

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

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Transformation Principle I:**A Combination of Collaboration and Competition Should Drive Improvements in the Quality, Costs, and Patient-Centeredness of Health Care, 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;**
- **Health care plans should compete to promote patient health and encourage patient use of higher-quality/lower-cost providers, but *should not* compete by refusing or discouraging coverage for less-healthy patients;**
- **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, while ~~maintaining or~~ reducing current expenditures; and**
- **Health care purchasers should encourage and support the transition to improved delivery of health care and improved payment systems.**

How Collaboration, Competition, and Reformed Payment Would Work

- A. Health care providers would strive to deliver the highest quality, most efficient care possible.
- B. Patients would select providers based on value.
- C. Information on provider quality and price would be publicly available.
- D. Providers would be paid for more comprehensive bundles of services, and wherever possible, for full episodes of care, rather than service-by-service fees, and would not be paid for poor quality care or preventable adverse events.
- E. Payment levels would be driven by provider competition, but with ceilings that will reduce total payments by 20% by 2011.
- F. Patients would have incentives to choose high-value services and to adhere to care plans.

How Collaboration, Competition, and Reformed Payment Would Work in the Transformed Healthcare System:

A. Health Care Providers Would ~~Strive to~~ Deliver the Highest Quality, Most Efficient Care Possible

- I-A1. Providers would 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).
- I-A2. Providers would deliver care to patients consistent with evidence-based guidelines, 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), and to demonstrate the effectiveness of the innovations through a collaborative.
- I-A3. 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 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.)
- I-A4. Collaboratives would define the minimum standards/expectations for outcomes of care, and payers would refuse to pay for care that does not meet the standards.
- I-A5. Health plans, purchasers, and providers would contribute financially to cover the cost of the collaborative processes for improving the quality of care.
- I-A6. Providers would involve patients in decision-making about care, and ensure that information about treatment options was provided by someone without a financial interest in the patient’s choice.

B. Patients Would Select Providers Based on Value

- I-B1. **[SOME MEMBERS INDICATE CONCERNS]** Consumers would be encouraged to select a lead ~~primary~~ care provider (a “medical home”) to provide care and to help them manage their care from other providers.

- I-B2. A clear definition and standards for “medical home” should be established through a collaborative effort of providers and health plans, and patients should be made aware of which providers meet the standards.
- I-B3. Consumers would be given access to information regarding the risk-adjusted quality and cost of the care given to similar patients by each of the available providers, in order to make a decision about which provider to use based on relative value. (See Section C below.)
- I-B3. Providers would be expected and encouraged to proactively compete to serve consumers based on cost, quality, and patient-centeredness of care, and payers and purchasers would remove impediments to the ability of patients to use higher-value providers.
- I-B4. 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.

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

- I-C1. All providers would 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.
- I-C2. The outcomes and processes to be collected would be defined through a collaborative process involving providers, payers, and consumers. 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. **[SOME MEMBERS INDICATE CONCERNS]** In addition, all providers would be required to submit information on the prices they are paid for episodes of care (as defined in Section D) to the central organization/agency. ***[SHOULD PROVIDERS BE REQUIRED TO SUBMIT INFORMATION ON COSTS?]***

- I-C4. **[SOME MEMBERS INDICATE CONCERNS]** The central organization/agency would 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.
- I-C5. The central organization/agency would publish audited information on each provider's quality and price in order to help consumers find the highest-value providers. Prices would be reported based on episodes of care, as defined in Section D.
- I-C6. Health plans, providers, and purchasers 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 More Comprehensive Bundles of Services, and Wherever Possible, for Full Episodes of Care, Rather Than Service-by-Service Fees, and Would Not Be Paid for Poor Quality Care or Preventable Adverse Events

- I-D1. For as many types of patients and conditions as possible, the provider would be paid a single, "bundled" payment for all of the services which are required for a complete episode of care. (In the case of chronic illness or preventive care, an "episode" would be defined as a period of time; in the case of acute illness, an "episode" would be begin at the initial diagnosis of a condition and end with completion of all treatment of that condition.) The monthly amount that the provider is paid would depend on patient's level of risk and severity, based on a standard risk/severity-adjustment methodology developed by a payer/provider collaborative. The provider would also receive a bonus/penalty adjustment to this payment based on the relative level of utilization of services which are related to the patient's conditions but which are not included in the bundle.

