DRAFT – FOR DISCUSSION ONLY
Minnesota Health Care Transformation Task Force
PRINCIPLES, ISSUES, AND RECOMMENDATIONS

Transformation Principle I:

A Combination of Collaboration and Competition Should Drive Improvements in Health Care Quality and Costs, Supported by Health Care Payment Systems That Encourage Evidence-Based, High-Value Health Care

- **Health care providers and payers should collaborate to determine the ideal care that should be delivered in order to achieve good outcomes;**
- **Health care providers should compete to achieve the most efficient and effective execution in delivering ideal care;**
- **Health care plans should compete to (1) lower administrative costs for processing claims, (2) promote patient health, and (3) encourage patient use of higher-quality/lower-cost providers, but *should not* compete by refusing coverage for less-healthy patients; and**
- **The current health care payment system should be dramatically changed to (1) eliminate the current disincentives for maintaining health and providing high quality, efficient care, (2) eliminate the current incentives for overuse of care, and (3) directly engage consumers in choosing and using high-value health care providers and services.**

What the Transformed Healthcare System Should Look Like for Patients with Chronic Illnesses:

NOTE: *For simplicity, this section is intended to define how the health care delivery and payment system should function for patients with chronic illnesses, since that is where the largest proportion of health care expenditures are incurred and since that is what most of the Task Force's discussions have focused on. Many of the points below will likely also be applicable to major acute care and preventive care, although the basic method of payment (Section D) may differ.*

A. Patients Would Select Providers Based on Value

I-A1. Each patient would select a lead provider (a "medical home") to provide care and to help them manage their care.

I-A2. The patient's selection would be based on information regarding the quality and cost of the care given to similar patients by each of the available providers. (See Section C below.)

B. Health Care Providers Would Deliver the Highest Quality, Most Efficient Care

I-B1. The care provided to the patient would be consistent with evidence-based guidelines developed by state and national organizations, where such guidelines exist. However, providers would be expected and encouraged to develop innovations in care delivery that will increase value (i.e., higher quality and lower costs).

I-B2. Providers would be required to use electronic medical record systems and patient registries as a condition of payment. Statewide standards for electronic medical record systems and patient registries would be established, using existing registry systems where possible.

I-B3. Providers would be encouraged to participate in collaborative processes for identifying processes that improve patient outcomes (e.g., the processes sponsored by the Institute for Clinical Systems Improvement).

C. Information on Provider Quality and Price Would Be Publicly Available

I-C1. All providers would be required to submit appropriate electronic information on the outcomes and processes associated with patient care to a central organization/agency (e.g., Minnesota Community Measurement) for the purposes of quality measurement, with protections for patient confidentiality.

I-C2. The outcomes and processes to be collected would be defined through a collaborative process involving providers and payers. The priority would be on reporting the *outcomes* a provider achieves for similar patients, where good measures of outcomes and good methods of risk adjustment exist. Where good outcome measures and/or risk adjustment methods do not exist, reporting would focus on the extent to which the provider complies with evidence-based guidelines for care where there is strong evidence supporting the relationship between process measures and outcomes.

I-C3. In addition, all providers would be required to submit information on the prices they charge for care to the central organization/agency.

I-C4. The central organization/agency would also collect information from patients on the extent to which providers act as true agents for patient decision-making.

I-C5. The central organization/agency would publish information on each provider's quality and price in order to help consumers find the highest-value providers.

I-C6. Both health plans and providers would be required to contribute to the cost of the central organization/agency to pay for the cost of collection, analysis, and dissemination of data on quality and cost of care.

D. Providers Would Be Paid For A Comprehensive Bundle of Services

I-D1. The provider selected by the patient would be paid a fixed monthly amount (the "Chronic Care Management" fee) to cover all of the care management, preventive services, and minor acute care needed by the patient for all of the patient's chronic illnesses. Minor acute care unrelated to the chronic illness, major acute care (of any type), or long-term care needed by the patient would be paid for separately.

