

DRAFT – FOR DISCUSSION ONLY
Minnesota Health Care Transformation Task Force
RECOMMENDATIONS FOR THE
TRANSFORMATION OF HEALTH CARE
IN MINNESOTA

CONTENTS/SUMMARY

TRANSFORMATION PRINCIPLE I: The Health of Minnesotans Must Be Significantly Improved and All Major Organizations in the State Should Accept Responsibility for Helping Achieve Aggressive Health Improvement Goals..... 3

What a Transformed Health Promotion System Should Look Like:..... 3

- A. Aggressive Goals for Reduction in Obesity, Tobacco Use, Alcohol Abuse, and Drug Addiction Should Be Priorities for the State as a Whole and for Employers, Schools, Communities, and the Health Care System.3
- B: ~~After initial progress is made on the goals for obesity, tobacco use, and alcohol use~~By 2011, additional goals should be established for reductions in other health conditions, for improvements in environmental factors, and for prevention of other diseases that will reduce health care costs.....4
- C. ~~A Specific~~ The Minnesota Department of Health’s Comprehensive Statewide Health Promotion Plan for Achieving the Goals Should Be ~~Developed and Regularly Updated by Key Stakeholders Who Accept Accountability for Its Implementation~~ Adopted and Implemented by the Legislature and All Key Stakeholders.4
- D. Progress in Achieving Goals Should be Publicly Reported5
- E. The Comprehensive Statewide Health Promotion Plan Should Be Updated Annually.....5

Implementation Steps and Responsible Organizations: 7

~~TRANSFORMATION PRINCIPLE II: A Combination of Collaboration and Competition Should Drive Dramatic Improvements Must Be Made in the Quality, Costs, and Patient-Centeredness of Health Care in Minnesota Through a Combination of Collaboration and Competition by Providers, Supported by Health Care Payment Systems That Encourage Evidence-Based, High-Value Health Care. 9~~

What a Transformed Healthcare Delivery System Should Look Like: 9

- A. Health Care Providers Should Deliver the Highest Quality, Most Efficient Care Possible9
- B. Information on Provider Quality and Price Should Be Publicly Available 10
- C. Assistance Should Be Given to Providers to Help Them Improve Their Quality and Efficiency 11

Implementation Steps and Responsible Organizations: 11

TRANSFORMATION PRINCIPLE III: Health Care Payment Systems Should Be Restructured to Support and Encourage Evidence-Based, High-Value Health Care 13

What a Transformed Healthcare Payment System Should Look Like:..... 13

- A. Payment Systems Should Hold Health Care Providers Accountable for Quality, Care Coordination, and the Total Cost of Care..... 13

B. The Basic Structures of Payment and Pricing Must Also Be Reformed15

C. Individuals Should Be Given Information and Incentives to Choose More Cost-Effective, Higher-Quality Providers16

D. A Critical Mass of Purchasers and Payers Must Support the New Payment Systems on a Sustained Basis.....16

Implementation Steps and Responsible Organizations: 17

TRANSFORMATION PRINCIPLE IV: The Overall Size and Cost of the Health Care System Should Be Reduced In Order to Make Health Care More Affordable19

A. Providers Should Reduce the Costs of Care Per Patient (Including Administrative Costs) While Maintaining or Improving Quality.....19

B. Health Plans Should Reduce Costs, Particularly Administrative Costs, For Both the Health Plan Itself and For Providers.21

C. The Transition to a Smaller Health Care System Should Be Encouraged and Facilitated.22

D. New Health Care Technologies Should Only Be Used When They Improve Value.23

E. Additional Providers Should Be Encouraged to Enter Markets That Are Underserved or Do Not Have Adequate Competition.24

Implementation Steps and Responsible Organizations: 24

TRANSFORMATION PRINCIPLE V: All Minnesotans Should Be Able to Obtain Necessary Health Care at An Affordable Cost..... 25

What a Transformed Health Insurance System Should Look Like: 25

A. Insurers Who Offer Individual Policies Should Be Required to Sell Policies to Anyone Who Wishes to Buy One. (Guaranteed Issue).....25

B. The Same Plans Offered to Small Groups Should Be Available to Individuals. (Merger of Small Group and Individual Markets)25

C. Premiums Should Only Vary Based On Age, Individual Health Behaviors (e.g., Smoking), and Geography. (Modified Community Rating)25

D. Risk Equalization Payments Should Be Made to Health Plans Based on the Relative Health of Their Enrolled Population.25

E. A Health Insurance Exchange Should Be Established Through Which Individual and Small Group Insurance Products Would Be Sold.....25

F. All Citizens, Including Current Minnesota Comprehensive Health Association (MCHA) Enrollees, Should Have the Responsibility to Obtain and Retain Health Insurance Coverage That is Affordable.....26

G. All Employers Above a Minimum Size Should Be Required to Offer Section 125 Plans to Enable Pre-Tax Payment of Premiums.26

H. Incentives Should Be Provided to Encourage Employers That Currently Offer Group Coverage to Continue Doing So. (Erosion Control)26

Implementation Steps and Responsible Organizations: 26

EXPECTED IMPACTS FROM THE TRANSFORMATION..... 28

APPENDIX A: Legislative Mandate to the Task Force..... 29

TRANSFORMATION PRINCIPLE I:

The Health of Minnesotans Must Be Significantly Improved and All Major Organizations in the State Should Accept Responsibility for Helping Achieve Aggressive Health Improvement Goals.

What a Transformed Health Promotion System Should Look Like:

A. Aggressive Goals for Reduction in Obesity, Tobacco Use, Alcohol Abuse, and Drug Addiction Should Be Priorities for the State as a Whole and for Employers, Schools, Communities, and the Health Care System.

