

DRAFT – FOR DISCUSSION ONLY
**An Example of How Minnesota’s
 Transformed Health Care System Will Work**

The following is an illustration of how Minnesota’s Transformed Health System would work in a particular, hypothetical case. This is intended merely as an example for purposes of illustration, not as either an implied mandate as to how providers would have to behave or a prescription for how care should be provided to an individual in this situation.

Part I: Mr. Smith is a single, 55-year old man with a family history of heart disease and multiple personal risk factors for heart disease, including smoking, overweight, and high cholesterol.

| How Today’s Health Care System Works for Mr. Smith | How the Transformed System Will Work for Mr. Smith |
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| <p>Mr. Smith sees a primary care physician infrequently, typically only when he has a specific medical problem. He selected the physician practice from the network list provided by his health plan, based only on a neighbor’s recommendation, since there was no difference in cost among the different physicians on the list and he had no information on their relative quality.</p> <p>Mr. Smith’s physician typically discusses with him only the specific concern which prompted Mr. Smith to make the appointment, and does not probe to find any other health issues Mr. Smith may have; the physician may mention, in passing, that it would be desirable for Mr. Smith to stop smoking, lose weight, and/or lower his cholesterol. As a result, Mr. Smith is not aware of how high his risk is of developing heart disease. Mr. Smith is not proactively contacted by his doctor’s office to encourage him to stop smoking, lose weight, etc., or to remind him of the need for vaccinations, cancer screenings, etc.</p> | <p>After Mr. Smith completes a health risk assessment made available by his employer, his health insurance plan suggests he should choose a physician practice or clinic that has been qualified to serve as a medical home for patients at risk of heart disease. Mr. Smith selects a medical home and its associated health care system from several choices available under his health plan. He selects the medical home in the lowest-cost tier which had the best quality ratings for patients with heart disease. (If he had selected a medical home in a higher-cost tier, he would have had to pay a higher monthly contribution to his employer for the cost of his health insurance.)</p> <p>The clinic he selects as a medical home assigns a physician/nurse team to work with Mr. Smith to develop a plan for reducing his risk factors for heart disease, as well as ensuring he has other preventive care, such as vaccinations and cancer screenings. The nurse calls Mr. Smith periodically to check on his progress in implementing the plan, suggests modifications to parts of the plan that he is having trouble implementing, helps him join programs for weight reduction and smoking cessation, and sets up an office visit when appropriate for an in-person physical assessment.</p> |

| <p>How Today's Health Care System Works for Mr. Smith's Physician</p> | <p>How the Transformed System Will Work for Mr. Smith's Physician</p> |
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| <p>Mr. Smith's physician is paid for a short visit with Mr. Smith to diagnose and treat (or refer for treatment) the specific medical problem that prompted Mr. Smith to schedule the visit. The physician is not paid to spend extra time with Mr. Smith to identify his health risk factors, to work with him to develop a plan for reducing those risk factors, or to follow up with him by phone or email to see if he is having difficulty implementing the plan. (Only additional office visits or procedures result in higher payment for the doctor.) In fact, the more health problems Mr. Smith develops that bring him into the doctor's office, the more the doctor is paid. Mr. Smith's doctor does not ask a nurse in his office to stay in touch with Mr. Smith, since Mr. Smith's health insurance will not pay for the contacts by the nurse, so the physician practice only interacts with Mr. Smith when he comes for a visit. The doctor's office has no information system that enables it to track Mr. Smith's visits or the status of his preventive care.</p> | <p>Under Levels 1 & 2 of Payment Reform:</p> <p>Mr. Smith's primary care physician is paid a care management fee to spend the time with Mr. Smith to improve his health. His physician is eligible to receive this fee because the physician's practice has the information systems and non-physician team members needed to provide effective care management. The amount of this fee is based on the number and kinds of health risk factors that Mr. Smith has. In addition, the physician (through the clinic or practice where he/she works) receives a bonus payment if Mr. Smith's health status improves and he has fewer risk factors and medical problems.</p> <p>Under Level 3 of Payment Reform:</p> <p>The health insurance premium cost to Mr. Smith for the care provided by the health care system he selects is based on a bid submitted by the health care system. The bid defines what the health care system will charge to provide all of the care needed by a population with a standardized mix of health conditions. The actual payment to the health care system will be based on the actual services provided by the health system to all of the patients covered by the health insurance plan, the individual fees the system charges for each of those services, and an assessment of the relative health conditions and risk factors of all of the health plan members that the system is caring for. Periodically, the actual services provided and the actual severity/risk of the patients cared for will be analyzed and compared to the bid from the health care system. If the care system's total charges to the health plan, after adjusting for the severity/risk of the population, are higher than the amount it bid, then the fees the system is paid for individual services would be adjusted downward so that the total amount the system is paid would be within the bid amount.</p> <p>This gives the health care system an incentive to (a) set its fee levels appropriately and (b) manage the utilization of services by all of its</p> |

