Minnesota Department of
Human Services

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Health Care Payment System Reform in Minnesota

Report to the Legislature
December 2007

Prepared by:
Department of Commerce
Department of Employee Relations
Department of Health
Department of Human Services

Copies of the report can be printed from the DHS Web site, www.dhs.state.mn.us/healthcare/studies.

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The total cost of salaries, printing and supplies incurred in development and preparation of this report was $10,000 and has been included in this report as required by M.S. 3.197.

This reporting requirement had been prepared in accordance with Laws of 2007, Chapter 147, Article 15, Section 17, health care payment system reform:

> Subdivision 1. Payment reform plan. The commissioners of employee relations, human services, commerce, and health shall develop a plan for promoting and facilitating changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:
>
> (1) reward the provision of cost-effective primary and preventive care;
> (2) reward the use of evidence-based care;
> (3) discourage underutilization, overuse, and misuse;
> (4) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments; and
> (5) encourage consumers to maintain good health and use the health care system appropriately.
>
> In developing the plan, the commissioners shall analyze existing data to determine specific services and health conditions for which changes in payment rates and methods would lead to significant improvements in quality of care. The commissioners shall include a definition of the term "quality" for uniform understanding of the plan's impact.
>
> Subd. 2. Report. The commissioners shall submit a report to the legislature by December 15, 2007, describing the payment reform plan. The report must include proposed legislation for implementing those components of the plan requiring legislative action or appropriations of money.

Within this report the following terms have these meanings:

> **Quality:** *The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*
> This is the definition of the Institute of Medicine (and can be found at http://www.iom.edu/CMS/8089.aspx).
>
> **Value:** Value in health care is achieved when we realize the maximum health outcome for each dollar spent on health care.
>
> **Payment reform:** Any change in how dollars are spent on health care services or how those services are purchased so that there is a measurable improvement in the quality and price, resulting in better value for individuals and populations.

EXECUTIVE SUMMARY

This report describes the State of Minnesota's current and proposed efforts to reform the way it purchases health care. Most of the reforms currently in place were instituted within approximately the past five years in an attempt to achieve better health care and as a reaction to the steep increase in the cost of health care. Despite these efforts costs are rising unsustainably not just for state agencies but for all Minnesotans.

Changing the way health care is paid has significant potential to not only reduce the cost of health care but to improve the quality of care, its outcomes, and to promote a more efficient use of health care system resources. Current payment systems need to be fundamentally re-designed to promote value and accountability, while providing better coordination of care resulting in fewer costly complications.

The predominant health care payment system in Minnesota rewards providers with a fee for each individual service provided regardless if the service was necessary, effective or successful. This payment system results in a reward system that pays for piecework without regard for quality. If the health care costs are to be brought under control the payment system must be addressed.

Methods of reforming the health care payment system have been much discussed in recent years. Throughout the country, think tanks, government agencies, employer groups and others have all worked to develop programs and techniques to change the health care payment system resulting in a wide variety of experiments with varying results.

This report describes the current payment reform efforts of both the Departments of Human Services (DHS) and Employee Relations (DOER). The programs and techniques in use today and those being planned are the results of program managers applying the best innovations available for the populations served. Both departments have instituted tools based on the analysis of the needs of their populations and the success of other groups utilizing the program or technique.

The goals of payment reforms at DHS and DOER have evolved over time. It seems fair to argue that while the first reforms were geared primarily towards cost control there has been emphasis on heath care quality. Since the first reforms were implemented the understanding of the need for payment reform has matured into four general themes:

- Empowerment of individuals to be responsible for their health care decisions by providing them with information and other support and encouragement. This includes decisions about their personal health and about the cost and quality of the health care they choose to receive. Examples include tiering of provider clinic systems, health assessments, medication therapy management, and consumer initiatives.

- Increased transparency and accountability in provider price and quality. Demand that providers provide cost effective, quality care at a reasonable and understandable price. Examples include tiering of provider clinic systems, performance measures, nursing home report card, not paying for never events, and PriceRX.

- Improved coordination of care. One major stumbling block has long been the inability to effectively pay for cognitive services. Issues have included the lack of payment codes and an integrated system in which cognitive services can be paid. Examples of this include medical homes, medication therapy management, DIAMOND (Depression Improvement Across Minnesota Offering a New Direction).

- Stimulation of provider competition so that the price and quality is improved for all Minnesotans. Both agencies are in the early stages of attempting to purchase health care services in a manner that helps drive down the cost for all Minnesotans. Examples include tiering of provider clinic systems, public reporting of cost and quality, and centers of excellence.

Most payment reform measures in use by the two departments fall under more than one of these categories but few have impact on each category. Part of the reason for this is that these reforms are largely "first step" measures. They do not seek a comprehensive reform of the health care system but rather they tend to be stop-gap measures.

A comprehensive transformation of the health care system in Minnesota has been the work of the Health Care Transformation Task Force authorized by the 2007 Legislature. The Task Force is working to "advise and assist the governor regarding activities to transform the health care system" and is charged with developing "a statewide action plan for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans."

One of the objectives of the Task Force is to change the way health care is paid so that the quality and safety of care is improved and costs are reduced, or in other words, so that a system that pays for value, not volume of services, is achieved. It is the Task Force proposal that is recommended here.

The Task Force is proposing a process with three different levels of payment reform to promote greater provider accountability for health care costs and quality. In brief the levels are:

- Level 1: providers receive explicit payments for quality of care in a budget neutral way, most likely as withholds.

- Level 2: providers assume greater responsibility for coordinating care for patients with chronic conditions. Providers will need specific types of systems in place for monitoring and managing care. Rewards will be made with an additional fee but it is expected that the increased use of care management will result in less use of acute care services resulting in an overall cost savings.

- Level 3: providers assume responsibility for the total cost of care for the patients they manage. Providers submit bids based on the total cost of care for a defined population. Because providers are accountable for the total cost of care for a population they will have incentive to innovate and redesign systems and make investments to provide care more effectively and efficiently.

This proposal also includes several other fundamental reforms to the way that health care is priced and paid for in Minnesota:

- Current payment systems will be restructured to preferentially reward primary care, care management, and other cognitive services.

- All providers will move to a system of payment (for non-Medicare, non-Medicaid patients) that establishes a single price for services.

- Explicit payments for care management that improves quality and reduces cost will be added to existing provider reimbursement structures.

- Payment mechanisms for "baskets" of services will also be added to existing provider reimbursement structures.

- Consumers will be given incentives to choose more cost-effective, high-quality providers and to use a medical home.

The final piece of the Task Force recommendation is to achieve and sustain a critical mass in terms of the number of participating providers and patients. Potential mechanisms for achieving and sustaining this critical mass include:

- Making participation a condition of receiving payment for patients paid for with state funds (state employees and public program enrollees) — this requirement will apply to both health plans and health care providers

- Extending the participation requirement to the small group and individual markets as well as the fully-insured market

- Encouraging voluntary participation by other market players (self-insured employer plans)

DHS and DOER will proactively lead the reform of the health care market through the payment reform mechanisms currently in place as well as through the recommendation of the Task Force focusing on those efforts that most benefit their respective populations. The goal is to use competition to drive the total cost of health care down 20 percent by 2011 while improving quality, accountability and transparency.

