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Health Care Purchasing Authority (HCPA)

Executive Summary

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Minnesota Department of Employee Relations

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I. Introduction

Minnesota Session Laws 2005, Chapter 156, Section 47, requires the Commissioner of the Minnesota Department of Employee Relations (DOER), in consultation with other state agencies, to report to the Minnesota Legislature on the creation of a "Health Care Purchasing Authority" (HCPA) responsible for "all state purchasing of health care." The study legislation also allows state agencies to enter into interagency agreements regarding formation of the HCPA.

This report is being submitted in compliance with the statute. It describes several options for the creation of an HCPA, for review and consideration by the Legislature and to contribute to additional dialog on the topic of Health Care Purchasing Authority (HCPA) and related health care reform.

The HCPA study legislation also includes a number of additional provisions regarding the HCPA itself. These provisions have been addressed within the scope of the study charge, recognizing the need for pending legislative review and response to this report regarding the initial step of creating a HCPA.

One such HCPA-specific requirement is that the HCPA define a "secure benefit set" providing coverage for preventive care, prescription drugs, and catastrophic coverage. The HCPA legislation authorizes the secure benefits set to be made available to public sector employers through an existing voluntary health insurance pooling arrangement known as the Public Employees Insurance Program (PEIP), as well as to others in the future. DOER administers PEIP and is forwarding a report on the secure benefits set concept under separate cover to provide information and to facilitate discussion of the secure benefit concept as part of the broader legislative consideration of the HCPA.

II. Study Methods

As required by the study statute, DOER met with commissioners and staff of the following state agencies: Health; Human Services; Labor and Industry; Corrections; Commerce; and Administration. In addition, DOER met with the Commissioner and staff of the Department of Finance and the Director of the Minnesota Comprehensive Health Association.

The interagency effort produced a series of inventories of current state purchasing activities, purchasing functions and support, and health care quality measurement and quality assurance activities. These inventories were important to better understand the scope of state health care involvement and to help in exploring possible new connections and synergies. The interagency dialog also provided a forum for the exchange of views, expertise, and real-world experience as well as a sounding board for ideas and options. In addition, the study included reviews of other related studies and reports, contacts and meetings with other counterparts and experts, and participation in both local and national relevant conferences. DOER also met with its contracted actuarial and benefits consultants, Deloitte Consulting LLP, regarding the secure benefit concept.

III. Study Backdrop and Focus

A number of challenges and developments form an important backdrop to the study and have shaped and focused it, including:

- Continuing concerns about high and rising health care costs, despite some recent moderation in rates of cost growth;
- A broad, national awareness of massive underperformance of the US health care system, marked by variable and sometimes poor quality, with a growing call for significant restructuring of how health care is delivered and paid for;
- Recent efforts and developments in Minnesota's health care market and in state government to address the problems above through greater transparency of health care costs and quality, and through efforts to align and reinforce incentives to bring about desired change and improvements.

Given this backdrop, the HCPA study legislation makes important references to achieving "unified", "joint", and coordinated health care purchasing by state government. To date, these objectives have often been considered in terms of pooling various state groups -- such as state employees, enrollees of public programs like Medicaid, and others – to gain leverage in negotiating discounts with health care providers, and for achieving administrative cost savings through economies of scale.

However, in practice it is often difficult to implement such pooling arrangements because of differences in the covered populations and different federal and state regulations that may apply. There may also be differences in administrative and service delivery system requirements, with differing organizational or operational expertise and capabilities, and varying competing demands and responsibilities. Cost savings may be relatively low or temporary, or may accrue largely from cost shifts to other groups with less leverage, such as small employers and persons purchasing individual coverage. Rarely will such strategies alone lead to the large scale changes now called for in well-known, well-received national studies such as the national Institute of Medicine's 2001 landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*.[1]

Crossing the Quality Chasm, and an equally well-known predecessor report, *To Err Is Human: Building a Safer Health System,* documented significant shortcomings in the American health care system. *Crossing the Quality Chasm* concluded that "Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm." The report stressed that bridging the chasm demands "a fundamental, sweeping redesign of the entire health care system" that will "require changing the structures and processes of the environment in which health care professionals and organizations function."

