



**VALUE-DRIVEN HEALTH CARE PURCHASING:
CASE STUDY OF WISCONSIN'S
DEPARTMENT OF EMPLOYEE TRUST FUNDS**

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ABSTRACT: The Wisconsin Department of Employee Trust Funds (ETF), the largest purchaser of employer coverage in the state, has pursued value for state and local government employees and their families through a number of means, including: public reporting of health plan performance; tiered premiums used to encourage members to purchase more efficient plans; financial rewards to health plans that meet cost and quality benchmarks; an innovative pharmacy benefit management model emphasizing transparency; and a statewide public-private health data repository. Cooperation and dialogue among like-minded stakeholders is very strong in the Wisconsin health care market and has contributed to ETF's success in moderating its costs. One of the challenges ETF now faces is how to shift its value-driven strategies from models that emphasize cost to ones emphasizing quality. The community is also experiencing challenges in minimizing duplication and confusion in its efforts to pursue value in health care purchasing.

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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.

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BACKGROUND

Wisconsin's Department of Employee Trust Funds (ETF) purchases health care for more than 250,000 active state and local employees and 115,000 retirees and their dependents, making it the largest purchaser of employer coverage in the state. ETF contracts with 18–20 health plans through its Group Health Insurance Program (GHIP), the largest single non-federal health plan in Wisconsin, which has annual expenditures of more than \$800 million. The GHIP also has two self-insured health plans administered through a third party.¹ These health plans, under contract with ETF, offer a standard “Uniform Benefits” package and compete in a premium rate bid process.

ETF has become a leader in value-based purchasing (VBP) in the state, ahead of most private purchasers despite an environment of like-minded stakeholder leaders and coalitions. ETF introduced managed care to state employees in 1983, for example, and has moved about 90 percent of members into managed care organizations.² With health care costs escalating in the mid- to late-1990s, ETF Secretary Eric Stanchfield saw the need to reach another level of value-driven health care. In 2002, the Group Insurance Board, which oversees ETF, issued a series of directives to pursue VBP through an incremental approach.

A pivotal event that both reflected and furthered ETF's new efforts was the creation in 2003 of a full-time point person to direct VBP and act as a liaison with the private sector. ETF hired Nancy Nankivil Bennett, an individual familiar with private and public stakeholder leaders and with experience working in both private health care organizations and coalitions. Importantly, she reports directly to the secretary of ETF and faces no bureaucratic obstacles, and she is authorized to make VBP decisions on behalf of the agency.

ETF's objective is to attain the best cost value for employees and in the process improve efficiency and quality of the health care system—in effect to “raise all boats.” It switched from a somewhat adversarial relationship with health plans in terms of negotiating prices to a more objective one based on rewarding quality and efficiency. As a very large purchaser, ETF is able to encourage health plan cooperation by reminding the plans that ETF could contract directly with health care providers (and bypass the plans) if the health plans do not add value.

In addition to its own efforts, ETF is very much involved in collaborating with private purchasers, payers, and providers; other state agencies (e.g., Medicaid); and public-private initiatives. Three such Wisconsin initiatives that focus on the tenets of value-driven health care are the Wisconsin Collaborative for Health Care Quality (WCHQ), the Wisconsin Health Information Organization (WHIO), and a hospital-sponsored public reporting tool, briefly described below.

WISCONSIN EMPLOYEE TRUST FUND INITIATIVES

Public Reporting for Members

Public reporting is the primary focus of ETF's VBP efforts. According to Secretary Stanchfield, "What gets reported gets improved." ETF provides comparative performance information on the health plans offered to members in its annual "It's Your Choice" guide (in print form and on its Web site), which is intended to assist state employees in health plan selection. ETF began by reporting Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results in 1996 and has added other nationally recognized performance measures such as Healthcare Effectiveness Data and Information Set (HEDIS) since then. The 2007 guide includes the following measures for each health plan:

- whether (and which among) a health plan's network hospitals have:
 - recently submitted data to Leapfrog (see www.leapfroggroup.org)
 - fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum
 - provided data for prior year's error prevention measures and two of three clinical measures reported through CheckPoint (see www.wisconsinhealthreports.org)
 - provided data on Medication Reconciliation, a new CheckPoint error prevention measure that indicates a hospital's progress on identifying the most complete and accurate list of medications a patient is taking when admitted. The information is used to provide appropriate medications within the health care system;
- whether a 24-hour nurse line is available to members;
- whether the plan has an electronic diabetes registry used to send screening reminders to people with diabetes;
- percentage of calls received by member services call centers that were answered by a live voice within 30 seconds, and percentage that were abandoned by the caller before being answered;

- number of complaints filed by members; and
- quality improvement initiatives.