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| | <p>patients. If it can submit a lower bid (through lower unit costs and/or better utilization management), it will be able to attract more patients, which in turn will allow it to spread its fixed costs across a broader range of patients, enabling it to be more profitable and to further reduce the individual fees it charges for services.</p> <p>In terms of individual patients, if Mr. Smith gets sick, his health care system is responsible for fully caring for him, and the health system will receive extra payment for extra care that Mr. Smith requires. However, if the health system provides large numbers of services, particularly expensive services, not only to Mr. Smith but to many other people it is caring for, the fees/prices paid to the health system for each service (both services for Mr. Smith and for other patients) would be reduced periodically so that the total cost of the care the system provides to all patients would stay within the amount it bid. If Mr. Smith stays well and uses relatively fewer expensive health care services, the health system would benefit financially, and it would also receive higher quality ratings. So the health system has an incentive to ensure that Mr. Smith's medical home devotes the time and effort needed to help Mr. Smith develop and implement his health improvement plan.</p> |

Part 2: Mr. Smith stops smoking, loses weight, and reduces his cholesterol, and he feels better for several years. However, he then experiences mild chest pain while exercising.

| <p>How Today's Health Care System Works for Mr. Smith</p> | <p>How the Transformed System Will Work for Mr. Smith</p> |
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| <p>Mr. Smith goes to the nearest emergency room, where he is seen by a cardiologist who recommends an angiogram, and the cardiologist schedules an angiogram at the hospital where the emergency room is located. Mr. Smith receives a lengthy itemized list of all of the hospital charges for the angiogram, along with a bill for the copayment amount required under his health insurance policy. Mr. Smith does not realize that his health insurance pays the hospital much less than the total amount on the charge list he receives. If Mr. Smith has no health insurance, he is expected to pay the full amount of the hospital charges shown on the itemized list.</p> <p>The angiogram shows that Mr. Smith has minor blockage of two coronary arteries. The cardiologist who performed the angiogram recommends that Mr. Smith have stents inserted, and Mr. Smith agrees to have the stent procedure performed by the same cardiologist at the same facility where he had the angiogram.</p> <p>On his next visit to his primary care doctor, the doctor is surprised to learn that Mr. Smith has had stents inserted and is taking new medications.</p> | <p>Mr. Smith calls his medical home, which arranges for him to come in to the office immediately for an assessment. The doctor at the medical home consults with a cardiologist in the health care system, recommends he have an angiogram, and reviews with him a list of facilities that perform angiograms. For each angiogram facility, the list summarizes the outcomes for people who had angiograms in the prior year (e.g., the percentage of patients who experienced complications) and states the total price that is required for performing the angiogram, including the fees for the cardiologist who performs the test. The list shows that facilities offering CT angiograms, rather than invasive angiography, have higher quality and lower costs.</p> <p>Mr. Smith chooses the CT angiography facility with the highest quality rating, even though its price is 20% higher than the lowest-cost facility, which means that he will be responsible for paying the 20% difference in addition to a standard copayment required by his health insurance policy. He is not restricted to using angiogram providers owned or operated by the health care system with which his medical home is affiliated, although he may have to pay somewhat more to use a provider outside that health care system. Mr. Smith's medical home electronically sends all of his pertinent medical records to the cardiologist at the chosen facility.</p> <p>The angiogram shows that Mr. Smith has minor blockage of two coronary arteries. Since there is no need for immediate action, Mr. Smith's medical home physician and/or a cardiologist affiliated with the health care system talks with Mr. Smith to explain the options and the evidence associated with them, which include medical management, use of stents, or coronary artery bypass graft surgery. After understanding the risks and benefits of</p> |

