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Center for Health Care Purchasing Improvement (CHCPI)

Annual Report
(August 2006 – December 2007)

Report to the Minnesota Legislature 2008

Minnesota Department of Health

May, 2008

MINNESOTA MDH DEPARTMENT OF HEALTH

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Center for Health Care Purchasing Improvement (CHCPI)
Annual Report
(August, 2006 – December, 2007)

Summary

This first annual report of the Center for Health Care Purchasing Improvement (CHCPI) is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 43A.312. The report encompasses the period from the Center's inception in the last half of 2006 through the end of the calendar year, 2007.

The State of Minnesota currently purchases health care services on behalf of over 765,000 Minnesotans at costs of over $4.5 billion annually[i] – the single most rapidly growing component of the state budget. The CHCPI was established in late July, 2006 following enactment of Minnesota Statutes, section 43A.312 during the 2006 legislative session. The Center serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services" and is authorized to participate in other related health care improvement activities, including simplification and streamlining of health care administration. It is funded through an annual base appropriation of $100,000, and support from other agencies and budgets.

A variety of studies have characterized the current health care delivery and financing system as disjoint and fragmented, with variable or often poor quality, and burdened by skewed payment incentives that do not align for optimum value and performance.[ii] However, Minnesota is fortunate to be home to several unique, nationally-recognized health care collaborations and innovations working to help address the need for systemic change. A goal of the Center is to build upon this foundation for health care improvement through further use, enhancements, and alignment of these resources and tools.

During the time period covered by this report, the Center served in two primary roles:

1) Supporting and coordinating efforts to align and bring about greater transparency, improved outcomes, and accountability in health care; and,
2) Supporting and coordinating a first-in-the-nation effort to reduce health care administrative costs and burdens.

In the first role above, the Center provided dedicated staffing, coordination, policy and program research, liaison, and other services in support of and as part of broader state and community-wide health care improvement efforts. While much remains to be done to strengthen Minnesota's health care system, the Center has participated as part of a wide range of efforts that have helped make Minnesota a recognized leader in: more science-based, results-focused medical care; health care transparency, with public performance measures at the health plan, hospital, and clinic system level; and better alignment of health care financial rewards and incentives with new forms of health care pay-for-performance.

In its second role, CHCPI is acting as project manager and staff to aid Minnesota to become the first state to develop and implement rules for the standard, electronic exchange of high volume, routine, health care administrative transactions. The rulemaking is complex, being undertaken in consultation with a large group of stakeholders and industry representatives, and is being completed to meet very tight statutory deadlines. When fully implemented, the rules will greatly reduce health care administrative burden and cost throughout the health care system, allowing more of every health care dollar to be spent on patient care and health.

Center for Health Care Purchasing Improvement (CHCPI)
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Introduction

Annual Report

This first annual report of the Center for Health Care Purchasing Improvement (CHCPI) encompasses the period from the Center's inception in the last half of 2006 through the end of the calendar year 2007 This report is being submitted to fulfill the requirements of Minnesota Statutes, section 43A.312, that

> *"The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health Web site and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement."*

CHCPI Background

The State of Minnesota currently purchases health care services on behalf of over 765,000 Minnesotans at costs of over $4.5 billion annually – the single most rapidly growing component of the state budget. The Center for Health Care Purchasing Improvement (CHCPI) was established by the 2006 Legislature with the enactment of Minnesota Statutes, section §43A.312, to "*support the state in its efforts to be a more prudent and efficient purchaser of quality health care services.*"

The Center was also authorized to

> *"aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing. The common strategies and approaches shall promote greater transparency of health care costs and quality, and greater accountability for health care results and improvement. The center shall also identify barriers to more efficient, effective, quality health care and options for overcoming the barriers."*

The Center's enabling statute further provides that the Center may undertake a variety of activities with "the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies." These activities include for example:

- "support the Administrative Uniformity Committee under section 62J.50 and other relevant groups or activities to advance agreement on health care administrative process streamlining";
- "initiate projects to develop plan designs for state health care purchasing";
- "convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies"; and,
- "contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance".