~~I-A1: Ambitious but realistic multi-year goals for reduction in obesity should be established~~ The percentages of Minnesotans who are overweight or obese should be reduced as follows:

- Have no increases in the percentages of Minnesotans who are obese or overweight in 2008 and 2009;
- Reduce the total percentage of Minnesotans who are obese and overweight by at least 1% per year, so that no more than 15% of Minnesotans are obese, and no more than 35% are overweight (i.e., at least 50% of Minnesotans have a healthy weight) by 2020;

~~I-A2: Ambitious but realistic multi-year goals for reduction in tobacco use should be established~~ The percentage of Minnesotans who use tobacco should be reduced as follows:

- Continue reductions in the percentages of Minnesotans who use tobacco by at least 0.2% in 2008 and 2009;
- Reduce the percentage of Minnesotans who smoke by 2% per year beginning in 2010, so that the percentage who use tobacco is cut in half to 9.5% by 2013; and
- Continue reducing the percentage of Minnesotans who use tobacco after 2013 to a goal of less than 5%.

~~I-A3: Ambitious but realistic multi-year goals for reduction in alcohol addiction should be established~~ The percentage of Minnesotans who abuse alcohol should be reduced, as follows:

- *To Be Determined Based on MDH Recommendations*

~~I-A4: The percentage of Minnesotans who are addicted to drugs other than alcohol should be reduced~~, as follows:

- *To Be Determined Based on MDH Recommendations*

~~I-A5: All Minnesotans should complete a confidential health risk assessment each year and establish individual goals for health improvement.~~

I-A6: The Legislature and state agencies should encourage and/or require employers, schools, communities, and health care organizations throughout the state to adopt similar, age-specific goals for each of these priority health conditions and diseases. Achievement of these goals should be a high priority for each of these organizations and groups. In particular,

- The State of Minnesota should be accountable for achieving the goals for its employees.
- The Minnesota Department of Education should be engaged to determine the best way to ensure that schools are held accountable for making progress on health promotion goals, particularly those with a close relationship to learning.

B: ~~After initial progress is made on the goals for obesity, tobacco use, and alcohol use~~ By 2011, additional goals should be established for reductions in other health conditions, for improvements in environmental factors, and for prevention of other diseases that will reduce health care costs.

I-B1: The goals should be based on an analysis by the Minnesota Department of Health of:

- The magnitude of the impact of the health condition, environmental factor, or disease on health care costs and quality of life;
- The potential change in the incidence or prevalence of the condition/factor/disease based on interventions with demonstrated effectiveness; and
- The strength of the scientific evidence connecting the condition or factor to disease and costs.

I-B2: In all cases, goals should be (a) ambitious enough to achieve significant reductions in health care costs and/or reductions in the growth in health care costs, but (b) realistic based on what has been achieved in the past, what has been achieved in other communities, and what analyses indicate is achievable in the future. In addition to aggregate goals, wherever possible, goals should be disaggregated by demographic group and by sector (employers, schools, etc.) in order to enable better targeting of interventions and measurement of progress.

C. A Specific The Minnesota Department of Health's Comprehensive Statewide Health Promotion Plan for Achieving the Goals Should Be Developed and Regularly Updated by Key Stakeholders Who Accept Accountability for Its Implementation Adopted and Implemented by the Legislature and All Key Stakeholders.

I-C1. The Legislature should enact legislation supporting the following policy initiatives needed to produce system-level change:

- Enhancing physical education in schools. *Additional specifics to be provided by MDH.*
- Increasing access to places for physical activity. *Additional specifics to be provided by MDH.*
- Promoting healthy foods in schools. *Additional specifics to be provided by MDH.*
- Increasing access to healthy foods in communities. *Additional specifics to be provided by MDH.*
- Making public places and workplaces smoke-free. *Additional specifics to be provided by MDH.*
- Increasing the price of tobacco products. *Additional specifics to be provided by MDH.*
- Increasing access to clinical preventive services. *Additional specifics to be provided by MDH; may be covered by actions under Transformation Principles II, III, and V.*

I-C2. The Legislature should provide the resources needed by the Minnesota Department of Health to implement the plan.

I-C3. Employers, schools, communities, and healthcare providers should provide the resources needed by their employees to implement the plan.

D. Progress in Achieving Goals Should be Publicly Reported

I-D1. The Minnesota Department of Health should report annually on progress toward achieving the goals. To the maximum extent possible, progress measures should 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.

I-D2. Organizations that implement priority intervention programs and/or achieve significant progress toward priority goals should receive certifications and awards and be publicly recognized. Organizations which fail to achieve progress might also be publicly reported.

I-D3. The cost savings (or increases) in each goal area and from each intervention should be reported, along with an analysis of who benefited from the savings (e.g., purchasers, health plans, providers, etc.)

E. The Comprehensive Statewide Health Promotion Plan Should Be Updated Annually

I-E1. The Minnesota Department of Health should work with other appropriate organizations to identify the known effective interventions for addressing the highest-ranked causes of illness and ~~diseasedeath~~. Both Interventions that are directed at

individuals, at populations, and interventions that are directed at environmental factors should be included.

- I-E2. Representatives of key stakeholders (employers, schools, communities, and health care organizations) should work together to identify the barriers to replication of effective interventions, e.g.:
- Cost
 - Accessibility
 - Acceptability
- I-E3. The key stakeholders should develop strategies for overcoming the barriers for different populations in each of the settings. Where research already exists identifying successful interventions, these interventions should be incorporated into the strategies. Where there is not sufficient evidence about what approaches would work, research and demonstration projects should be undertaken. For example, research could be conducted to determine whether rewards or penalties are more effective, 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), and whether there are better ways to deliver public health services “where people are.”
- I-E4. Where legal or regulatory barriers prevent implementation of effective programs, changes should 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..
- I-E5. The business case for health promotion interventions should be defined to encourage all organizations to implement them and/or to determine what resources are needed to offset costs. The business case should include the contribution that success would make to lowering direct health care costs and to reducing indirect costs to each stakeholder, such as lower employee absenteeism, better performance in school, etc.
- I-E6. Programs should be evaluated by the Minnesota Department of Health or the organizations that undertake them, and successful interventions should be rapidly disseminated to, and implemented by, additional appropriate organizations, with adequate resources to achieve success. Unsuccessful interventions should be promptly eliminated.

