MEETING SUMMARY
Minnesota Health Care Transformation Task Force
August 16, 2007   9:00 a.m.–12:30 p.m.

Attendance

Task Force Members:

Representative Thomas Huntley, Co-Chair
Commissioner Cal R. Ludeman, Co-Chair
Peter Benner
Senator Linda Berglin
Charles Fazio
Thomas M. Forsythe
Michael Howe
Carolyn Jones
Sean Kershaw
Paula Klinger
Tony Miller
Charles Montreuil
Maureen Reed
Senator Julie Rosen
David Wessner
R. Scott Wright

Staff:

James Golden
Scott Leitz
Harold Miller
Julie Sonier

Goals and Focus for the Meeting

Three goals were defined for the meeting:

1. Developing a shared understanding of how the current health care system does and does not work for populations that consume a lot of resources;
2. Formulating an initial framework for a shared vision of how the system should work and the kinds of changes needed to achieve that; and
3. Identifying some of the key implementation challenges and their political/economic implications, and options for overcoming those challenges.

Congestive Heart Failure (CHF) and Diabetes were used as two examples around which to focus the discussion. They were selected as examples because individuals with

these conditions use the majority of current health care resources, spending for these conditions is increasing, and Minnesota has been a leader in improving care for these conditions. Moreover, diabetes is a precursor to congestive heart failure, so preventing or reducing the severity of diabetes can reduce spending on both diabetes and congestive heart failure.

A Framework for Thinking About Health Care Costs

A basic mathematical model describing the variables affecting health care costs was presented to help guide the Task Force's thinking about ways to control costs.

Total health care costs represent the sum of the costs of treatment for each individual condition or disease affecting individuals, and the costs of treatment for each individual condition are affected by (1) the total number of people in the population, (2) the proportion of people who have the condition, (3) the proportion of the people with the condition who are treated, (4) the number of services per year received by people treated for the condition, and (5) the average cost for each service received as part of the treatment.

VARIABLES CONTRIBUTING TO HEALTH CARE COSTS

$$\text{Health Care Costs} = \sum_{\text{conditions}} \left[\#\ \text{People} \times \%\ \text{with Condition} \times \%\ \text{Treated} \times \#\ \text{Services Per Person Per Year} \times \text{Avg.Cost Per Service} \right]$$

An increase or decrease in any one of the factors can affect total health care costs. For example, as the population of Minnesota increases, health care costs will increase; as the population ages, more people will develop chronic diseases, and as awareness about chronic diseases increases, a higher percentage of people will seek treatment, also increasing costs. A reduction in the number of services per person or the cost of services will reduce health care costs.

In addition, however, the factors are often interdependent. For example, even if the number of services per person per year is reduced, health care costs may still increase if the average cost per service increases. Efforts to treat diseases more effectively may result in an increase in the percentage of people treated for that disease or in the number of people treated for a precursor (e.g., reducing the number of heart failure patients may require an increase in the level of treatment of people with diabetes), which can increase health care costs.

In order to cut health care costs by 20%, one or a combination of these factors, either for all conditions or for the conditions involving the largest costs, will need to be reduced significantly, and in order to restrain growth in health care costs over time, the rate of growth in the (controllable) factors will need to be limited.

Summary of Discussion

The Task Force discussed a demonstration project undertaken by Park Nicollet Health Services to reduce hospital readmissions among people with congestive heart failure. There was general agreement that this kind of approach to caring for patients with chronic illness was a desirable way that health care costs could be reduced and health care quality could be improved. The Task Force discussed how projects such as this could be continued, expanded, and replicated, and how to translate the reduction in utilization of high-cost services into permanent reductions in health care costs.

In the course of the Task Force's discussions, a number of ideas, issues, and options were discussed. These are framed below as Potential Transformation Principles, Issues, and Options. These will be discussed in more detail at future Task Force meetings before any final decisions are reached.