I-D2. If the patient requires an unusually large number of services compared to similar patients, and the provider documents that the services were medically necessary, the provider would be eligible to receive an outlier payment to compensate for the provision of the extra services. However, if the additional services were due to medical errors, provider-induced infections, or other avoidable complications, the provider would not be eligible to receive the outlier payment.

I-D3. The provider would receive a significant bonus/penalty adjustment to the monthly payment amount based on:

- (1) the *outcomes* the provider achieves for the patient (or for a group of similar patients), where good measures of outcomes and good methods of risk adjustment exist or (2) the extent to which the provider complies with evidence-based guidelines for care where (a) good outcome measures and risk adjustment methods do not exist and (b) there is strong evidence supporting the relationship between process measures and outcomes;
- the level of utilization of major acute care or other services related to the patient's chronic illnesses which are paid separately from the monthly chronic care management fee; and
- the level of patient involvement in decision-making about care, particularly for preference-sensitive care.

I-D4. The patient's selected provider would be responsible for paying any other providers (physicians, laboratories, or hospitals) required to deliver the services needed by the patient.

I-D5. All health care payers would pay providers on the same basis.

I-D6. Health care providers would be able to propose packages of services and prices to provide care for specific populations or diseases/conditions that are different than the payment system defined above. Payers would jointly agree to change their payment systems to pay for services in this way if they provide greater value (possibly with differences in patient co-pays).

E. Payment Levels Would be Driven By Provider Competition

I-E1. The fixed monthly amount that the provider is paid would depend on the number and type of chronic illnesses that the patient has, as well as other characteristics that affect the level of services required to provide good care for the patient.

I-E2. Each provider would propose the amount that they wanted to be paid for each type of patient to be served. The patient's employer or health plan could negotiate with the provider for a lower price. Payment levels might be higher in areas with a small number of providers than in areas with a large number of providers, in order to encourage additional providers to enter the market.

I-E3. The patient's employer or health plan would specify the proportion of the provider's price that it would pay, and the amount that the patient would be required to pay. The combination of the pre-defined payment from the employer/plan and from the patient would be considered payment-in-full by the provider.

I-E4. Providers would be able to lower their prices at any time, and patients would be permitted and encouraged to switch to higher-value providers (i.e., providers with lower costs for equal or higher quality) at any time.

F. Patients Would Have Incentives to Choose High-Value Providers/Services and to Adhere to Care Plans

I-F1. Patients would be required to pay more to use lower quality/higher cost providers. For example, the patient could be required to pay all or a portion of 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.

I-F2. Patients would receive financial incentives from their health plan (or the purchaser of their health plan) for (1) achievement of desired outcomes where outcome measures are available and (2) for adherence with evidence-based process measures where outcome measures are not available. For example, the patient's contribution to the cost of insurance and/or their copayments for specific services might be lowered if they have better outcomes or better adherence with desirable processes.

I-F3. The benefits available to patients would be adjusted to reduce barriers to accessing services or assistance that would facilitate

patients achieving better outcomes or better adherence. (For example, if cessation of tobacco use is to be encouraged, benefits would cover all or a portion of the costs of tobacco cessation classes, nicotine substitutes, etc.)

G. Additional Issues Still To Be Addressed

I-G1. What types of standards should be used for measuring outcomes for performance-based payment?
- Time period over which outcomes are measured
- Population-based outcomes vs. individual patient outcomes
- Individual physician measures vs. group measures
- Locally-developed vs. national measures

I-G2. What protections are needed against "cherry-picking" and "lemon-dropping" (i.e., exclusion of sick and high-risk patients)?

I-G3. What should be done where there is over-consolidation of providers (i.e., lack of competition)?

I-G4. What should be done about providers with lucrative practices involving non-evidence-based care?

I-G5: What adjustments in the payment system, if any, should be made for small providers?

I-G6. How should medical education be paid for?

I-G7 What changes to anti-trust laws are needed to support development and implementation of new payment approaches by all payers and providers?

I-G8. What adjustments to benefit sets are needed to implement payment reform? E.g.,
- Access to health promotion/prevention services
- Access to alternative providers

I-G9 How should payment conflicts among multiple providers in non-integrated systems be resolved?