Implementation Steps and Responsible Organizations:

F. Actions by the State Legislature

I-F1. By December 31, 2008, the Legislature and Governor should enact legislation implementing the policy initiatives described in Recommendation I-C1.

I-F2. The Legislature should annually appropriate the funding needed by the Minnesota Department of Health and other state agencies to implement the Comprehensive Health Promotion Plan.

G. Actions by the State Executive Branch

~~I-G1. By December 31, 2008, the Minnesota Department of Health should establish a confidential online health risk assessment tool that all citizens can use to identify their health risks and establish individual goals for improvement.~~

I-G1. The State of Minnesota should continue encouraging each of its employees to complete an annual health risk assessment, and it should establish annual goals for improvement of employee health consistent with the statewide goals.

I-G2. By June 30, 2008, the Minnesota Departments of Education and Health should recommend a way to ensure that schools are held accountable for making progress on health promotion goals, particularly those with a close correlation to learning.

H. Actions by Other Organizations

I-H1. Every employer should encourage its employees to complete an annual health risk assessment, it should establish annual goals for improvement of employee health consistent with the statewide goals, and it should implement employee health promotion programs that will enable achievement of the goals.

I-H2. Every public school should encourage its employees students to complete an annual health risk assessment, it should establish annual goals for improvement of student health consistent with the statewide goals, and it should implement student health promotion programs that will enable achievement of the goals.

I-H3. Every community should encourage its residents to complete an annual health risk assessment, it should establish annual goals for improvement of resident health consistent with the statewide goals, and it should implement community health promotion programs that will enable achievement of the goals.

I-H4. Every health provider should encourage its patients and employees to complete annual risk assessments, it should establish annual goals for improvement of patient and employee health consistent with the statewide goals, and it should implement health promotion programs that will enable achievement of the goals.

I-H5. Every parent should have their children complete an annual health risk assessment.

TRANSFORMATION PRINCIPLE II:

A Combination of Collaboration and Competition Should Drive Dramatic Improvements Must Be Made in the Quality, Costs, and Patient-Centeredness of Health Care in Minnesota Through a Combination of Collaboration and Competition by Providers, Supported by Health Care Payment Systems That Encourage Evidence-Based, High-Value Health Care

- Health care providers, with the participation of health plans, patients, and purchasers, 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; and
- Health care purchasers should encourage and support the transition to improved delivery of health care ~~and improved payment systems.~~

What a Transformed Healthcare Delivery System Should Look Like:**A. Health Care Providers Should Deliver the Highest Quality, Most Efficient Care Possible**

- II-A1. Providers should be encouraged to participate in collaboratives for improving patient outcomes through evidence-based processes (e.g., the processes sponsored by the Institute for Clinical Systems Improvement).
- II-A2. Providers should deliver care to patients consistent with evidence-based guidelines, where such guidelines exist. However, providers should be expected and encouraged to develop innovations in care delivery that will increase value (i.e., higher quality and lower costs), and to demonstrate the effectiveness of the innovations through a collaborative.
- II-A3. Providers should 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 should be established, using existing national registry systems where possible. (A “registry” is a list of patients all of whom have a common condition or group of conditions, along with information about the care they receive and the outcomes they experience. It is used for evaluating the effectiveness of care programs across a large group of patients and also to help providers ensure adherence with clinical guidelines by identifying individual patients who need specific procedures or services consistent with guidelines.)

- II-A4. Collaboratives should define the minimum standards/expectations for outcomes of care, and payers should refuse to pay for care that does not meet the standards.
- II-A5. Health plans, purchasers, and providers should contribute financially to cover the cost of the collaborative processes for improving the quality of care.
- II-A6. Providers should involve patients in decision-making about care, and ensure that information about treatment options is provided by someone without a financial interest in the patient's choice.
- II-A7. Providers should provide culturally appropriate care to all of their patients. Health plans should pay for Interpreter services may be needed to enable non-English speaking patients to communicate effectively with health care providers.

B. Information on Provider Quality and Price Should Be Publicly Available

- II-B1. All providers should be required to submit standardized electronic information on the risk-adjusted outcomes and processes associated with patient care (with protections for patient confidentiality), using a standardized system for risk adjustment, to a central organization/agency (e.g., Minnesota Community Measurement) for the purposes of public reporting. This would include any reports currently submitted to specialty societies and other regional or national quality improvement organizations.
- II-B2. The outcomes and processes to be collected should be defined through a collaborative process involving providers, payers, and consumers. The priority should 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 should 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.
- II-B3. The central organization/agency should also collect information from patients on the extent to which providers act as true agents for patient decision-making, either using the results of patient satisfaction surveys currently collected by providers or others, and/or through patient satisfaction surveys developed by the central organization/agency.
- II-B4. The central organization/agency should publish audited information on each provider's quality ~~and price~~ in order to help consumers find the highest-value providers. ~~Priees would be reported based on episodes of care, as defined in Section D.~~

II-B5. Health plans, providers, and purchasers should 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.