The following sub-bullets are intended to define more specifically how these concepts would be operationalized 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.

- I-D1a. **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** For patients with chronic illnesses, the provider selected by the patient would be paid a fixed monthly amount (the "Comprehensive Chronic Care" Payment) 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.

The amount of the payment would vary depending on the number and type of chronic illnesses that the patient has, based on a standard risk/severity-adjustment system established through a payer/provider collaborative. Minor or major acute care *unrelated* to the chronic illness would be paid for separately. Ideally, the cost of major acute care needed by the patient for their chronic illnesses would also be covered by this payment, but initially, the Comprehensive Chronic Care Management Payment might only include outpatient/ambulatory care.

[SHOULD NOT BE A “ONE-SIZE-FITS-ALL APPROACH; PROVIDERS WILL SEEK TO INCREASE VOLUME OF UTILIZATION OF WHATEVER THE PAYMENT BUNDLE IS; NEED TO FIRST IDENTIFY WHAT CARE NEEDS TO BE INCLUDED.]

I-D1b: for major acute care and other services which are related to the patient’s conditions or which are preventable by the provider’s services and which are *not* covered by the monthly Comprehensive Chronic Care Payment, the provider would receive a significant bonus/penalty adjustment to the monthly payment level based on the utilization of those services, so that the provider shares partially in the financial risk associated with these services; and

I-D1c: ***[SOME MEMBERS INDICATE CONCERN OR OPPOSITION]*** if there are patients requiring an unusually large number of services which the payer/provider collaborative agrees are not adequately addressed by the risk/severity adjustment system, 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. ***[POTENTIAL ADMINISTRATIVE NIGHTMARE.]***

I-D2. The provider selected by the patient would not be paid for services that do not meet minimum standards for processes and/or outcomes established by the collaborative as defined in I-A4.

I-D3. The provider would not charge nor be paid extra for any services or costs required due to avoidable errors, hospital-acquired infections, etc.

I-D4. ***[SOME MEMBERS INDICATE CONCERN]***The provider would receive a significant bonus/penalty adjustment to the payment amount based on: ***[P4P SYSTEMS ARE COSTLY TO ADMINISTER. PRICE SHOULD NOT BE FIXED, BUT SET TO REFLECT VALUE.]***

- (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; and

- the level of patient involvement in decision-making about care, particularly for preference-sensitive care.

I-D5. 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 which are included in the bundled payment.

I-D6. **[SOME MEMBERS INDICATE CONCERNS]**All health care payers would pay providers on the same basis. ***[PRACTICALITY OF HAVING ALL HEALTH PLANS PAYING PROVIDERS ON THE SAME BASIS?]***

I-D7. **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** Health care providers would be able to propose bundling additional services into the episode of care price. 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). ***[WOULD LEAD TO INCREASE COSTS; DIFFICULT TO ADMINISTER.]***

E. Payment Levels Would be Driven By Provider Competition, But With Ceilings that Will Reduce Total Payments by 20% by 2011.

I-E1. **[SOME MEMBERS INDICATE CONCERNS]** 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. ***[INSUFFICIENT COMPETITION IN SOME PARTS OF THE STATE TO SUPPORT THIS. PRICES MAY NOT REFLECT TRUE VALUE.]*** However, payment levels to any provider, after adjusting for changes in patient volume and level of severity, will be no higher than in 2007, and will be reduced by at least 20% by 2011.