The CHCPI was initially established and administered as a unit of the Department of Employee Relations (DOER). However, in January, 2007 Governor Pawlenty announced that DOER would be merged with other state agencies. Legislation enacted in 2007 clarified that the "duties relating to health care purchasing improvement under Minnesota Statutes, section 43A.312, are transferred on or before June 1, 2008, to the commissioner of health."[iii] The transfer of the Center to the Minnesota Department of Health was officially made on July 29, 2007, and CHCPI now operates as a section within the Minnesota Department of Health (MDH), Health Policy Division.

The Center received a base appropriation of $100,000. As prescribed in statute, the CHCPI is staffed by a Director, who was appointed in late July, 2006. For a period in 2006 to early-2007 it housed two additional staff. At present the Center includes the Director and one additional staff member to assist in coordinating and staffing health care administrative simplification efforts described later in this report. Personnel and other costs in excess of the base appropriation have been funded through inter-agency agreements using additional budget sources.

CHCPI's two primary roles during this reporting period

During the time period covered by this first annual report, the Center has served in two primary roles:

1. Supporting and coordinating efforts to align and bring about greater transparency, improved outcomes, and accountability in health care; and,
2. Supporting and coordinating a first-in-the-nation effort to reduce health care administrative costs and burdens.

The Center focused to a greater extent on the first role above during the period August, 2006 to June 2007, but continues an ongoing involvement in this area. It concentrated more strongly on the second role during the period June – December, 2007, and will likely maintain its focus on this role during most of 2008.

In fulfilling these roles, the Center has acted in a variety of capacities, providing: dedicated staff support; expertise and source of best practices; research and analysis; liaison and outreach; and as a facilitator, coordinator, and catalyst to leverage the resources of state agencies and organizations to improve state health care purchasing. These roles and functions are further reviewed below.

CHCPI OPERATIONS, ACTIVITIES, AND IMPACTS

1. Aligning And Fostering Greater Health Care Transparency, Improvement, And Accountability

Background

For too long, health care purchasers, including the State, have largely assumed the quality of health care as a given. They have typically paid for "medical piecework" in which the volume of services and outputs, rather than desired outcomes and quality, was rewarded. The result, according to a variety of national and Minnesota-specific reports, is that US health care is marked by exceptionally high costs, with widely variable and often poor quality.

Purchasers have further exacerbated the piecemeal approach to health care by imposing an often confusing array of uncoordinated demands, performance measures, and incentives on the health care market. In the absence of clear, consistent expectations and rewards for excellence and value, health plans and health care providers waste additional time and money on individual, fragmented responses to differing market messages. In order to have greatest impact, as well as minimal administrative burden and cost, it is important that purchasers become aligned with common, reinforcing methods of measuring and reporting health care performance, rewarding high value health care, and holding the health care system more accountable for results.

Fortunately, Minnesota is home to several nationally recognized health care collaborations and innovations that create unique opportunities to bring about greater alignment and value in health care (see examples, below). A goal of the Center is to build upon the state's strong foundation for health care improvement through further use, enhancements, and alignment of these resources and tools.

Examples of Nationally Recognized Minnesota Health Care Collaborations and Innovations

- Institute for Clinical Systems Improvement (ICSI) -- ICSI is an independent, non-profit organization founded in 1993 to improve health care quality and to help identify and accelerate the implementation of the best clinical practices. It is comprised of 62 member organizations and is funded by six Minnesota health plans; its combined medical groups and hospital systems represent more than 8,500 physicians.[iv] ICSI clinical guidelines have been cited in the federal government's "National Guideline Clearinghouse" and by other national groups.

- MN Community Measurement – MN Community Measurement is a broad-based nonprofit organization working to accelerate the improvement of health by publicly reporting health care information "in a fair, usable and reliable way to medical groups, regulators, purchasers and consumers".[v] MN Community Measurement was spotlighted by President Bush in his 2006 visit to Minnesota to announce the federal government's "Value Driven Health Care" initiative, and is the source of comparative measures of performance used in the "Bridges to

Excellence" program (see BTE description below). One national report on health plan performance summarized the significance of MN Community Measurement in this way:

"The Minnesota report is important because it shows individual indicators recorded at the practice level. Consumers can see information about practices that are performing well on a wide variety of measures. MN Community Measurement takes this collaborative project one step further by creating and reporting on composite measures. The report shows, for example, that physicians should take at least five specific steps when treating each patient with diabetes. .... This sets a higher, but appropriate, bar for performance. Many practices score in the 90% range for individual measures, such as patients with diabetes that get recommended cholesterol tests. But when measured against the standard of all five steps being done and outcomes reached, the best performing practice reaches this goal less than one quarter of the time."[vi]