C. Assistance Should Be Given to Providers to Help Them Improve Their Quality and Efficiency

II-C1: **[SOME MEMBERS INDICATE CONCERNS]** 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. ***[ICSI IS RESPONSIBLE FOR THIS NOW.]***

Implementation Steps and Responsible Organizations:

D. Actions by the State Legislature

II-D1. By December 31, 2008, the Legislature and Governor should enact legislation (or amend existing legislation) requiring all health care providers to use electronic medical record systems and patient registries that meet state standards by June 30, 2010.

II-D2. By December 31, 2008, the Legislature and Governor should enact legislation requiring all health care providers to submit standardized electronic information on the risk-adjusted outcomes and processes associated with patient care to Minnesota Community Measurement no later than December 31, 2009, and requiring Minnesota Community Measurement to publish annual reports on the quality of care delivered by individual providers no later than June 30, 2010.

II-D3. By December 31, 2008, the Legislature and Governor should enact legislation requiring health plans, health providers, and health purchasers to annually contribute funding to cover the costs of quality improvement processes through the Institute for Clinical Systems Improvement beginning in 2009.

II-D4. By December 31, 2008, the Legislature and Governor should enact legislation requiring health plans, health providers, and health purchasers to annually contribute funding to cover the costs of quality reporting through Minnesota Community Measurement beginning in 2009.

E. Actions by the State Executive Branch

II-E1. By December 31, 2008, the Minnesota Department of Health should establish statewide standards for electronic medical record systems and patient registries, consistent with existing national registry systems where possible.

II-E2. By December 31, 2008, the Department of Employee Relations and the Department of Human Services should require that providers participate in appropriate quality improvement collaboratives established by the Institute for Clinical Systems Improvement as a condition of participation in and payment by the state employee health insurance program and the Medicaid program.

F. Actions by Other Organizations

II-F1. By December 31, 2008, the Institute for Clinical Systems Improvement should establish or continue quality improvement collaboratives for conditions and treatments where significant savings in health care costs are possible, including for all major chronic diseases. These collaboratives should define the minimum standards/expectations for outcomes of care.

II-F2. By June 30, 2009, the Institute for Clinical Systems Improvement should insure that mechanisms exist whereby health care providers can receive technical assistance in improving the quality of care they deliver.

II-F3. By December 31, 2008, the Institute for Clinical Systems Improvement should develop standards for involvement of patients in decision-making about care.

II-F4. By June 30, 2009, all health care providers should participate in appropriate quality improvement collaboratives established by the Institute for Clinical Systems Improvement.

II-F5. By December 31, 2010, all health care providers should implement and use electronic medical record systems and patient registries that meet state standards.

II-F6. By June 30, 2009, all health care providers should establish processes for involving patients in decision-making about care, and ensure that information about treatment options is provided by someone without a financial interest in the patient's choice.

II-F7. By June 30, 2009, Minnesota Community Measurement should establish a system for providers to report risk-adjusted outcomes and processes associated with patient care, including a standardized system of risk adjustment.

II-F8. By December 31, 2009, all health care providers should begin submitting standardized electronic information on the risk-adjusted outcomes and processes associated with patient care to Minnesota Community Measurement.

II-F9. By December 31, 2010, Minnesota Community Measurement should begin collecting information from patients on the extent to which their health care providers are appropriately involving them in decisions about care.

TRANSFORMATION PRINCIPLE III:**Health Care Payment Systems Should Be Restructured to Support and Encourage Evidence-Based, High-Value Health Care**

- **Providers should be accountable for the total cost and quality of care for a given the population they care for;**
- **Individuals should be empowered with information on the quality and cost of care and should be responsible for choosing providers and services based on value, with minimal restrictions on switching providers;**
- **Payment systems should support improved coordination of care (medical home concept);**
- **There should be increased full transparency and vigorous provider competition on price and quality; and**
- **A sufficient number of purchasers and payers should support the restructured payment system in order to achieve and sustain the “critical mass” needed to make the reform successful.**

What a Transformed Healthcare Payment System Should Look Like:**A. Payment Systems Should Hold Health Care Providers Accountable for Quality, Care Coordination, and the Total Cost of Care**

III-A1: Payment reforms to achieve greater provider accountability for quality, care coordination, and the total cost of care should be achieved in 3 stages. ~~This proposal includes 3 different stages of payment reform to promote greater provider accountability for health care cost and quality.~~ Some providers, such as large Twin Cities area integrated care systems, may be ready today to participate in level 3; others may only be ready for level 1. ~~It is anticipated (required?) that All health care providers should move to level 3 by January 1, 2012 within 3 years following implementation.~~

III-A2: **Level 1** of payment reform will involve making payments to providers explicitly depend on the quality of care they provide:

- Providers meeting specific targets (or who show a certain amount of improvement over time) will be eligible for these quality-based payments. These payments will be incorporated into existing payment systems in a budget neutral way, most likely as withholds.
- For primary care providers, the quality measures will include, as a minimum, preventive services, coronary artery disease, diabetes, asthma, and depression.
- For specialty care, where the availability of quality measures is more limited, specialty societies have developed quality

indicators that can be measured and reported publicly, and they should be encouraged to develop additional quality indicators.

- Other indicators of specialty care quality and efficiency can be incorporated, such as the existence of care infrastructure (e.g., electronic record systems), collection and internal/external reporting of results, and measures of efficiency on specifically defined procedures.
- Hospitals will also be paid for quality using existing measures.

III-A3: **Level 2** of payment reform will involve providers assuming greater responsibility for coordinating care for patients, particularly those with chronic conditions.

- Providers at level 2 will ~~be eligible to receive~~ “care management fees” for monitoring and managing care.
- Providers will need to meet specific standards, including having specific types of systems in place, to be eligible for care management fees. Initially, the ~~care management fees~~ standards will be based on processes, but eventually they should quickly evolve to be based on cost and quality results.
- Although the care management fee creates an additional payment to providers, it is expected that increased use of care management will result in less use of acute care services and overall cost savings.
- The quality-based payments in Level 1 would also be included in Level 2.

