California HealthCare Foundation

All Together Now:
Coordinating California's Public Sector Health Care Purchasing

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Contents

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Bailit Health Purchasing is a health care consulting firm that supports state efforts to purchase health care services and managed care services more effectively.

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About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

3 Introduction

Methodology

4 Findings from Other States

States' Initiation of Coordinated Purchasing Activities

Types of Coordinated Purchasing Efforts

Barriers to Coordinated Purchasing

Structural Reorganization to Facilitate Coordination

9 Findings from California

Potential Benefits of Coordinated Purchasing for California

Prospects for Coordinated Purchasing in California

10 Viable Coordinated Purchasing Actions for California

Standing Multi-agency Entity

Aligned Purchasing Strategies with Individual Variations

11 Conclusion

13 Appendices

A: Coordinated Purchasing Activities by Selected States

B: Health Plan Overlap Across California Insurance Markets

16 Endnotes

Introduction

States are major purchasers of health care services. State Medicaid and State Children's Health Insurance Program (SCHIP) expenditures, plus state-directed purchasing of health insurance for public sector employees, account for a considerable portion of total health care spending by the state. For example, in 2014 Medi-Cal, California Public Employees' Retirement System (CalPERS), and insurance purchased through Covered California (California's health benefit exchange or marketplace) are expected to cover nearly 10 million Californians under age 65, which is almost one-third of that population in the state. (See Table 1.)

Table 1. Approximate Share of Nonelderly Californians Covered via Statewide Public Purchasers, 2014 Estimates

PURCHASER	ENROLLMENT (millions)	SPENDING (billions)
Medi-Cal	7.4	$32.9
CalPERS	1.1	$5.4
Individual Market, subsidized portion	1.0	$3.4
Total, Publicly Purchased	**9.5**	**$41.7**
Californians with Health Insurance	30.0	$166.5
Public Purchase Share	**32%**	**25%**

Source: Data assembled by Katherine B Wilson for the California HealthCare Foundation, based on data and forecasts from the California Health Benefits Review Program, CalPERS, Covered California, UC Berkeley/UCLA CalSim model, the California Department of Health Care Services, Centers for Medicare and Medicaid Services, US Census American Community Survey, California Department of Finance. Estimates should be viewed as conservative approximations. More information is available on request from CHCF.

Because of such substantial numbers affected by public purchasing, policymakers nationally have shown a long-standing interest in the potential benefits of coordinating health care purchasing across Medicaid, SCHIP, public employee benefits, health insurance marketplaces, and other publicly funded and/or directed health purchasing programs. Many of these policymakers believe that coordinated health care purchasing would enhance market leverage, which would in turn increase the value obtained. In addition, many policymakers are interested in the potential for state purchasers and nonstate employer purchasers, including employer coalitions (e.g., the Pacific Business Group on Health), to collaborate.

The Patient Protection and Affordable Care Act (ACA) has intensified this interest, offering states extensive federal financial support and new authority to expand health insurance coverage and to better organize their purchasing activity. In California, the legislature and successive administrations of both parties have embraced ACA opportunities, establishing Covered California and expanding eligibility for Medi-Cal up to 133% of the federal poverty level (FPL).

This report provides a fresh look at how state purchasing activities are focused and coordinated. In anticipation of new opportunities and heightened interest in coordinated purchasing as ACA coverage expansions take effect in January 2014, this paper examines coordinated purchasing experience in California and other states, draws out lessons from those experiences, and assesses perspectives on and opportunities for coordinated purchasing in California.

Methodology

This paper's researchers gathered information regarding 17 states' experiences with coordinating purchasing, in some instances dating back to 1995.[1] States were selected using a convenience sampling methodology: Some states were chosen based on researchers' pre-existing knowledge of states' experience, and others were referred to researchers during the interview process.

In addition to state agency staff, researchers spoke with a sample of employer coalitions associated with the National Business Coalition on Health. Researchers interviewed staff at CalPERS, Covered California, California Department of Health Care Services (DHCS), the Pacific Business Group on Health (PBGH), and representatives of a sample of California health plans.[2]

Findings from Other States

States have been interested in opportunities to coordinate purchasing strategies across state agencies and with private employers since at least the 1990s.[3,4] This interest is based on a belief that purchasers have many common interests and that coordinated efforts can enhance market leverage. State purchasers define "value" in differing ways, but always include consideration of health care quality and cost. Other value attributes can include population health status, access to services, and patient experience.

Among those states considered by this project, enhancing market leverage to reduce costs was the primary rationale for pursuit of coordinated purchasing. Some interviewees, however, felt that state purchasers already have sufficient size and/or regulatory power to obtain preferred pricing. These interviewees believed that rather than direct cost savings, the greatest potential advantages to coordinated purchasing lay in addressing common strategic interests. Interviewees identified common strategic interests such as reduction in health risk factors (e.g., obesity) and chronic illnesses (e.g., diabetes) common across populations, and care and payment models that deliver superior care and outcomes at affordable cost.

States' Initiation of Coordinated Purchasing Activities

Initiation of coordinated purchasing efforts in almost all states considered by this project resulted from a governor's office directive. This was true regardless of party affiliation. Only in two instances (Kansas and Massachusetts) did a state legislature institute coordination, and in just one (Nevada) did coordination result from independent state agencies reaching out to one another.