- Minnesota State employee health benefits program, "Advantage" – The health benefits program for Minnesota State employees and dependents is a unique, tiered arrangement known as "Advantage." Under the Advantage program, primary health care clinic systems available to members of the state employee group are placed into one of four cost categories based on their total risk-adjusted costs for caring for group members. Members are free to select the primary care provider system of their choice, but pay more in the form of higher deductible, copays, and coinsurance if they choose more costly provider systems. In addition Advantage members are provided with links to Minnesota Community Measurement quality reports on provider groups of interest.[vii] Advantage works to improve health care transparency and accountability by providing information and incentives to:
  - *State employees and their families to look for and choose high value, high quality health care providers;*
  - *Health care providers to deliver value;*
  - *Both providers and consumers to protect/maintain/improve health and use health care resources wisely.*

  Advantage received a national, competitive "Innovation in State Government Award" from the national Council of State Governments in 2005 and has been presented and discussed as part of several national forums.

- Buyers Health Care Action Group (BHCAG) – BHCAG is a coalition of private and public employers working to "redirect the health care system to focus on a collective goal of optimal health and total value."[viii] It is actively helping sponsor and lead a variety of Minnesota health care improvement initiatives, especially Bridges to Excellence and "eValue8" measures of health plan performance (see following). BHCAG is also active at the national level, working with other business coalitions and national organizations on a variety of health care performance improvement efforts.

- "Bridges to Excellence" (BTE) – BTE refers to both: a national "not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts *"... to recognize and reward health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care"*;[ix] and, the name of the organization's national pay-for-performance program that pays financial bonuses to health providers

delivering optimal care of particular chronic diseases. Minnesota is implementing the BTE rewards program in an effort directed by BHCAG and involving eleven private and public health care purchasers including: the Carlson Companies; General Electric; Honeywell; 3M; Wells Fargo; as well as the Minnesota Department of Human Services (DHS) and Minnesota Department of Employee Relations (DOER). BTE in Minnesota uses clinical guidelines for optimal levels of care developed by ICSI, and MN Community Measurement performs the quality review and public measurement functions associated with the reward program.

- Governor's Health Cabinet – Governor Pawlenty's Health Cabinet was created in 2004 to use the state's health care purchasing influence to buy health care better, to streamline and improve health care regulation, and to drive the market to better results for all Minnesotans. It includes the commissioners of the following seven state agencies, working together to better align state health care purchasing: Human Services (chair), Employee Relations, Health, Commerce, Labor and Industry, Finance, and Administration.

- Smart Buy Alliance – The Health Cabinet's efforts were expanded and magnified in late 2005 by joining with the private sector, including both large and small employers, in the Smart Buy Alliance. The Alliance draws together the collective purchasing power of nearly 3/5 of all Minnesotans. The goal of the Alliance is to use common, market-based health care purchasing principles to alter how health care is delivered and paid for to produce far better results at less cost. These principles include:
  - *Identifying and rewarding "best in class" health care providers;*
  - *Adopting uniform measures of quality and results;*
  - *Empowering consumers with easy access to information;*
  - *Accelerating the use of the latest information technology.*

  The Smart Buy Alliance and Health Cabinet have been subject of national studies and news articles.

- Evalue8 -- BHCAG and employers across the country developed eValue8™ as a standard tool to evaluate and report on health plan performance in areas such as: adoption of health information technology, member and provider communications, disease management, program administration, provider performance, patient safety, pharmacy management, behavioral health and financial stability.[x] The use of a standard evaluation and reporting tool reduces the number and variety of evaluation efforts to: reduce costs of evaluation; improve comparability of results across health plans; and to identify performance benchmarks and needs for improvement.