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| | <p>each approach, Mr. Smith decides to let his physician, or a cardiologist affiliated with the medical home, try and manage his condition using medications. Mr. Smith's medical home physicians and non-physician team members track his progress closely through email and phone contacts as well as in-person visits.</p> |

| How Today's Health Care System Works for Mr. Smith's Providers | How the Transformed System Will Work for Mr. Smith's Providers |
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| <p>Angiogram providers are paid an amount that they negotiated with Mr. Smith's health plan, which is much lower than the amount shown on the list of charges that Mr. Smith receives. Mr. Smith pays a standard copayment regardless of which provider he uses, so the provider cannot attract more patients by charging less.</p> <p>The cardiologist who performs the angiogram also inserts stents and performs coronary artery bypass surgery, and is paid for each procedure performed, with the highest payments for interventions like stents or surgery, so the cardiologist has a financial disincentive to recommend medical management of Mr. Smith's condition.</p> | <p>Under Levels 1 & 2 of Payment Reform:</p> <p>Each angiogram provider defines and publishes a price for performing angiograms (and the same price is charged to all patients, regardless of which health insurance plan they use). Mr. Smith's health plan pays a fixed amount for CT angiograms, which is based on the lowest price charged by high quality CT angiogram providers. Mr. Smith pays a standard copayment amount plus the difference, if any, between the provider's price and the amount paid by the health plan. This gives angiogram providers an incentive to keep their costs low and to compete on both cost and quality to attract patients like Mr. Smith. Mr. Smith has a financial incentive to use the lower-cost angiogram providers, unless he feels that a provider has sufficiently higher quality to justify him paying a higher price out of his own pocket.</p> <p>Mr. Smith's primary care physician would receive an increased care management payment for advising him and monitoring his care, and the primary care physician and/or cardiologist would receive a bonus or penalty payment based on the outcomes for patients diagnosed with coronary artery disease and the frequency of use of expensive interventions relative to other physicians. In addition, information on the outcomes they achieve for patients will be reported publicly.</p> <p>Under Level 3 of Payment Reform:</p> <p>The physicians and angiogram facility that provided Mr. Smith's care are paid based on the prices currently in effect under the health</p> |

care system's bid, after adjustments for the overall performance of the health care system relative to the bid. The providers will be paid differently depending on whether his coronary artery blockage is treated medically or surgically, just as it is today. However, if the health care system uses surgical treatment for many patients when medical treatment would be equally or more effective, then the health care system would be at risk of exceeding its bid price and having the individual fee amounts reduced, so Mr. Smith's physicians have a small financial incentive to use a less expensive intervention. However, because the physicians are also measured on outcomes, they have an incentive to avoid under-treating Mr. Smith if surgery is really more appropriate.

There would be an increase in the overall payment to the health system if its patients are sicker on average than the general population, particularly if they have illnesses that are not preventable by the health system. For example, once Mr. Smith is diagnosed with active heart disease, despite efforts to prevent it, he would raise the overall severity/risk profile of the patient population his health care system is serving.

Mr. Smith has an incentive to select the highest-quality, lowest-cost care option for each aspect of his care, which helps his health care system control costs. If Mr. Smith chooses an angiogram provider that is not owned or operated by the health care system with which his medical home is affiliated, the system would provide him a financial allowance for the angiogram, and he would pay the difference between that allowance and the price charged by the angiogram provider he chooses.