I-G10. What (other) undesirable consequences could result from the changes, and how can they be mitigated or eliminated?

How Minnesota Should Achieve the Transformation:

I-H1: One or more payer/provider collaborative organizations should provide technical assistance to providers to help them reinvent their care processes in order to improve quality and/or reduce costs (e.g., using Toyota Production System methods). Improvements that can be made without new payment systems should be pursued immediately.

I-H2: Payers and providers should work together to define the details of the different payment structure, with payers taking the lead in convening the process. A transition process for implementing the new payment structure could be defined (e.g., beginning with modifications to the fee-for-service system to pay differently for care management services). The BHCAG Patient Choice model might provide a starting point.

I-H3: One or more payer/provider collaborative organizations should provide technical assistance to providers to help them define their costs of care, price their services, and manage their operations successfully under the new payment model.

I-H4: High-value providers should be encouraged to provide services in underserved or low-competition areas of the state.

I-H5: Patient incentives should be phased in, beginning with providing information to patients on how differences in quality and outcomes between providers will translate into health impacts and cost differences for the patient over time, then requiring patients to pay more to use lower quality/higher cost providers.

I-H6: Careful monitoring should be established to identify unintended consequences (e.g., providers refusing to care for high-risk patients, upcoding of conditions for higher payment, implementation problems in specific areas of the state, etc.) and to make modifications to payment systems, quality and price reporting, incentives, etc. in order to mitigate or eliminate them.

Implementation Steps and Responsible Organizations:

To be added…

Expected Impacts from the Transformation:

Reduction Over Baseline Costs: ______________%

Reduction in Annual Inflation: ______________%

Reduction in Mortality/Morbidity: ______________%

Transformation Principle II

The Overall Size and Cost of the Health Care System Must Be Reduced

This section has not yet been discussed by the Task Force.

Issue 11: How can providers be encouraged to reduce fixed costs (including administrative costs) in response to lower aggregate volume of health care utilization and shifts to lower-cost types of care?

Options:

11a: Use market forces to transition the system, but get the incentives right so the market is achieving what is desired.

11b: Reward providers for becoming more specialized in the services where they can provide the highest quality and lowest cost (e.g., specialty hospitals vs. general hospitals).

11c: Encourage low-quality, high-cost providers to go out of business.

11d: Encourage/assist health care providers to provide training and education necessary for their current workers to find employment in a transformed health care system or elsewhere in the economy.

11e: Create greater accountability among providers for reducing costs in response to reduced payment, e.g., link the tax advantages of not-for-profit status to the ability of providers to provide less costly, higher quality health care.

11f: Reduce the costs of doing business for health care providers, e.g., lower administrative costs, lower malpractice insurance costs.

11g: Refuse to increase payments to providers to cover the costs of underutilized capacity.

11h: Require health care providers to report publicly on their fixed costs relative to direct care provided.

11i: Encourage/require providers (and professional associations of providers) to identify "top 10" lists of areas of waste and inefficiency in health care and report on their progress in addressing those areas.

Implementation Strategy:

- To be determined…

Issue 12: How can health plans be encouraged to reduce administrative costs (both of the health plan itself and for providers)?

Options:

12a: Rely on competition among health plans to keep administrative costs at a minimum.

12b: Require health plans to publish information on their administrative costs relative to payments made to providers.

12c: Conduct a benefit-cost analysis of current administrative requirements placed by health plans on providers, and eliminate requirements that do not demonstrate a clear return on investment.

12d: Identify potentially duplicative health care improvement processes implemented by both health plans and providers (e.g., care management systems), and determine the most efficient/effective ways of achieving the underlying goals.

Implementation Strategy:

- To be determined…

Issue 13: How should the transition to a smaller health care system be encouraged and facilitated?

Options:

13a: Project the likely number of future jobs in each health care occupation under a transformed system, and communicate the changes to individuals who are considering entering education and training programs for the health professions.

13b: Provide technical assistance and transition financing to providers to help in restructuring operations for smaller volume.

13c: Encourage/assist health care providers to provide training and education necessary for their current workers to find employment in a transformed health care system or elsewhere in the economy.