I-E2. **[SOME MEMBERS INDICATE CONCERNS]** The consumer's employer or health plan would specify the proportion of the provider's price that it would pay, and the amount that the consumer would be required to pay. The combination of the pre-defined payment from the employer/plan and from the consumer would be considered payment-in-full by the provider. The cost to the consumer for using the highest-value providers would be set at

a level deemed affordable to the consumer. ***[HOW TO ASSURE AFFORDABILITY OF PATIENT'S SHARE?]***

- I-E3. **[SOME MEMBERS INDICATE CONCERNS]** Providers would be able to lower their prices at any time.
- I-E4. Patients would be permitted and encouraged to switch to higher-value providers (i.e., providers with lower costs for equal or higher quality) on at least an annual basis.
- I-E5. Payment levels to each provider for an episode of care or group of patients will be lower than current levels, and the total of all payments under this system will be 20% lower by 2011.

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

- I-F1. Patients would be personally responsible to pay for care of low value or uncertain efficacy.
- I-F2. **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** Patients could 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. ***[IT IS NECESSARY FIRST TO IDENTIFY WHAT CARE PROCESSES ARE APPROPRIATE AND WHERE INCENTIVES MAY BE NEEDED FOR PATIENT ADHERENCE.]***
- I-F3. The benefits available to patients would be adjusted to enable patients to access services or assistance that would facilitate 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
 - Risk/severity-adjustment methods

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- I-G2. What protections beyond risk/severity-adjustment 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. Should payment for medical education be bundled into a provider’s payment or paid for separately?
- 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: **[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.]**
- I-H2: **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** Purchasers, in consultation with consumers and providers, should state their support for an improve payment system and establish a timetable for transitioning to it. 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 should be defined, potentially 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. **[SHOULD NOT TRY TO**

IMPROVE THE FEE-FOR-SERVICE SYSTEM; NEED EVIDENCE THAT THE BHCAG MODEL WORKED.]

- I-H3: Payment changes should be defined initially for those types of patients and conditions where the largest return on investment is expected in the short run.
- I-H4: Payment changes for the patients/conditions defined in I-H3 should be implemented initially in those parts of the state where there are a sufficient number of providers to allow competition based on value.
- I-H5: **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** 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 restructure their operations successfully under the new payment model. ***[THESE SERVICES ARE CURRENTLY AVAILABLE FROM CONSULTANTS.]***
- I-H6: 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.
- I-H7: **[SOME MEMBERS INDICATE CONCERNS]** High-value providers should be encouraged to provide services in underserved or low-competition areas of the state.
- I-H8: **[SOME MEMBERS INDICATE CONCERNS]** Patient incentives should be phased in as standardized risk adjustment measures are developed, 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-H9: **[SOME MEMBERS INDICATE CONCERNS]** 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**

- Health providers should establish and achieve goals for reducing the cost of care per case on a risk-adjusted basis by actively seeking to eliminating waste and improving efficiency.
- Underutilized services, particularly those of below-average quality, should be scaled back or eliminated.
- Health plans should ~~actively seek to~~ reduce their own administrative costs and the administrative costs imposed on providers.
- New capital investment should only be made 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 by the Task Force.

Issue 11: How can providers be encouraged to reduce ~~fixed~~ costs of care per patient (including administrative costs) while maintaining or improving quality, particularly 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:** [SOME MEMBERS INDICATE CONCERN] Encourage low-quality, high-cost providers to go out of business.
- 11d:** [SOME MEMBERS INDICATE OPPOSITION] 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, develop plans to eliminated the waste and inefficiency, and report on their progress.
- 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).
- 11k:** Set total spending growth limits on providers and publicly report on their status.
- 11l:** Develop methods of preventing price gouging in consolidated markets.
- 11m:** Encourage/require providers to provide care with a “limited warranty.”
- 11n:** Eliminate expensive diagnostic testing to validate the need for treatment when the treatment cost is significantly less than the cost of testing.

Implementation Strategy:

- To be determined...

Issue 12: How can health plans be encouraged to reduce costs, particularly 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:** [SOME MEMBERS INDICATE OPPOSITION] 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.
- 12e:** Set standards for definitions of administrative costs and require health plans to itemize their services and costs accordingly.
- 12f:** Require health plans to open their financial statements for public review.

12g: Establish a ceiling for health plan administrative costs, based on the levels achieved in other states and countries.