Experience in some of these states with governor-directed initiatives has shown, however, that the impetus for coordinated purchasing may be lost when the governor's term ends. Several states reported that their efforts diminished or terminated when a governor left office. Similarly, in the case of Kansas, efforts waned when legislative leadership changed.

Coordinated Purchasing Defined

To study experience with and opportunities for coordinated purchasing across various entities and states, researchers for this project instructed interviewees to understand "purchasing" as referring to any of three sets of activities:

1. Procurement of and contracting with health plans
2. Assessment of health plan performance
3. Management of health plan performance

Interviewees expanded the concept of purchasing to include procurement and contracting for other vendor services (e.g., pharmacy benefit management), professional services (e.g., actuarial), and software (e.g., data warehouse).

In addition, some interviewees focused more on how their purchasing strategies affected provider behavior than plan behavior. The interviews confirmed that public and private health care purchasers across the United States are increasingly focused on the actions of providers and their impact on cost and quality, rather than solely focused on the actions of health plans. Therefore, the prospect for coordination across purchasers depends to a significant degree on the overlap in not only health plans, but also on the overlap in providers serving those obtaining coverage through the purchasers.

As for the "coordinated" aspect of coordinated purchasing, some interviewees focused on the use of shared state staff to support multiple purchasing programs while other interviewees tended to think of coordinated purchasing as joint purchasing across state programs. Researchers encouraged these interviewees also to consider alignment of broad purchasing coordination strategies and management processes. Examples of the latter include purchasers using related, though not necessarily identical, standards regarding payment reform and medical home adoption.

State agencies have only rarely taken the initiative on their own toward coordinated purchasing with other public or private sector entities. Heavy workloads, fear of lost autonomy, uncertainty about potential gains, and the general insular culture within which many state agencies operate all work against agency-initiated coordination efforts. One interviewee stated, "Unless the governor really holds us accountable, changing will be slow."

Agency-level initiation is possible, however, as evidenced by the Nevada state employee benefit program director deciding of his own volition to engage in joint procurement with the state's Medicaid program.

Types of Coordinated Purchasing Efforts

States have attempted to coordinate both operational activities and purchasing strategies across two or more state agencies or other state purchasers. (For a state-by-state list and description of coordinated purchasing strategies, see Appendix A.) Coordinated operational activities include:

- Common pharmaceutical benefits manager (GA, NY[5])
- Common health plans (GA)
- Common dental and vision providers (NY)
- Common claims system (GA[6])
- Common document-imaging software (KS)
- Common data warehouse (KS)
- Common contractors for actuary and audit (NV)
- Common performance measurement activity (MN, NY)
- Shared management positions (GA, KS)
- Shared policy staff across Medicaid and state employee health plans (OR, WA)

Efforts to coordinate health purchasing strategies appear to be more common in recent years than the use of common vendors. Coordinated purchasing strategies include:

- Common language for requests for proposals (RFPs) and/or contracts (e.g., quality and utilization management requirements) (MA, MN, NM, OR, WA)
- Coordinated approaches to payment reform in RFP and health plan contracts (MA, OR)
- Joint RFP for health plan contracts (NV)
- Common preferred drug list (GA)
- Common fee schedule (OH)
- Common performance measures (MN, OR)
- Agreement about nonpayment for potentially preventable readmissions, complications, and "never events" (clearly identifiable adverse events that were serious and preventable such as wrong-site surgery or serious injury while under care in a health facility) (NY)
- Common pay-for-performance methodology with providers (MN)
- Patient-centered medical home support (MA, NY, RI, and others)

Two case examples of states that have taken recent action to coordinate purchasing activity provide a more detailed illustration of the practice.

In Massachusetts, the public employee health purchasing entity and the Medicaid agency are each furthering aligned payment reform through independent contracting efforts. While the two bodies procure separately and craft their requirements independently, they are each advancing payment and delivery system reform using common goals:

- The fall 2012 public employee benefit program RFP required a fixed percentage of covered lives under population-based payment contracts by target dates; otherwise, a penalty on the contractor's administrative fee was applied.
- The winter 2013 Medicaid RFP introduced population-based payment contracts for providers, using a consistent methodology across Medicaid Managed Care Organizations (MCOs) and the state's Medicaid fee-for-service program.

In Oregon, purchasers have worked to align measure sets and a common delivery model across Medicaid, the state's health insurance marketplace, and the state employee health benefit program:

- The Medicaid core measure set will inform the 2013 state employee benefit program RFP measure set.
- The second round of marketplace contracts will be aligned with the core measure set.
- The state is promoting a "coordinated care" delivery model across all state health care purchasing, whereby all state purchasers may contract with provider-operated "coordinated care organizations."
- The state is slowly connecting with large employer purchasers (e.g., Intel) and business coalitions committed to maximizing purchasing value to expand their coordinated purchasing activities and thereby increase their leverage.

These examples from other states identify practical approaches that may be replicable in California.

Barriers to Coordinated Purchasing

A significant barrier to coordinated purchasing has been the tendency of government units to work in silos.[7] Coaxing agency staff out of their silos and into coordinated purchasing efforts faces formidable resistance: Interviewees openly shared concerns about loss of autonomy, authority, and staffing that could result from coordination, as well as lack of trust in the efficiency and effectiveness of other agencies. Interviewees noted how little regular communication occurs across agency boundaries, and one shared the particular fear that structural coordination was likely to stifle creativity:

"[Coordinated purchasing] puts the cold hand of conformity on innovation. I don't want to give up the freedom to experiment. I'm a risk taker. I don't think I could survive operating in Medicaid."