- Adverse events reporting – Minnesota is the first state in the nation to enact legislation that requires Minnesota hospitals to report annually on the frequency of 27 adverse events (medical mistakes) identified by the National Quality Forum (NQF) as medical events that should never happen (also referred to as "never events"). The law requires hospitals to develop action plans for prevention and improvement. The Minnesota Department of Health (MDH) publishes an annual public report of Minnesota hospitals and these 27 adverse events.[xi]

- QCare – Quality Care and Rewarding Excellence -- Governor Pawlenty signed an executive order in August, 2006 creating QCare – Quality Care and Rewarding Excellence. QCare sets

goals for significant health improvement in four key areas -- diabetes, heart disease, preventive care, and patient safety – and requires the Minnesota Department of Human Services (DHS) and the Minnesota Department of Employee Relations (DOER) to adopt strategies and provide incentives in their payment and contracts to help achieve the goals.[xii] The QCare concept and goals were established by a consortium of state, legislative, and health care experts as part of a National Governor's Association (NGA) "Center for Best Practices". This group also continues to provide strategic direction and oversight to QCare and serves as the "QCare Council".

In addition to the examples above, legislation enacted in 2007 created a Health Care Transformation Task Force and a separate health care study charge to another legislative commission, the Health Care Access Commission. Both groups met frequently in public meetings and hearings in 2007 and early 2008. The Health Care Transformation Task Force was created to "advise and assist the governor regarding activities to transform the health care system" and was charged with developing "a statewide action plan for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans." The Task Force's final action plan was forwarded to the Legislature and the Governor in February, 2008.[xiii] The Legislative Commission on Health Care Access forwarded recommendations on how to achieve the goal of universal health coverage as described in Minnesota Statutes, section 62Q.165 to the Legislature in January, 2008. In preparing its report, the Commission also examined health care cost containment and payment reform strategies. [xiv]

At the same time DHS also undertook a number of innovative programs in 2007 to improve health care delivery and outcomes and to align incentives for desired health care results and accountability. The programs included for example: improving primary care through care coordination and the establishment of "medical homes" for Minnesota Health Care Programs clients; Provider Directed Care Coordination, to establish payment on a per member per month basis for patients in the fee for service population whose health needs exceed a defined level of complexity, and who are cared for in clinics that provide a set of care coordination/medical home services; and other initiatives.[xv]

CHCPI Participation In and Support of the Examples Above

The Center contributed to the broad backdrop of change and alignment of health care performance measurement, purchasing, and accountability reforms above with:

Staff and staffing support

- *Health Cabinet and Smart Buy Alliance*
  The Center provided staff support for the Governor's Health Cabinet and Smart Buy Alliance, including: preparing and presenting on a range of topics and issues to the Health Cabinet and the Alliance; logistics, planning, and assistance with meetings and events; and assistance in developing presentations, communications, and outreach materials for use by Cabinet members. As part of this support, the CHCPI worked with staff of other state agencies in identifying and examining a number of health care performance measurement, pay-for-

performance, information technology, and other related health care issues. In June, 2007, the Center planned, and participated in a daylong strategic planning retreat of the Health Cabinet for discussion and review of these issues, many of which were subsequently continued in the context of the Transformation Task Force and the Legislative Commission on Health Care Access.

- *QCare – Quality Care and Rewarding Excellence*
  Shortly after creation of the Center in 2006, Governor Pawlenty signed an executive order creating QCare. The Center participated in planning and staffing a large public meeting held in August 2006 at the Minnesota History Center to create awareness of the initiative. The Center, along with other MDH staff, has provided ongoing staff support to the QCare Council and assistance in developing interim targets for health care improvements, strategies and incentives for reaching the improvement goals, and other work. Most recently it has provided staff support for efforts to further broaden awareness of QCare and align it with other related activities through a series of joint meetings between the Governor's Health Cabinet, QCare Council, and an ongoing, broad-based "Quality Summit" stakeholder forum organized by the Stratis organization, which serves as the state's Medicare quality improvement organization (QIO) and in other convening and health policy research capacities. The first of the joint meetings was held in November, 2007, and explored goals for improving diabetes care and outcomes in Minnesota, and steps and responsibilities of the various stakeholders toward achieving those goals. The Center also participated in a follow-up meeting in January, 2008 to begin development of more detailed plans and approaches for improvements.

Outreach and communication

Outreach and communication is important to create a common awareness of key health care issues and to foster an exchange of information and ideas about best practices or solutions to address the issues. The Center assisted in developing a variety of communications and presentation materials for the Health Cabinet, and has presented locally and nationally as well. In the period covered by this report, for example, the Center presented to Minnesota legislative committees, and to groups such as the Minnesota Chamber, a local academic health policy symposium, and a large, national health care "Quality Colloquium" in Boston, Massachusetts.