The Task Force's final action plan will not be presented to the Legislature and the Governor until February 1, 2008. Because the Task Force is still meeting, it is possible that further refinements to the payment reform objective are possible. Consequently, the Task Force report might vary slightly with the recommendations here and legislation can not be included at this time but will be put forth in conjunction with the Task Force's report.

DEPARTMENT OF EMPLOYEE RELATIONS

About the Department of Employee Relations

The Department of Employee Relations (DOER) provides insurance benefits, through the State Employee Group Insurance Program (SEGIP), to 115,000 state employees and their dependents in all three branches of government, Minnesota State Colleges and Universities and certain quasi state agencies such as the Minnesota Historical Society and the Minnesota State Fair. The benefits provided include health, dental, and life insurance as well as short- and long-term disability and long-term care insurance.

Health care insurance is the largest non-wage cost of employment for the State of Minnesota. In 2007 health insurance is estimated to cost $504 million and consume over 93 percent of total employee insurance costs. Since 2001, employee health insurance costs have risen nearly 39 percent and are projected to rise another 6.7 percent in 2008.

The high cost of health care is only part of the costs the state faces when an employee gets sick. In 2006, state employees used 2.2 million hours of sick leave at a cost of $66.9 million. Added to this is the cost of lost productivity and employee replacement. In some cases, the state also incurs the cost of making reasonable accommodations for disabled employees to return to work.

SEGIP strives to control employee health care costs through a variety of means. These include measures to help employees stay healthy, ensuring a wiser and more informed use of health care dollars, as well as generating savings by "paying smarter." It also sponsors programs to keep work environments safe and healthy so that employees can maintain a higher quality of life and the state holds down costs.

Background

Before some payment reform measures could be implemented SEGIP needed to put certain program features in place. These included: a greater control over plan design and aggregate claims data; methods of determining what is quality health care and what is cost efficient health care; and a means of communicating information to members about the quality and cost efficiency of health care. These features are now in place, and continue to be refined to better meet the needs of SEGIP members.

SEGIP moved to a fully self-insured health care program in 2001 for greater control over plan design, for ease of program administration, and cost savings associated with assuming liability for its own claims. Having greater control over plan design allows SEGIP the independence to make decisions specific to its population and the increased flexibility to quickly implement changes. However, because SEIGP is defined as a "governmental plan" under the federal ERISA regulations, its plans comply with all of Minnesota's health care legislatively prescribed mandates and regulations.

This self-insured health plan is known as the Minnesota Advantage Health Plan. SEGIP administers Advantage and contracts with three health plans — Blue Cross Blue Shield of Minnesota, HealthPartners, and PreferredOne — to provide clinic networks and to pay claims. The three health plans also provide additional services on a contractual basis.

Self-funding provides SEGIP with important financial and administrative advantages. SEGIP no longer pays risk margins, assessments, and related costs that would otherwise be paid to insurers. Investment income on cash flow and reserve holdings is retained by the program and used to defray plan costs. SEGIP estimates that self-insuring saves approximately 2 percent of total program costs each year.

Becoming self-insured enabled SEGIP to establish a data warehouse to hold de-identified claims data. Access to claims data in a standardized format enables SEGIP to understand more about the health status of the Advantage population, to identify the prevalence of high cost conditions in its population, and to analyze claims costs associated with network providers. This increased control over the program makes it possible to implement cost containment features and health improvement programs that best improve the plan and meet the specific needs of state employees and their dependents.

Information about quality care is another tool necessary for health care reform. MN Community Measurements was established, in part, to provide Minnesota citizens with information about the quality of care delivered by provider groups in an easy to understand and fair manner. SEGIP links its Website containing clinic tiering information to MN Community Measurements so its members have access to information about the cost and quality of care delivered by network providers. This information helps Advantage members choose provider groups based on the broader cost and quality factors.

Advantage Health Advisors (AHA) is a service designed to provide health care related information to State of Minnesota employees and their family members. Licensed nurses are available 24/7 to answer questions about provider and facility selection, health conditions, treatment options, health plan coverage and cost sharing. The program communicates and coordinates a wide variety of health care information necessary to help members make wise choices about their health care. AHA helps facilitate price and quality transparency in an easy to use manner for Advantage members.

Payment Reform Methods

SEGIP uses a variety of programs to help meet the health care needs of state employees and their dependents. Staff strives to identify and implement programs that best improve the quality of health care members receive based on the best data available. The following programs feature some level of payment reform. Some of these programs are well under way and have achieved measureable results while others are just being implemented or a payment reform component is just being added.

Tiering

At the core of the Minnesota Advantage Health Plan is the tiering of primary care clinics. Tiering offers incentive for both members and providers to be smarter about health care delivery. Advantage providers are placed into cost tiers based on their risk-adjusted cost of delivering health care. It is important to note that lower cost providers deliver higher quality care by keeping members out of high cost events. The tiers are further refined through the collective bargaining process to ensure that all employees have access to a low cost, high quality care primary clinic within 30 miles of where they live or work.

Members choose the primary care clinic of their choice. However, selecting clinics in higher tiers will result in higher point of service costs, such as copays, deductibles, and coinsurance, than charged for clinics in lower tiers. This method of cost differentiation at the point of care delivery reinforces messages about relative cost and efficiency among providers every time a medical service is received, while still allowing members' choice. Tiering helps create price transparency for Advantage members.

The financial incentives imbedded in tiered networks generate competition among clinic systems leading to more efficient use of health care resources. Because Advantage is self-insured, it has the added flexibility to allow custom fee schedules to be set by provider groups. This enables individual provider groups to improve their efficiency and/or adjust their fee schedules to qualify for a more favorable cost level, resulting in additional savings.

Implementation of the Advantage Health Plan and its tiered system saved $33 million during its first two years compared with the previous health plan. Since then, SEGIP estimates that Advantage saves approximately 3 percent ($20 million in 2007) of annual health care costs by tiering efficient clinics at favorable levels. An additional 1 percent – 2 percent ($25 million in 2007) is saved because members move to lower cost clinics.

Another important outcome of tiering is that it has moved the discussion of health care costs from the program or health plan level to the provider group level. One of SEGIP's goals is to contribute to overall health care reform by incenting providers to change how they do business resulting in lower health care costs for everyone.

Performance Measures in SEGIP Contracts

The financial and administrative services agreements with each of the SEGIP's health plans include incentives and penalties for cost management and administrative performance. The plans may earn incentives or owe penalties depending on their success or failure in attaining mutually agreed upon performance levels.

The activities that are measured vary from plan to plan and from year to year, but generally fall into three categories:

- Cost management (e.g., prescription drug claims, chiropractic services, behavioral health claims).

- Health outcomes (e.g., reporting and performance metrics for case and disease management, diabetes education, HEDIS measures such as breast cancer screening).

- Operational performance (e.g., claims timeliness and financial accuracy, customer satisfaction, lost call rate).