13d: Educate citizens and public officials about the advantages of a smaller health care system.

13e: Require health care providers to publicly report on their efforts to reduce costs and improve community health.

Implementation Strategy:

- To be determined…

Issue 14: How and when should new health care technologies be utilized?

Options:

14a: Require new technologies to be "budget neutral," i.e., costing no more on an episode-of-care basis than current technologies, unless there are substantial improvements in patient outcomes.

14b: Limit payments for services to current levels plus normal inflation, regardless of which technologies are used.

14c: Limit payment for new technology to those conditions for which effectiveness has been proven by randomized controlled trials.

14d: Establish a public/private collaborative organization to review new technologies and report publicly on their relative value.

Implementation Strategy:

- To be determined…

Issue 15: Should changes in care processes that are more expensive, but improve patient quality of life, or which increase costs in the short run and save money in the long run, be supported?

Options:

15a: Identify specific areas of care where net costs can be reduced (e.g., areas of overutilization), and require cost reductions to be implemented in those areas in conjunction with care changes that require increases in net costs.

15b: Quantify the benefits for employers and patients of reduced time, work absenteeism, etc., and encourage care process improvements where the total costs (including both health care spending and value-of-time) are reduced.

15c: Limit payments/spending to current levels (plus inflation), and allow patients to spend more if they want the improved value, or allow competition to find ways to deliver the higher quality at a lower cost.

Implementation Strategy:

- To be determined…

Expected Impacts:

Reduction Over Baseline Costs: _______________%

Reduction in Annual Inflation: _______________%

Reduction in Mortality/Morbidity: _______________%

Transformation Principle III:

Goals for Significantly Improving the Health of Minnesotans Should be Adopted, All Major Organizations in the State Should Accept Responsibility for Helping Achieve The Goals, and Reports on Progress Should Be Issued Annually

What a Transformed Health Promotion System Should Look Like:

A. Statewide Goals and Priorities for Health Improvement Would Be Established

III-A1. The Minnesota Department of Health would quantify and rank the causes of illness and disease based on their impact on health care costs and quality of life, e.g., tobacco use, obesity, air quality, low-birthweight babies, etc.

III-A2: Ambitious multi-year goals for reductions in specific illnesses/diseases or improvements in specific causes of illness and disease would be established based on:

- The magnitude of the impact of the illness on health care costs and quality of life;
- The potential change in the incidence or prevalence of the illness/disease based on interventions with demonstrated effectiveness (See Section B).

III-A3: Organizations throughout the state (e.g., employers, schools, etc.) would be encouraged/required to adopt similar goals for the populations they influence.

B. Methods of Achieving the Goals Would Be Identified and Their Use Would be Encouraged

III-B1. The Minnesota Department of Health would identify the known interventions for addressing the highest-ranked causes of illness and disease. Both interventions that are directed at individuals and interventions that are directed at environmental factors would be included.

III-B2. The barriers to replication of effective interventions would be identified, e.g.:

- Cost
- Accessibility
- Acceptability

III-B3. Strategies for overcoming the barriers for key populations or in key settings would be identified through research and demonstration projects. For example, research could be conducted to determine whether rewards or penalties are more effective, and whether it is

more effective to change the supply side (e.g., the availability of unhealthy foods) or the demand side (i.e., the willingness of individuals to eat unhealthy foods).

III-B4. Where legal or regulatory barriers prevent implementation of effective programs, changes would be made (or advocated for). For example, the state could help employers overcome regulatory barriers to health promotion and incentive programs, e.g., anti-discrimination laws, ERISA restrictions, etc..

III-B5. The business case for health promotion interventions would be defined to help encourage appropriate organizations to implement them and/or to determine what resources were needed to offset costs.

III-B6. Successful interventions would be implemented by appropriate organizations, with adequate resources to achieve success.

III-B7. Programs would be evaluated and unsuccessful interventions would be eliminated.