Potential Transformation Principle I: Health Care Payment Systems Should Support Higher Quality, Lower Cost Care for People With Chronic Diseases

There was general agreement that the major impediment to improving care and management of patients with chronic diseases was that current health care payment systems:

- do not directly cover the kinds of services which are essential to improved disease management, such as making telephone contacts with patients, using nurses and nurse practitioners to educate and monitor patients, purchasing basic monitoring equipment (e.g., scales for heart diseases patients to weigh themselves on), etc.; and
- do not give providers incentives to keep patients healthy (indeed, they actively discourage them from keeping patients healthy) or to reduce the number of services, particularly expensive services, provided to patients.

A number of specific issues and options for improving payment systems were discussed, including:

Issue 1: Should payment systems measure and reward performance based on processes or outcomes?

The Task Force discussed several options for how payment systems could measure and reward performance:

Option 1a: Pay based on a provider's success in complying with processes defined in clinical practice guidelines.

Option 1b: Pay based on both a provider's success in complying with processes defined in clinical practice guidelines and on the provider's success in achieving desirable outcomes for patients. (For example, a reward pool could be established, and distributed to providers based on the relative outcomes they achieve.)

Option 1c: Pay primarily or solely based on a provider's success in achieving desirable outcomes for patients.

Option 1d: Pay initially based on a combination of process and outcomes, but transition to a system based primarily or solely on outcomes as quickly as possible.

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- Pay-for-process incentives could be based on the percentage of time that providers deliver the best care as defined in ICSI guidelines.
- If the best provider is only providing good care 22% of the time, is that good enough to be rewarded?
- Providing the best quality care according to guidelines may not result in cost reductions.
- The desired outcome for patients is better health; health care is merely a mechanism for getting there.
- Some of ICSI's guidelines define health care process measures, not patient health outcome measures.
- Paying based on whether providers implement specific processes has the potential to stifle innovation and rigidify current practices.
- No interventions work in 100% of cases, and no one knows all of the factors affecting outcomes, so variation in outcomes across providers is inevitable.
- In order to use either process- or outcome-based performance standards, there needs to be an appropriate mechanism of risk adjustment. If a successful program attracts sicker patients, its measured outcomes may get worse.
- Risk adjustment can potentially create an undesirable incentive to make patients sicker in order to increase payment.
- Outcomes need to be clearly defined, e.g., are reductions in hospital readmissions due to increased mortality, a shift to other hospitals, or a true reduction in utilization of services?
- A combination of process and outcome measures can give all providers an opportunity to improve.

- A method for facilitating the transition from pay-for-process to pay-for-outcomes is needed.
- Patient satisfaction as well as expenditure-related outcomes should be considered.
- Who should define the outcomes to be rewarded, consumers or policy-makers?
- Under fee-for-service payment systems, costs may increase in the short run if compliance with processes goes up.
- An outcome-based focus may facilitate adoption by payers, since it increases the probability of improved health and reduced costs.
- Some outcomes are immediate, but some can only be measured over a long period of time.
- There is a British model based on outcomes – how is it working, and is it costing more than expected?
- How can we get poor performers to improve faster?
- Some differences in provider performance may be due to differences in the communities they're serving (e.g., differences in smoking rates by provider may be due to differences in smoking rates in the communities they are serving).

Issue 2: **Should payment be made based on delivery of specific services, based on a course of treatment to achieve specific outcomes, or based on the delivery of all treatments needed to maintain health for an individual?**

In addition to the issue of rewards for performance discussed in the previous issue, a closely related, but separate issue is the extent to which payment systems should define the specific services for which providers will be paid and the amounts that will be paid for each, or whether payment should be made for a "package" or "bundle" of services designed to achieve certain outcomes. At least three different options can be considered:

Option 2a: Pay providers a fixed amount for each specific service offered to a patient, and define which services will and will not be paid for. This is similar to the current fee-for-service system used to pay physicians and to pay hospitals for outpatient care. (A performance bonus or penalty based on processes or outcomes can be paid on top of these service-based fees.)

Option 2b: Pay providers a fixed amount to cover all of the services needed to treat a patient for a particular condition. For acute care, this is similar to the current DRG payment system used to pay hospitals for inpatient care, and is generally referred to as "episode of care" payment. For patients with chronic illnesses, this is similar to what

is called "condition-specific capitation" payment. (A performance bonus or penalty based on processes or outcomes can be paid on top of this amount. For example, the provider could be paid a fixed amount per member per month for all of the care required for an individual's chronic disease, and then a reward pool could be distributed to providers based on risk-adjusted outcomes.)