Three-Tier Premium

ETF's premium-contribution tiering program, begun in 2004, is designed to motivate employees to select health plans based on cost and quality. Each health plan is assigned to one of three tiers, and member premium contributions vary by tier. Tier designation is based primarily on cost, though ETF is trying to shift toward greater emphasis on quality.

Each plan submits a "per member per month" premium equivalent, and these equivalents are arrayed into three tiers based on calculated "break-points." Plans that fall outside of Tier 1 are provided with risk-adjusted information to reassess their premium equivalent. In contracting cycles, several plans have adjusted their premium to advance from Tier 2 to Tier 1, or from Tier 3 to Tier 2.

In an effort to include quality in its tiering program, ETF gives health plans extra points if they score well on patient safety; customer satisfaction; diabetes and hypertension care management; and rates of childhood immunizations and cancer screenings. Quality points have moved a plan from Tier 2 to Tier 1 in previous contracting cycles and will continue to be weighed more heavily as the data and methodology become more robust. In the future, ETF may consider applying penalties to plans that provide subpar quality based on the methodology.

In 2007, nearly all 19 health plans are in Tier 1 as a result of the actuarial and quality methodologies. ETF can "tighten" the tiers across time (again, based on the robustness of the data/methodology), which will create more differentials in the plan tiering. During the negotiating process, for example, plans that originally fell outside of Tier 1 but then reduced their premiums were able to move to Tier 1, rendering significant savings. The 2007 member monthly contributions for the majority of active workers are listed below:

Tier	Single Rate	Family Rate
1	\$27	\$68
2	\$60	\$150
3	\$143	\$358

After the first year of the tiered model, enrollment among Tier 2 plans declined slightly, but the enrollment shifts are still too subjective to associate with tiering

exclusively. Perhaps more important at this time than its direct effect on consumer choices is impact of tiering on health plans. The program creates incentives for them to hold down costs charged to the state in order to receive Tier 1 designation. ETF officials acknowledge the risk of health plans shifting costs to other purchasers in the form of higher premium growth, but it has not found objective evidence of this to date. ETF hopes that enhancing the role of quality vs. cost in its tiering program will improve health care, and eventually reduce costs, for all consumers.

Quality Composite System: Paying for Performance

In addition to variable contributions from employees, ETF's "Quality Composite System"—begun in 2004—provides enhanced premiums to health plans displaying favorable patient safety and quality measures. The health plans are compared on HEDIS and CAHPS performance measures, with special weights given in the following areas:

- disease management for diabetes and hypertension;
- preventive care and wellness (cancer screenings, tobacco cessation);
- technology (Computerized Physician Order Entry);
- patient safety (participation in Leapfrog patient safety initiatives and CheckPoint); and
- customer service.

The "carrots" are currently 0.5 percent to 2 percent of premium. The system uses a hybrid methodology that creates an aggregate score based on the performance of the variables above. National benchmarks, as well as state performance comparisons, go into the calculation. ETF is exploring Pay for Performance at physician, physician practice, and hospital levels. It is also considering penalties related to poor performance "stick" tactics, which would possibly be built into differentials in the tiering methodology.

Centralized Pharmacy Benefit Management

In 2004, ETF carved the pharmacy benefit out of the health plan packages, self-insured the benefit, and centralized operations into a newly created Pharmacy Benefits Manager (PBM) called Navitus Health Solutions. This new, innovative PBM model emphasizes transparency, evidence-based pharmacy, and incentives that promote savings and quality.

Complete financial transparency is built into the ETF-Navitus arrangement. Unlike the behind-the-scenes deals and rebates PBMs typically employ, all Navitus records are open to purchaser auditing, including retail and manufacturer contracts. All discounts and rebates negotiated between the PBM and pharmaceutical companies flow back to the state instead of being retained by the PBM. Unlike the traditional PBM model in which

the PBM is paid only a token administrative fee but receives significant rebates, ETF pays Navitus administrative fees of \$2.50–\$3.50 per member per month, eliminating its incentive for demanding pharmaceutical company rebates. So the PBM is not “chasing” rebates that often result in the purchase of more expensive, brand-name medications. The PBM does receive a bonus for saving the state money, further aligning incentives for cost containment.