III-A4: **Level 3** of payment reform will involve providers and care systems assuming responsibility for the total cost of care for the patients they manage.

- Providers and care systems will submit bids on the total cost to care for a given population. (Ultimately, provider bids should be based on value (i.e., quality and cost), rather than simply cost.)
- In order to be eligible to bid, providers will need to meet certain standards for quality of care.
- Actual payments to providers will still likely be based on the current fee-for-service and episode-of-care payment system (for tracking delivery of services and resource use, and as a cash flow mechanism for reimbursing providers), but the levels of payment will be adjusted to match the bids made by the provider. The explicit care management fees under Level 2 would continue to be used as part of the underlying fee structure in Level 3, and the quality standards required for providers to receive these fees would remain in place.

- In addition, the payments to providers will be risk-adjusted based on the health of the population they manage, to avoid penalizing providers for enrolling caring for a less healthy population. Risk adjustment would be focused on things that providers cannot control, and would be combined with quality incentives to reward providers (or not penalize them) for keeping their patients healthy (i.e., lower risk).
- Because this mechanism holds providers accountable for the total cost of care of the population they manage, providers will have incentives to innovate and redesign systems and make investments to provide care more effectively and efficiently.
- The quality-based payments in Level 1 will also be included initially in Level 3. Ideally, they will be temporary and phased out, since (a) they impose administrative costs on providers and (b) under Level 3, patient choice and competition should give providers stronger incentives to improve quality. However, the quality-based payments may continue to be needed in non-competitive markets.

B. The Basic Structures of Payment and Pricing Must Also Be Reformed

III-B1: ~~Current payment systems would be restructured so that they preferentially reward~~ Fee levels for primary care, care management, and other cognitive services should be increased relative to other services. Current payment systems are believed to underpay for these types of services compared to procedures. This reform would promote greater use of primary care, and paying more for primary care would address some of the financial incentives that have resulted in fewer medical students choosing primary care careers. (This would not require a complete reweighting of all fee levels for all services.)

III-B2: All providers should ~~move to a system of payment that establish a single price for each service billed on a fee for service basis that all payers~~ (other than Medicare and Medicaid) would pay. Providers would no longer have to negotiate prices with numerous third party payers, and payment rates to a particular provider would no longer vary based on the type of insurance a person has. Instead, providers would set prices that are visible throughout the community and easy to understand. This change would promote greater competition by providers, as well as reduce health plan and provider administrative costs. (Providers and health plans could continue to negotiate on network participation.)

III-B3: Payment Mechanisms to enable payment of a single price for “baskets” of services would also be added to existing provider reimbursement structures. This change would improve price transparency for consumers, and also explicitly create incentives for providers to improve efficiency and quality. In addition, it

provides additional points of provider competition beyond just health plan/care system choice. Core components of the baskets would be defined by a community-wide process, to enable “apples to apples” comparisons by consumers. Providers would be free to innovate on care design, extra services, and efficiency within the baskets.

C. Individuals Should Be Given Information and Incentives to Choose More Cost-Effective, Higher-Quality Providers

III-C1: All providers would be required to submit information on the prices they are paid for care to the central organization defined in recommendation II-B-1 (e.g., Minnesota Community Measurement), which would publish this information in conjunction with quality information in order to help consumers find the highest-value providers.

III-C2: Consumers should incur lower costs for using more cost-effective, higher-quality providers. Health plans should set allowed reimbursement based on the level of payments to cost-effective providers, and enrollees who seek care from higher-cost/lower-value providers should be required to pay the difference.

III-C3: Consumers should also be given incentives to choose and use a medical home. This goal could be accomplished through lower premiums, lower cost-sharing, or other incentives. “Virtual” medical homes should be permitted for consumers who wish greater flexibility in managing their care.

III-C4: Consumers should not be restricted from switching providers, but they could be required to pay more if they choose to switch medical homes frequently.

III-C5: In order for price and quality transparency initiatives to have the greatest effect, consumers would need access to easy-to-use information on both price and quality. Internet-based tools should be developed to help consumers make comparisons and to understand differences in out of pocket costs based on their *own specific* health plan benefits.

III-C6: During the initial implementation of the system, consumers should not be forced to pay more to use lower-value providers if there is strong evidence that higher-value providers do not have sufficient capacity to care for them.

D. A Critical Mass of Purchasers and Payers Must Support the New Payment Systems on a Sustained Basis

III-D1: In order to make it worthwhile for providers and care systems to participate in this new payment system, it needs to involve a significant percentage of their patients. Similarly, in order to make it cost-effective for payers to change their payment systems, a

significant number of providers need to participate. Therefore, in order to be successful, this effort payment reform must include as many providers and payers as possible. Potential mechanisms for achieving and sustaining “critical mass” include:

- Making participation a condition of receiving payment for any patient paid for with state funds (i.e., state employees and public program enrollees) – this requirement would apply to both health plans and health care providers;
- Requiring participation by all state and local units of government, including school districts;
- Extending the participation requirement to the small group and individual markets;
- Extending the participation requirement to the entire fully-insured market; and/or
- Encouraging voluntary participation by other market players (self-insured employer plans).

Implementation Steps and Responsible Organizations:

E. Actions by the State Legislature

III-E1. By June 30, 2008, the Legislature and Governor should enact legislation designating [an organization] to develop a detailed implementation plan for the new payment system.

III-E2. By December 31, 2008, the Legislature and Governor should enact legislation requiring that participation by providers and health plans in the new payment system is a condition for receiving payment for any patient paid for with state funds (state employees and persons whose health care is paid for through state programs).