SEGIP believes that contractually mandating the health plans to measure and report on these aspects of their performance—and requiring financial risk on their part—provides an additional step towards ensuring quality and cost containment in the delivery of services under Advantage.

Never Events

Never Events, or adverse events, are events that should never, ever happen in a hospital. They are very serious, tragic events such as wrong site surgeries or administering the wrong blood type. While rare, they have profound consequences.

The 2004 Minnesota Legislature required that Minnesota hospitals, regional treatment centers, and outpatient surgery centers report on the frequency of the 27 Adverse Health Care Events (M.S. § 144.706 – 7069) as defined by the National Qualify Forum. In addition, the hospitals are required to conduct a root cause analysis of adverse health care events and put a corrective action plan into place to ensure that they do not occur again.

In September 2007 Governor Pawlenty announced that Minnesota was the first state in the nation to establish a statewide policy under which hospitals in Minnesota will not bill for any of the 27 reportable adverse events. This requires the hospital to conduct a significant examination of the individual set of circumstances surrounding an adverse event to ensure that all services associated with it are not billed. Hospitals and claim payers still need to work out billing and payment procedures that ensure that an adverse event is never billed or paid.

During 2008 SEIGP will work through Buyers' Health Care Action Group (BHCAG) and the Smart Buy Alliance to develop best practices related to billing and payment systems and developing avenues to educate members about the importance of patient safety.

This new state-wide policy means that now all of the health plans serving SEGIP will no longer pay for Never Events. This change in payment policy helps move towards improved health quality by reinforcing the need to provide quality services the first time and every time.

Single Pharmacy Benefits Manager

The MN Advantage Health Plan entered into a contract with a single pharmacy benefit manager (PBM) to provide, customize and manage an integrated retail, mail, and specialty pharmacy program beginning with plan year 2008. Advantage previously provided pharmacy benefits through three different PBMs embedded in each plan.

There were several reasons SEGIP opted to move to a single PBM: to save dollars, to enjoy greater transparency, to provide improved customer service, enhanced clinical programs, and increased administrative flexibility.

SEGIP estimates that the opportunities provided by a single PBM will save the plan between $4 and $6 million each year. Moreover, the new contract is fully transparent—that is, 100 percent of drug rebates, administration fees and market share incentives from drug manufacturers flow back to the plan. There are no "hidden revenues" from sources such as grants and cost sharing, and SEGIP has full audit access to all contracts, systems and processes.

Another reason for this change is improved customer service. Members will work directly with an integrated call center that creates a single point of access for members, pharmacies, and physicians, providing consistent, uniformity, knowledgeable and timely responses.

A single PBM will promote administrative flexibility, allowing Advantage to offer program-wide clinical services that will reduce pharmacy costs and better educate members. These include:

- a generic copay waiver program designed to allow a member to try certain generic medications as alternatives to high cost, brand name counterparts;

- a new Medication Therapy Management (MTM) program aimed at fully utilizing the expertise of the pharmacist in three crucial areas: preventing and resolving drug-related problems, providing education, and choosing drugs that provide the best medical outcomes and cost-efficiency; and

- a tablet-splitting program saving money for both members and Advantage. Many prescription drugs are available in higher-dose tablets for the same price as lower-dose tablets. By splitting the higher-dose tablets in half, members can get their usual dose for about half the cost.

By changing the way it purchases pharmacy benefit services, SEGIP is able to receive improved services that focus on cost minimization with an eye on quality and appropriate drug utilization, in addition to greater cost transparency and administrative flexibility.

Mail Order Pharmacy Benefits

SEGIP offers two mail order pharmacy options. Employees may order prescription drugs through the domestic mail order pharmacy at a reduced cost. Members pay a two-month copay but receive a three month supply. The program incurs a slight loss as the copay does not cover total costs but as members begin to use the mail order options more it is expected this program will save the program dollars.

The second option is the Canadian mail order pharmacy through which members can order select drugs at no cost to the member. The formulary consists of drugs that have a high utilization rate within the plan and can be purchased cheaper through the Canadian pharmacy. The Canadian mail order pharmacy services were developed as part of Governor Pawlenty's plan to help reduce the cost of prescription medicines for all Minnesotans. DHS is responsible for ensuring that the participating Canadian pharmacies continue to meet the screening criteria established to ensure the safety of the drugs purchased by both state employees and the general public.

Electronic Prescribing

Governor Pawlenty announced in June, 2007 that the state will implement electronic prescribing (e-prescribing) for state employees and their dependents by 2011. He further announced that DOER and other state agencies will participate in the move to e-prescribing for all Minnesotans.

E-prescribing is the use of an automated or electronic online data entry system to produce a prescription rather than a hand written one. The potential benefits for such a system are enormous and include:

- Improved patient safety: eliminates dispensing the wrong prescription due to the illegibility of the writing. The system can automatically check the prescription and the others the patient is taking to ensure harmful interactions are avoided.

- Formulary adherence: costs are held down by an automatic check of the health plan formulary to ensure the prescription is included.

- Streamlined communications: the number of calls to physician offices to clarify prescriptions is reduced by the receipt of legible prescriptions adhering to the formulary.

The foundation necessary to successfully implement an e-prescribing feature for Advantage is already under construction. SEGIP's contract with its PBM includes language describing the participation required of both parties for this initiative. Corollary language is anticipated in its next contracts with the plans.

SEGIP, and its pharmacy benefits manager, are already working with the Minnesota Health Information Exchange (MN HIE) to achieve the goal of all SEGIP providers e-prescribing by 2011. MN HIE is a private-public, not-for-profit collaborative that interconnects stakeholders for the purpose of electronically exchanging accurate, standardized health information in a secure manner to improve quality of care, assure greater patient safety, and manage the cost of healthcare delivery. The Minnesota e-Health Initiative is a public-private collaborative that that under Minnesota Statutes is charged with making recommendations to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. MN HIE and the Minnesota e-Health Advisory Committee are the entities coordinating the development of e-prescribing with the Minnesota health care industry and stakeholders.

State agencies are using their ability to contract with PBMs, health plans, and provider networks, to lead the Minnesota market to a point in which e-prescribing is a standard health care practice. The potential for increased quality, safety, and cost savings by implementing e-prescribing is a beneficial outcome for all Minnesotans.

Bridges to Excellence

Bridges to Excellence (BTE) is a national employer driven pay for performance effort paying doctors for improvement in the quality of care they deliver and rewarding effective and efficient care. SEGIP, as a member of BHCAG, joined with other large Minnesota employers in implementing this program.

BTE rewards doctors for meeting care standards in the treatment of selected conditions. The Institute for Clinical Systems Improvement (ICSI) developed the standard for optimal diabetic care followed in the Minnesota BTE. The rewards are determined by an annual health care quality analysis conducted by MN Community Measurement (MNCM). Less than 6 percent of patients in Minnesota were receiving diabetic treatment that met the ICSI standard in 2004.

Diabetes was selected as the first targeted condition because it is one of the most prevalent and fastest growing chronic illnesses in Minnesota. SEGIP estimates that each diabetic member

receiving optimal care saves the state $700 per year. These savings are a combination of $350 in direct medical costs and $350 in indirect costs including reduced absenteeism and increased productivity.

