay for Performance Programs.* These programs—using extra payments to reward health plans or physician practices for quality improvement and patient-focused high-value care—are integral components of the VBP strategies in Wisconsin and Minnesota. For example:

- ETF’s “Quality Composite System” awards enhanced premiums to health plans displaying favorable and quality measures. The health plans are compared on HEDIS and CAHPS performance measures; ETF is considering ‘stick’ tactics (penalties related to poor performance) as well.
- Minnesota’s Bridges to Excellence (BTE) is an employer-led P4P program for physicians used by large, self-insured employers and DOER (state employees); Medicaid plans to adopt it as well. A modification of the national BTE initiative,<sup>14</sup> Minnesota’s program uses locally developed measures to reward physicians for optimal care in diabetes. In 2006, physicians at 9 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’s BTE plans to add heart disease care in 2007. BTE uses the same metrics that the Minnesota health plans use to reward physicians in their networks, thereby promoting uniformity and minimizing the data collection burden to providers.

*Centers of Excellence.* This strategy takes public reporting one step further by selecting the best performers and giving them special designations. The expectation is that patients are more likely to select the publicly recognized hospitals and physician practices, which should result in improved health outcomes. This strategy also provides incentives for providers to improve their performance in seeking the designation.

- Minnesota’s Best in Class program, for example, assesses 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, with special emphasis on volume of patients. Certain physician practices and hospitals are then certified as “Best in Class” for specific procedures, and patients are informed of these designations through telephone assistance with specialty care referral and scheduling. This program costs a group less than \$2 per member per month and is intended to steer patients to better performing providers. The Labor Management Coalition, a Smart Buy Alliance member, is promoting this initiative, and one of its member groups has estimated a 2.5 to 1 return on investment. The program has faced obstacles, however: some physician practices refuse to participate by providing data because they already have high market share and are therefore indifferent to the incentive involved, or they fear that they will not be certified. As with more general public reporting, the success of this approach depends upon evidence that consumers (and other purchasers) more often select certified providers.

*Combination Strategy.* When Wisconsin’s ETF centralized its pharmacy benefit into a newly developed Pharmacy Benefit Manager (PBM), it used value-driven principles of transparency and incentives. ETF helped create a PBM that would have no “secret” deals with pharmaceutical manufacturers; all rebates flow to the state. Further, the PBM receives a bonus if the state saves money; thus, the two organizations’ incentives are aligned. The PBM also has developed a three-tier, evidence-based formulary and other quality/efficiency-based initiatives. The result of these pharmacy initiatives has been savings estimated at \$160 million across three years. Finally, the benefits of these initiatives have been extended to state residents without drug coverage. By complying with the formulary/preferred drug list, members receive the same discounts and rebates as those negotiated for state employees.

## CHALLENGES TO MOVING AHEAD

The case study initiatives provide insights to obstacles and tradeoffs involved in implementing value-driven health care. Many of these challenges involve achieving the critical mass to change the system.

**Bringing along the market.** In the long run, successful VBP requires a change in the entire market. The more purchasers involved in an effort, the greater the influence and negotiating power and the lower the cost-shifting. According to Carolyn Pare, CEO of BHCAG, the philosophy of the Smart Buy 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.’” These sentiments were echoed by experts in all four sites. Several of those interviewed compared creating a value-based health care system to turning around an enormous ship.

**Reaching agreement among disparate purchasers.** Purchasers have different priorities; e.g., Smart Buy members have found it hard to agree on strategies, so each is continuing to pursue its own but within a common set of principles, with different purchasers placing varying weight on price and different aspects of quality. One way to address this disagreement is to push for transparency, making the information available and user-friendly, and to allow purchasers and consumers to define value their own way and make decisions accordingly.

**Getting employers to look beyond cost.** Most employers continue to be focused on reducing their short-term health care costs as opposed to improving the quality and long-term value of care. Understandably, they are concerned with the current year’s budget and prefer to focus on their own business, leaving quality improvement to the health plans, hospitals, and physicians who are the experts. It is particularly difficult to get smaller employers and unions on board. To address this difficulty, some case study participants found it helpful to conduct regional meetings around the state and allow individual employers and consumers to hear from their peers.