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.

12i: Provide medical debit cards to consumers to enable more efficient payment for low-cost services.

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: **[SOME MEMBERS INDICATE OPPOSITION]** 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: **[SOME MEMBERS INDICATE OPPOSITION]** 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: **[SOME MEMBERS INDICATE CONCERNS]** 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.
- 14e:** Pay for new technologies based on a Quality Adjusted Life Year (QALY) or cost-effectiveness calculation.
- 14f:** Establish a separate pool of funding or payment mechanism for new, unproven, and experimental treatments, procedures, and drugs.
- 14g:** Cover the cost of care only if it is provided as part of a national randomized controlled trial.
- 14h:** Assure that those who promote or financially benefit from new therapies share in the cost of care.

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:** **[SOME MEMBERS INDICATE OPPOSITION]** 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.
- 15d:** Establish a Quality Adjusted Life Year (QALY) target/maximum and require patients to pay out of pocket for treatments that exceed the target.

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. Specific, Aggressive Goals and Priorities for Health Improvement Among Specific Populations Should Be Established for the State as a Whole and for Employers, Schools, Communities, and the Health Care System.

III-A1: Ambitious but realistic multi-year goals for reduction in obesity should be established, 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 1.3% 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 2013;
- ~~Continue reducing the percentages of Minnesotans who are obese or overweight after 2013.~~

III-A2: Ambitious but realistic multi-year goals for reduction in tobacco use should be established, as follows:

- Continue reductions in the percentages of Minnesotans who smoke by 0.2% in 2008 and 2009. ~~Have no increase in the percentage of Minnesotans who smoke in 2008;~~
- Reduce the percentage of Minnesotans who smoke by 2% per year beginning in 2010, so that the percentage who smoke is cut in half by 2013;
- Continue reducing the percentage of Minnesotans who smoke after 2013.

III-A3: Ambitious but realistic multi-year goals for reduction in alcohol addiction should be established, as follows:

- *To Be Determined Based on MDH Recommendations*

~~III-A4: Ambitious but realistic multi-year goals for reduction in drug addiction should be established, as follows:~~

III-A4: After initial progress is made on the goals for obesity, tobacco use, and alcohol use, additional goals should be established for reductions in other health conditions and for prevention of other diseases (e.g., drug addiction, air quality, water quality, low-

birthweight babies, pesticides, etc.) based on an analysis by the Minnesota Department of Health of:

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

III-A5: 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, what analyses indicate is achievable in the future, etc. 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.

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

- The State of Minnesota should ~~seek to 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. A Specific Plan for Achieving the Goals Should Be Developed and Regularly Updated by Key Stakeholders Who Accept Accountability for Its Implementation

III-B1. 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 disease. Both interventions that are directed at individuals and interventions that are directed at environmental factors should be included.

III-B2. 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

III-B3. 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.”

III-B4. 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..

III-B5. The business case for health promotion interventions should be defined to help encourage all organizations to implement them and/or to determine what resources were 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 ~~other benefits of interest~~ to each stakeholder, such as lower employee absenteeism, better performance in school, etc.

III-B6. 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 would be promptly eliminated.

C. Progress in Achieving Goals Would be Publicly Reported

III-C1. 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.

III-C2. 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.

III-C3. 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.)

Implementation Steps and Responsible Organizations:

- By December 31, 2007, the Minnesota Department of Health should revise the Comprehensive Statewide Health Promotion Plan to define specific actions that could be taken to achieve the goals on obesity reduction and tobacco use, and to establish a process for defining goals for reduction in alcohol addiction and drug action improvements in other priority health-related issues and defining actions to achieve those goals.

Expected Impacts from the Transformation:

Reduction Over Baseline Costs:

- From obesity reduction: ~~0.39~~1.6% by 2011, 2.0% by ~~2020~~2013
- From smoking reduction: ~~0.72~~2.0% by 2011, ~~1.45~~4.1% by 2013
- From alcohol addiction reduction: *to be determined*
- ~~From drug addiction reduction: *to be determined*~~

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**

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, ~~and a common experience pool should be used to determine premium rates.~~ (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.**

IV-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.**

IV-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.