The Center also participated with the Health Cabinet in meetings and follow-up with the Commonwealth Fund, a large health care policy, grant-making and research foundation, as part of the Fund's site visits to report on Minnesota's "value-driven" health care purchasing efforts.[xvi]

The CHCPI was subsequently invited and agreed to serve as part of a national advisory group to advise a recently initiated "Public Employee Health Plan (PEHP) Forum on Health Care Quality". The PEHP forum is funded in part through the Commonwealth Fund and is specifically designed to attract public employee health plans from across the country to exchange ideas, best practices, and other information. The Center provided information and suggestions for a PEHP/Commonwealth Fund report on *"Public Employee Health Plans and the Health Care Quality Agenda: What are the Options"* for publication January, 2008. The report includes profiles of several state health care purchasing and performance improvement initiatives, including Minnesota's Advantage program and Smart Buy Alliance efforts. The Center has also

agreed to present on features of Minnesota's health reforms and serve as a resource at a national PEHP webcast scheduled for 2008.

Best practice development and review, strategy, and problem solving

- *BHCAG and Smart Buy Alliance.*
  The Center Director serves on the BHCAG Board of Directors, which works with the BHCAG executive director in setting priorities and planning activities for BHCAG. The Center also serves as a liaison and contact regarding state health care purchasing and other activities. BHCAG itself, as well in its role as a member of the Smart Buy Alliance, has been an active proponent and supporter of BTE, EValue8, QCare Council and Quality Summit, and other initiatives. In conjunction with BHCAG, the Smart Buy Alliance, and Governor's Health Cabinet, the Center participated in a variety of events and meetings designed to bring about greater alignment of common health care performance measurement, quality improvement activities, and rewards and incentives for stronger performance and accountability, including:

  - BHCAG member meetings on a variety of topics and issues, which serve as an important community forum for health care purchasers to explore health care issues and to continuously expand and refine efforts like Bridges to Excellence.
  - A meeting of a large group of stakeholders with federal Department of Health and Human Services (HHS) Secretary Michael Leavitt to align with federal efforts to improve the value of health care delivery and outcomes known as "Value-Driven Health Care" [xvii] The meeting resulted in 35 purchaser and provider organizations from around Minnesota agreeing to take steps to reach four key objectives – or "cornerstones" -- of Value-Driven Health Care: transparency of costs, transparency of quality, greater use of interoperable health information technology (IT) health; and incentives to improve the quality and value of the health care delivered.
  - Site visits and community dialogues with health plans participating in eValue8 measurement and reporting to: discuss eValue8 findings; demonstrate purchaser support for greater performance measurement and reporting; provide feedback, and to explore opportunities for improvement. As part of an ongoing effort to continually refine eValue8 as a decision support tool, the 2007 eValue8 Request For Information (RFI) included nineteen questions measuring health plan progress toward implementing the four cornerstones of the federal Value Driven Health Care initiative.

- *Collaboration with State Agencies*
  The Center coordinates with state agencies at a variety of levels. For example, in 2006-2007 it:
  - Collaborated with BHCAG, DHS, and DOER in planning and addressing implementation questions and issues related to the BTE program;
  - Met in 2006 and 2007 with DHS and the DOER to discuss and brainstorm possible QCare contracting provisions in state contracts with health plans and vendors. DHS has included a number of QCare-related provisions in its contracting. DOER

continues to explore possible Q-Care provisions with the health plan administrators it contracts with;

- Participated in a series of working meetings in late 2006 and in 2007 to explore concepts for greater reporting of health care provider costs and prices for commonly performed procedure and services. The meetings included additional state agency staff, Minnesota Community Measurement, BHCAG, and focused on strategies for bringing greater health care cost transparency to the market. This work is continuing at this time.

New level of collaboration: During this same period, the CHCPI also introduced a new level of state agency collaboration. Three state agencies – Human Services; Corrections; and Labor and Industry – have physician medical directors who help develop and implement policy and programs related their department's areas of health care responsibility. The Center convened the first meetings ever of these state medical directors, as well as the medical director of the Minnesota Comprehensive Health Association (MCHA), the state's high risk pool for medically uninsurable individuals, to begin to explore their respective areas of responsibility, key activities and interests, and possible opportunities for greater collaboration and coordination. Further work in this area was postponed as the Center focus shifted to supporting a rulemaking effort for greater health care administrative streamlining and cost reduction in late 2006 and 2007 (described later in the report).