Option 2c: Pay providers a fixed amount to cover all of the services needed to treat a patient for all of their conditions. This is similar to what is generally called "(full) capitation" payment. (A performance bonus or penalty based on processes or outcomes can be paid on top of this amount.)

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- Current payment systems and benefit designs generally do not authorize payment for the kinds of services used in successful disease management programs.
- A system that pays on a service-by-service basis has to define what the essential elements of successful programs are.
- Each of the options requires a clear definition of which individuals (i.e., patients) are eligible for the services/payments.
- Providers are reluctant to take on the risk associated with a capitation-type system.
- Minnesota has dual-eligible seniors in capitated programs now; why can't that be extended to other populations?
- Is it possible to have a truly outcomes-based payment system that is not structured using episode-of-care or condition-specific capitation payment?
- Payment systems should incorporate a profit incentive for providers to deliver care well and improve outcomes.
- Providers may need to make an upfront capital investment to initiate a new program; should the risk of a return on that investment be shared with the payer?
- Some programs that will improve outcomes and save money in the long run will increase operating costs in the short run; should payment levels increase in the short run to cover that, and who should take the risk as to whether costs will be reduced in the long run?
- Both payment systems and providers need to be more integrated, since patients have multiple conditions that need to be managed in a coordinated way.
- Health plans provide some disease management services now; should these be shifted to providers?

- Does condition-specific capitation require a consumer to be "locked-in" to a particular system, which consumers find undesirable? Are there good models of condition-specific capitation systems?
- Patients would need to be educated about a transition from the current pay-for-visit model to a system based on payment for a course of treatment.
- The payment system needs to be structured in a way that promotes health with fewer services.

Issue 3: Should patients be given financial incentives to adhere to provider-recommended actions that affect process and outcome measures?

Task Force members noted that improving performance on outcomes, and even on many process measures, depends on patient cooperation, commitment, and ability as well as the actions taken by the provider. Two different options were discussed:

Option 3a: Encourage patients to adhere to provider-recommended actions by explaining the benefits to them in terms of improved health, but do not provide financial incentives to patients for adherence.

Option 3b: Provide financial incentives to patients based on their adherence to recommended process measures.

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- The Park Nicollet intervention project didn't include any incentives for participation by patients. It's unclear how many of the patients in the Park Nicollet intervention refused to participate or cooperate with the care management process, or whether an even larger reduction in readmissions might have been achieved with greater participation.
- It is unclear whether and how much financial incentives will improve patient adherence.
- Ideally, a disease management program should be "portable," so that a patient can switch providers and still be able to participate.
- Some providers may be better at eliciting patient compliance, and it may be possible for other providers to learn from them.

Issue 4: Should there be differences in payment structures for urban vs. rural areas, and for large vs. small providers?

The Task Force members noted that there were differences between urban and rural areas, and between large and small providers, that could affect the ability to implement changes in payment systems. For example:

- Providers in urban areas are inherently able to do higher volumes of procedures, which has been shown to improve outcomes.
- Larger providers are more likely to have Electronic Medical Record (EMR) systems.
- Smaller providers will have smaller numbers of cases, which will result in greater volatility in outcomes (since a single outlier case will significantly affect averages).

This suggested two different options for further consideration:

Option 4a: **Payment structures should apply equally to all types of providers and all parts of the state.**

Option 4b: **Payment structures should be adapted to reflect differences in the size and types of providers in different areas, e.g., through demonstration projects in specific areas.**

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- There are providers in more rural areas of the state and the rest of the country that have demonstrated leadership in quality and costs, so one should not assume that rural areas will have lower quality.
- Since the best approach to many aspects of payment reform is not known (not just the impacts on rural areas and small providers), it may be preferable to conduct demonstrations of alternative payment systems in specific geographic areas before implementing them statewide.

Issue 5: Do all or most payers need to agree on a different payment structure?

The Task Force discussed the fact that if a method of providing care provides better outcomes, it should be applied to all patients who can benefit from it, regardless of who their payer is. But if only one payer supports the change in care, the provider may be financially unable to implement it.