Savings are not achieved at the expense of quality. A Pharmacy & Therapeutics (P & T) committee evaluates drugs on the basis of clinical effectiveness, side-effects, drug interactions, and cost. Navitus then negotiates with companies for the purchase of pharmaceuticals in each drug class. The P & T recommendations are used to create a three-tier, evidence-based formulary, whereby copayments are lower for the most cost-effective drug for the selected condition.

Navitus is also involved in about 25 quality- and efficiency-based initiatives, including a sampling program that promotes generic drugs. Another is a tablet-splitting program whereby patients using a half-tablet prescription pay half the normal copayment, and ETF pays about half the prescription cost (since many medications are priced the same, regardless of strength).

The new PBM model has resulted in significant savings to ETF. The move to Navitus has been credited with saving approximately \$160 million in drug costs from 2004 to 2006. In plan year 2004, ETF experienced a 6 percent decrease in its overall amount spent for drugs from the previous year, when each health plan was responsible for managing the pharmacy benefit. This savings has had a direct impact on the overall health care premiums for state members.

The benefits of ETF’s non-traditional approach to pharmaceutical purchasing go beyond state and local employees. Working with the state, Navitus has created the BadgerRx Individual Prescription Drug Value Card—a program for state residents without drug coverage. By complying with the formulary/preferred drug list, members receive the same discounts and rebates negotiated for state employees. The state funds the rebate component for BadgerRx members until reconciliation with the pharmaceutical companies.

Looking to the future, ETF and Navitus are exploring ways to integrate pharmacy further into the overall value-driven focus, e.g., developing disease management programs and exploring Medicaid and the State Children’s Health Insurance Program (SCHIP) adopting the ETF formulary.

Public–Private Collaboration

ETF clearly plays a role and has influence in the broader health care community. The secretary previously served on the board of the Leapfrog group, and ETF has a place on the steering committees of Safecare Wisconsin (previously the Wisconsin Patient Safety Institute); Wisconsin Hospital Association–CheckPoint (provides public reporting on hospital quality and patient safety performance, described below); Wisconsin Healthcare Purchasers for Quality (includes public and private purchasers publicly reporting health care cost, quality, patient safety information); the Wisconsin Health Information Organization (WHIO) (promoting transparency through data collection and public reporting, described below), and others. As noted earlier, ETF has a full-time person who is an active liaison with other stakeholders and public–private initiatives.

RESULTS OF VALUE-DRIVEN PURCHASING

ETF has experienced significant savings without having to cut benefits or shift costs to members. Officials attribute the savings to their value-driven initiatives: tiered premiums, quality incentives, and an innovative PBM model. As noted above, savings related to pharmacy initiatives are estimated at \$160 million across three years. Perhaps the best indication of impact is the single-digit premium increases (after many years of double-digit growth) across the last three years: 2005 plan year at 4.9 percent; 2006 plan year at 9.8 percent; and 2007 plan year at 7.4 percent. It must be noted, however, that health insurance premiums have fallen nationally over the 2005–2007 period.³

In addition to the financial savings, ETF Director of Strategic Health Policy Nancy Nankivil Bennett points out that the value-driven initiatives “result in clinical and administrative improvements” not only for state and local employees, but “likely extend beyond ETF patients.” Anecdotal evidence suggests that quality improvements are occurring within provider organizations and are associated with the range of value-driven and quality-improvement efforts in the community.

Like-Minded Stakeholders: Promoting Transparency and Quality

Wisconsin has a history of collegial relationships among key actors in health care, including leaders of business coalitions, the hospital association, major health plans, state officials (particularly ETF), the state pharmacy association, and other stakeholders. Many of the same individuals are on one another’s boards and often work together on commissions, task forces, and new collaboratives. While these individuals and the groups they represent span the political spectrum, most agree on the importance of transparency and public reporting in improving the health care system. Below, three major public reporting initiatives and a pilot project involving incentives are described.⁴

Wisconsin Health Information Organization

Created in 2005, WHIO is a non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals, physicians, and state agencies.^{5, 6} WHIO is building a statewide, centralized health data repository based on voluntary reporting of private health insurance claims. The database will include health care claims as well as pharmacy and lab data from insurers, self-funded employers, health plans, Medicaid, and ETF. Such information will be used to develop reports on the costs and, eventually, the quality of care in ambulatory settings. The goals are to encourage providers to improve their performance; enable employers and consumers to make informed purchasing decisions; inform public health efforts; and secure value in health care purchasing. System security and patient confidentiality is a top priority for WHIO, including strict compliance with HIPAA (Health Insurance Portability and Accountability Act) regulations. This rule is strongly specified in the vendor requirements.