Further, employers generally do not have the motivation to base decisions on quality or to place financial incentives on workers (or are under contract-related constraints preventing them from doing so). Yet effective VBP requires that employers look beyond price and incorporate quality in their health purchasing decisions. They must be convinced of the benefits to themselves and their employees of using incentives to steer workers toward better value plans and providers. They may begin with providing



information, just as Minnesota groups inform workers about which specialist practices meet the Best in Class designation, but do not at this time impose financial consequences on the workers' decisions. Eventually, however, financial consequences may be necessary to change behavior in a significant way, and education can help to minimize the backlash. For example, when Wisconsin's ETF implemented tiered premiums in health plan selection, it found early resistance from workers. ETF found it very helpful to inform and educate members and unions about the new incentives and why they were being imposed; ETF then reinforced the message by reporting to workers the savings achieved.

**Getting Medicaid on board and past federal constraints.** Even Minnesota's very active coalition of large businesses felt it needed the state government—both state employees and Medicaid, the state's largest purchasers of health care—to really move the market. But despite interest by Medicaid officials, the program faces constraints that make certain VBP strategies more difficult. Many Medicaid programs have implemented P4P, but Minnesota officials described “extensive federal regulations providing 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” that promote true value. They also noted that tiered premiums or copayments tied to value in Medicaid would require federal waivers. According to Minnesota Department of Health Commissioner Cal Ludeman, federal Medicaid guidelines are “focused on quality assurance rather than quality *improvement*.”

**Getting consumers engaged.** All sites are struggling with getting consumers to pay attention to and use comparative performance information in their selection of health plans and providers. Progress in this area requires making data easily accessible and understandable to consumers, and educating them on how to use the information. Many of the VBP strategies studied rely on some form of consumer education and decision-making support. For example, Minnesota's Best in Class program is coupled with a Patient Advocacy Support System, or “PASS.” PASS advocates provide 24 hour-per-day telephone assistance with specialty care referral and scheduling; they also inform consumers about Best in Class providers, but let them decide where to go based on their own needs and priorities. Financial incentives are not tied to using the certified providers, but some groups are considering increased copayments and deductibles if individuals do not access the information, regardless of whether and how they use the information in their provider decision. Also, Minnesota is beginning a large-scale public awareness campaign to educate consumers about the principles of VBP, such as the need to become informed, active, decision-makers in their family's health care.

Another set of challenges involves striking delicate balances, or addressing tradeoffs and competing demands.

**Finding balance between cooperating with and challenging the market.**

Even under Models 1 or 2 (purchaser-only initiatives), purchasers must still work cooperatively with suppliers. The challenge is in getting stakeholders who have traditionally been adversaries out of their “silos” to work together toward a common goal of a more effective and efficient health care system. Also, it is helpful to consider what motivates different players. Across different markets, for example, physicians tend to be competitive and want to look good compared to others, though physician associations are often opposed to public reporting and raise concerns about imperfect measures and tools. They do, however, pay attention to how they rate. Health plans and hospitals view transparency as a tool to improve quality, while purchasers want transparency to reduce costs. While they have different motivations, the four case study sites illustrate the fact that these groups can generally agree on the importance of public reporting, despite their disparate objectives. Another way to align incentives is to tie reimbursement to performance, and some sites are beginning to do this, albeit in a small way given imperfections in measurement.

Similarly, aggressiveness must be balanced with incremental change to maximize cooperation. Nearly all Wisconsin ETF health plans are in Tier 1 because planners found it important to maintain good relations with the health plans in early stages of their tiering program. Such heavy weighting on Tier 1, however, is clearly less effective in “moving” consumers and providers, and setting more stringent Tier 1 criteria as the program evolves may be wise. And while the Massachusetts GIC required all of its contracting health plans to make their entire books of business data available for the purposes of tiering, it also gave the plans flexibility in designing their tiering programs.

**Obtaining support from top leadership while staying above politics.**

Leaders of VBP initiatives should have support from the governor but not be dependent on such support. In this way, the initiative does not automatically collapse with a change in administration. Similarly, value-driven efforts by the agency purchasing health care are much more stable if the top official is not a political appointee.