~~IV-E2. At a minimum, premiums, rating and issuance rules should be the same inside and outside of the Exchange.~~

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

IV-E3. Policies should be offered with a minimum benefit set that covers necessary ~~, evidence-based~~ care but does not cover care that has been demonstrated to be ineffective.

IV-E4. Incentives would provided to encourage participation of small groups in the Exchange.

IV-E5. Large group policies would not be sold through the Exchange. ~~employers should not be permitted to use the Exchange.~~

- F. **All citizens, including current Minnesota Comprehensive Health Association (MCHA) enrollees, should have the responsibility to**

obtain and retain health insurance coverage ~~purchase a health insurance policy through the Exchange.~~

IV-F1. MCHA as a mechanism for providing coverage should be phased out over time, but the MCHA assessment should be retained or modified in order to help cover the costs of subsidies.

IV-F2. Subsidies should be provided to individuals and families who cannot afford approved benefit plans through the Exchange or through their employer ~~insure that the minimum benefit plan is affordable for all individuals.~~

IV-F3. Affordability should be defined based on both premiums and out-of-pocket costs.

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)

Unresolved Issues and Questions

- What impact will the merger of the small group and individual markets have on premiums?
- What needs to be done to assure compliance with ERISA?
- How will a “basic evidence-based benefit set” be defined/developed? How will it evolve over time? The definition should include both what services are covered and what the consumer share would be. At a minimum, principles governing the benefit set should be established by the Task Force.
- What impact will the proposed benefit set have on what plans are being offered now?
- How much will it cost to offer the minimum benefit set?
- How will affordability be defined? Should it be a sliding scale based on percentage of income? Should it include both premiums and out-of-pocket costs?
- How much subsidy will be needed to insure affordability?
- What contribution will the availability of Section 125 plans make to affordability?
- What should be done about employers providing defined benefit plans that fail to keep pace with rising costs, resulting in a higher share of cost borne by the individual versus the employer over time?
- Should there be minimum loss ratios for the merged individual/small group market?
- Should public programs eventually be folded into the exchange as well?

- What enforcement mechanisms should be used to insure compliance with the individual mandate and the requirement for employers to offer section 125 plans?
- What other factors should be authorized for premium variation, e.g., healthy behaviors? gender?
- What impact will there be on pension plans?
- Must individual and small group plans be sold through the Exchange, or could they still be sold outside of it?
- What will the impact be on MinnesotaCare?
- The purpose of each element of the recommendations needs to be clearly defined.

Implementation Steps and Responsible Organizations:

The Minnesota Department of Health should:

1. Estimate the likely cost to a household of a "minimum benefit set" insurance policy, with cost including both premiums 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 (defined in terms of percentage of income)

Expected Impacts from the Transformation:

Reduction Over Baseline Costs: _____%

Reduction in Annual Inflation: _____%

Reduction in Mortality/Morbidity: _____%

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 be 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)

Issue 9: 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)

Issue 20: What actions could be taken to improve the health of Minnesotans?**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
- **[SOME MEMBERS INDICATE CONCERNS]** 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
- **[SOME MEMBERS INDICATE CONCERNS]** Ban transfats
- **[SOME MEMBERS INDICATE CONCERNS OR OPPOSITION]** Tax foods with high sugar and/or fat content.
- Encourage walkable communities
- Dramatically increase public health budgets; set a goal of a 25%/75% split between public health and entitlement expenditures.
- Deliver public health services “where people are” (e.g., schools, community centers, pharmacies, etc.) to optimize their impact.

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 and other minorities
- 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
- Remove unhealthy foods from cafeterias and vending areas in health care facilities

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
- **[SOME MEMBERS INDICATE CONCERNS]** 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

Issue 21: How can the ability of Minnesotans to obtain necessary health care at an affordable cost be improved?

Options (Straw Poll Votes in Parentheses Represent Priorities for Discussion at State Coverage Institute meeting in Chicago):

- 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 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.