C. Progress in Achieving Goals Would be Publicly Reported

III-C1. The Minnesota Department of Health would report on progress toward achieving the goals. To the maximum extent possible, progress measures would be disaggregated by community, organization, demographic group, etc. in order to identify where shortfalls are occurring and enable technical assistance efforts to be appropriately targeted.

III-C2. Organizations that implement priority intervention programs and/or achieve significant progress toward priority goals would receive certifications and awards and be publicly recognized. Organizations which fail to achieve progress might also be publicly reported.

Potential Strategies and Options for Improving Health

The following are examples of the types of interventions which would be evaluated and prioritized through the above process:

Population-Wide Strategies:

- Encourage everyone to go through a health risk assessment and a follow-on program to address identified risks, similar to what the state and some employers do.
- Encourage implementation of ICSI guidelines on primary prevention by all institutions
- Encourage seat belt usage
- Improve labeling of foods

- Provide adequate funding to resume/expand anti-smoking ads
- Identify health problems that will be larger in the future, and begin addressing them now
- Improve drinking water quality, air quality
- Prevent low-birthweight babies
- Ban transfats
- Tax foods with high sugar and/or fat content.
- Encourage walkable communities

Strategies for Specific Populations or Communities:

- Address safety issues in communities that discourage people from being outside and active
- Provide exercise equipment in poor communities
- Focus on African Americans
- Address the growth in autism, which increases costs in school and adulthood

Health Provider Strategies

- Encourage health providers to provide the initial message about healthy behaviors to patients, so employers, schools, etc. can reinforce it

Employer-Based Strategies:

- Remove unhealthy foods from workplaces
- Encourage "non-exercise-associated thermogenesis," i.e., activities at work that use calories
- Provide health insurance benefits that support the desired behaviors
- Encourage/facilitate joint action by employers, e.g., some large employers have resources they can share with smaller employers. The current Infoshare program could provide a foundation for this.
- Provide financial incentives to individuals to maintain desirable weight levels.

School-Based Strategies

- Remove unhealthy foods from schools and other environments
- Provide education for children on health promotion
- Provide more time for physical education programs in schools and more effective physical education, e.g., more cardiovascular components; less team, and more individual activities

- Replicate Arkansas' report cards to parents on children's BMI
- Provide quality school breakfasts, in addition to lunches

Public Health Strategies:

- Obtain information on the effectiveness and resources available to the Minnesota Department of Health's programs, and strengthen the most effective programs

Implementation Steps and Responsible Organizations:

To be added...

Expected Impacts from the Transformation:

Reduction Over Baseline Costs: ______________%

Reduction in Annual Inflation: ______________%

Reduction in Mortality/Morbidity: ______________%

Transformation Principle IV: All Minnesotans Should Be Able to Obtain Necessary Health Care at An Affordable Cost

Issues To Be Addressed:

(Straw Poll on Priorities for State Coverage Institute Meeting in Parentheses)

- Restructuring the payment system **(13)**
- Restructuring small group/individual markets (issuance rules, merger of markets, etc.) **(6)**
- Creating and capturing savings to pay for coverage, including from uncompensated care **(5)**
- Reforming laws/regulations that limit solutions (e.g., ability to bring franchisees into self-insured plans) **(3)**
- Improving outreach **(1)**
- Filling the gap between public coverage and Section 125 plans **(1)**
- Allowing or prohibiting age bands in insurance pricing
- Mandating coverage
- Creating a health insurance exchange
- Requiring guaranteed issue
- Providing mechanisms for reinsurance and risk adjustment

APPENDIX A
Issues and Options Discussed by the Task Force

Issue 1: **Should payment be made based on delivery of specific services, based on a course of treatment to achieve specific outcomes for a particular health condition, or based on the delivery of all treatments needed to maintain health for an individual?**

Options (Straw Poll Votes in Parentheses):

1a: Pay providers a fixed amount for each specific service offered to a patient, and define which services within the current benefit set will and will not be paid for based on evidence. 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 could be paid on top of these service-based fees.) **(5)**

1b: Pay providers a fixed amount to cover all of the services within the current benefit set that the provider and patient determine are needed to treat the patient for a particular condition based on evidence. 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 could 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.) **(9)**