- *Other related efforts*

  In 2006 the Center served as part of a community-wide health care reform dialogue organized by the Minnesota Medical Association known as "Healthy Minnesota: A Partnership for Reform." The effort brought together leaders in health care, business, state government, labor, education, and consumer advocacy to recommend and implement strategies for health care reform. The Center was a member of Healthy Minnesota's "Insurance Reform Work Group" and presented to other work groups. Healthy Minnesota reported out recommendations for health care reform that also served as the basis for a legislative reform proposal in the 2007 legislative session. The proposal was discussed with other reform proposals and contributed to support for subsequent enactment of the Health Care Transformation Task Force and Legislative Commission on Health Care Access report.

Impacts

The Center has participated as part of a larger collaboration of state agency and other groups discussed above, across a range of activities to build upon and accelerate a number of important Minnesota reform efforts. Much remains to be done, and Minnesota still faces significant health care cost, quality, and access challenges. However, as a result of number of combined efforts Minnesota is a visible, recognized leader in:

- Science based health care and consensus-driven clinical practice guidelines

  The Institute for Clinical Systems Improvement (ICSI) remains a significant, nationally recognized source of science-based health care clinical guidelines and quality improvement.

ICSI guidelines have been incorporated in health care performance measures by MN Community Measurement and Bridges to Excellence.

- Greater transparency of health care costs and quality

Minnesota is one of the few states in the nation that has achieved a "triple play" in health care transparency, with well-defined, ongoing, comparable, publicly reported measures of health care performance at the level of health plans, clinics, and hospitals. This triangulation approach to health care performance measurement of measures includes:

- "eValue8" measures of health plan performance;
- Minnesota Community Measurement reports on clinic level quality; and,
- hospital measures such as the annual Adverse Event reports.

Each of the measures is continually being improved and expanded, leading to new uses and applications. At the same time, new audiences are becoming more aware of the measures as an aid to making more informed health care decisions and improving health. The eValue8 measurement and reporting tool for example was expanded in 2007 to include measures specific to the federal Value-Driven Health Care Initiative. Minnesota Community Measurement is implementing broader data collection through direct data submission by clinics. Links to all three levels of reporting and comparison, as well as much additional health care information, are available at a single, public, "one-stop shop" website maintained by the Minnesota Department of Health at www.minnesotahealthinfo.com.

- Pay for performance in health care

As a result of its participation in the Bridges to Excellence, the Advantage state employee health benefit plan, QCare, and other initiatives, Minnesota is a leading example of innovative changes and alignment of new payment incentives to encourage greater value health care.

In 2006 the Minnesota State employee group health benefits program, Advantage, became the first public sector health care purchaser in the nation to make financial rewards under the BTE program to health care providers identified as providing superior quality diabetes health care and outcomes. In 2007, the Minnesota Department of Human Services (DHS) became the first Medical Assistance (Medicaid) program in the nation to reward providers demonstrating superior health care performance under the BTE program. At this time, Minnesota currently has the largest participation in Bridges to Excellence of any state, with over 760,000 lives, or nearly 1/7 of the state population.

In 2007 three Minnesota medical groups and 35 clinics received BTE awards for reaching a performance target of twenty percent or more of their patients with diabetes receiving optimal diabetes care. Sixty-four clinics received BTE rewards for achieving a performance target of 50% or more of patients with coronary artery disease receiving optimal care for their condition.

2. Health Care Administrative Simplification and Savings

As discussed below, the CHCPI focused extensively in 2007 on supporting and coordinating first-in-the-nation effort to reduce health care administrative costs and burdens.

Overview

Not only is greater alignment of appropriate incentives and practices needed to improve delivery and outcomes of health care services, but it is also needed to improve health care administrative functions and to reduce administrative costs. Unlike the financial, transportation, and other sectors of the economy, health care has lagged far behind in its use of efficient, effective standard electronic exchange of routine business transactions. The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient, much more burdensome, and much more costly to the health care system.