Both ETF and the Wisconsin Department of Health and Family Services (DHFS), which administers the state's Medicaid program and SCHIP, are participating in the initiative. To finance the effort, each private member group makes a contribution, which the state will match through funds derived from assessments on physicians and a small contribution by ETF.

WHIO will focus on each episode of care—tracking a health problem from its first encounter with a health care provider through the completion of the last encounter—sometimes involving multiple physicians and services. The group believes this approach can best assess the full cost (and best practices) of treating a health problem. Members acknowledge that calculating such episodes poses serious technical and other challenges. Many hospitals and physicians are concerned that this effort is primarily payer-driven and needs greater input from health care providers. WHIO is considering contracting with WCHQ, which has experience in data-related activities (described below).

Wisconsin Collaborative for Healthcare Quality: Performance and Progress Report

Founded in 2003, the Quality (WCHQ) includes physician groups, hospitals, health plans, employers, and labor organizations that want to enhance transparency and promote quality in the health care system. Primarily physician-driven, WCHQ publicly reports comparative information on its member physician practices, hospitals, and health plans through an interactive Web-based tool. Comparisons are organized into a range of conditions and quality dimensions such as diabetes management, hypertension, postpartum, cancer screening, access to care, and patient satisfaction. WCHQ has also begun measuring efficiency for some measures.⁷ The information is based on an “all patient, all payer” platform.

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." The information is used primarily by providers, because most employers and consumers are "just not there yet." WCHQ is developing a new consumer workgroup to help make its performance reports more useful to laypeople. The organization hopes to eventually conduct an empirical evaluation of the link between its reporting and the observed clinical improvements in the state. The WCHQ comparisons are not used by ETF currently, because the information does not cover the entire state; in addition, ETF purchases care through health plans, whereas WCHQ's focus is primarily at the physician group/clinic level.

CheckPoint

The Wisconsin Hospital Association (WHA) has also become involved in public reporting. Its CheckPoint Web tool (www.wicheckpoint.org) compares hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia; 8 surgical service measures, and 5 error prevention goals. WHA also offers PricePoint, which reports hospital charges. The 128 hospitals that voluntarily participate serve 99 percent of the state's population.

According to WHA President Steve Brenton, "Hospitals realized that it is better to be proactive than to let someone else dictate quality measures." Both physicians and hospitals have been supportive of CheckPoint. "They believe that public reporting improves quality, which is the key for controlling hospital costs," says Brenton. "While hospitals always tracked their own quality measures, public reporting allows them to see where they are compared to others." The information is also available to purchasers—both employers and consumers—but as with WCHQ's experience, neither group has been very active in using the information. WHA hopes that consumers will be more interested when CheckPoint adds CAHPS consumer satisfaction measures. Also, Brenton points out that consumers will benefit as their providers use the data to improve performance.

Medication Therapy Management Services Initiative

A collaborative between pharmacy providers and third-party payers (health plans, employers, and state agencies, including ETF and DHFS) is working to establish a standard set of pharmacist-provided medication and disease management services, as well as a dispensing quality credentialing process. The initiative is designed as both pay-for-performance and a quality improvement endeavor. Its objectives are to improve medication use to enhance health outcomes, reduce costs for participating payers, and advance/differentiate pharmacy practices. Under the initiative, pharmacists would be educated to provide and receive reimbursement for additional services beyond typical dispensing of medicine. These include the following:

- patient and family counseling to promote adherence to medication regimes;
- comprehensive medication review and assessment to identify, resolve, and prevent medication-related problems, such as adverse drug events;
- formulation of a medication treatment plan;
- targeted medication reviews to monitor and evaluate a patient's response to therapy;
- referrals to appropriate health care providers when necessary; and
- coordination and integration of medication management services with broader health services received by the patient.

The Pharmacy Society of Wisconsin plans to pilot the initiative with about 50 pharmacies during 2007 and evaluate the impact of the program before expanding it. Recent discussions have taken place with a vendor to provide the technical infrastructure for the pilot. ETF is working with its PBM, Navitus, to determine areas of duplication, as well as efficiency and quality enhancement opportunities.