1c: Pay providers a fixed amount to cover all of the services that the provider and patient determine are needed to treat the patient for all of their conditions (both chronic and acute). This is similar to what is generally called "(full) capitation" payment. (A performance bonus or penalty based on processes or outcomes could be paid on top of this amount.) Payments would be adjusted for patient risk and conditions. **(4)**

1d: Pay providers based on one of the above methods, but with prices the providers establish, with transparent information about price and quality, and with consumers having the ability to choose providers. **(12)**

1e: Not yet Defined **(1)**

Approach to Chronic Care Payment Developed by the Task Force:

- Encourage an evolving process of defining and delivering the appropriate care for all chronic conditions that a patient has
- Pay a lead provider a fair, risk-adjusted price for that care on a fixed, monthly basis
- Make outlier payments to providers for unusually complex patients
- Make performance payments to providers based on outcomes, including preventable conditions, utilization of major acute care, etc.
- Additional notes:
    - All payments and processes should be evidence-based where evidence exists
    - Don’t ignore improvements to the fee-for-service payment system in the short-run
    - Good outcome measures will be needed
    - Different payment structures may be needed for different systems of care
    - Important to anticipate and monitor for unintended consequences (providers refusing to care for high-risk patients, upcoding of conditions for higher payment)
    - Pay a single, higher amount for a patient with multiple conditions, not multiple payments for each condition
    - Insure proper incentives exist to avoid preventable acute exacerbations (e.g., broken hip)
    - Will the administrative costs of condition-specific capitation be significantly higher than for full patient capitation?
    - Don’t delay making improvements in care until payment reforms are in place
    - Is integration of providers required to support condition-specific capitation?
    - Look at the BHCAG Patient Choice model, which had a combination of capitation and fee-for-service
    - Use episode-of-care payment for those conditions where it is appropriate
    - The change in payment needs to be combined with an appropriate care approach

Issue 2: How should payment levels be established to accurately reflect the costs of providing care and to encourage efficiency?

Options (Straw Poll Votes in Parentheses):

2a: Encourage competition among providers on the price of care (see Issues 9 and 10). The health plan would pay the provider's price (after negotiation), with no consumer charge. **(2)**

2b: A state agency or a public-private collaborative (with representation from both payers and providers) should determine a suggested payment level based on a study to estimate the cost of delivering evidence-based care for each service or for each category of diagnosis and severity (i.e., a "suggested price" for the service or episode of care). Providers would either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they would accept (i.e., their "price" for the service or episode of care) for that category of patient. **(3)**

2c: Each payer should determine the price it is willing to pay for a service or episode of care, and negotiate with each provider on the actual price to be paid. **(3)**

2d: Encourage competition among providers on the price of care. The payer would determine the proportion of the price (after negotiation) it will pay, and the consumer would pay the difference. **(9)**

Issue 3: Should payment systems measure and reward performance, and should measures be based on processes or outcomes?

Options (Straw Poll Votes in Parentheses):

3a: Pay based on a provider's success in complying with evidence-based processes defined in clinical practice guidelines. **(0)**

3b: Pay based on both a provider's success in complying with evidence-based 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.) **(0)**

3c: Pay primarily or solely based on a provider's success in achieving desirable outcomes for patients. **(0)**

3d: 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 (no later than January, 2011). **(3)**

3e: Pay based on outcomes where good measures of outcomes and good methods of risk adjustment exist, and pay based on process measures where (a) good outcome measures and risk adjustment methods do not exist and where (b) there is strong evidence supporting the relationship between process measures and outcomes. **(12)**

3f: Refuse payment for services that do not meet minimum standards for processes and/or outcomes. **(9)**

3g: Refuse additional payment for avoidable errors, hospital-acquired infections, etc. **(17)**

3h: Make performance information public, but do not create explicit financial incentives based on performance. **(2)**

3i: Make performance-based payment only for chronic conditions. **(1)**

3j: Make performance-based payments based on value, not just clinical quality. **(2)**

Issue 4: **Should payment systems pay each provider involved with a patient's care separately or jointly?**
(Note: where hospitals and physicians are part of an integrated system, or where multiple physicians are in a group practice, this issue deals primarily with payments made to multiple separate systems or multiple physician practices, not to the distribution of payments within an existing system or group practice.)