In addition to the problem of silos, interviews with agency personnel in other states revealed a number of other barriers to coordinated purchasing. Barriers most frequently cited include differences among agencies in:

- Mission, values, and program priorities
- Population health care needs
- Benefit design (e.g., covered services, enrollee cost sharing)
- Governing law
- Form of governance (e.g., state agency for Medicaid, quasi-independent oversight body with joint labor/management governance for public employee benefit program)
- Funding sources
- Use of carve-out vendors
- Payment rates, and thereby provider networks
- Participating health plans
- Appropriate staffing sufficiently available for coordination activities

When several of these barriers combine, it is easy to see why the promise of coordinated purchasing has been realized less often than states have desired. But some of these barriers alone can pose a substantial impediment to coordinated purchasing. For example, the staffing required to coordinate can stymie purchasing efforts even when there is a compelling case to be made for coordination. Three interviewees had the following to say about staffing requirements for coordination as a barrier:

- "It is difficult to coordinate with [state employees] when [Medicaid] agency staff is so thin that we barely have time to do what the agency needs to do by itself."
- "We have no time to go through the effort to align. I think a lot of it is resources and time to figure out what was the same and what was different. We have been cutting staff the last few years."
- "Medicaid agency staff feel overwhelmed. They see the potential but don't know where to start."

Structural Reorganization to Facilitate Coordination

To overcome barriers to coordination, some states have made specific structural changes to assist state government entities in working together on shared goals.

Agency Consolidation

A small number of states have consolidated disparate agencies under the direction of one newly created "super" health agency with responsibility for most or all state health care purchasing, and others are contemplating such a strategy. Examples of this approach include the Washington Health Care Authority (1989), the Georgia Department of Community Health (1999), the Kansas Health Policy Authority (2005), and the Oregon Health Authority (2009). However, the extent to which structural integration has contributed to health purchasing coordination has varied across these states. In Georgia and Kansas, largely uncoordinated purchasing functions have continued despite the consolidated agency. Agency consolidation in Washington also initially had limited effect on coordinating health purchasing, but recent attention to the topic has created greater purchasing coordination in that state.

Interagency Executive Council

Some states have created an interagency executive council to assist with coordination of purchasing. These are informal bodies populated with senior agency executives tasked with coordinating health purchasing policy. Examples of this approach include a "Health Cabinet" in Minnesota and the "A Team" in Washington. Agency heads and/or their deputies meet monthly or quarterly to share information and to define and advance a common health care purchasing agenda. The effectiveness of these bodies has varied depending upon the priority and clarity of the charge they have been given (usually by the governor's office), on the culture of the participating agencies, and on the ability and willingness of the designated representatives to work together.

Work Groups and Staff-Level Interactions

Some states have not pursued structural solutions at all but have relied instead on more informal work groups and staff-level interactions to coordinate purchasing. These efforts have varied in effectiveness based on strength of direction, agency culture, and the personalities of the agency representatives.

Successful Coordination in Oregon

The state of Oregon has taken concrete steps to forge better health care purchasing integration. The state's Medicaid program, addiction and mental health treatment activities, high-risk pool, Family Health Insurance Assistance Program, Public Employees Benefit Board, Oregon Educators Benefit Board, and Division of Public Health have all been brought under the direction of the Oregon Health Authority (OHA). Oregon has also pursued coordinated purchasing through centralized health policy development across purchasing programs, including focused policy direction through the following positions:

Director of accountability and quality, responsible for:

- Establishing a core set of common metrics across the OHA so that it can compare performance across all of the agency's lines of business.
- Developing quality initiatives in each area, aligned around the "triple aim" of improving care, improving population health, and reducing costs, and the OHA's delivery system transformation quality goals ("right place, right time, right care"; lower readmissions; improved perinatal and maternity care; better chronic conditions care; increased adoption of patient-centered primary care homes; increased integration of physical and behavioral health care). These initiatives use multiple policy levers, including the rule-making process, contract requirements, and incentive structures.

Chief medical officer, who establishes common medical policy across the OHA.

Director of pharmacy policy, who establishes pharmacy policy across all of the entities involved; where there are boards with policy authority, the goal is alignment of pharmacy policy.

In addition, Oregon is beginning to eliminate duplicate structures in its programs by integrating customer service (including for grievances and complaints), provider relations, communications, and quality improvement and quality assurance functions.

Minnesota's Interagency Executive Council

Minnesota's variously named interagency executive councils have been successful and longstanding. The original council was created under Governor Arne Carlson and has continued, with different names and somewhat different focuses, under four successive governors of different parties.