SEGIP began participation in BTE in April, 2006. That year the goal was for 10 percent of patients in a medical group to receive optimal diabetic care. After reviewing approximately 700 clinics, MNCM found that nine medical groups achieved the goal. SEGIP awarded those medical groups a total of $55,000. SEGIP estimated that for every dollar it spent on provider rewards and the administration of the program it saved $5.60. SEGIP is the largest contributing entity within BTE program.

One of benefits of the BTE program is its features are reassessed and enhanced each year. In 2007 a move began to reward on the clinic level and eliminate evaluations on the medical group level. Rewarding on the clinic level allows the consumer greater transparency and improves provider engagement. The goal was raised from 10 percent to 20 percent of patients receiving optimal diabetic care. In the end, three medical groups and 36 individual clinic sites achieved this goal and were rewarded a combined total of $82,200 by SEGIP. SEGIP's return on investment in 2007 was $4.20 for each dollar spent on BTE's administration and rewards.

As SEGIP enters its third year in BTE several improvements are under consideration. Its participation in BTE may be expanded to include coronary artery disease. Also under consideration is the establishment of a tiered performance target structure that is intended to motivate continuous improvement across the care systems. Under this tiered system each level will have performance targets equal to or higher than the 2007 performance target (likely to be 25 percent, 30 percent and 35 percent). Finally, the reward limitation of $20,000 per clinic site will be eliminated to further motivate improvement.

Quality Care and Rewarding Excellence

In July 2006, Governor Pawlenty introduced Quality Care and Rewarding Excellence (QCare) a new quality standard program used by the state in its health care purchasing policies to reward top performing providers while saving health care dollars. The QCare program implements quality of care standards, sets aggressive targets for health care providers, makes measures available to the public online, and changes the health care payment system to reward quality rather than quantity.

SEGIP's contracts with all three of its health plans include the provision that all policies and procedures will be implemented accord with the marketplace response to the QCare initiatives. This includes quality measures, coordinating disease management efforts, setting targets for health care providers, making measures available online to the public, and where appropriate modifying provider payment systems with incentives and assessments that emphasize quality care. The specific health care areas QCare efforts are directed to include diabetes, cardiac care and prevention, and venues including inpatient and outpatient hospitalization, preventive. BTE is an example of a program under the QCare umbrella.

Health Assessments

SEGIP began offering state employees enrolled in the Advantage Health Plan the option of completing a health assessment in 2005. By choosing to take the assessment employees are rewarded with both a monetary savings and information about their personal health.

Health assessments were initially used as a prevention tool to encourage employees to be more involved in their own health risk management. SEGIP is now moving the program to the next step in which the assessment will help encourage more employees to improve their health.

During the first two years employees who voluntarily completed the assessment received a $5 reduction for office visit copay for themselves and their dependents. Employees opting to complete the 2007 assessment will receive the same reduction in the office visit copay if they also agree to a follow-up call from a health coach from their health plan. The coach will consult with employees on ways to reduce their health risk and may describe health improvement programs available to them.

Another incentive added to the 2007 assessment is a smoking cessation component. Employees and dependents who agree to participate in a plan sponsored smoking cessation program will not be charged for formulary nicotine replacement therapies. The goal is to encourage members to quit smoking by making it easier on their pocketbooks.

To date SEGIP has relied on the health plans to provide estimates of the value the health assessment tool has produced for the program. The next step is to better integrate this tool with SEGIP's efforts to measure programs ability to change behavior and improve health as well as to reduce claims.

Centers of Excellence

SEGIP in partnership with the state employee labor unions, Blue Cross Blue Shield Minnesota, HealthPartners and PreferredOne developed a Centers of Excellence (COE) program. This program identifies health care providers and faculties with the best patient care and outcomes so members have information to help make wise decisions about their individual health care.

The program brings together "best-in-class" providers and facilities to effectively and efficiently manage the care of patients with select costly disease states or procedures that require highly specialized, technical care. COEs have been established in the areas of bariatric surgery and transplants. Networks for the treatment of lower back pain and cardiac conditions are on the immediate horizon.

The underlying principle behind this program is that best quality care translates into lower costs in the long run. In other words, doing it right the first time is cheaper than doing it twice. Providers and facilities must demonstrate competence, superior outcomes, and a coordinated service approach in order to meet COE criteria. Programs are reevaluated each year to ensure they continue to meet standards for which they were originally selected.

This program directs Advantage members to providers who meet the strict COE criteria. Advantage members are provided the COE network information on the SEGIP Website and

when calling AHA. The incentive to use a COE for employees is the knowledge that they will receive high quality care. For providers participation means an enhanced reputation and special referrals. As the networks become more established SEIGP intends to incent members to chose COE providers and facilities.

DIAMOND Project

It is expected that SEGIP will participate in the DIAMOND (Depression Improvement Across Minnesota Offering a New Direction) project which is slated to begin in March 2008. This project is under development by ICSI and provides an integrated sustainable approach to the treatment of depression in primary care that combines a unique, evidence-based best practice model and a payment model that supports its use.

The DIAMOND initiative seeks to help primary care medical groups implement practice redesign and to help payers develop a payment model that is better aligned with best practices. The redesigned practice model includes a standard assessment tool, a registry to systematically provide follow-up and monitor treatment, relapse prevention, and psychiatric liaison phone consultation with the primary care physician and caseload supervisor. The program brings these services together through a care manager who provides education, self-management support, monitoring, coordination of care with both the primary care and behavioral health providers and facilitates treatment changes. Importantly, the program will include a payment system that bundles all associated services into one cost that includes case management which is often unfunded under traditional medical treatment models.

Medication Therapy Management

In July 2007, SEGIP launched a medication therapy management (MTM) program as a pilot study for certain Advantage Health Plan members with diabetes. This program was added even though other disease management programs were already serving many members with diabetes. The goal for this program was to provide an alternative method of assisting and supporting diabetic members in the behavior change and decisions needed to better manage their condition.

The MTM program incents its approximately 400 participants by waiving copays for all medicines and supplies associated with managing their disease and other co-morbid conditions in return for regularly checking in with their pharmacist. The pharmacist provides education about the purpose of and need for the participant's medicines and helps ensure those medicines are used correctly. The pharmacist also monitors the participant's progress in other programs such as weight loss, exercise, and smoking cessation. It is anticipated that these members will learn to better manage their condition thereby live a healthier life and save the program dollars.

Outcomes have yet to be identified because this program is so new. SEGIP anticipates its first outcome results in approximately one year.

Chronic Disease Management

Advantage features a chronic disease management program to improve the health of members, hold down the cost of operating the state employee health plan, reduce employee absenteeism and increase productivity. The services for this program are provided through each of

Advantage's three health plans (Blue Cross Blue Shield of Minnesota, HealthPartners, and PreferedOne).

The health plans invite SEGIP members to join the disease management program based on the presence of one or more of six chronic disease states: asthma, diabetes, coronary heart disease, chronic obstructive pulmonary disease, chronic kidney disease and depression.
Members in the program receive regular calls from a health plan representative, usually a registered nurse. The nurse seeks to ensure each member is successfully managing their condition and provides additional services as necessary. Generally, these services are designed to promote the member's understanding of the disease, behavior modifications and medication compliance, and support for self-monitoring techniques used to track the disease.