Options (Straw Poll Votes in Parentheses):

4a: Separate payments should continue to be made for non-physician hospital care and for (each of) the physicians providing care for a patient's condition. **(1)**

4b: A single payment should be defined for all of the physicians providing care for a patient's condition (either as part of an episode of care for an acute condition, or ongoing care for a chronic illness). Groups of providers should be required to define a single accountable payee for receiving and allocating a payment amongst themselves. **(0)**

4c: A single payment should be defined for all of the providers (including hospitals and all of the physicians) providing care for a patient's condition (either as part of an episode of care for an acute condition, or ongoing care for a chronic illness). Groups of providers should be required to define a single accountable payee for receiving and allocating a payment amongst themselves. **(14)**

4d: Not Yet Defined **(1)**

Implementation Strategy:

- A process needs to be defined for resolving payment conflicts in non-integrated systems.

Issue 5: Should patients be given financial incentives to seek appropriate preventive care and to adhere to provider-recommended actions that affect process and outcome measures?

Options (Straw Poll Votes in Parentheses):

5a: Encourage patients to seek appropriate preventive care and 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 to recommended actions. **(1)**

5b: Provide financial incentives to patients based on their use of appropriate preventive care and adherence to evidence-based process measures. **(0)**

5c: Provide financial incentives to patients for achievement of desired outcomes (where outcome measures are available) and based on adherence with evidence-based process measures (where outcome measures are not available). **(6)**

5d: Provide financial incentives to providers to increase involvement of patients in care planning and decision-making. **(0)**

5e: Collect and publish patient ratings on the extent to which providers act as true agents for patient decision-making. **(10)**

5f: Provide incentives to both providers and patients to encourage achievement of outcomes and patient adherence to evidence-based processes. **(13)**

5g: Modify benefits to enable patient compliance **(11)**

Issue 6: How should new payment systems be implemented across the state?

Options (Straw Poll Votes in Parentheses):

6a: Payment structures should apply equally to all types of providers and all parts of the state. **(0)**

6b: 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. **(4)**

6c: Payment levels should be higher in underserved areas in order to attract providers. **(11)**

6d: Payment structures should provide incentives for providers to form more integrated care systems (or disincentives to remain independent). **(6)**

6e: Providers should given technical assistance to help them organize their structure, care processes, management systems, etc. to respond effectively to new payment systems. **(12)**

6f: Not Yet Defined **(2)**

Issue 7: Do all or most payers and providers need to agree on a different payment structure?

Options (Straw Poll Votes in Parentheses):

- **7a:** A single large payer is sufficient to initiate improved payment systems. **(1)**
- **7b:** A majority of payers need to change payment systems in order to make them viable. **(1)**
- **7c:** Payers should be required to change payment levels for specific services or bundles of services in response to a proposal from a provider or group of providers (see also Issue 9). **(1)**
- **7d:** A majority of providers need to support a common change in payment systems. **(0)**
- **7e:** Payers and providers should work together to define a different payment structure, with payers taking the lead in convening the process. **(11)**

Issue 8: How should the availability of data on the quality of patient care and cost of services be improved?

Options (Straw Poll Votes in Parentheses):

- **8a:** Provide financial rewards to providers using electronic medical record systems and patient registries meeting minimum standards. **(1)**
- **8b:** Impose financial penalties on providers not using electronic medical record systems and patient registries meeting minimum standards. **(1)**
- **8c:** Require providers to use (some type of) electronic medical record systems and patient registries as a condition of payment. Existing registry systems should be used where possible. **(15)**
- **8d:** Establish statewide standards for electronic medical record systems and patient registries. **(16)**
- **8e:** Require all providers to submit appropriate electronic information on patient care to a central organization/agency for the purposes of quality measurement, with protections for patient confidentiality. **(15)**
- **8f:** Require all providers to publish information about their outcomes and patient satisfaction levels. **(4)**
- **8g:** Require all providers to publish their prices for specific services or episodes of care. **(7)**
- **8h:** Require both health plans and providers to contribute to the cost of the agencies/programs that collect and disseminate data on quality and cost of care. **(14)**
- **8i:** Provide state funding to cover the costs of the agencies/programs that collect and disseminate data on quality and cost of care, at least initially. **(2)**