Option 5a: **A single large payer is sufficient to initiate improved payment systems.**

Option 5b: **A majority of payers need to change payment systems in order to make them viable.**

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- Is it feasible to get multiple payers to agree to pay differently?
- It may be particularly difficult to get Medicare to pay differently; should initial changes be focused on younger populations?

Potential Transformation Principle II: A Combination of Collaboration and Competition Should Drive Improvements in Health Care Quality and Costs

The Task Force felt that an improved payment structure was necessary, but not sufficient, to transition health care providers to more efficient and effective approaches to providing care. Moreover, clinical practice guidelines and greater transparency are also not sufficient; Minnesota has been a national leader in the collaborative development of clinical practice guidelines through the Institute for Clinical Systems Improvement (ICSI) and in publishing information on provider performance through Minnesota Community Measurement, but this has not been sufficient to truly transform the health care system.

There was general agreement that in order to achieve the desired transformation, the health care system needed to be driven more by the kinds of competitive forces that exist in other industries. However, there was also agreement that there is value in collaboration among health care professionals in advancing the state-of-the-art in knowledge about the best ways to achieve improved outcomes.

It was proposed that both collaboration and competition be fostered by encouraging collaboration in defining what is required for quality care, and by encouraging competition in the execution of quality care delivery:

Potential Transformation Principle IIA:

Encourage collaboration among health care providers to determine the ideal care that should be delivered in order to achieve good outcomes; and

Potential Transformation Principle IIB:

Foster competition among health care providers to achieve the most efficient and effective execution in delivering ideal care.

Two specific issues were discussed regarding how to implement these principles:

Issue 6: How should providers be encouraged to develop new approaches to care and/or lower prices?

The Task Force discussed one approach – issuance of an RFP – to encouraging innovation and competition, along with some variations on that approach:

Option 6a: Payers should issue Requests for Proposals to providers, asking them to propose packages of services and prices to provide care for specific populations or diseases/conditions, and then payers should select the proposals that offer the best value.

Option 6b: Payers should issue Requests for Proposals to providers, but should also hold a conference of potential provider respondents to discuss the desirable elements of benefit design,

care delivery, and patient incentives before proposals are prepared and evaluated.

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- The RFP approach should initially be pursued with a non-Medicare population (e.g., diabetics).
- Should the "packages" of care be disease-focused, or patient-focused?
- It's not clear what would be accomplished in the provider conference beyond what ICSI is currently doing.
- The key thing is to foster competition in how to improve execution, since that's where the variance is.
- Will bringing providers together to discuss common approaches violate antitrust rules?
- Anti-trust rules are less of a barrier than they are represented to be.
- It's important for the provider's proposal to clearly define both the up-front investment and the expected return-on-investment (ROI).
- The RFP process should be tested in pilot markets before attempting a statewide rollout.
- The providers' responses should include the types of patient incentives needed.
- The RFP approach will symbolize a more business-like approach to health care provision.
- We need to look at non-health care models, e.g., auto safety and auto insurance, to transform the health care system.
- Minnesota hasn't really funded innovations in how to improve execution
- Should the packages that providers propose be disease-specific, or patient-focused?
- Many/most providers don't understand their own cost structures well enough to reprice services properly.
- Providers find it too hard to try and renegotiate pricing separately with multiple payers.
- Providers view ROI as "increased revenues," not "reduced costs."
- Don't let the perfect be the enemy of the good. Encourage providers to develop and try new approaches that are better than the current system and let the approaches be improved over time.

Issue 7: How should patients be encouraged to choose lower-cost, higher-quality providers?

Task Force members generally agreed that because the key decisions generally occur at the "retail" level, i.e., between consumers and providers, there needed to be better ways of encouraging patients to use lower-cost, higher-quality providers. Options include:

Option 7a: Give patients information on how differences in quality and outcomes between providers will translate into cost differences for the patient over time (e.g., higher co-payments for additional treatments needed in the future).

Option 7b: Require patients to pay more to use lower quality/higher cost providers, e.g., require the patients to pay the differential between the price of the provider they want to use and the price of providers with lower cost and equivalent or higher quality.

Option 7c: Give patients a fixed amount of money and let them choose which provider/program to use.