III-E3. By December 31, 2008, the Legislature and Governor should enact legislation requiring that all local governments, including school districts, use only health plans and providers participating in the new payment system.

III-E5. By December 31, 2008, the Legislature and Governor should enact legislation requiring that all health plans sold through the Exchange and elsewhere in the state participate in the new payment system.

F. Actions by the State Executive Branch

III-F1. By June 30, 2009, the Minnesota Department of Human Services should implement the new payment system for all participants in the state’s public health care programs, including MinnesotaCare and the Medicaid program. The Department should seek any necessary approvals from the Centers for Medicare and Medicaid

Services (CMS) for implementation of the payment system in Minnesota's Medicaid program.

III-F2. By June 30, 2009, the Minnesota Department of Employee Relations should implement the new payment system for all state employees.

G. Actions by Other Organizations

III-G1. By December 31, 2008, the [designated organization] should develop a detailed implementation plan for the new payment system with involvement from purchasers, payers, and patients. The plan should provide for initial implementation of the new payment system no later than June 30, 2009.

III-G2. By December 31, 2008, the members of the Buyers Health Care Action Group should commit to participate in the new payment system.

III-G3. By December 31, 2008, each of the largest health care providers in the state should commit to participate in the new payment system.

III-G4. By December 31, 2008, each of the major health plans in the state should commit to participate in the new payment system.

III-G5. All purchasers and payers should discontinue their existing pay-for-performance systems as soon as the new payment system is in place.

TRANSFORMATION PRINCIPLE IV:**The Overall Size and Cost of the Health Care System Should Be Reduced In Order to Make Health Care More Affordable**

- Health providers should reduce the cost of care per case on a risk-adjusted basis by eliminating waste and improving efficiency.
- Underutilized services, particularly those of below-average quality, should be scaled back or eliminated.
- Health plans should reduce their own administrative costs and the administrative costs imposed on providers.
- Providers should only make new capital investment where there is a clear case that the overall value of health care will be improved in the communities being served.
- New, unproven, or experimental treatments, procedures, and drugs should be provided in a manner that systematically advances knowledge and restrains resource consumption.

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

A. Providers Should Reduce the Costs of Care Per Patient (Including Administrative Costs) While Maintaining or Improving Quality.**Options:**

Y/N/M/?

- | | |
|----------|--|
| 11/0/2/0 | 11a: Use market forces to transition the system, but get the incentives right so the market is achieving what is desired. <ul style="list-style-type: none"> • <i>Need better value info before market can work</i> |
| 10/0/2/1 | 11g: Refuse to increase payments to providers to cover the costs of underutilized capacity. <ul style="list-style-type: none"> • <i>This would eliminate access hospital payment; not always appropriate.</i> |
| 10/1/2/0 | 11f: Reduce the costs of doing business for health care providers, e.g., lower administrative costs, lower malpractice insurance costs. |
| 8/2/3/0 | 11j: Encourage patients to use providers who become more specialized in the services where they can provide the highest quality and lowest cost (e.g., specialty hospitals vs. general hospitals). <ul style="list-style-type: none"> • <i>Create benefit designs that do this</i> • <i>Can't assume specialization always creates value.</i> |
| 8/2/2/1 | 11i: Develop methods of preventing price gouging in consolidated markets. |
| 7/2/4/0 | 11n: Eliminate expensive diagnostic testing to validate the need for treatment when the treatment cost is significantly less than the cost of testing. <ul style="list-style-type: none"> • <i>Should be a function of the payment system and benefit design.</i> • <i>Safety is also a consideration.</i> |

-
- 7/3/2/1 11m: Encourage/require providers to provide care with a “limited warranty.”
- *Let the market determine if providers want to do this.*
- 7/4/2/0 11h: Require health care providers to report publicly on their fixed costs relative to direct care provided.
- 6/2/5/0 11c: Encourage low-quality, high-cost providers to go out of business.
- *Need to ensure access in certain parts of the state.*
 - *First there should be transparency of quality and price, then have benefits that support steering a person to the most efficient providers, and then let the market work. Not clear how to encourage people to go out of business.*
 - *Will occur naturally.*
- 6/3/3/1 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 (or to improve population health).
- 6/4/3/0 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).
- 5/5/3/0 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.
- *Seems paternalistic.*
- 4/4/5/0 11k: Set total spending growth limits on providers and publicly report on their status.
- *Give the market a chance to work first.*
 - *This is micromanagement.*
- 4/5/2/2 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, develop plans to eliminate the waste and inefficiency, and report on their progress.
- NEW 11o: Require each specialty organization to define and report quality measures for the providers in their specialty.
- NEW 11p: Establish portable medical records for patients.
- NEW 11q: Require patient-centered decision-making where a range of treatments is available.
- NEW 11r: Tort reform by placing a cap on settlements and requiring the plaintiff to pay legal costs of the defendant if the case is shown to be groundless.
- NEW 11s: Remove prohibition on corporate practice of medicine to allow greater leverage and competition.

- NEW** **11t:** Create incentives for the adoption of EMR on a single interoperable standard (e.g., CCR) to improve the sharing of information and reduce the administrative costs of maintaining records.
- NEW** **11u:** Provide mechanisms for shared savings among providers.
- NEW** **11v:** Pay providers for quality/value improvement work.
- NEW** **11w:** Allow providers flexibility in how practices deliver care, e.g., non-visit care, use of a team approach, clinicians practicing at the top of their license, etc.
- NEW** **11x:** Implement shared decision making models that are patient-centered and friendly.

B. Health Plans Should Reduce Costs, Particularly Administrative Costs, For Both the Health Plan Itself and For Providers.