Crossing the Quality Chasm also stressed that health care purchasing and payment practices need to be redesigned to help create incentives for change. The report recommended building "stronger incentives for quality enhancement" and payment methods that:

> *"provide an opportunity for providers to share in the benefits of quality improvement, provide an opportunity for consumers and purchasers to recognize quality differences in*

[1] Crossing the Quality Chasm: A New Health System for the 21st Century (2001), IOM. An online version of the report is available at the National Academies Press website at http://www.nap.edu/books/0309072808/html/. Citations from *Crossing the Quality Chasm* used in this HCPA executive summary report are from a shortended .pdf summary listed as "PDF Brief" at http://books.nap.edu/catalog/10027.html.

health care and direct their decisions accordingly, align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes, and enable providers to coordinate care for patients across settings and over time."

As a result of many inherent limitations of a primarily discount-driven or price-driven strategy, and because the HCPA legislation itself does not specify such a strategy, this study has focused on the broader issue of bringing about more fundamental and sustainable changes in health care. As detailed in *Crossing the Quality Chasm*, the hallmarks of a better, more cost-effective, higher quality health care system include:

- greater transparency of health care costs and quality to aid decision making and improvement; and
- aligning incentives to ensure that the health care system is accountable for greater results and value.

In practice, this means an HCPA capable not only of exerting its collective purchasing "muscle", but more importantly, exercising a new level of "brainpower" that is information rich, incentives-oriented, and quality and outcomes focused. The ideal Health Care Purchasing Authority would be one in which the whole is greater than the sum of the parts, acting together in well planned, well choreographed movements to bring about the reforms described in *Crossing the Quality Chasm*.

The State has a unique opportunity and can play a valuable role in helping achieve the system reforms envisioned in *Crossing the Quality Chasm*. It is a major health care purchaser and market force, directly purchasing on behalf of more than 780,000 residents, or approximately one in seven Minnesotans – at annual costs totaling more than $4 billion. Two primary components of state health care purchasing in particular, health benefits for state employees and their families, and public programs such as Medicaid and MinnesotaCare, have unique potential to catalyze change.

State public program health expenditures are a major, rapidly growing, visible budget item receiving considerable legislative, consumer, taxpayer, and media attention. Public program decisions and operations affect virtually all health care providers and a significant cross-section of all Minnesotans statewide. State employee health benefits are also not only a significant budget expenditure in their own right, but have historically been a source of innovation that has attracted wide local and national attention and health market response. For example, the state employee health benefits program was an early example of the "managed competition" concept of offering employees choices of competing health plans, and recently received a national "Innovation in State Government" award for its introduction of a unique tiered benefit program.

Efforts to further coordinate state health care purchasing and bring about the other reforms outlined in *Crossing the Quality Chasm* through a HCPA will also need to consider changes already occurring in the market and in state government. Market pressures, increasing consumer and purchaser demand, and provider responses to concerns raised in *Crossing the Quality Chasm* and other related studies reports have had an impact. Minnesota has recently made important strides in providing greater transparency of health care costs and quality to consumers, purchasers, and health care providers. In the last year alone, important new standard, comparative measures of health care provider performance have provided a wealth of previously unavailable information on performance of Minnesota's health care system. Examples of recent health care measurement and reporting include: a public report on health plan performance, based on a new tool called "eValue8"; MN Community Measurement reports

on key quality indicators of performance of clinic systems representing over 700 clinics around the state; and public reporting of "Adverse Events" at Minnesota hospitals.

At the same time, a Governor's Health Cabinet was recently formed to bring all state agencies with health care purchasing responsibilities together to identify best purchasing practices and ways of acting more in concert to align and reinforce incentives for delivering higher value health care. The concept was later broadened to include the private sector, with the formation of the "Smart Buy Alliance" comprised of public and private sector purchasers representing nearly sixty percent of Minnesotans, working together to adopt common strategies and practices to improve the value of health care received.

IV. Health Care Purchasing Authority Options and Approaches and Discussion

This study focused on developing options for legislative review and consideration regarding a Health Care Purchasing Authority to more fully coordinate and direct Minnesota state government's health care purchasing. It is important that the options be considered in line with the system reform objectives such as those outlined in *Crossing the Quality Chasm*, and with Minnesota's unique health care environment at this time.

A continuum of four types of options was developed to illustrate different approaches and various tradeoffs to creating a state Health Care Purchasing Authority. The options reflect divergent views and experiences, both within state government, and in the relevant literature and in practice. Some key variables and tradeoffs distinguishing the options include:

- The mechanisms or approaches used to coordinate and choreograph state health care purchasing;
- The amount of government restructuring and reorganization required;
- Anticipated costs, complexity, and time requirements of any changes;
- Perceived benefits and impacts; and,
- Feasibility and practicality of the options.

The four types of options with a number of respective perceived benefits and limitations are briefly summarized below. Each option would also have responsibilities for the development and availability of the "secure benefit concept" described in the study statute, and briefly noted above.