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- The only way to tap into competitive forces is to provide ways of comparing providers and let patients choose.
- Better data on both outcomes and costs will be needed to enable patient incentives to work.
- The consumer ultimately pays for health care anyway.

Potential Transformation Principle III: Mechanisms Are Needed to Ensure That "Savings" in Payments For Treatment Result in Net Reductions in the Total Cost of Health Care, and the Community Needs to Be Prepared for a Transition to a Health Care System That Costs 20% Less

The Task Force members discussed the fact that reducing *payments* to providers would not necessarily reduce the *costs* of providers. Most of a provider's costs are fixed in the short run, and it is often easier for a provider to try and increase utilization of other services to make up losses in revenues rather than reduce their underlying costs of operation. The health care cost equation described earlier is like a balloon – if you squeeze it at one end, it may just get bigger at the other end, with no net reduction in total costs. A chart presented at the Task Force's first meeting ("The Sad History of Health Care Cost Containment as Told in One Chart") demonstrates that in the past, cost reductions have tended to be temporary, partly because providers have successfully found ways to increase utilization or prices in order to offset cuts in payment.

As a result, it may be necessary to explicitly discuss and educate people about what the health care system may look like if it costs 20% less. For example, will there be fewer nurses? More primary care doctors and fewer specialists? Fewer hospitals? Lower salaries for health care professionals? Both providers and communities will need to begin making the changes needed to transition to a health care system with lower, and more slowly increasing, costs.

Some options which could be considered for transitioning to a less costly, higher quality health care system include:

Option 8a: Use market forces to transition the system, but get the incentives right so the market is achieving what is desired.

Option 8b: Encourage providers to become more specialized in the services where they can provide the highest quality and lowest cost (e.g., specialty hospitals vs. general hospitals).

Option 8c: Encourage low-quality, high-cost providers to go out of business.

Option 8d: Create greater accountability among providers for reducing costs in response to reduced payment.

Option 8e: Reduce the costs of doing business for health care providers, e.g., lower administrative costs, lower malpractice insurance costs.

Points raised by the Task Force members regarding this issue and the options for addressing it included:

- There has been success in reducing costs and increasing accountability for maintaining lower costs in the area of imaging; this could be extended to other areas.
- Some services that are more generously paid subsidize other services that are underpaid; the pricing for all services needs to be “right” so that good decisions about value, specialization, etc. can be made.
- Significantly reducing costs in the health care system is analogous to the transformation that was required in public school systems to accommodate fewer students, including closing and consolidating schools.

Other Issues

Commissioner Ludeman and Scott Leitz reminded the Task Force that the Robert Wood Johnson Foundation had selected Minnesota to participate in its State Coverage Institute. The state’s Team would be participating in a 3-day meeting in Chicago on September 26-28. The State Coverage Institute staff were making a site visit to St. Paul

immediately following the Task Force meeting, and Commissioner Ludeman encouraged any Task Force members who could attend the site visit to do so.

Topics for Future Meetings

The Task Force agreed that it would discuss the issues and options further at its next meeting, and would also examine the payment and delivery issues related to prevention of illness as well as treatment of illness. The Task Force asked that models from other states or countries similar to the options discussed and any research available on the issues discussed be identified and made available to the Task Force.

The Task Force discussed a draft list of topics for its future meetings, currently scheduled for September 17, October 22, November 19, December 3, December 10, and January 7. In addition to the topics listed in the draft, the Task Force members suggested the following topics:

- Affordability of health care for individuals
- How the legislative mandate for “100% coverage” should be defined
- Encouraging prevention of illness
- Controlling the “medical arms race”
- Examining whether change models used in public health and environmental improvement could be applicable to health care system transformation
- Reducing disparities in access to quality health care
- Encouraging/helping providers to reduce current fixed costs

In addition, it was noted that part of the Task Force meeting on September 17 would be used to prepare for the State Coverage Institute Team’s meeting in Chicago at the end of September, and the results from that meeting would be discussed at the Task Force’s October 22 meeting.

Commissioner Ludeman emphasized that considerable work and discussion should take place before the Task Force’s next meeting on September 17, including through email exchanges, and he encouraged the Task Force members to contribute and respond to issues and ideas raised between now and the next meeting.