Studies have shown that exchanging common health care administrative transactions on paper, or in nonstandard formats, is more expensive than standard, electronic data exchanges and can result in problems of incomplete or incorrect information that cause delays and further expense. One recent national study estimated that the costs of processing paper health care claims at $1.58 per claim, or nearly double the cost of electronic billings, at 85 cents per claim.[xviii] A 2006 report estimated that between $15.5 and $21.8 million is spent annually in Minnesota for follow-up telephone calls between health care providers and payers to resolve questions related to eligibility and claims.[xix]

Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur every minute, every day, millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity. As described below, the CHCPI is playing an important role in implementing requirements that administrative transactions be exchanged electronically, using a standard data content and format, to reduce overall administrative costs in Minnesota's health care system by an estimated $70 million per year by 2013.[xx] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to also meet other goals for health care performance measurement and improved patient care.

Center Involvement and Impacts

In late 2006 the CHCPI responded to interests on the part of the Health Cabinet to explore opportunities for rapidly aligning efforts to streamline and simplify routine health care administrative transactions. In December, 2006, the Center planned and staffed a site visit to a promising example of alignment for health care administrative simplification in Utah, known as the Utah Health Information Network (UHIN). Minnesota's site visit delegation included nearly twenty state and private sector representatives, which met with a similar large contingent from UHIN for two days of discussion and information exchange.

The site visit led to broader discussions and momentum for changes in Minnesota to accelerate health care administrative simplification and standardization efforts. That interest culminated in the 2007 session with passage of Minnesota Statutes, section 62J. 536 -- first-in-the-nation legislation requiring that all health care providers and group purchasers (payers) exchange the following three types of common health care administrative transactions electronically, in a standard format, by 2009:

- eligibility inquiry and response (to determine health insurance coverage levels and benefits of patients);
- claims (provider billings); and,
- payment/remittance advice (information on payments to providers and any adjustments to billings).

The standards for the required electronic transactions are being developed as rules by the Minnesota Department of Health (MDH) in 2007 and 2008. They are based on federal Health Insurance Portability and Accountability Act (HIPAA)[xxi] requirements and the Medicare program, with modifications the Commissioner of Health finds appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC). The AUC is a broad-based, voluntary group representing Minnesota's public and private health care payers, hospitals, health care providers and state agencies. It has served since 1992 to develop agreement among payers and providers on standardized administrative processes. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. As the rules are developed, they will be announced at least one year in advance of their 2009 effective dates, to allow health care providers and payers time to become aware of and comply with the requirements.

Since passage of the legislation and with the transfer the Center to the MDH, the Center has served in a project manager role to assist the rule development process, and has focused especially in this area during the last six months of 2007. The rulemaking is unprecedented and complex, requiring significant technical input of affected stakeholders, as well as substantial outreach and communication to inform health care providers, payers, and others of the legislation and rules, within a very short timeframe.

The Center provides planning, project management, management of a contract with a consultant that is also assisting in the development of the standards, and direct staff support to the AUC. The rule development includes the governance structure of the AUC, numerous stakeholder-led technical work groups, and other groups, some meeting as often as twice a week during key phases of rule development. The Center has also planned, organized, and staffed two additional large, public stakeholder meetings in 2007. The meetings were focused in particular on identifying any claims data exchange issues considered unique to workers' compensation, property and casualty, and auto insurance carriers. These carriers are not subject to federal HIPAA administrative simplification requirements but must now comply with the new state law and rules. As a result, the MDH-AUC rulemaking process must also identify and address possible business information needs or other needs that may be unique to these carriers. (The CHCPI organized and staffed a third large meeting to further explore possible unique data needs for non-HIPAA covered entities in March, 2008.)

In addition, the CHCPI developed press releases, articles for publication, issue briefs, submissions to the State Register, materials for two websites, and other communications and presentations for ongoing outreach and communication about the law. For example, the Center, working with the Department of Human Services and the AUC notified more than 24,000 health care providers in the state of the new requirements. It also worked with the Department of Commerce to notify all licensed insurance carriers in the state of the new law and rules.

In December, 2007, following extensive development and review by the AUC, as well as opportunities for further outside reviews and public comment, MDH adopted rules for the eligibility inquiry and response transaction – the first of the three transactions to be exchanged electronically in a standard format. The rules for the eligibility transaction become effective January 15, 2009 and will help health care providers quickly and accurately verify their patients' insurance coverage and the medical benefits or services for which they are eligible.