GOVERNOR	TERM	INTERAGENCY EXECUTIVE COUNCIL NAME
Arne Carlson	1991–1999	Health Policy Commissioners
Jesse Ventura	1999–2003	Health Policy Council
Tim Pawlenty	2003–2011	Health Cabinet
Mark Dayton	2011–present	Health Reform Subcabinet

Different state administrations have used the body for different purposes, including developing policy, coordinating communication, and learning about respective purchaser activities. Governors Ventura and Pawlenty were particularly interested in how the state could operate more effectively as a health care purchaser, not only across state agencies but also in coordination with the private employer community. Governor Pawlenty separately directed the creation of the "Smart Buy Alliance," a body that was co-led by the state, the Buyers Health Care Action Group (BHCAG, an employer coalition), and organized labor. The Smart Buy Alliance focused attention on common measurement of health plan performance using the National Business Coalition on Health's eValue8 tool, promotion of the Leapfrog Group's patient safety initiatives, cost transparency, creation of a standard quality measurement set, and adoption of the Bridges to Excellence provider pay-for-performance program for use within its Medicaid program, generally consistent with practice of BHCAG employer members.

While the intensity and focus of activity by these bodies has varied over the past 22 years, Minnesota state agencies and the private employer purchaser community continue to communicate on health purchasing activities.

Minnesotans involved in these bodies in their different formations have attributed their state's success in sustaining coordinated purchasing activity to the following factors:

- Continuity of key state staff
- Strongly articulated directives to coordinate on a clear cross-agency issue
- Skilled agency leadership at the cabinet and subcabinet level
- A state culture of collaboration to solve problems[8]

In comparing the Minnesota experience with the potential for coordination in California, some notable differences must be considered, including Minnesota's much smaller population and many fewer health plans and providers. Also, in Minnesota — unlike in California and some other states — most providers are willing to treat Medicaid beneficiaries. This lack of a two-tier delivery system in Minnesota appears to be the most important factor in successful coordinated purchasing there, one that does not exist in California and which may make coordination much more difficult to effectuate in California.

Findings from California

Until recently, there has been little purchasing coordination among California state health care purchasers or with private employer purchasers. Historically, DHCS and CalPERS have not coordinated purchasing efforts. CalPERS staff has considered the possibility but so far has concluded that there are no meaningful opportunities to do so, especially because DHCS and CalPERS programs have different provider networks.

CalPERS and PBGH, however, have viewed each other as more likely partners. CalPERS joined the PBGH board in the 1990s, and while CalPERS continues to act independently, it has joined PBGH in meetings with health plans and providers on broad strategic initiatives, including the California Physician Performance Initiative and multi-payer database development.[9,10] Despite this sometime strategic cooperation, CalPERS staff observes that health purchasing coordination with private sector entities is still a challenge: "You have to get large companies to pay a lot of attention to something that is not core to what they do."

There has been recent heightened interest and activity in coordinated purchasing that may produce more results. First, the Let's Get Healthy California Task Force helped define crosscutting objectives for state health care purchasing. Pursuant to a May 3, 2012, executive order from Governor Brown, US Department of Health and Human Services Secretary Dooley appointed a task force to develop a 10-year plan "to make Californians healthier." That multi-stakeholder body, composed of 23 state leaders and 19 expert advisors, produced a December 2012 report that, in turn, served as the starting point for a multi-stakeholder Centers for Medicare and Medicaid Services (CMS)-funded State Innovation Model planning grant.[11] The grant is being used to develop a vision for reforms, including payment and delivery system reforms that state purchasers will need to support aligned purchasing activities.

The emergence of Covered California as a new public purchaser has significantly increased coordinated purchasing activity in the state. While some state-operated marketplaces have chosen to operate as passive clearinghouses, Covered California is an "active purchaser" state-operated marketplace.[12]

Covered California activity has made purchasing coordination a management priority. This is evidenced by alignment of its health plan RFP and contracts with questions, standards, and performance measures used by CalPERS, DHCS, and PBGH, drawing most heavily from CalPERS. Covered California has also aligned with national employer purchasers by using the National Business Coalition on Health's eValue8 tool. Covered California used a common proposal evaluation model with CalPERS and sent a common message with CalPERS to the provider market that they are seeking integrated delivery models. Finally, Covered California staff worked closely and productively with DHCS staff to develop coordinated enrollment policies and systems.

Covered California would like to have large public and private purchasing entities act in concert on major issues such as medical homes, care management for high-risk patients, and wellness. As one interviewee said, "We need to build a process for alignment. In 2014, we can regroup with other purchasers to set the bar for 2015 and beyond."

PBGH, like Covered California, is optimistic about the prospects for coordinated purchasing in California. PBGH cites opportunities to advance adoption of common provider-level measures, build incentives into contracts for meaningful use of electronic health records, and advance clinical improvement in areas of high spending and high performance variability.

Potential Benefits of Coordinated Purchasing for California

In California, as in many other states, purchaser aims for maximizing value are often compromised by conflicting messages sent by state, federal, and private purchasers, and by health plans. Positive change can be facilitated through clear communication that provides consistent direction on care delivery models, common measures, and aligned performance improvement priorities and financial incentives.

CalPERS, Covered California, and DHCS are all large purchasing entities with significant market leverage. As such, they influence health plans and providers through their messages and actions. Still, their influence is limited by the fact that their voices often conflict with those of the CMS, the Health Resources and Services Administration, private employers, accrediting bodies, state regulating

agencies, and others that seek to influence health plans and providers. A prominent example of such conflict is in reporting requirements and quality standards, whose variations create a cacophony of expectations for plans and providers.