**Overcoming data and technical challenges.** Health plans and providers are generally protective of their pricing and discounts, so obtaining financial information on which to assess cost and efficiency can involve lengthy and wrenching negotiations. Further, the data requirements on health plans associated with the data collection efforts

reviewed for this report were quite extensive (according to one interviewee, the process in Minnesota’s initiative takes a health plan approximately 1,000 hours and \$100,000 to complete). This process can be particularly onerous for smaller health plans and underscores the need for purchasers to work together to standardize their data demands and reduce reporting redundancies. The plans should develop their reporting requirements with a mind toward reducing or at least rationalizing the administrative burden on plans and providers.

Once the data are obtained, technical difficulties often arise associated with multiple data systems, risk adjustment, lack of automation among various providers, and multiple coding of physicians (the same physician may have different identification numbers used for billing different health plans). These factors make assigning accurate quality and efficiency ratings extremely challenging. Even after extensive “cleaning” of data by an independent data firm in Massachusetts, for example, a few health plans noted that the data files they received post-analysis still included a number of physicians listed multiple times under different ID numbers, requiring additional time and resources to fix. Yet while an initiative can collapse under accusations of “bad data,” care must be taken to avoid “making perfect the enemy of the good.” That is, while an initiative must strive for perfectly clean data, it should not postpone all measurement until it attains that ideal. Clearly, a balance must be reached.

**Reaching consensus on standards.** Local and state initiatives must weigh the benefits of adopting nationally recognized medical standards—thus avoiding the time and expense of reinventing the wheel—against the benefits of using local experts to enhance buy-in. A compromise is to begin with national standards, but add a local spin to promote ownership. Also, several stakeholders found it very helpful to be involved in national quality initiatives such as Care-Focused Purchasing, a national data aggregation effort whose measures serve as a guide for data collection efforts behind the Puget Sound Health Alliance’s public reports.<sup>15</sup> This involvement allowed them to participate in cutting-edge national standards development and quickly adopt them into local or state initiatives.

While national standards are growing, they are still limited. Best practices in diabetes care are nationally recognized, for example, but no such consensus has been reached on treatment for many medical conditions. The Puget Sound Health Alliance’s Clinical Improvement Team is still debating a set of measures for treatment of back pain that were released by the NCQA. In addition, protocols for spine care have also been put on hold until further evidence and research are amassed.

**Ensuring that multiple initiatives build on and support each other rather than duplicate efforts.** When multiple public reporting initiatives are being pursued among different stakeholders (e.g., Minnesota, Wisconsin), one of the biggest challenges is minimizing duplication (resulting in confusion to the public) and maximizing collaboration. While competition may be considered healthy, funds are limited for these efforts, so communities that learn from and build on one another will make the most progress. Wisconsin’s new statewide WHIO database initiative, for example, has taken the opportunity to build on existing reporting efforts rather than reinventing the wheel. Another way that Wisconsin stakeholders are trying to reduce the “noise” from multiple reporting efforts is through a new Quality Integration Steering Committee. Composed of top leaders from four health-related organizations, the group is exploring how to link the data efforts, share knowledge, and leverage structures already in place.

**Balancing the need to address multiple challenges with the need to show results.** All of the initiatives studied faced a difficult dilemma related to timing. On one hand, they had to face the numerous and daunting challenges described above, which naturally slowed implementation of their programs. On the other hand, the VBP planners felt under pressure to show real progress in order to keep the parties interested and supportive—both financially and in terms of sharing their data. For example, health plans and providers wanted evidence that employers and consumers were using the information reported publicly, and that they were responding to incentives, in order for their investment to be worthwhile. And purchasers wanted to see evidence that VBP leads to cost savings, despite the nearly universal acceptance among interviewees that reducing costs was not a short-term goal of VBP efforts.

In other words, for the initiatives to be self-sustaining, the planners need to measure progress and success so they can make a business case for VBP. But in addition to the many obstacles noted above, all of the initiatives rely on voluntary adoption of common (or at least compatible) practices, filtering down multiple layers. For example, Minnesota’s Smart Buy Alliance encourages agreement and adoption of strategies first at the broad alliance level, then filtering down to member coalitions; to member employers and union groups; to individual employees and consumers. Because of these multiple layers, the value-based strategies are at great risk of not being adopted on a large scale and will not show results fast enough to maintain interest and support in the initiative.