Services are provided through a multi-tiered approach with higher risk members receiving more services than those with lower risk. Participants who achieve a certain level of control over their condition "graduate" from the program.

The disease management program is an add-on to SEGIP's contracts with the plans. Two of the health plans are paid for their services on a per-member-per-month basis with a different rate charged for each of the disease states while the third health plan is paid a single bundled annual fee for all its services.

SEGIP staff are currently evaluating and working to improving the chronic disease management program. Although the program initially produced impressive cost savings it is not clear that expectations continue to be met. It has become apparent that an effective program will target the right participant and the right condition with the appropriate severity for the optimal length of time. Staff are working with the plans to develop a mutually agreed upon set of goals for the 2008 plan year. Once established, failure to meet those goals will result in a financial assessment.

DEPARTMENT OF HUMAN SERVICES

About the Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS), in cooperation with its county partners, helps people meet their basic needs so they can live in dignity and achieve their highest potential. Consumers include: seniors who need help paying for hospital and nursing home bills or who need home-delivered meals, families with children who need help during a financial crisis, parents who need child support enforcement or child care money, and people with physical or developmental disabilities that need assistance to live as independently as possible.

DHS programs include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, Minnesota Family Investment Program (MFIP) (Minnesota's version of the federal Temporary Assistance for Needy Families program), General Assistance (GA), child protection, child support enforcement, child welfare services, and services for people who are mentally ill, chemically dependent or have physical or developmental disabilities.

DHS also provides direct service through its regional offices for the deaf and hard of hearing and through State Operated Services, which provides direct care to people with disabilities and those who pose a risk to public safety.

DHS employees work closely with employees from Minnesota's 87 counties, who provide most of the direct services to Minnesotans in need.

Human services spending accounts for approximately 25 percent of the state's total budget. Of that spending, more than 90 percent is spent on health care and long-term care programs and related services, including MinnesotaCare, Medical Assistance, General Assistance Medical Care, mental health services, alternative care services, chemical dependency services and regional treatment center services.

DHS' budget also covers other department services, including MFIP, as well as GA, subsidized child care, child support enforcement, Minnesota Supplemental Assistance (MSA), Food Support, and other social services and administration.

Like other health care purchasers, DHS has implemented various health care payment reform measures. Following is a description of the measures enacted to meet the needs of the population served.

RxConnect

In the fall of 2003, Governor Tim Pawlenty instructed DHS and DOER, as well as other agencies, to develop new ways to help Minnesotans reduce their prescription medicine expenses. The order resulted in the development of RxConnect, a Website that provides information about affordable prescription medication options. The site includes:

- Information about medications, safety and cost-savings tips, and programs to help low-income Minnesotans find affordable medications.

- A consumer tool, RxPrice Compare, that lists prescription prices at local pharmacies.

- Information on ordering medications from Canadian pharmacies.

Minnesota RxPrice Compare is a Web-based tool that enables consumers to compare local pharmacy prices of about 400 brand, generic, and therapeutic alternative medications. The site allows consumers to compare specific brand and generic prices for the same drug, the differences in price by pharmacy, and prices of therapeutic alternative medications.

Consumers may search by county, city, or ZIP code to find a medication's price at Minnesota and border city pharmacies. Posted prices are either derived from recent claims submitted by pharmacies to DHS for payment or posted directly online by the pharmacy. If a pharmacy updates the Website and then submits a claim for a price different than the posted price, the new claim price replaces the price on the Website. Prices are updated by DHS every two weeks.

Minnesota RxPrice Compare also provides consumers information necessary to identify and locate cost effective medications. The site defines brand name, generic, and therapeutic alternative medications. Safety precautions are outlined and instructions on how to use the site are included. A link to the *Consumer Reports Best Buy Drugs* Website offers consumers a resource to compare clinical aspects of therapeutic alternative medications.

Minnesota RxPrice Compare is available to all consumers, whether or not they have prescription drug coverage. In addition to helping hold down the cost of insurance, the information provided on this Website is especially valuable for consumers with no prescription drug coverage, those with a health savings account, Part D recipients who want to avoid the "doughnut hole," and consumers who can purchase a medication for less than their pharmacy benefit copay.

Minnesota RxPrice Compare is an important vehicle for creating transparency in health care pricing. It provides consumers a quick and easy method of comparison shopping. The site reveals the price differences between pharmacies, brand medications and their generics, and a brand and its therapeutic alternatives. Minnesota RxPrice Compare shows consumers that price differences exist and that sometimes these differences are significant.

RxConnect provides a link to information about ordering medication from Canada. The Canadian pharmacies listed on this site have been inspected by Minnesota officials. RxConnect gives Minnesotans a safe option to access medications that may be more affordable in Canada. Minnesotans may compare the prices offered by the Canadian site with Minnesota pharmacy prices posted on RxPrice Compare.

Medication Therapy Management Services

The 2005 Minnesota Legislature directed DHS to pay qualified pharmacists for Medication Therapy Management services (MTM) for General Assistance Medical Care recipients. The MTM program was developed with the input of an advisory committee representing pharmacy groups and other interested parties.

Medication Therapy Management is a defined service or group of services that optimize

therapeutic outcomes for individual patients. Some MTM services are independent of, but can occur in conjunction with, the provision of a medication product. For DHS, MTM means providing the following services:

- performing or obtaining necessary assessments of the patient's health status
- formulating a medication treatment plan
- monitoring and evaluating the patient's response to therapy, including safety and effectiveness
- performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- documenting the care delivered and communicating essential information to the patient's other primary care providers
- providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications
- providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens
- coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

To be eligible for MTM the patient must be an outpatient taking four or more prescriptions to treat or prevent two or more chronic conditions. Patients not meeting this criteria may also be identified by DHS as recipients who would benefit from MTM and referred to a qualified provider.

Pharmacist must enroll with DHS to provide MTM services. A provider for MTM services must be a Minnesota licensed pharmacist and have graduated from a college of pharmacy after May 1996 or passed a DHS approved Accreditation Council of Pharmacy Education program, practice in a pharmacy or an ambulatory care setting, such as a clinic or hospital, as part of multidisciplinary team. The provider's facility must have a structured patient care process allowing for assessment, development of a care plan and evaluation; utilize an electronic MTM services documentation system that is specifically designed to optimize the therapeutic outcomes of the patient's medications and meet strict privacy and space requirements designed to ensure patient safety and comfort.

The pharmacist must document each patient encounter. Documentation must include identification information about the patient as well as information about the current and resolved medical conditions, allergies, contact information for the primary physician and information describing the encounter.

An important feature of the documentation is to make an assessment of drug problems identified. This includes a range of practices including a determination that the medications are appropriate, that the patient needs additional medications, if the doses are appropriate to meet the goals of the therapy, and an evaluation of the effectiveness and safety of current drug therapy.