Coordinated purchasing could produce a number of benefits for each of these California public entities and for PBGH and any other employer purchaser with which the three public purchasers might wish to collaborate:

Added influence. If coordinating purchasers communicate a set of common priority performance expectations, with common measures and attached financial incentives or disincentives, to a shared insurer or hospital system, they are likely to have greater impact than if purchasers communicate different sets of priority performance expectations.

Support for change. It can be difficult for public purchasers to effect change in their policies and processes, especially because they are subject to active stakeholder and legislative oversight. For these public purchasers, coordinated action, with or without private sector partners, can make it easier to make the case for change, both internally and externally, because acting in concert with other purchasers can lend credibility and support for the action.

Insight and expertise. CalPERS, Covered California, and DHCS each has significant purchasing sophistication with different perspectives, objectives, strategies, and expertise. Coordinated purchasing offers a real opportunity for each entity to acquire information and expertise from the others.

Prospects for Coordinated Purchasing in California

Researchers found varying levels of interest and commitment to coordinated purchasing across CalPERS, Covered California, DHCS, and PBGH. All appear open to the concept, and some overlap already exists. (See Appendix B regarding the limited overlap in health plans across CalPERS, Medi-Cal, Medicare, and commercial insurance markets.)

But as in other states, significant challenges to effective coordinated purchasing must be overcome in California, some of which include:

- Limited overlap in health plans and providers across Medi-Cal and other programs
- Absence of a gubernatorial or legislative directive to coordinate
- Lack of a tradition of public purchasers working closely together
- Heavy existing workloads

The Covered California insurance marketplace has the potential to be a game changer in overcoming these challenges. Its leadership is committed to coordinated purchasing, and the marketplace will be serving a population anticipated to straddle the commercial and Medi-Cal delivery system and health plan markets. DHCS has always worked with a distinct provider network from those contracted by CalPERS and by PBGH member employers, but Covered California's decision to contract with both commercial market health insurers and traditional Medi-Cal health plans, and therefore indirectly with providers that serve both markets, creates a new coordination opportunity.[13] The increased delivery system and plan overlap provides a rationale for CalPERS, DHCS, and PBGH to all coordinate purchasing with Covered California, and thus indirectly with one another.

Viable Coordinated Purchasing Actions for California

Informed by the experience of the 16 other states studied and by the perspectives of leading California health care purchasers and other stakeholders, this project has identified two specific actions that could be initiated in California to facilitate coordinated purchasing across the state's three large public health care purchasing entities: CalPERS, Covered California, and DHCS.

Standing Multi-agency Entity

Without having to make structural changes to existing entities, the state could create a standing multi-agency entity that could regularly convene to ensure ongoing, structured, facilitated dialogue among the state's three health care purchasing entities. Such regular meetings can serve to build understanding and trust among the agencies' leadership, and thereby lead to the strategic advancement of coordination efforts.

While there is much that distinguishes California and Minnesota, Minnesota's sustained model (see box on page 8 and "Findings From Other States"on page 4) of convening its three public health care purchasing entities, sometimes joined by other agencies, may serve as an exemplar for California. The Minnesota experience shows that coordinated purchasing among state entities requires senior-level commitment, which is greatly enhanced if agency executives are in regular, organized communication with one another, focusing on identification of shared priorities and on how each entity can act toward shared purchasing goals.

In California, participation by PBGH in the regular group discussions, or perhaps in separate forums that add PBGH and other private purchasing entities including union trusts, might also be considered. It is worth noting, however, that Minnesota's inclusion of nonpublic entities in its Smart Buy Alliance proved problematic when the varied perspectives and interests of multiple participants made it difficult to achieve consensus. Initially, therefore, CalPERS, Covered California, and DHCS might best establish solely among themselves some common purchasing objectives and a process for working together. The planning process created for the CMS State Innovation Model grant might set the stage for such ongoing collaboration.

As for initiating such a joint entity, most coordinated health care purchasing efforts in other states have resulted from a governor's directive. In California, however, the effort might be longer-lasting if it can be initiated by agency executives themselves and therefore not be tied to the policy directive of an individual governor.

Aligned Purchasing Strategies with Individual Variations

The adoption of aligned purchasing strategies by the three large public purchasers in California can send a powerful message to the health care market. CalPERS, Covered California, and DHCS need to purchase health care coverage and services independently, for many important reasons, and so will need to retain some degree of purchaser variation. They can, however, use aligned purchasing strategies in their independent efforts as a concerted way to encourage delivery system change to improve access and quality and to reduce cost growth. Potential areas for alignment include:

- Common core measure set for transparency and accountability[14]
- Common core measure set for performance incentives
- Financial incentives, down to provider compensation
- Contractual requirements to implement specific delivery system changes, such as high-intensity primary care models
- Prioritization of performance improvement efforts in areas of common interest
- Contractual requirement to use the American Board of Internal Medicine Foundation's Choosing Wisely campaign to improve care and to eliminate unnecessary tests and procedures
- Health plan contractual requirements where varying approaches increase health plan administrative costs, and hence state costs, for little state benefit

Conclusion

Coordinating state health care purchasing activities has its appeal, but national experience has demonstrated that it is difficult to implement and sustain. While many states have pursued coordinated purchasing as a means to increase market leverage and to obtain lower prices, state purchasers already possess considerable market power. So some states — in particular Minnesota and Oregon — use coordination of state purchasing to advance systemic changes to the

financing and delivery of health care, specifically to influence the strategic priorities of contracted health plans and providers.