While there is no easy solution to these timing-related dilemmas, a helpful approach is to limit the focus of the VBP. This involves keeping the priorities to a reasonable number and zeroing in on issues that are most important to members; that is,

keeping the goals specific and do-able. The Smart Buy Alliance, for example, has determined that it must develop a business plan with concrete deliverables. At the same time, participants must view the initiatives as “works in progress” that require ongoing monitoring and change. If the impact is slow or less than hoped for, planners and stakeholders must not give up, but rather examine what needs to be modified.

### **History of collaboration and replicating value-driven health care models.**

One question that arose in three of the four sites studied (Minnesota, Puget Sound, and Wisconsin) was whether these value-driven models could be replicated in states and communities that do not have such histories of collaboration among stakeholders. Personal relationships among stakeholder representatives, and the ability to build on prior collaborations, helped to hold these newer efforts together. Nevertheless, a general view among participants was if strong leadership and political will is present, value-driven strategies can indeed be replicated in regions without such histories of collaboration, though they may take a little longer to get up to speed. In Massachusetts, for example, little prior stakeholder collaboration existed, but a very strong-willed leader of an organization with tremendous market power was able to get the ball rolling. Also, while value-driven health care champions are needed to jump start all of the initiatives, sustaining market movement require getting beyond the key personalities to have value-driven commitment institutionalized within organizations.

### **THE FUTURE OF VALUE-DRIVEN PURCHASING**

Two of the state employee agencies examined in this study report measurable savings resulting from their VBP initiatives. For example, Minnesota’s DOER reports that its incentive-based strategies, combined with its disease management focus, has contributed to 0 percent premium increase for 2006 and about \$20 million in savings being returned to the state employees through a “premium holiday.” Similarly, in August 2006, Wisconsin’s ETF announced that premium rate increases had averages in the single digits for the third year in a row. However, over the same period the growth in average insurance premiums nationwide also moderated, which was attributed to a sharp drop in prescription drug spending growth, lagged effects of earlier years’ slowing in cost growth, and a turn in the insurance underwriting cycle.<sup>16</sup>

More time and objective research are necessary to determine the true impact of the value-driven strategies in place, as well as those just being developed and implemented, on use of best practices, health outcomes, and efficiencies in the long term.

Although it is too early to measure in a quantifiable way the impact of most of the VBP initiatives reviewed in this study, purchasers expressed that they are seeing a change in the health care provider “culture.” Health plans and providers are paying attention, and many of them are using the information for their own quality improvement efforts. Many stakeholders cited the Institute of Medicine’s 2005 report, *Performance Measurement: Accelerating Improvement*, indicating that its call to pursue value and quality in health care is being heard.

If these purchasing initiatives can overcome the obstacles discussed in this report so they can continue to influence providers to enhance quality and efficiency of care, the potential to “raise all boats” is truly present—that is, not only for the current participants of the value-driven initiatives but for all users of the health care system. ETF’s Nancy Nankivil Bennett, director of strategic health policy, Wisconsin Department of Employee Trust Funds, points out that the initiatives “result in clinical and administrative improvements that likely extend beyond ETF patients.”

But keeping providers and health plans engaged requires that they see evidence that consumers and employers are paying attention and using the information. Tracking this evidence will require greater investments in consumer education and decision support. It will also require measuring, documenting, and presenting early evidence of successes and savings to employers—that is, making the business case for value-driven health care.

The ongoing decline of the traditional employer-based health coverage system and growth of employer adoption of consumer-driven health plans reinforce the need to provide consumer decision-making support. The data collection and public reporting that are key components of VBP can help provide critical tools for consumers to purchase care based on value.

VBP can also play an important role in state coverage reforms. As states such as California, Vermont, and the states discussed in this report and others experiment with health reforms involving purchasing pools and public-private partnerships, new opportunities have arisen to build VBP into these initiatives. The GIC leader and “champion,” for example, plays a role in Massachusetts’s broader health care reforms.