The Center is currently working with the AUC and an outside consultant on the development of the remaining rules for health care claims and payment/remittance advice transactions. The rules for the standard electronic exchange of claims will be announced by July 15, 2008, and will take effect July 15, 2009. Similar rules for the payment/remittance advice transaction will be announced by December, 2008, to take effect December 15, 2009. Both sets of rulemaking are proceeding on schedule to meet the deadlines above.

Endnotes

[i] Source: Minnesota Department of Human Service (DHS) and the Minnesota Department of Employee Relations (DOER), personal communications. DHS reports an enrollment of over 650,000 members, at annual state and federal costs of over $4 billion. DOER reports over 115,000 members, at annual costs of over $.5 billion.

[ii] See for example reports and studies such as Crossing the Quality Chasm: A New Health System for the 21st Century , Institute of Medicine, 2001 at http://www.nap.edu/openbook.php?isbn=0309072808; Report of the Minnesota Citizens Forum on Health Care Costs, February 2004 at: http://www.minnesotahealthinfo.org/other/citizensforum.pdf and resource material provided as part of the Governor's Health Care Transformation Task Force at: http://www.health.state.mn.us/divs/hpsc/hep/transform.

[iii] Minnesota Session Laws, 2007 Regular Session, Chapter 148, Article 2, Sec. 80.

[iv] Source: ICSI 2006 Annual Report at http://www.icsi.org/icsi_annual_report/annual_report_download.html. Additional information about ICSI can be found at: http://www.icsi.org/home/.

[v] Source: http://www.bhcag.com/.

[vi] Source: *The eValue8 Cornerstone Report: Measuring the Success of America's Health Plans* at http://www.nbch.org/eValue8/news/cornerstonereport.pdf , page 9.

[vii] For more information about the Advantage program, see Minnesota Department of Employee Relations (DOER) website at http://www.doer.state.mn.us/ei-segip/pdf/yebbooklet/healthcoverage.pdf.

[viii] Source: BHCAG website at http://www.bhcag.com/.

[ix] Source: Bridges to Excellence Website at: http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=2. More information on BTE can be found at: http://www.bridgestoexcellence.org/.

[x] Source: eValue8 website at http://www.evalue8.org/eValue8/about/index.cfm.

[xi] For more information about Minnesota's Adverse Events reporting, see Minnesota Department of Health website at http://www.health.state.mn.us/patientsafety/ae/index.html.

[xii] Governor Pawlenty's executive order creating QCare can be found at http://www.governor.state.mn.us/priorities/governorsorders/executiveorders/2006/july/PROD007735.html. Additional information regarding QCare can be found at the Minnesota Department of Health website at http://www.health.state.mn.us/healthinfo/qcare.html.

[xiii] Source: Minnesota Department of Health website at http://www.health.state.mn.us/divs/hpsc/hep/transform/.

[xiv] Source: 85th Legislative Session: The Legislative Commission On Health Care Access Final Report -- Recommendations Submitted To The Minnesota State Legislature, February 2008 http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf

[xv] For additional information on DHS initiatives such as "medical home", see for example http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139315.

[xvi] For more information, see Commonwealth Fund reports "Value-driven health care purchasing: Case Study of Minnesota's Smart Buy Alliance" at http://www.commonwealthfund.org/usr_doc/1054_Silow-Carroll_value-driven_Minnesota_case_study2.pdf?section=4039 and "Value-driven health care purchasing: Four States That Are Ahead of the Curve -- Overview" at http://www.commonwealthfund.org/usr_doc/1052_Silow-Carroll_value-driven_purchasing.pdf?section=4039.

[xvii] More information regarding Value-Driven Health Care can be found at the U.S. Department of Health and Human Services website, at http://www.hhs.gov/valuedriven/index.html.

[xviii] Source: An Updated Survey of Health Care Claims Receipt and Processing Times, May, 2006. AHIP Center for Policy and Research at http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

[xix] "2006 Administrative Simplification Project – Project Documentation. Nov. 10, 2006".

[xx] Center for Health Care Purchasing Improvement (CHCPI) analysis, January, 2008.

[xxi] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for: maintenance of health insurance coverage after leaving an employer; and standards for health-care-related electronic transactions. While HIPAA provided important standardization of electronic health care transactions, it did not address all standardization issues. Requirements of Minnesota Statues, section 62J.536 further harmonize and clarify HIPAA standards, for group purchasers and health care providers to exchange health care administrative transactions electronically.