

Payment Reform

Draft Proposal for the Transformation Task Force
November 15, 2007

Overarching goals of the payment reform proposal include:

- Provider accountability for the total cost and quality of care for a given population
- Empower individuals with information and make them responsible for choice
- Improved coordination of care (medical home concept)
- Increased transparency and provider competition on price and quality
- Achieving and sustaining “critical mass” to make the reform successful

1. Provider accountability for quality, care coordination, and total cost of care

Payment reforms to achieve greater provider accountability for quality, care coordination, and the total cost of care will be achieved in 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 will move to level 3 within 3 (?) years following implementation.

- **Level 1** of payment reform will involve explicit payments for quality of care. 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 preventive services, coronary artery disease, diabetes, asthma, and depression. Providers meeting specific targets (or who show a certain amount of improvement over time) will be eligible for these quality-based payments. Even 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. Other indicators of specialty care quality and efficiency can be incorporated, such as infrastructure using electronic records, collection and internal/external reporting of results, measures of efficiency on specifically defined procedures. Hospitals will also be paid for quality using existing measures.
- **Level 2** of payment reform will involve providers assuming greater responsibility for coordinating care for patients with chronic conditions. Providers at level 2 will need to have specific types of systems in place for monitoring and managing care, and will be eligible to receive “care management fees.” 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. Initially, the care management fees will be based on processes, but eventually they will be based on cost and quality results.

- **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 would submit bids on the total cost to care for a given population. In order to be eligible to bid, providers would need to meet certain standards for quality of care. Actual payments to providers would be risk-adjusted based on the health of the population they manage, to avoid penalizing providers for enrolling a less healthy population. 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.

2. Reform of underlying payment and pricing structures

In addition to payment reforms that hold providers accountable for quality, care coordination, and the total cost of care, this proposal includes several other fundamental reforms to the way that health care is priced and paid for in Minnesota:

- Current payment systems would be restructured so that they preferentially reward primary care, care management, and other cognitive 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.
- All providers would move to a system of payment (for non-Medicare, non-Medicaid patients) that establishes a single price for services billed on a fee for service basis. 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 would continue to negotiate on network participation
 - Health plans could set allowed reimbursement based on the level of payments to cost-effective providers, and enrollees who seek care from higher-cost providers could be required to pay the difference.
- Explicit payments for care management that improves quality and reduces cost would be added to existing provider reimbursement structures. The reason why this is necessary in a system where providers are accountable for the total cost of care is that existing fee for service structures will still likely be used for tracking delivery of services and resource use, and as a cash flow mechanism for reimbursing providers.

- Payment mechanisms 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.

3. Incentives for individuals to choose more cost-effective, higher-quality providers

Under this proposal, consumers would incur lower costs for using more cost-effective providers. Consumers would 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.

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 for consumers to make comparisons and to understand differences in out of pocket cost based on their *own specific* health plan benefits would be developed.

4. Achieving and sustaining critical mass

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. In order to be successful, this effort 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 (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
- Encouraging voluntary participation by other market players (self-insured employer plans)

The table below shows the estimated number of people affected, by type of current insurance. As shown in the table, an estimated 58.1% of the population is covered by either a state or local government sponsored employee health insurance plan, a state public program, private fully insured coverage, or is currently uninsured (this segment of the population is assumed to gain coverage as a result of the Transformation Task Force’s

insurance market reform proposal, mostly through public programs or through the individual market). An additional 1.5 million Minnesotans, or 30.3% of the population, is covered by a self-insured employer plan that could choose to adopt this model of payment reform as well. An estimated 20% of the current self-insured market would automatically participate in the payment reform proposal through its inclusion of state and local government employee health insurance plans.

Population Affected By Proposed Payment Reform

	Fully-Insured	Self-Insured	Total
State government		120,000	120,000
Local government (including school districts)	269,340	400,660	670,000
State public programs:			
Medical Assistance	498,406		498,406
MinnesotaCare	128,733		128,733
GAMC	39,201		39,201
MCHA	29,500		29,500
Private Insurance	1,134,830		1,134,830
Currently Uninsured	383,000		383,000
Total	2,483,010	520,660	3,003,670
Total Population			5,167,101
% of Population			58.1%

Source: MDH, Health Economics Program

5. Potential Cost Savings

Potential sources of cost savings from this proposal include:

- Consumers shifting from high-cost to low-cost providers
- Reductions in prices, as a result of providers competing more aggressively on price to attract patients
- Improved system efficiency (less overuse, underuse, and misuse of care) due to financial incentives for providers to redesign care for better management of high-cost conditions
- A shift in investment toward population health and away from “supply-sensitive” and “preference-sensitive” care

One potential mechanism for “capturing” savings would be to require health plans to demonstrate savings in order to have their premium rates approved by the Department of Commerce.

MDH is still working on developing estimates for the potential size of the cost savings of this proposal.