CHALLENGES

ETF has faced a few challenges during its implementation of VBP. When premium tiers were first introduced some employees distrusted the system, but ETF earned credibility over time as it saw positive results in the form of premium moderation. Also, ETF responded by starting the "It's Your Benefit" newsletter to educate the workers and explain why the new initiatives made sense; this helped assuage employee concerns.

A number of challenges are associated with the various value-driven health care initiatives across Wisconsin:

- With multiple public reporting initiatives being pursued among Wisconsin stakeholders, one of the biggest challenges is minimizing duplication (resulting in confusion to the public) and maximizing collaboration. While competition may be considered healthy, the state has limited funds for these efforts, so communities that learn from and build on one another will make the most progress. Wisconsin's new WHIO database has an opportunity to build on existing reporting efforts rather than "reinventing the wheel." Another way that 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 organizations (WHIO, WCHQ, WHA, and WMS), the group is exploring how to link data efforts, share knowledge, and leverage structures already in place.

- Purchasers are interested in moving toward comparing physician performance at the individual (vs. clinic) level, citing large variations in quality within group practices. Physicians, however, tend to be very much opposed to this, pointing out that the measures do not consider patient compliance and other factors out of their control. Providers are concerned about misuse of information.
- Data collection is challenging for many reasons. For example, providers and health plans are protective of their pricing and discounts. In addition, technical difficulties are associated with multiple systems, risk adjusting, and lack of automation.
- Funding is limited for developing, implementing, and sustaining these initiatives.
- Developing a sustainable business model for health information collection and reporting requires demonstrable evidence that the initiatives affect behaviors and decisions. While providers are reportedly using public information to gauge their performance, for example, consumers and employers are not yet using the data in their health care purchasing decisions. Employers remain “discount-driven” rather than “quality-driven,” and very few active, vocal employers are creating incentives for their workers. Without evidence that the initiatives are leading to higher quality and better value care, getting providers and others to contribute or support them will be more difficult.
- The history of collaboration and “champions” among stakeholders has driven the Wisconsin community’s progress in value-driven health care to date. Views are mixed, however, on whether value-driven health care has successfully moved beyond the key personalities to be institutionalized within organizations. Also, other regions without the same history of collaboration may have more difficulties in replicating these kinds of efforts.

LESSONS LEARNED

A number of lessons emerge from the Wisconsin’s value-driven health care experiences. ETF leaders attribute their success to working cooperatively but refusing to accept the status quo. They see great value in moving away from the traditional adversarial relationship between purchasers and providers/plans; instead, they are building relationships with other stakeholders and asking: “What can we work on together?” Similarly, it was important for ETF as a purchaser to maintain a good relationship with labor and keep employees and unions (which represent 80 percent of public employees) in the loop—that is, informed in advance of new incentives such as tiered premiums, and reasons for all changes. Thus, cooperating with the market and challenging the market takes a delicate balance. ETF found that it must make changes incrementally to build buy-in and trust, but it must be willing to break “silos” within state government and anticipate

resistance from employees and providers. It must also continually reassess and refine initiatives. As Stanchfield put it, “Value-based purchasing never ends.”

ETF’s independent status helped it to develop and maintain relationships with a range of stakeholders. It functions as a trust and is governed by a board, and its director is not a political appointee but rather is selected by the board. Thus, ETF is essentially above politics; it is not viewed by others as a regulator or state agency, but as a facilitator, enabler, and leader in value-driven health care.

ETF has achieved this role through a combination of leadership and core competencies including size, staff, and credibility. ETF’s secretary is a champion who strongly believes that VBP can “raise all boats.” As the largest purchaser of employer health care in the state, ETF has much influence in the market and is willing to assert its market power during negotiations with health plans. Its key staff are dedicated to value-driven health care and highly regarded by other stakeholders. In addition, ETF has learned that it must budget for VBP, devoting resources to research and development.

Another lesson is the importance of considering what motivates different players. For example, most physicians are competitive and want to look good compared to others; purchasers want transparency to reduce costs; providers want transparency to improve quality. Though these groups have different motivations, they can come together to agree on at least the concept of public reporting, if not the details.

Some stakeholders maintain that the key to success is having large, multi-specialty groups (about 60 percent of physicians in Wisconsin are in 37 large groups) and provider-owned hospitals. In this market the physician groups are aligned with the hospitals, and bringing just a small number of people together can have a large impact. Strong competition among health plans and providers also appears helpful, with each interested in showing they perform better than others.