And finally, the federal government can support value-driven health care through a variety of policies and investments, including the following:

- *Easing of requirements on Medicaid regarding health plan reporting and establishing a fast-track waiver so states can more easily adopt value-driven tools and strategies.* These changes must be balanced, however, with adequate protections to ensure that new flexibility is not abused that would diminish coverage to Medicaid enrollees or impose penalties for meeting criteria beyond the control of enrollees;
- *Providing financial support and technical assistance to regional groups/collaboratives that need reliable research and information on quality and efficiency.* This support may include convening conferences to promote replication of successful or promising value-driven initiatives and funding evaluations. Also, Quality Improvement Organizations (QIOs), which work with consumers, physicians, hospitals, and other caregivers to ensure that patients get “the right care at the right time,”<sup>17</sup> may refocus to provide technical assistance for collection and use of information. The governance of QIOs may be expanded to include more stakeholders; one case study participant suggested that existing multi-stakeholder groups actually become the QIOs. In this way, QIOs would be more “organic,” driven from within the community instead of imposed from without;
- *Providing ongoing assistance with health information technology that is necessary for reliable and timely reporting of data.* The most significant examples of this are the Medicaid Transformation Grants (MTGs), authorized by the Deficit Reduction Act, which are funding states to adopt innovative methods for improving the effectiveness and efficiency of their Medicaid programs. Almost all states that applied for and received MTGs are planning to use them to develop health information technology systems. In January 2007, \$103 million in awards were announced; and
- *Continuing the move toward value-driven health care in Medicare, and allowing Medicare to be involved in regional or state level public-private value-driven pilots and initiatives.* Examples include establishing uniform quality standards and data requirements on health plans and providers to avoid confusion and administrative burdens, participating in public data repositories, and generally aligning purchasing principles and reimbursement policies with incentives to promote high value care.

As promising as VBP may be, its limitations must be underscored. As suggested in this report and the accompanying case studies, a considerable amount of time must be available for VBP initiatives to gain significant participation and reach the critical mass needed to make an impact on their local market. The case study sites highlighted in this report have a good head start, but replication in other regions that have different histories and cultures may be more challenging. The value-driven health care movement will be

further slowed by attempts to address the technical and other formidable challenges described in this report.

Because most results of value-driven initiatives to date are at an anecdotal level, it will be critical to conduct objective, empirical evaluations of these efforts to fully assess their impact on quality of care, health outcomes, and costs. Indeed, seeing measurable impact on cost and quality will come slowly and in some cases will not be seen at all in the short term (particularly given new investments in health information technology, data collection, analysis, etc.). Therefore, VBP must be viewed as an important element in a broader, more comprehensive effort to improve the performance of the health care system. Such an effort should include demand and supply-side quality improvement initiatives, and it should be integrated with comprehensive coverage, access expansion, and cost-containment strategies.



## APPENDIX. MASTER★ INTERVIEW GUIDE

### Value-Oriented Purchasing to Improve Health System Performance

- I. Interviewee Information
  - A. Name/Title/Role?
  - B. Organization?
  - C. Role in initiative (e.g., public or private purchaser, health plan/provider, evaluator, etc.)?
  
- II. Definition and Motivation
  - A. How do you define “value”? How do you define “value-based purchasing”?
  - B. What was the key impetus or trigger behind this value-oriented purchasing strategy (e.g., large variation in outcomes or practice patterns, premium spike, a fiscal crisis or legislative event)?
  - C. Who took the lead in its development (e.g., agencies/organizations/individuals)?
  
- III. General Strategy
  - A. How would you describe the general strategy?
  - B. What was the overarching objective?
    - E.g., reduce costs to state/employer/consumer; improve patient/employee satisfaction, quality of care, health outcomes, efficiencies, “value,” expand access to care/coverage.
  - C. What is its scope? How many lives does the purchasing strategy involve?
    - If state government, what populations are involved (e.g., state employees, Medicaid, SCHIP, mental health)? Which agencies/departments participate?
    - Have you partnered with other public or private purchasers? Which ones?
    - What do you think is the minimum volume needed to achieve the purchasing clout to make the strategy work?
  - D. Was your initiative built upon or enhanced by “pay for performance” or “value-based purchasing” developments in other sectors? Was it motivated by these developments in other states, or by other purchasers in your state?
  - E. Is there overlap or competition with other similar initiatives? If so, does that help or hinder your efforts? Describe.

★ *Note: Guide will be tailored to the particular program and organization/individual.*

#### IV. Initiative Components

What are the strategy's key components? FOR EACH . . .

##### *Mechanism*

- A. Description of mechanism: e.g., tiered networks (varied copays/cost-sharing), setting uniform performance standards, cost/quality reporting requirements, information technology demands on health plans and providers; favor providers and health plans that are certified for highest quality . . .
- B. What is the primary focus (e.g., costs, performance, other)?
- C. What is the role of contracting? E.g., have you built the new standards, demands or incentives into RFPs? . . . into contract negotiations?
- D. Is there involvement by other stakeholders? Describe.