Finally, the assessment must include a written plan including goals and actions needed to resolve issues of current drug therapy, an evaluation of success in meeting goals of medication treatment plan, information, instructions and resources delivered to the patient, and the content of pharmacist's communications to patient's other health care providers.

One of the revolutionary aspects of MTM is it allows pharmacists to be paid for providing cognitive services. Payment codes have been developed for MTM by the Pharmacist Services Technical Advisory Coalition. These HIPAA-compliant codes are used by pharmacists to bill Medicare and other third parties for MTM services. DHS is using these codes to reflect the estimated time to perform the service.

The level of payment varies based on patient need. The payment factors considered are the number of medications the patient is currently taking, the number of drug therapy problems the patient has at present, and the number of medical conditions for which the patient is currently being treated. Payments can vary from $34 for 15 minutes of service to $148 for more than one hour of service.

MTM also addresses health care payment system reform in two other major ways. First, it rewards providers for the use of the most cost-effective settings, medications, devices, providers, and treatments. The MTM program specifically addresses the use of the most cost effective drug therapies and counsels patients in areas such as compliance to optimize drug therapy. The program guides patients and providers in the appropriate use of drugs, and cautions on side effects, the prevention of interactions and compliance.

Second, MTM encourages consumers to maintain good health and use the health care system appropriately. The program uses a newly created structure that pays pharmacists to deliver a service that augments their historic service delivery. The program uses pharmacists to deliver drug monitoring in a more cost effective manner than has been done in the physician's office. The program uses the pharmacist to enhance and support the effectiveness of the physician.

Minnesota Nursing Home Report Card

The Minnesota Nursing Home Report Card, jointly developed by the Minnesota Department of Health and DHS, is an effort to provide transparency in regard to quality for consumers of nursing home services. The report card scores each Medicaid certified nursing facility on a wide range of quality measures. This information allows individuals considering nursing home placement for them selves, or for a loved one, to compare quality performance along several dimensions. In addition, for individuals who have already chosen a facility, standardized quality measures can empower them to advocate, from an informed perspective, for quality improvement. And finally, nursing home managers have standardized measures across the entire industry to enable benchmarking.

The Minnesota Nursing Home Report Card may be accessed on the Web at:
http://www.health.state.mn.us/nhreportcard/

The report card allows the user to access a report about a specific facility or to access a list of facilities, and then their individual reports, within their specified geography. The list will be prioritized based on quality scores, using quality measures prioritized by the user.

The quality measures in the report card are:

- Resident quality of life ratings – based on annual face-to-face interviews with a sample of residents in each facility,
- Minnesota Quality Indicators – risk adjusted, assessment based measures of clinical care and outcomes,
- Hours of direct care – acuity and wage adjusted,
- Staff retention – the portion of direct care staff retained for at least a full year,
- Temporary staffing agency use – the portion of direct care staff hours provided by outside staffing agencies,
- Proportion of single rooms – the portion of beds that are private, and
- State inspection results – findings of harm or immediate jeopardy from the federal certification survey.

Each facility is ranked on each quality measure using a ranking system with between one and five stars. Rankings are updated quarterly for measures 2, 6 and 7 while the others are updated annually.

As a purchaser of nursing home services for about 20,000 Medicaid recipients on any given day, DHS is seeking to use its dominant role in this industry to encourage quality improvement. Several pay for performance strategies are being pursued, all based on quality measures in the report card. These measures, described separately, include: quality based rate adjustments the Quality Add-On, Performance Incentive Payments and quality based spending limits in the newly adopted rate rebasing system.

Several pay-for-performance strategies are being pursued, all based on quality measures in the Report Card. These strategies include:

- Quality based rate adjustments – the Quality Add-On,
- Performance Incentive Payments, and
- Quality based spending limits in the newly adopted rate rebasing system.

The quality add-on uses a score for each facility based on six of the seven report card measures. Depending on legislation, this score is associated with a rate adjustment the facility receives. On October, 10, 2006, the quality add-on was up to 2.4 percent of the facility's operating payment rate, with an average of 1 percent. On October 1, 2007 it was up to 0.3 percent with an average of 0.13 percent. At the time of this writing there is no quality add-on for the rate year beginning October 1, 2008.

The performance incentive payment project offers time limited rate increases of up to 5 percent of the operating payment rate, in a competitive process. Facilities are invited annually to submit proposals for special projects that will lead to improvements in quality, greater efficiency and/or rebalancing of long term care. In the first year of the project, 20 proposals were accepted, out of 155 proposals. Selection criteria included the degree to which proposals were innovative, broad based, prospective, feasible and collaborative. Examples proposals that were accepted include:

- Facility and community strength training,
- Safe patient handling,
- Improved pain management,
- Prevention of skin breakdown, and
- Teaching skills necessary to return to community living.

Quality based spending limits in the newly adopted rate rebasing system will take effect on October 1, 2016. Prior to this time, the cost based system of setting operating payment rates will be phased-in. During the phase-in, the portion of the operating payment rate for care related costs will be limited to 120 percent of median costs for a facility's geographic peer group and facility type. Beginning in 2016, the limit will vary from 105 percent of the median to 125 percent of the median, depending on the facility's quality score. This means that the state will be paying a higher rate for higher quality but will limit rates more stringently for facilities with lower quality.

The quality add-on has been implemented for two years now. Using previously designated quality measures, with each measure weighted, a score is calculated for each facility. This score is used to determine the actual amount of the quality add-on. This amount is announced to facilities about six weeks before it goes into effect.

A request for proposals (RFP) for contact amendments for the performance incentive payment program is published annually. After publication of the RFP, training sessions are held throughout the state to help providers develop successful proposals. A review panel recommends proposals for negotiation. DHS staff then seek to negotiate amendments to facility contracts to allow participation in the project. Contract amendments have been signed for the first round of the project and proposals are due for the second round on December 31, 2007.

The variable spending limits will take effect October 1, 2016 if, six months earlier, the average medical assistance operating payment rate is at least 92 percent of the average operating cost.

The department views the combination of the quality add-on, performance incentive payments and quality based spending limits to be a very robust set of pay-for-performance initiatives. They provide for rewards for higher quality, incentives for innovation, and, eventually, more generous rates for higher quality.

Medical Home

As Minnesota's Medicaid agency, DHS has begun a process to transform health care delivery in the primary care setting. Legislation passed in both 2005 and 2007 combined with a Medicaid Transformation Grant has created a unique opportunity to work with providers and patients to change the structure of primary care delivery.

The DHS vision is to create a "medical home" for patients served by public programs. This will be achieved by transforming primary care delivery in to a system that proactively works in a team with patients and families to manage health and reduce the burden of chronic disease. It is expected that is approach will result in improved health concomitant with reduced costs.

DHS will build a payment structure and an infrastructure to support this transformation. In this payment structure, primary care providers will receive a new care coordination payment to actively and prospectively coordinate the care of patients with complex and chronic illness. Initially payment will be $50 per month for members with significant medical complexity. Over time, payment will be adjusted to reflect the complexity of the patient's needs. This new payment will require fundamentally different work than is routinely provided at this time. Pay for performance, a third payment mechanism, will follow and reinforce the expected outcomes from these projects. Pay for performance is already beginning for enrollees in public programs consistent with the governor's QCare goals for the care of those with diabetes and cardiac disease.

