Health Reform Implementation Update
February 2010

GUIDING PRINCIPLES: The unique, comprehensive 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.

Unprecedented collaboration among public and private partners – including consumers, patients, providers and payers – is critical to achieving these goals.

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.

- 40 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 eight 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 System.** MDH has contracted with a consortium led by MN Community Measurement (MNCM) to develop recommendations for a set of standard quality measures and a set of quality measures for public reporting. The measures development process included public input, including a 30-day comment period after the proposed rule was published in September. The final rule was adopted in December, and clinics have begun submitting data.
- **Provider Peer Grouping.** The peer grouping system will compare providers based on value (including both quality and risk-adjusted cost), offering more comprehensive information for consumers, providers, health plans and employers. The system will use the quality measures currently used and those under development, as well as de-identified encounter data. An advisory group whose charge was to make recommendations to the Commissioner of Health on how to appropriately compare providers has written a final report on the methodology. The report is available on our Web site, and MDH has solicited public comments on it. MDH will be announcing the selection of a vendor to implement the system in the coming weeks.

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. The adopted rule for certification of health care homes became effective in January. MDH and DHS are in the process of developing the payment methodology, and final recommendations will be presented at a public meeting on March 12. Two educational conferences have been done with further development of the learning collaborative in process. The first annual update to the Legislature is available on our Web site.
- **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 will include diabetes, prediabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain and total knee replacement. MDH is reviewing comments from the administrative law judge on the proposed baskets of care rule.

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 Web site.
- **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 Web site.
- **Projecting health care costs and measuring savings.** In June 2009, MDH produced baseline health care spending projections through 2018. In June 2010 MDH will begin publishing annual estimates for public and private health care spending. As required by law, MDH will determine the difference between actual and projected spending and the percentage of estimated savings that are attributable to state-administered health care programs.

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