##### *Data Collection and Measurement*

- E. What types of performance measures are being used? (e.g., satisfaction, clinical outcomes, other?)
  - i. Do you now or plan to collect or slice data by race, ethnicity, gender, income, geography, or other potential indicators of disparity?
  - ii. What was the selection process? Did you base the measures on established standards (e.g., HEDIS, Leapfrog, CAHPS, other)?
  - iii. How and by whom are they being measured? How do they go about reporting it?
  - iv. Did you find that IT was necessary? If so, how was it developed, financed?
- F. What are the performance goals?
  - i. Are any benchmarks (national, regional, or hospital-based)?
  - ii. Are evidence-based clinical guidelines or "best practices" used?
  - iii. Are goals set for your health plans/providers related to meeting an absolute "score," making a certain percentage improvement over past performance, or other threshold?
- G. Does the strategy involve providing comparative information to consumers? . . . to providers/others? How do you assure that information is accurate and up-to-date? . . . appropriate for that audience? . . . used by that audience?

##### *Use of Incentives/Pay-for-Performance*

- H. Role of incentives: To what extent do you use rewards (carrots) vs. punishments (sticks)?

- I. To whom are the incentives targeted (enrollee/employee/patient, physician, hospital, health plan, other)?
  - o What was their reaction to the new purchasing strategy?
  - o What is at stake: e.g., financial bonus or withhold, percent of premium, steering patients to certain plans through differential premiums or auto-assignment?
  - o Is this enough incentive to change [provider or consumer] behavior?
  - o If not, what would be a better incentive level that would change behavior?
- J. Other than incentives, are there other ways you have held providers/health plans accountable for high quality or efficiency?

V. Key Ingredients behind: 1) Implementation, 2) Success, and 3) Sustainability

- A. What were the key factors needed to get the program going? Probe re: leadership, collaboration, purchaser volume/clout, IT, cost or quality crisis?
- B. What steps did you go through in order to get to this point (e.g., stage 1—data reporting; stage 2—process outcomes, stage 3—financial incentives, etc.)?
- C. If a collaboration, how was it created and nurtured? Who are the members?
- D. What are the key factors for achieving success? Probe as above.
- E. What are the key factors for sustaining and expanding the program? Probe as above.

VI. Accomplishments and Outcomes

- A. How is progress assessed?
- B. Have you examined process outcomes: e.g., impact on reporting and use of performance-related data among patients and health plans; choosing or contracting with higher-performing health plans or providers; administrative or clinical programs to improve indicators that are not up to standards; changes in care-seeking behaviors, patient satisfaction?
- C. Have you measured “final outcomes” if any at this stage, e.g., changes in health outcomes, costs, other? I.e., does your experience make the business case for quality or value?
- D. What outcomes are expected, and when?
- E. Is there any indication that process or outcome changes related to this program extend beyond this population, toward systemwide reforms? Describe.

## VII. Challenges

- A. If public purchaser: Would you share with us major barriers to implementation? Probe re: political, legislative, bureaucratic, other constraints.
- B. If private purchaser: Would you share with us major barriers to implementation? Probe re: union, management, competition, lack-of-volume, privacy laws, other constraints.
- C. Were there certain environmental barriers (political, regulatory, market-related)?
- D. What is the organizational focus (e.g., health plan/individual provider/care system) for value purchasing? Are there limitations of that organizational focus for value purchasing?
- E. Any professional (e.g., health plan, provider) resistance to comparisons based on quality or costs?
- F. Any public/enrollee resistance to or lack of interest in comparisons based on quality or costs?
- G. Any employer resistance or lack of interest in quality (vs. cost alone), or reluctance to impose financial incentives or limits on workers?
- H. Any resistance to data collection and reporting? Any technical difficulties/barriers with data collection?
- I. Inadequate staff, or hardware/IT to do this? Any needed change of mindset among your internal staff to focus on value?
- J. Any other major obstacles or challenges faced?
- K. For each obstacle, how was it addressed? Was it successfully overcome?

## VIII. Next Steps

- A. What are your plans for the future? E.g., will you continue or build on these purchasing strategies? Describe upcoming strategies, implementation plan.
- B. Do you anticipate any barriers to these plans?
- C. What would help ensure the success of these plans?