NEXT STEPS

ETF officials stress that their initiatives are “works in progress” that require ongoing monitoring and change. The department has recently hired a physician who serves as its chief medical adviser as it ratchets up VBP efforts. ETF officials believe that a physician in this position will provide the clinical credibility needed for ETF initiatives and be more effective in holding providers accountable.

Stanchfield expressed the department's dedication to shifting the focus from cost to quality and value. The shift will involve driving incentives through the system, and making health plans compete against each other. The department is considering tiered *copays* based on quality of providers selected.

WHIO is also moving ahead. The group has hired a director and received five strong proposals from organizations to develop the data collection and reporting system. As of early April 2007, WHIO was in contract negotiations with its preferred vendor and finalizing data-sharing agreements among its participating organizations. And various stakeholders are working with other regional groups and states to see if the tools and models described in this case study are transferable.

CONCLUSION

The purchaser of health care for Wisconsin state employees has taken the initiative in pursuing VBP strategies through leadership, market power, and strong collaboration with stakeholders. It is using a combination of strategies that began with an emphasis on cost but is trying to increase emphasis on quality. ETF's model may be transferable to other large purchasers and coalitions if the lead organization has independence, good staff, and willingness to build relationships in the community.

Wisconsin has a history of collaboration among stakeholders and many leaders are champions of transparency in health care. These individuals have spearheaded numerous public reporting efforts, including a new statewide data repository initiative. Since the results of these efforts to date are anecdotal, conducting objective, empirical evaluations of the initiatives described in this case study will be critical to assessing their impact on clinical care, health outcomes, and costs. Though it has many obstacles to overcome, Wisconsin should be watched as a model in public-private collaboration in value-driven health care.

FOR MORE INFORMATION

For more information on ETF's purchasing programs, contact:

Nancy Nankivil Bennett, Director of Strategic Health Policy, Wisconsin Department of Employee Trust Funds, at nancy.nankivilbennett@etf.state.wi.us.

ETF's official Web site is: www.etf.wi.gov.

The joint portal for the Wisconsin Collaborative for Health Care and the Wisconsin Hospital Association's CheckPoint and PricePoint public reporting initiatives is: www.wisconsinhealthreports.org.

NOTES

¹ ETF also administers retirement and other benefit programs for more than 500,000 Wisconsin Retirement System participants and 1,400 employers.

² This compares to the 55 percent overall (private sector and public sector combined) managed care penetration rate in Wisconsin for 2006 (<http://www.mcareol.com/factshts/factstat.htm>).

³ For example, Kaiser Family Foundation and Mercer Human Resources Consulting surveys found employer health cost or premium growth at 7.7 percent and 6.1 percent, respectively, in 2006. The Federal Employees Health Benefits premiums grew by 6.4 percent in 2006 (<http://www.ahipresearch.org/PDFs/CostTrends2006.pdf>).

⁴ In addition to the initiatives described, the Wisconsin Medical Society is planning to develop an information repository containing demographics and relationships among physicians, clinics, hospitals, and health plans; this information will be used to promote administrative simplification, quality improvement initiatives, and other purposes.

⁵ 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.

⁶ John Toussaint, CEO of ThedaCare and champion of VBP, led the effort to establish WHIO.

⁷ WCHQ developed a quadrant analysis to demonstrate the relationship between quality outcomes and risk-adjusted charges, one approach to quantifying the value each member hospital provides when caring for patients with specific conditions. See <http://www.wchq.org/index.php>.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*States in Action: A Bimonthly Look at Innovations in Health Policy*](#). Newsletter.

[*Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve*](#) (August 2007). Sharon Silow-Carroll and Tanya Alteras.

[*Value-Driven Health Care Purchasing: Case Study of the Massachusetts Group Insurance Commission*](#) (August 2007). Tanya Alteras and Sharon Silow-Carroll.

[*Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance*](#) (August 2007). Sharon Silow-Carroll and Tanya Alteras.

[*Value-Driven Health Care Purchasing: Case Study of Washington State's Puget Sound Health Alliance*](#) (August 2007). Tanya Alteras and Sharon Silow-Carroll.

[*Lessons from Local Access Initiatives: Contributions and Challenges*](#) (August 2007). Karen Minyard, Deborah Chollet, Laurie Felland, Lindsey Lonergan, Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong.

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[*State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers*](#) (January 2007). Alice Burton, Isabel Friedenjohn, and Enrique Martinez-Vidal.

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