In California, the creation of Covered California creates new opportunities for coordinated purchasing, as does California's State Innovation Model grant planning process. Covered California has contracted with a mix of health plans that serve both the commercial employer-based market and the Medi-Cal market, giving it a sound basis for coordinating with both DHCS and CalPERS. Further, Covered California leadership has voiced strong interest in and taken steps toward coordinated purchasing. The federally funded State Innovation Model planning grant requires the state to consider how best to use its purchasing activities and its policy levers to transform health care payment and delivery in the state.

California's largest health care purchasers — DHCS, Covered California, and CalPERS — have the leverage to significantly influence health care in California. By crafting aligned procurement policies and documents that require the same types of performance and by using coordinated incentives for the same desired behaviors, they can have greater impact than by signaling different messages through unaligned practices.

The new Covered California health plans contract has a clause that provides a good example:

> "Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers, including at the individual physician and hospital level, using the most current nationally recognized or endorsed measures, including National Quality Forum (NQF), in accordance with the principles of the Patient Charter for Physician Performance Measurement."[15]

If DHCS and CalPERS adopted similar language, together the three purchasers could propel California health plans to move more quickly and comprehensively toward provider performance transparency.

Coordinating purchasing is not technically difficult. It does, however, require leadership and the investment of some measure of scarce management time and attention. If California's public purchasers are willing and able to make such a commitment, the state will be more likely to maximize the value obtained through its health plan contracts and to enhance health and health care for all Californians.

Appendix A: Coordinated Purchasing Activities by Selected States

This table summarizes the coordinated purchasing activities identified by this project as occurring for at least some period between 1995 and 2013 within the studied states. The activities were initiated by the states for a range of reasons, including amassing purchasing power to achieve lower costs, creating state administrative efficiencies, and influencing the priorities and behaviors of health plans and/or providers.

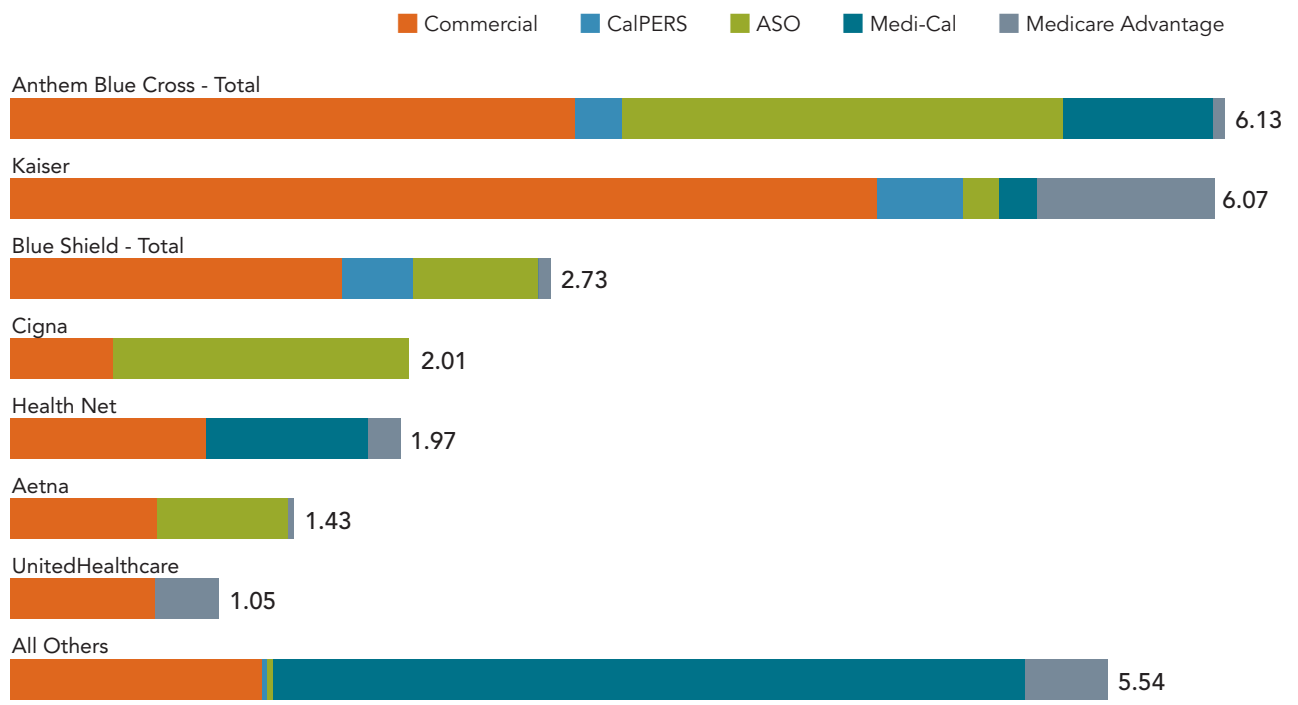
The table includes 14 of the 16 states discussed in the report. Although Connecticut and Tennessee explored coordinated purchasing activities, neither took steps toward implementation at the time of the interviews. Therefore, these two states are not included.