## IX. Lessons and Recommendations

- A. Are there any lessons you or your organization have learned in trying to purchase health care based on value? Describe.
- B. Are there certain purchasing practices that you've experienced that you would NOT recommend for replication? Why?
- C. Are there strategies that you think are successful but not replicable elsewhere? Why/why not?

- D. What purchasing strategies developed or used here WOULD you recommend be adopted by other organizations? What kinds of organizations would be appropriate (Medicaid programs, state employees, private businesses, coalitions, other)?
- E. What would be the best ways to get that message and those strategies to others? I.e., how can lessons be effectively disseminated to and adopted by those who are not pioneers?
- F. Are there any policy changes that might contribute toward replication, expansion, or incorporating these strategies into broader delivery system reform?
  - o How could state legislators/federal policymakers/researchers/grantmakers play a role? E.g., regulations, technical assistance, clearinghouse of best practices?

## NOTES

<sup>1</sup> Agency for Healthcare Research and Quality, *Evaluating the Impact of Value-Based Purchasing: A Guide for Purchasers*, AHRQ Publication No. 02-0029 (Rockville, Md.: AHRQ, May 2002); V. Maio, N. I. Goldfarb, C. Carter et al., *Value-Based Purchasing: A Review of the Literature* (New York: The Commonwealth Fund, May 2003).

<sup>2</sup> See U.S. Department of Health and Human Services, <http://www.hhs.gov/transparency/government/index.html>.

<sup>3</sup> AHRQ, *Evaluating the Impact*, 2002.

<sup>4</sup> J. Meyer, R. Lise, and R. Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers* (Rockville, Md.: AHRQ, Nov. 1997).

<sup>5</sup> AHRQ, *Evaluating the Impact*, 2002.

<sup>6</sup> Meyer et al., *Theory and Reality*, 1997.

<sup>7</sup> Maio et al., *Value-Based Purchasing*, 2003.

<sup>8</sup> See for example L. Duchon and V. Smith, *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials* (Health Management Associates for National Association of Children's Hospitals, Sept. 2006); K. Llanos, J. Rothstein, M. B. Dyer et al., *Physician Pay-for-Performance in Medicaid: A Guide for States* (Lawrenceville, N.J.: Center for Health Care Strategies, Apr. 2007); K. Kuhmerker and T. Hartman, *Pay-for-Performance in State Medicaid Programs: A Quantitative and Qualitative Survey of State Medicaid Directors and Programs* (New York: The Commonwealth Fund, Apr. 2007); *Pay for Performance: A Decision Guide for Purchasers* (Rockville, Md.: AHRQ, Apr. 2006).

<sup>9</sup> The GIC also administers benefits for Housing and Redevelopment Authority personnel; City of Springfield employees and retirees; and retired municipal employees and teachers in certain governmental units.

<sup>10</sup> It should be noted that Everett Clinic staff served as leaders on the pharmaceutical-prescribing Clinical Improvement Teams and were already focusing on generics before the alliance's guidelines were released.

<sup>11</sup> 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.mmhealthcare.org/~main.cfm>.

<sup>12</sup> State agencies joined the group in 2006 when Governor Jim Doyle signed the Health Care Transparency Bill (AB 907), authorizing the state to compile a new database in partnership with WHIO.

<sup>13</sup> Personal communication, Sept. 2006.

<sup>14</sup> For more information, see <http://www.bridgestoexcellence.org/bte/>.

<sup>15</sup> For more information, see <http://www.mercerhr.com/pressrelease/details.jhtml;jsessionid=SNYMZ5UBI4W34CTGOUFCHPQKMZ0QUJLW?idContent=1239135>.

<sup>16</sup> P. Ginsburg, B. Strunk, M. Banker et al., "Tracking Health Care Costs: Continued Stability But at High Rates in 2005," *Health Affairs* Web Exclusive (Oct. 3, 2006):w486-w495; *Health Cost Trend Remains Stable at 7-8 Percent* (AHIP Center for Policy and Research, Nov. 2006).

<sup>17</sup> QIOs are overseen by the Centers for Medicare and Medicaid Services. Currently, 53 QIOs are responsible for each U.S. state and territory, as well as the District of Columbia.

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