Options:

- 12/1/0/0** **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.
- 12/1/0/0** **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.
- 11/1/0/0** **12h:** Define the role that health plans should continue to play under the transformed system, eliminate the functions that are no longer necessary, and reduce administrative costs accordingly.
- 10/1/1/1** **12f:** Require health plans to open their financial statements for public review.
- *Only information that doesn't cause anti-trust concerns.*
 - *Only if also done for other stakeholders*
- 9/3/1/0** **12b:** Require health plans to publish report information on their administrative costs relative to payments made to providers.
- 9/3/1/0** **12e:** Set standards for definitions of administrative costs and require health plans to itemize their services and costs accordingly.
- 7/5/1/0** **12a:** Rely on competition among health plans to keep administrative costs at a minimum.
- 6/3/2/1** **12i:** Provide medical debit cards to consumers to enable more efficient payment for low-cost services.
- *Too specific; let the system determine how to be more efficient.*
- 4/4/4/1** **12g:** Establish a ceiling for health plan administrative costs, based on the levels achieved in other states and countries.
- NEW** **12j:** Conduct a benefit-cost analysis of current administrative requirements placed on health plans by statute and regulations, and eliminate requirements that do not demonstrate a clear value.

- NEW** **12k:** Review specific instances in the financing of care where collaboration among payers would be beneficial to advancing a value-improvement initiative, and create a safe environment in which discussions could take place, similar to what was done in the DIAMOND initiative.
- NEW** **12l:** Require annual health assessments to identify patients at risk of chronic disease.
- NEW** **12m:** Review the value of the limitation in the state to nonprofit health plans.
- NEW** **12n:** Tax health plan reserves as if they were profits of a for-profit corporation.

C. The Transition to a Smaller Health Care System Should Be Encouraged and Facilitated.

Options:

- 9/2/2/0** **13d:** Educate citizens and public officials about the advantages of a smaller health care system.
- *This is a difficult message and not necessary.*
- 7/5/1/0** **13e:** Require health care providers to publicly report on their efforts to reduce costs, improve community health, and improve quality.
- *This adds cost to providers.*
 - *There have been mandates like this before, without clear effect.*
- 5/4/3/1** **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.
- *Projecting this is very hard and likely inaccurate.*
- 5/5/2/1** **13b:** Provide technical assistance and transition financing to providers to help in restructuring operations for smaller volume.
- 4/6/2/1** **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.
- NEW** **13f:** Provide transition financing to providers to help in restructuring operations for smaller volume.
- NEW** **13g:** Reduce the number of higher education slots for healthcare providers where oversupply exists.

D. New Health Care Technologies Should Only Be Used When They Improve Value.

Options:

- 9/2/2/0 **14c:** Limit payment for new technology to those conditions for which effectiveness has been proven by randomized controlled trials.
- *Should be done through benefit design*
- 9/3/0/0 **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.
- 8/2/2/1 **14d:** Establish a public/private independent collaborative organization to review new technologies and report publicly on their relative value.
- *Could do this in collaboration with NICE in Britain or other U.S. states which need/want to do something similar.*
- 8/3/1/1 **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.
- 7/2/3/1 **14f:** Establish a separate pool of funding or payment mechanism for new, unproven, and experimental treatments, procedures, and drugs.
- *Combine with 14a. Society does need to determine how to offer protocols for times when the answers are unknown, so patients do not feel they are being denied care.*
 - *Health plan funds should not be used to further research of drug and device manufacturers.*
- 6/1/4/1 **14e:** Pay for new technologies based on a Quality Adjusted Life Year (QALY) or cost-effectiveness calculation.
- 6/2/4/0 **14h:** Assure that those who promote or financially benefit from new therapies share in the cost of care.
- 6/3/2/1 **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.
- 5/3/5/0 **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.
- 5/5/3/0 **14g:** Cover the cost of care only if it is provided as part of a national randomized controlled trial.
- *This is a subset of 14f*
- 3/3/5/1 **14b:** Limit payments for services to current levels plus normal inflation, regardless of which technologies are used.

- 2/2/7/2 **15d:** Establish a Quality Adjusted Life Year (QALY) target/maximum and require patients to pay out of pocket for treatments that exceed the target.
- *Doesn't a community-wide technology assessment process and minimum benefit set achieve the same thing?*
- NEW** **14i:** Require higher copayments when a more costly technology is selected by the consumer.
- NEW** **15e:** Develop a benefit set based on value.
- NEW** **15f:** Charge ICSI with aggressively pursue more overuse issues, similar to diagnostic imaging.

E. Additional Providers Should Be Encouraged to Enter Markets That Are Underserved or Do Not Have Adequate Competition.

Options:

- NEW** **22a:** Identify geographic areas where a shortage of health care providers is projected, and develop plans to encourage training and service in those areas.
- NEW** **22b:** Expand the number of dental providers available, in order to reduce use of emergency rooms.
- NEW** **22c:** Allow more than two provider agreements for a physician in a nurse practitioner protocol.

Implementation Steps and Responsible Organizations:

- F. Actions by the State Legislature**
- G. Actions by the State Executive Branch**
- H. Actions by Other Organizations**

TRANSFORMATION PRINCIPLE V:**All Minnesotans Should Be Able to Obtain Necessary Health Care at An Affordable Cost**

What a Transformed Health Insurance System Should Look Like:

- A. Insurers Who Offer Individual Policies Should Be Required to Sell Policies to Anyone Who Wishes to Buy One. (Guaranteed Issue)**
- B. The Same Plans Offered to Small Groups Should Be Available to Individuals. (Merger of Small Group and Individual Markets)**
- C. Premiums Should Only Vary Based On Age, Individual Health Behaviors (e.g., Smoking), and Geography. (Modified Community Rating)**
- D. Risk Equalization Payments Should Be Made to Health Plans Based on the Relative Health of Their Enrolled Population.**

V-D1. Payments should be designed to eliminate incentives for “cherry picking” low risk patients and to reward plans that do a good job of managing care for sicker populations

- E. A Health Insurance Exchange Should Be Established Through Which Individual and Small Group Insurance Products Would Be Sold.**

V-E1. All individual and small group insurance products should be sold only through the Exchange. To the extent that individual and small group insurance products are sold outside the Exchange, the premiums, rating, and issuance rules should be the same as those sold inside the Exchange.