STATE	COORDINATED PURCHASING ACTIVITIES
Georgia	➤ Single pharmacy benefit manager (Medicaid, State Employee Health Plan [SEHP], and state university system) ➤ Common preferred drug list (Medicaid, SEHP, and university system) ➤ Common health plans (SEHP and university system) ➤ Single claims platform to serve all plans (state dropped the strategy as soon as it awarded the contract) (Medicaid, SEHP, and university system) ➤ Common management positions, such as chief financial officer (Medicaid, SEHP, and university system)
Kansas	➤ Common document-imaging software for workflow management (Medicaid, SCHIP, and SEHP) ➤ Common data warehouse (Medicaid, SCHIP, and SEHP)
Massachusetts	➤ Common requirement of health plans to move to global payment with providers (Medicaid and SEHP) ➤ Common health plan RFP content (marketplace and Medicaid) ➤ Multipayer medical home initiative (Medicaid and SEHP) ➤ Cost and quality challenge to health plans (Medicaid, SEHP, private employers via employer coalition) to achieve annual cost growth and quality improvement targets
Minnesota	➤ "Health cabinet" (Medicaid, SEHP, and other state entities) ➤ Common pay-for-performance strategy (Medicaid, SEHP, private employers via employer coalition) ➤ Use of eValue8, Leapfrog, transparency of cost for 100 procedures, creation of a Chartered Value Exchange,[16] Bridges to Excellence, and common performance metrics (Medicaid, SEHP, private employers via employer coalition) ➤ Performance targets through QCare[17] (Medicaid, SEHP, private employers via employer coalition) ➤ Common contract language (Medicaid and SEHP)
Mississippi	➤ Legislation passed to establish a joint purchasing pool (Medicaid and SEHP)
Nevada	➤ Joint RFP (Medicaid and SEHP) ➤ Common contractors for actuary and audit (Medicaid and SEHP)
New Mexico	➤ Common quality standards for immunizations across contracts (Medicaid and SEHP)
New York	➤ Nonpayment for certain potentially preventable readmissions, complications, and "never events" (Medicaid and SEHP) ➤ Drug pricing (procured but not implemented) (Medicaid and SEHP) ➤ Dental and vision services (Medicaid and SEHP) ➤ Wellness (i.e., incentives for health behaviors regarding obesity and chronic disease self-management for homeless beneficiaries) (Medicaid and SEHP) ➤ Common pay "bump" for Patient-Centered Medical Home Levels 2 and 3 (Medicaid and SEHP) ➤ Common actuary (Medicaid and SEHP) ➤ Provider network requirements and monitoring, as well as other health plan contractual requirements (Medicaid and marketplace)

STATE	COORDINATED PURCHASING ACTIVITIES
Ohio	➤ Fee schedule alignment (Medicaid and corrections system) ➤ Common strategic objectives across contracts (Medicaid and SEHP)
Oregon	➤ Common contract language to participate and report to patient safety commission, participate in electronic health records incentive programs (Medicaid and SEHP) ➤ Common RFP requirement, including for performance metrics, alternative payment with providers, and behavioral health/primary care integration (planned for October 2013 SEHP RFP) (Medicaid and SEHP) ➤ Employee with policy development authority for both state employee program and Medicaid (Medicaid and SEHP) ➤ Quality initiatives that are aligned around the Triple Aim and around the state authority's quality goals for delivery system transformation (Medicaid and SEHP) ➤ Common medical and pharmacy policy development (Medicaid and SEHP) ➤ Integration of customer service (including for grievances and complaints), provider relations, communications, and quality improvement and quality assurance functions (planned Medicaid and SEHP)
Rhode Island	➤ Health insurer affordability standards related to primary care investment, HIE support, and hospital contracting (Medicaid, marketplace, and health insurance regulations)
Vermont	➤ Shared call center, enrollment system, and agency staffing (marketplace and Medicaid)
Virginia	➤ Common requirement of MCO National Committee for Quality Assurance accreditation (Medicaid and SEHP)
Washington	➤ Common purchasing strategies such as service authorization, payment methodology, quality (early deliveries, cesarean sections), generics use, emergency department use reduction (Medicaid and SEHP) ➤ Common drug list (Medicaid, SEHP, Workers Compensation) ➤ Common health technology assessment process (Medicaid and SEHP) ➤ Policy staff that bridge programs (Medicaid and SEHP)

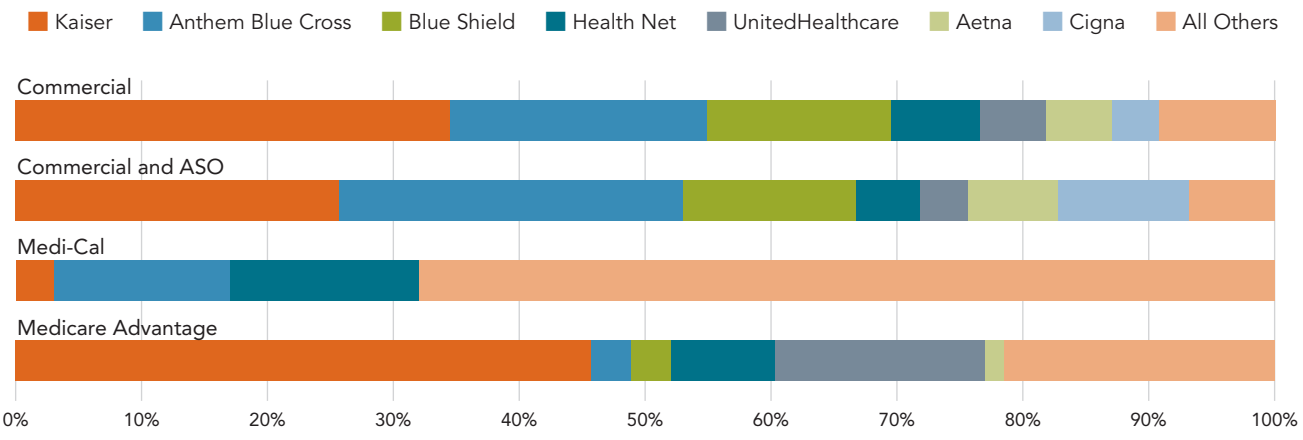
Appendix B: Health Plan Overlap Across California Insurance Markets

