

Health Reform Implementation Update December 2010

GUIDING PRINCIPLES: Minnesota's 2008 health reform package seeks to create meaningful, transformative health reform based on the Institute for Healthcare Improvement's Triple Aim. The goals of the Triple Aim are to *simultaneously*:

- Improve the health of the population;
- Improve the patient/consumer experience; and
- Improve the affordability of health care.

POPULATION HEALTH

While all of the reforms strive to improve the health of all Minnesotans, an integral part of the health reform law is the public health component, the Statewide Health Improvement Program (SHIP). The goal of SHIP is to help Minnesotans live longer, healthier lives by reducing the burden of chronic disease. SHIP will use effective, evidence-based strategies to create changes in policies, environments and systems to support healthy behaviors that reduce tobacco use and obesity, the leading preventable causes of illness and death.

- 41 grants have been awarded to community health boards throughout the state (several submitted joint applications) and tribal governments. These grants cover all of Minnesota's 87 counties and nine of 11 tribal governments.
- Grantees are required to create community action plans, assemble community leadership teams, establish partnerships, and implement and evaluate interventions in order to make progress toward a set of process and performance measures.

MARKET TRANSPARENCY & ENHANCED INFORMATION

These reforms aim to improve the transparency of health care quality, cost and value in Minnesota, and to provide better information so that consumers, providers, purchasers and policymakers can make more informed decisions about health care. The goal of this transparency is to promote quality improvement, better management of chronic disease and more efficient resource use.

- **Statewide Quality Reporting and Measurement System.** MDH has contracted with a consortium led by MN Community Measurement (MNCM) to identify and develop recommended measures to be publicly reported by Minnesota physician clinics and hospitals. MNCM will also assist MDH in vetting proposed changes to a broader standardized set of quality measures for which health plans may require providers to submit data. The measure identification and development process is ongoing and includes opportunities for public input, both prior to and as part of an annual formal rulemaking process. The first quality rule was adopted in December 2009; a statewide quality report on clinic and hospital measures established in that rule was published in November 2010 and is available on our website. The Commissioner is required to annually review standardized quality measures, including the subset to be publicly reported. MNCM submitted recommendations to MDH for changes to the 2010 administrative rule. The adopted rule was published on November 29.
- **Provider Peer Grouping.** The peer grouping system will compare providers based on value (including both risk-adjusted quality and cost). The system will initially rely on existing quality measures and eventually incorporate other measures currently being developed, as well as de-identified health care claims data for information on price and resource utilization. A contract has been awarded to Mathematica Policy Research to implement the provider peer grouping system, for total care and up to six identified specific health conditions. Mathematica will also collaborate with Minnesota Community Measurement on quality reporting issues and the University of Minnesota to evaluate the project. Work on the project will build on the approach outlined by the Provider Peer Grouping Advisory Group in summer 2009. A Provider Peer Grouping Reliability Work Group has been convened. Monthly conference calls to update stakeholders on the project are ongoing.

CARE REDESIGN & PAYMENT REFORM

The law incorporates models that will change the way we deliver and pay for health care, with the goal of improving quality, reducing costs and promoting more consumer engagement in health care choices.

- **Health Care Homes.** A health care home is a redesign of primary care, allowing providers, patients and families to work in partnership to improve health and quality of life. Health care homes aim to improve the patient experience by centering care around the patient and family, improving access to care, and coordinating care between providers and community resources. Health care homes also represent one type of payment reform because providers will be reimbursed for care coordination and recertified based on outcomes. Certification standards for health care homes were created through a stakeholder process. MDH and DHS have developed the payment methodology and a tool providers can use to categorize patients for payment. To date, 47 health care homes have been certified, with many more in the process of certification.
- **Baskets of Care.** Baskets of care will bundle services together in order to encourage providers, payers and consumers to think differently about episodes of care by packaging related services together in a way that supports high-quality, lower-cost care. Baskets pull together health care services that are currently paid for separately, but are usually combined to deliver a full diagnostic or treatment procedure for a patient. The initial eight baskets include diabetes, prediabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain and total knee replacement. The permanent rule relating to baskets of care became effective in March.

SUPPORTING ACTIVITIES

- **Consumer Engagement.** The law requires that MDH develop strategies to engage consumers around the issues of cost and quality in health care. MDH has been embedding discussions and awareness about these issues throughout the health reform efforts. MDH is exploring what incentives are needed to get consumers to act themselves or advocate for health system changes. A report to the Legislature is available on our website.
- **E-health.** MDH and the e-Health Advisory Committee are working to ensure that all health care providers have interoperable health records by 2015. This effort is supported by an estimated \$600-800 million in Medicare and Medicaid incentive payments for meaningful use of electronic health records. MDH and DHS are actively working through state and Federal efforts to help providers meet health information exchange and quality reporting requirements for the incentive payments.
- **Administrative simplification.** Health care payers and providers are now required to conduct eligibility verifications, claims and remittance advice transactions electronically using a standard format and content. Implementing these standards is expected to save the health care delivery system \$60 million annually. MDH and the Minnesota AUC are currently working on developing standard transactions guides for new Federal requirements and to achieve further administrative simplification.
- **Essential benefit set.** A work group met this fall to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. Challenges associated with designing the essential benefit set include tradeoffs between comprehensiveness of benefits and affordability, and designing mechanisms to encourage greater use of effective health care services and less use of ineffective or low-value services. The work group's report to the Legislature is available on our website.
- **Projecting health care costs and measuring savings.** MDH has published annual estimates for public and private health care spending, as well as 10-year projections for what health care spending would have been without Minnesota's health reforms. MDH is required by law to determine the difference between actual and projected spending and the percentage of estimated savings that are attributable to state-administered health care programs. This comparison did not yield savings for 2008, largely because many of the health reforms had not taken place. The report is available on our website.

For more information: www.health.state.mn.us/healthreform