V-E2. At least initially, there should be a limited selection of plans through the Exchange (e.g., 3 products per carrier at each benefit level; allowing variations on plan design that are actuarially equivalent).

V-E3. Policies should be offered with a minimum benefit set that:

- Covers necessary, evidence-based care;
- Does not cover care that has been demonstrated to be ineffective; and
- Covers other services that produce good outcomes at a reasonable cost.

V-E4. Incentives should be provided to encourage participation of small employers to offer insurance through groups in the Exchange.

V-E5. Large group policies would not be sold through the Exchange.

F. All Citizens, Including Current Minnesota Comprehensive Health Association (MCHA) Enrollees, Should Have the Responsibility to Obtain and Retain Health Insurance Coverage That is Affordable.

V-F1. MCHA as a mechanism for providing coverage should be phased out over time. (The funding currently raised through the MCHA assessment may need to be replaced in some fashion to help cover the costs of subsidies.)

V-F2. Subsidies should be provided to individuals and families who cannot afford approved benefit plans through the Exchange or through their employer.

V-F3. The affordability of a health insurance plan should be defined based on both premiums and out-of-pocket costs the combined cost to an individual or family of:

- premiums;
- deductibles; and
- copays and coinsurance.

V-F4. Affordability limits should be defined in terms of a sliding scale based on income for households with income up to at least 300% of poverty. Affordability limits should vary by age and by geography (to incorporate differences in the costs of other living expenses).

V-F5. A mandate for individuals to purchase insurance would be considered in the future if voluntary efforts to expand coverage sufficiently fail.

G. All Employers Above a Minimum Size Should Be Required to Offer Section 125 Plans to Enable Pre-Tax Payment of Premiums.

H. Incentives Should Be Provided to Encourage Employers That Currently Offer Group Coverage to Continue Doing So. (Erosion Control)

Implementation Steps and Responsible Organizations:

I. Actions by the State Legislature

V-II. By December 31, 2008, the Legislature and Governor should enact legislation that establishes the Health Insurance Exchange under the auspices of [agency/organization], and which requires that by January 1, 2010, (a) all small group and individual health insurance policies will be sold through the Exchange, and (b) all insurers offering small group and individual health insurance policies will do so in compliance with guaranteed issue and modified community rating requirements.

V-I2. By December 31, 2008, the Legislature and Governor should enact legislation establishing a mechanism for providing subsidies to make health insurance coverage through the Exchange that meets minimum benefit standards established by the Legislature affordable for individuals and families with incomes up to a maximum limit established by the Legislature, based on an affordability standard established by the Legislature.

V-I3. By December 31, 2008, the Legislature and Governor should enact legislation requiring all employers with more than [X] employees to offer Section 125 plans to their employees.

V-I4. By December 31, 2008, the Legislature and Governor should enact legislation establishing incentives to encourage employers to continue offering group coverage and to encourage small employers to offer insurance to their employees through the Exchange.

J. Actions by the State Executive Branch

V-J1. By December 31, 2008, the Minnesota Department of Health should:

1. Estimate the likely cost to a household of a "minimum benefit set" insurance policy, with cost including premiums, deductibles, and copays and coinsurance and out-of-pocket expenditures.
2. Estimate the impact of having lower costs in the health care system and healthier consumers on the cost of a basic plan.
3. Compare that cost to (current and projected) distributions of household income for (projected) uninsured households to determine how many households would experience a cost that exceeded various percentages of income.
4. Calculate the subsidy needed to bring the cost to households within different potential ceilings of affordability (defined in terms of percentage of income).

V-J2. By June 30, 2008, the Minnesota Department of Health should recommend the appropriate benefit levels, subsidy amounts, and affordability standards that should be established by the Legislature in order to enable any Minnesotan to purchase health insurance through the Exchange.

K. Actions by Other Organizations

V-K1. By June 30, 2009, the Health Insurance Exchange should establish a system for risk equalization payments to health plans selling insurance through the Exchange.

EXPECTED IMPACTS FROM THE TRANSFORMATION

PRELIMINARY Summary of Potential Health Care Cost Savings		
	\$ millions	Percent of total spending:
Base: Projected Spending in 2010	\$ 41,100.0	
Payment reform:	\$ 4,110.0	10.0%
Consumer responsiveness to price		
Lower prices (provider competition)		
Improved system efficiency (less overuse/underuse/misuse)		
Investment in population health instead of supply sensitive/preference sensitive services		
Insurance reform (estimates for 2010):		
Uncompensated care	\$ 393.2	1.0%
Public coverage (uninsured who are currently eligible for public programs)*	\$ (1,225.0)	-3.0%
Subsidies for private coverage affordability**	\$ (62.0)	-0.2%
Administrative efficiency	\$ 1,767.3	4.3%
Prevention and health promotion (cumulative savings through 2010)		
Overweight/obesity	\$ 287.0	0.7%
Smoking	\$ 451.0	1.1%
TOTAL	\$ 5,721.5	13.9%

*Estimated state share would be 58%, federal share 34%, and enrollee premiums 8% of total.
 **Subsidies to cap premiums for individual coverage at 10% of income.

APPENDIX A: 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.