Figure 1. Lines of Business, by Carrier (in millions)



Notes: Commercial enrollment category excludes CalPERS enrollment (both insured and self-insured offerings), which is reported separately here. Administrative Services Only (ASO) enrollment excludes CalPERS self-insured lives and reflects AB 1083 reporting. Figures do not include Medicare Supplemental insurance, Healthy Families, or AIM enrollment.

Figure 2. Market Share for Business Lines



Notes: Market Share figures include CalPERS enrollment under the specific carriers. Figures do not include Medicare Supplemental insurance, Healthy Families, and AIM.

Sources (Figures 1 and 2): Analysis by Katherine B. Wilson for the California HealthCare Foundation based on AB 1083 Enrollment Reporting, for December 2012: California Department of Insurance, Covered Lives Report, www.insurance.ca.gov; Department of Managed Health Care, Enrollment Summary Report, adjusted to include Health Net Community Solutions enrollment (Medi-Cal), www.hmohelp.ca.gov; and CalPERS Health Benefits Enrollment Report, Basic Enrollment, March 2013.

Endnotes

1. In addition to California, the states included Connecticut, Georgia, Kansas, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, Ohio, Oregon, Rhode Island, Tennessee, Vermont, Virginia, and Washington.
2. State agency and PBGH interviewees were identified by CHCF staff. Interviewed health plans were jointly identified by the project researchers and CHCF, with the following criteria: (a) serving Medi-Cal and/or CalPERS enrollees, (b) geographic diversity, and (c) for Medi-Cal, representatives of County-Organized Health Systems, local initiative plans, and commercial plans.
3. M. H. Bailit and L. L. Burgess, *Group Purchasing: A Timely Strategy for State Medicaid Agencies* (Princeton, NJ: Center for Health Care Strategies, 1996).
4. *Health Care Services Common Interests,* Report to the New Mexico Legislative Health and Human Services Committee, New Mexico Human Services Department (November 1, 2009), www.insurenewmexico.state.nm.us.
5. The state changed course prior to implementation and did not proceed with the strategy as planned.
6. Ibid.
7. Scott D. Pattison, "Eliminating Silos in Government," Governing Blog, April 5, 2006, www.governing.com.
8. Greg Moody and Sharon Silow-Carroll, *Aiming Higher for Health System Performance: A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard: Minnesota,* The Commonwealth Fund (October 2009), www.commonwealthfund.org. Noting the tendency of Minnesotans to work together on cooperative ventures, a Commonwealth Fund report referred to the state as "the land of 10,000 collaboratives."
9. The California Physician Performance Initiative (CPPI) is a multi-stakeholder initiative to measure and report on the performance of California physicians. The work is being conducted by the California Cooperative Healthcare Reporting Initiative, a statewide collaborative of physician organizations, health plans, purchasers, and consumers that are working collectively to help consumers and purchasers make informed health care decisions.
10. "CMS Certifies California Organization to Collect and Disseminate Provider Health Care Data," California Hospital Association, last updated May 3, 2013, www.calhospital.org. The California Healthcare Performance Information System will combine Medicare and health plan insurance claims data to provide health care performance information. CHPI is managed by the Pacific Business Group on Health (PBGH), a consortium of CalPERS, Covered California, health plans, large businesses, and public employers. CHPI is funded through a grant from Blue Shield of California, PBGH purchasers' contributions, and support from participating health plans.
11. *Let's Get Healthy California Task Force Final Report,* "Let's Get Healthy California" Task Force (December 19, 2012), www.chhs.ca.gov.
12. "Establishing Health Insurance Marketplaces: An Overview of State Efforts," Kaiser Family Foundation, last modified May 2, 2103, kff.org.
13. "California Connected Announces Plans and Rates for 2014," Covered California, last updated May 23, 2013, www.coveredca.com.
14. "Core measure set" refers to a group of measures in common, but individual purchasers might choose to supplemental that core measure set to address issues of particular interest to the purchaser. For example, Medi-Cal might have reason to add measures specific to pediatric developmental testing and substance abuse screening due to the characteristics of the Medi-Cal population.
15. *Qualified Health Plan Contract for 2014,* Covered California, last modified May 21, 2013, www.healthexchange.ca.gov.
16. These were multi-stakeholder coalitions composed of health care purchasers, providers, health plans, and consumer advocacy organizations to advance what the Bush Administration defined in 2008 as the "four cornerstones of Value-Driven Health Care."
17. QCare was an initiative to improve quality and to control health care costs under Governor Pawlenty.