Three key components have come together to create this opportunity. The first, Provider Directed Care Coordination (PDCC/ now call Primary Care Coordination - PCC) was passed by the 2007 Legislature and awaits approval by CMS. In PCC the department will pay a per member per month fee (averaging $50) to providers coordinating care for patients with complex illness in the DHS fee for service population. (Of the 670,000 patients in the publicly supported Minnesota Health Care programs, approximately 200,000 are in fee for service program and of those, approximately 106,000 are disabled.) The criteria for participation as a PDCC provider and the threshold for patient complexity are being developed by the department in conjunction with the medical community. This process is discussed further below.

The second is Communication and Accountability for Primary Care Systems (CAPS) was enabled by a Medicaid Transformation Grant that will provide an electronic interface between the department and providers focusing on care coordination. At the present time, the department processes claims, but receives little information about the clinical status of those in public programs. Conversely, providers are not able to receive information in the department's records

that would help providers optimize the care they deliver. Claim records from the department containing diagnoses, procedures, and medication histories are not available to support patient care decisions. The CAPS grant will create that interchange. Providers will be able to submit to the department key care plan information on patients actively being managed in the PDCC project and receive key information from the department's database to support the care of those individuals. At all times privacy will be protected and concerns will be thoroughly addressed. Data obtained by the department from the CAPS project will provide a new opportunity to evaluate the effectiveness of the PDCC program and plan for future enhancements.
The third component is the Intensive Care Coordination program. Passed by the 2005 Legislature it was designed to provide an intensive level of care coordination by a provider organization for individuals in the DHS public programs with the highest resource needs. As part of that grant, the grantee, Axis Health, is to develop a predictive modeling risk adjustment system to identify patients whose intensive needs will continue. From this group, Axis will create intervention strategies to improve health and bring down cost for the most complex 300 individuals. In the creation of this contract, the department specifically expanded the scope of the modeling component. This grant and surrounding work will now create a mechanism to stratify the medical care coordination needs of patients served by the fee-for-service component of MHCP.

The integration of these three efforts will create a payment support infrastructure for transformational change in primary care—a risk adjusted care coordination capitation. The existing model of payment only for treatment of acute episodic illnesses and face to face preventative service visits will be replaced by proactive care planning and management with the patient and families.

Several challenges are easily apparent in this transformation. Most importantly, primary care systems will have to restructure to partner with their patients in this new manner. Practices will need to transform to "medical homes" where care of chronic illness is prospectively coordinated in conjunction with the patient and family. This will require a refocus at the clinic level. Where most primary care has been an individual provider effort, the creation of efficient care coordination systems will require the development of practice level teams. Providers and allied health professionals have little expertise in this type of teamwork and planning. Support via efforts such as learning collaboratives will be needed and is funded in the legislation.

The experience of the Minnesota Medical Home Learning Collaborative has been illustrative in this regard. The Collaborative is a combined effort of the Minnesota Department of Health, the Minnesota chapter of the American Academy of Pediatrics, and DHS. Funding is supplied via a grant from the federal DHS's Maternal Child Health Bureau. In the collaborative, teams of a pediatric provider (pediatrician, family practitioner, or pediatric nurse practitioner), a clinic based care coordinator, and the parents of two children with special health care needs work together to plan the medical home improvements in that practice. These teams meet regularly (one to two times per month) in a practice setting to plan and implement improvements. The collaborative meets regularly (three times yearly) to share information, reinforce medical home implementation principles and plan future practice based improvements. These teams have been effective in creating practice transformation. Initial care improvement results have shown much

more effective coordination of care and initial utilization outcome results have shown a significant decrease in expensive services while maintaining or increasing preventative services.

A similar, but differently focused effort is organized by the ICSI's DIAMOND project. This project focuses care coordination at the practice level for the identification and treatment of depression in adults. Like the Medical Home Learning Collaborative, DIAMOND focuses on the creation of a care coordination team at the practice level, in this case to create a specific care product.

From these collaboratives, it is recognized that up front support to change practices beyond payment reform is likely to be needed.

A second challenge will be the creation of the specific measurable criteria for payment for care coordination. Criteria such as the creation of an individualized care plan and access to a practice based care coordinator with dedicated time for that role will be keystones of these requirements. Other criteria that have proven useful in the Medical Home Learning Collaborative, such as the presence of patients on practice planning teams and the use of learning collaborative are reflective of a successful transformational process and will be considered as requirements.

This fall and winter the department is hosting informational and working sessions involving patients, providers, and health plans to develop recommendations for these criteria. DHS recognizes that a conversation about these efforts should be an inclusive community endeavor to serve as a milestone for the entire community. To that end the process has been developed to be inclusive and cosponsored by constituencies representing the breadth of health care stakeholders. The workgroup has a meeting schedule through the spring of 2008. The workgroup has proposed the domains of PCC to include a patient registry, care plan, in-practice care coordinator, family engagement, quality improvement, community engagement, and use of learning collaboratives. Specific operational definitions are now being developed in each of these areas.

A third challenge will be the creation of an equitable system of payment for care coordination services. This payment should compensate providers for their work, while expecting, measuring, and rewarding clinical outcome improvements. From the macro system vantage point care improvement should be measurable across the population and costs should be saved or increases mitigated. Value should be increased.

To create such an equitable system, the risk adjustment methodology must identify both the medical and social/demographic factors associated with medical care coordination. To date most risk adjustment methodologies only look at medical factors. Furthermore, care must be taken to avoid the "year two" problem. Such a problem exists when a provider successfully manages their patients to better health only to be penalized by a reduction in payment because the improved utilization of that panel of patients in the second year of participation decreases the disease burden in the risk calculation.

A last challenge for a risk adjustment system will be the addition of clinical data. Currently data about management is most often inferred from the claims stream. For example, patients with high blood pressure are assumed to be compliant if their prescriptions for anti-hypertensives are

filled. Actual blood pressure measurement is only available if chart audits are conducted. As CAPS is developed and other electronic medical records are linked, the "faucet drip" of clinical information will turn into a "fire hose torrent." The incorporation of this data to enhance the system and create value is a challenge that must be prospectively addressed. (DHS and the health care community have begun to address this through the creation of the Minnesota Health Information Value Exchange (MN-HIE) not specifically addressed here.)

Healthcare is entering a period when the opportunities for payment reform will multiply. A balance will need to be achieved amongst payment for direct service, a clinical results oriented, but disease specific pay for performance system, and the process oriented patient risk adjusted care coordination process being developed here. The dynamics of that balance will be fluid for some time.

DHS believes that primary care reform is currently among the key challenges of health care transformation. As outlined, the Minnesota health care community is well poised to take the next steps in this journey. Improvements envisioned in primary care will go a long way towards healing the health care system and improving the health of the DHS population.