8j: Providers should agree on quality measures to be used within each specialty **(8)**

8k: Require all providers to submit information on prices to a central organization/agency for the purposes of helping consumers find the highest-value providers. **(14)**

<u>Issue 9</u>: **How should providers be encouraged to develop higher quality and lower cost (price) approaches to care?**

Options (Straw Poll Votes in Parentheses):

9a: Health care purchasers or 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. Payers should select the proposals that offer the best value and direct patients to those providers. (The issuers of the RFP could convene 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). **(3)**

9b: Health care purchasers or 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. Patients should then be allowed to select the packages of services and prices that offer the best value (see Issue #10). **(2)**

9c: Health care providers should propose packages of services and prices to provide care for specific populations or diseases/conditions. Payers should agree to change their payment systems to pay for those services if they provide greater value (possibly with differences in patient co-pays). **(9)**

9d: Health care payers should give providers financial rewards for better performance (see Issue #3). **(11)**

9e: Health care purchasers or payers should define minimum standards/expectations for outcomes of care based on best practices nationally, and refuse to pay for care that does not meet the standards. **(8)**

9f: Health care payers should encourage and allow providers to reduce their prices for individual services on at least an annual basis, and payers and purchasers should actively encourage patients to use higher-value providers (i.e., providers with lower costs for equal or higher quality) for care. **(8)**

9g: Providers should be required to publish data on the prices and outcomes of their services, with auditing by a central agency (e.g., Minnesota Community Measurement), and patients should be encouraged to choose higher-value providers for care. **(7)**

9h: Providers should be required to submit data on the prices and outcomes of their services to a central agency (e.g., Minnesota

Community Measurement) for analysis and publication, and patients should be encouraged to shift care to higher-value providers. **(8)**

9i: One or more payer/provider collaborative organizations should provide technical assistance to providers to help them reinvent their care processes in order to improve quality and/or reduce costs (e.g., using Toyota Production System methods). **(12)**

9j: One or more payer/provider collaborative organizations should provide technical assistance to payers to help them reinvent their payment systems in order to support higher-value care processes. **(12)**

Issue 10: How should patients be encouraged to choose lower-cost, higher-quality (i.e., higher-value) providers and services?

Options (Straw Poll Votes in Parentheses):

10a: Give patients information on how differences in quality and outcomes between providers will translate into health impacts and cost differences for the patient over time (e.g., higher co-payments for additional treatments needed in the future). **(0)**

10b: 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. **(11)**

10c: Refuse to pay for providers or for care of low value or uncertain efficacy. **(9)**

10d: Give patients a fixed amount of money (based on their specific health conditions) and let them choose which providers/programs to use based on information on cost and quality. **(5)**

10e: Encourage high-value providers to enter underserved or low-competition areas of the state (see also Issue 6). **(9)**

10f: Encourage a progression from Option 10a to 10b and then to 10c, d, e. **(11)**

APPENDIX B
Legislative Mandate to the Task Force

The Task Force will develop a statewide action plan for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans. The action plan must include the following, with specific and measurable goals and deadlines for each:

- Actions that will reduce health care expenditures by 20 percent by January 2011, and limit the rate of growth in health care spending to no greater than the percentage increase in the Consumer Price Index for all urban consumers plus two percentage points each year thereafter.
- Actions that will increase the affordable health coverage options for all Minnesotans and other strategies that will ensure all Minnesotans will have health coverage by January 2011.
- Actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality.
- Actions that will improve the health status of Minnesotans and reduce the rate of preventable chronic illness.
- Proposed changes to state health care purchasing and payment strategies that will promote higher quality lower cost health care.
- Actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs.
- Options for serving small employers and their employees, and self-employed individuals.
- Actions to reduce administrative costs.