Option A – A new "cabinet level agency" HCPA

Some argue that in order to accomplish a truly integrated and coordinated model of state health care purchasing, with similar goals and incentives for maximum system response, requires a single new overarching cabinet-level agency with responsibility for all state health care purchasing policy and management of operations. Under this scenario, state government would be restructured to bring most or all existing state purchasing responsibilities and activities together "under one roof", with a single new management and oversight.

As envisioned, the new agency and its management would have wide-ranging state health care purchasing responsibilities for most or all state covered populations, ranging from state employees to public program enrollees to state correctional system inmates and others. The new agency would centralize and directly administer most or all aspects of:

- Setting specifications and objectives in contracting with providers and vendors;
- Contract and performance management;

- Design and implementation of administrative systems and support;
- Data and information processing, and analysis;
- Health care quality and performance strategies and measures; and,
- Purchasing support (e.g., actuarial, legal, data-analytic, and other services, whether provided internally or by contracts).

It could also potentially have responsibility for overseeing and administering most or all:
- Billing and enrollment system(s);
- Member information, communications, and support system(s); and,
- Claims adjudication and payment.

Perceived benefits
- Eliminates existing agency and program-based health care purchasing "silos"
- Ensures more uniformity of state purchasing policy and operations
- Eliminates or streamlines redundant activities to achieve administrative savings
- Creates a single, direct path to the Governor and a more direct chain of accountability for activities and results

Perceived limitations
- Requires significant restructuring
    - Initial estimates of movement of 80-400 state staff, depending on scope and activities of new agency
    - Considerable cost for reorganization
        - Facilities
        - Communications and IT technical infrastructure
        - Personnel issues
        - Communications and relationships with stakeholders
    - Considerable time and energy to reconfigure
        - Upwards of 1-2 years
        - Ability to focus on purchasing improvements and incentives for system-wide change during changeover period?
    - Would create another bureaucracy
        - Guarantees that new agency perform more efficiently or effectively than other bureaucracies?

Option B: "Utility" HCPA

This option assumes a much more limited, targeted reorganization and creation of a special health care purchasing "utility" function. The new utility function would serve as a central clearinghouse of high level technical and professional expertise to help guide and advise other state agency purchasing functions. In concept, the utility would be developed to both recommend best purchasing practices, as well as to review and work with agencies regarding purchasing activities to be consistent with best practices and overall state-wide health care purchasing goals. The utility is not viewed as an independent cabinet-level agency, but a special resource within an existing agency. The utility would likely have an executive director for management and relations with other senior staff and agency heads, as well as eight to ten senior level staff with specializations in areas of medical director, analyst, actuary, quality and performance measurement, and other disciplines.

Perceived benefits

- Agencies with purchasing responsibilities would have a single source of review, expertise, and guidance to help keep their efforts aligned with overall goals and strategies
- Little time-consuming or costly reorganization
- Potential to eliminate or streamline some redundant activities and achieve some administrative savings

Perceived limitations

- Limited staffing and resources – potentially limited ability to respond to agency needs
- Potentially limited ability to directly influence agency purchasing practices and strategies and to establish compliance with overall goals and objectives

Option C: Interactive HCPA

Option C is analogous to the current Governor's Health Cabinet. It would provide a vehicle for bringing state agencies with health care responsibilities together as a special standing group to collectively develop and implement health care purchasing strategies of broader interest. Under the existing Governor's Health Cabinet arrangement, the Governor has named one agency head to chair a special sub-cabinet made up of the existing agencies with health care responsibilities. The group meets on a regular basis, or is convened at the call of the chair or as otherwise needed, to identify best purchasing practices, and strategies and opportunities to implement the best practices in concert. Participating agency heads also draw upon and bring together agency staff and outside resources as in-kind support to the effort. The Health Cabinet is also engaged in similar broader efforts with private sector counterparts through the Smart Buy Alliance.

The Health Cabinet has provided forums and a vehicle for stakeholders to meet with and communicate directly with the state's key health care purchasers and regulators. It has created a single clearinghouse for health care quality and cost information for use within state government and the general public. With the Smart Buy Alliance, it has called for health plan participation in a standard, comparable measure of health plan performance known as eValue8, which was completed and made available in a report to the public. It has also called for and supported other forms of recent standard, comparable, public disclosure of health care provider performance, including Adverse Event reporting of hospital-based adverse patient events and MN Community Measurement reports on performance of clinic systems representing over 700 Minnesota clinics.