Quality Care and Rewarding Excellence (QCare)

In July 2006 Governor Pawlenty introduced QCare–Quality Care and Rewarding Excellence–a new quality standard program that will be used by the State of Minnesota in its health care purchasing policies to reward top performing providers while saving millions of dollars in health care costs. The QCare program implements quality of care standards, sets aggressive targets for health care providers, makes measures available to the public online, and changes the health care payment system to reward quality rather than quantity.

DHS does this by implementing practice guidelines with their managed care organizations (MCOs). The MCOs adopt, disseminate, and audit the application of practice guidelines consistent with the QCare preventive care standards on the following:

- Child and adolescents immunization,
- Well-child visits,
- Chlamydia screening, and
- Breast and cervical cancer screening.

In addition, the MCOs must implement performance improvement projects. The MCOs select new projects based on one or more of the four QCare standard areas: diabetes care, cardiac care, prevention or hospital care and safety.

The MCOs must make disease management programs available for the QCare chronic diseases mentioned above and may earn financial performance payments based on the MCOs' preventative care services.

Bridges to Excellence

Bridges to Excellence is the pay for performance program DHS uses to reward providers based on the QCare goals. Diabetes and cardiac diseases are the sixth and second leading cause of death in Minnesota. They are serious chronic diseases that have a substantial impact on the

health of Minnesota Health Care Program (MHCP) enrollees. In order to make significant leaps to achieve better outcomes DHS rewards optimal care for these two chronic diseases.

Therefore DHS is participating in Bridges to Excellence an employer sponsored pay for performance program that financially rewards providers based on results for optimal chronic disease care. In 2006 DHS rewarded providers who achieved optimal care in the treatment of their diabetic patients and will reward for optimal care for coronary artery disease (CAD) in 2007.

Pay-for-Performance and Consumer Incentives

The 2007 legislative session authorized a patient incentive program understanding that patient engagement is a major issue for improving chronic disease care and positive results.

In order to reach optimal diabetic care, both providers and patients must be actively involved in the care and treatment of diabetes. In addition to rewarding physicians for optimal treatment for diabetic care DHS will begin a rewards program for diabetic patients in 2009.

Diabetic patients enrolled in DHS programs who reach optimal care, based upon the measures used for physicians under the BTE program, will receive a reward. This will allow DHS to maximize the efforts of state agencies to improve care for chronic illnesses in accordance with QCare.

As the BTE program expands to include rewarding additional chronic illnesses so will the patient incentive program. Following DHS rewards for optimal treatment in diabetes, DHS will reward patients for optimal care for CAD. The rewards DHS will begin with patients in the DHS fee for service (FFS) program.

TRANSFORMATION TASK FORCE PROPOSAL

The Health Care Transformation Task Force was authorized by the 2007 Legislature. One of the objectives of the Task Force is to change the way health care is paid so the quality and safety of care is improved and costs are reduced. In other words, so that a system that pays for value, not volume of services is achieved.

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
- Improve coordination of care (medical home concept)
- Increase transparency and provider competition on price and quality
- Achieve and sustain "critical mass" to make the reform successful

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 three stages or levels. This proposal includes three different levels 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 at level 3 while others may only be ready for level 1. It is anticipated that all health care providers will move to level 3.

- Level 1 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 will involve providers assuming greater responsibility for coordinating care for patients with chronic conditions. Providers at level 2 must 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 overall cost savings because the use of acute care services will be reduced. Initially, the care

management fees will be based on processes, but eventually they will be based on cost and quality results.

- Level 3 will involve providers and care systems assuming responsibility for the total cost of care for the patients they manage. Providers and care systems will submit bids on the total cost of care for a given population. To be eligible to bid, providers will be required to meet certain standards for quality of care. Payments to providers will be risk-adjusted based on the health of the population managed so that providers are not penalized for enrolling a less healthy population. Providers will have incentive to innovate and redesign systems and make investments to provide care more effectively and efficiently because the mechanism holds them accountable for the total cost of care of the population managed.

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 health care is priced and paid for in Minnesota:

- Current payment systems will be restructured so 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 will promote greater use of primary care, and paying more for primary care will address some of the financial incentives that have resulted in fewer medical students choosing primary care careers.

- All providers will 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 will no longer negotiate prices with numerous third party payers and payment rates will no longer vary based on the type of insurance. Instead, providers will set prices that are visible throughout the community and easy to understand. This change will promote greater competition by providers as well as reduce health plan and provider administrative costs.

    - Providers and health plans will continue to negotiate on network participation.

    - Health plans can 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 will be added to existing provider reimbursement structures. 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 will be added to existing provider reimbursement structures. This change will improve price transparency for consumers, and explicitly create incentives for providers to improve efficiency and quality. In addition, it offers additional provider competition beyond health plan/care system choice.

    - Core components of the "baskets" will be defined by a community-wide process, to enable "apples to apples" comparisons by consumers. Providers will be free to innovate on care design, extra services, and efficiency within the "baskets."

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

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

Achieving and sustaining critical mass

To be successful, this effort must include as many providers and payers as possible. In order to make it worthwhile for providers and care systems to participate in this new payment system, they need to involve a significant percentage of their patients. 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 will apply to both health plans and health care providers.

- 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 employers)

The Department of Health estimates that 58.1 percent of Minnesotans will be affected by this proposal. These individuals are covered by either a state or local government sponsored employee health insurance plan, a state public program, or private fully insured coverage, or are uninsured. An additional 1.5 million Minnesotans, or 30.3 percent of the population, is covered by a self-insured employer plan that could choose to adopt this model of payment reform. An estimated 20 percent of the current self-insured market will automatically participate in the payment reform proposal through its inclusion of state and local government employee health insurance plans.

RECOMMENDATION

Changing the way that health care is paid has significant potential to not only reduce the cost of health care but to improve the quality of care, its outcomes, and to promote a more efficient use of health care system resources. Current payment systems need to be fundamentally re-designed to promote value and accountability, while providing better coordination of care resulting in fewer costly complications.

This report recommends that the current payment reform efforts of both DHS and DOER be continued. The programs and techniques in use today and those being planned are the results of program managers applying the best innovations available to meet the needs of the populations served.

It is further recommended that the Executive Branch consider the payment reform recommendations of the Health Care Transformation Task Force and implement those recommendations that are cost effective and beneficial. Under this plan DHS and DOER will proactively lead the reform of the health care market in Minnesota. The goal of this set of initiatives is to use competition to drive the total cost of health care down 20 percent by 2011 while improving quality, accountability and transparency.

The payment reform strategy as envisioned by the Task Force involves providers progressively assuming greater responsibility for quality and cost and ultimately accepting accountability for the total cost of care for the populations they manage. Consumers, under this proposal, are incented to choose low-cost, high quality providers and to choose and use a “medical home” for better care coordination.

Finally, this proposal includes three different stages of payment reform to promote greater provider accountability for health care cost and quality. It is anticipated that all health care providers will move to level 3 within three years following implementation.

Under fee for service, payment is made for every service provided regardless of outcomes creating an incentive to increase the volume of services provided and to increase utilization in the high margin areas. The proposed new model pays providers for their total cost of care, thus creating incentives to manage total volume of services and finds ways to provide care more efficiently. This plan is important step in moving Minnesota health care industry away from the fee for service model.