Perceived Benefits

- Engages existing agency heads with expertise and authority in state health care purchasing and regulation in mutual problem solving and arriving at more uniform and cohesive purchasing strategies
- Uses existing resources
- Potential to eliminate or streamline some redundant activities and achieve some administrative savings
- Does not require reorganization or restructuring
- Can generally act based on existing authority and organization

Perceived Limitations

- Does not eliminate agency and program silos
- Based on voluntary cooperation, shared efforts, consensus among agencies

- Resources are limited to those currently available and in use for other purposes and priorities as well

Option D: Functionally focused HCPA

This option envisions a set of working relationships similar to those in the "Interactive" model above, but would be specifically focused only on a limited, pre-selected, specific set of high priority functions or desired changes and improvements. For example, the rise of obesity and diabetes-related conditions is rapidly reaching epidemic proportions and is affecting all state health care programs and purchasing. The functionally focused version of an HCPA would draw together agency heads with health care responsibilities to develop and implement common approaches aimed at greater diabetes awareness, prevention, improved treatment, and better outcomes. A similar type of emphasis might be to foster and accelerate the use of interoperable health Information Technology (health IT), to reduce errors in patient care, provide up-to-date patient information to aid diagnosis and treatment, and to reduce burdensome, expensive paperwork and administrative hassle factors throughout the health care system.

Perceived Benefits
- Engages existing agency heads with expertise and authority in state health care purchasing and regulation in mutual problem solving and arriving at more uniform and cohesive purchasing strategies
- Maintains tight focus on highly visible, high priority areas
    - Helps avoid "mission creep" and having too many objectives and insufficient time or resources to accomplish them
    - Limited, targeted focus easier to communicate, engage with stakeholders and the public
    - Performance of HCPA is easier to assess if targets are limited, narrow, focused
- Uses existing resources
- Potential to eliminate or streamline some redundant activities and achieve some administrative savings
- Does not require reorganization or restructuring
- Can generally act based on existing authority and organization

Perceived Limitations
- Does not eliminate agency and program silos
- Based on voluntary cooperation, shared efforts, consensus among agencies
- Resources are limited to those currently available and in use for other purposes and priorities as well

Discussion

The options above were provided to help illustrate an array of possible Health Care Purchasing Authority structures and relationships. Based on the work of national groups like the national Institute of Medicine, and its landmark *Crossing the Quality Chasm* report, key determinants of success in any HCPA option will be the degree to which any restructured, refocused state health care purchasing:
- Leads to greater transparency and accountability for health care costs and outcomes;
- Identifies, aligns, and reinforces the correct incentives to bring about maximum improvements in patient care and outcomes in the shortest time.

None of the options alone can guarantee success in reaching these goals. For example, the "Single Agency" option (Option A above) offers the advantage of bringing all the component parts together under a single line-authority leadership structure to help ensure that the parts are working in tandem for maximum impact. However, as discussed above, creating such an entity would likely require considerable time, effort, and expense. During its formation, attention and resources may be less available to address the underlying root problems of poor health care performance. Establishing line authority back to a single designated agency head for all state health care purchasing will be only as effective as the individual links in the chain and the agency leader. As many corporations have recently seen, from car manufacturers to airlines, even the best, strongest line-authority structures and leaders are often not sufficient to survive or manage the type of sea change considered necessary in health care.

The converse – working within existing agency structures and responsibilities – provides opportunities to coordinate already available resources and staff to quickly "hit the ground running." However, this arrangement is more ad hoc than the creation of a new single agency HCPA, and questions remain as to how such a model would remain cohesive and on track in the face of changing priorities, personnel, and budgets.

Regardless of the HCPA option selected, it will be important that the same standards and expectations desired for the health care industry and health care supply chain – for transparency and accountability, and for correctly aligned and reinforcing incentives to bring about maximum performance improvement – be developed and applied to state health care purchasing as well. The state's success in rapidly addressing one of its largest, fastest growing budget areas to the benefit of all Minnesotans may ultimately be less a function of the way an HCPA is organized and structured, and more determined by:

- High expectations and goals;
- The degree to which there is faster adoption of innovations already proven to work in other agencies or sectors;
- Demands for transparency and accountability for the state's performance as a health care purchaser, with standard, comparable measurement and reporting of progress toward goals; and,
- Consequences for poor performance in reaching goals, such as budget and other implications.

These are many of the same types of tools and incentives that are needed to help reduce health care costs and improve quality. Minnesota state government can most effectively position itself to help achieve these goals if it too takes some of the same strong medicine.