

REFORMING HEALTH CARE IN MINNESOTA:

SEPTEMBER 2008

THE ROAD AHEAD



The road to reform . . .



Judith Shank, M.D., former MMA president and chair of the MMA's Health Care Reform Task Force.

MMA vision for reform

The key features envisioned in the MMA plan were health insurance for all Minnesotans, a strong public health system with an emphasis on disease prevention, systems that support high-quality health care, and a health care delivery market focused on value.

As the former chair of the Health Care Reform Task Force, I have been very proud that the Minnesota Medical Association had the foresight and commitment to provide the leadership and resources to undertake this crucial effort. I couldn't be more pleased that the work that group did resulted in significant legislation that passed this year.

Back in 2005, when the MMA Board of Trustee approved the Physicians' Plan for a Healthy Minnesota, I thought we had the right plan for the right time, and it turned out others thought so as well.

Leaders in business, government, and health care all rallied around the Physicians' Plan, and the MMA was able to harness that enthusiasm to build support for ideas such as medical homes, increased public health spending, and payment reform.

What pleases me is that all along the way, physicians have been instrumental in moving this reform effort forward. Now that it is in its latest phase, and closer than ever to actually influencing and improving patient care, we need physicians to stay involved.

So please read this reform supplement that briefly looks back at what has transpired and then looks ahead to what needs to get done during the next two years to make concrete more of the reform ideas MMA physicians put forward in 2005.

The case for reform

As health care costs continue to rise and exert pressure on families, physicians, businesses, and state and local governments, consensus is building that the health care system needs to be reformed.

- The United States spends twice as much per person on health care as any other country.
- In Minnesota, the average increases in private health insurance premiums continue to outstrip growth in wages and incomes, as well as the rate of overall inflation.
- About 374,000 Minnesotans don't have health insurance.
- Opportunities to improve quality and reduce costs exist—especially in the treatment of patients with chronic illnesses.

A framework for reform . . .

The health care reform act signed May 29, 2008, was a significant step forward for the state's health care system. The MMA was instrumental in achieving the enactment of this legislation, which features many of the reforms physicians proposed in the MMA's 2005 health care reform plan.

The law includes new public health initiatives, eligibility increases for public

health insurance programs, and payment reforms to support chronic disease management, medical homes (which the state calls health care homes), and quality of care.

It does not, however, include detailed instructions. Instead, it sets general goals and timetables and leaves the details of implementation to work groups and the commissioner of health.

Since the devil is in the details, the MMA sees the next three years of implementation as a crucial time that will require physician input and vigilance.

The MMA has already appointed two members to the state's Health Care Reform Review Council and will continue to work for an outcome that will benefit doctors and their patients.

NOW THE HARD PART: THE DETAILS



Photo by Scott Walker

Donald Jacobs, M.D., (left) and George Schoephoerster, M.D., (right) are the MMA's two appointees to the 14-member Health Care Reform Review Council that will serve as an oversight committee.

It took more than four years, countless meetings, and large expenditures of political capital to pass health care reform legislation, and now it's time for the hard part.

"I expect that completing the work set out in the bill will be very difficult and challenging because now we are going to get down into the literal details," says MMA Trustee Donald Jacobs, M.D.

As one of the MMA's two appointees to the Health Care Reform Review Council, Jacobs will be in a good position to watch and influence the process. The council will oversee the entire process. In addition to Jacobs, George Schoephoer-

ster, M.D., a family physician from St. Cloud, was appointed in July to serve on the 14-member council.

Jacobs says he hopes to use his experience as a surgeon and head of a large medical group, Hennepin Faculty Associates, to help ground the council in the realities of treating patients.

"This is our chance as physicians to step to the table and shape the system into something that really works," he says.

Payment reform challenges

Changing the mechanics of payment will be one of the most difficult tasks, Jacobs says. "One of the challenges of payment reform is that you can't just wipe out the current financial infrastructure, it has to be changed in a thoughtful, phased way."

A red flag that Schoephoerster will look for regarding payment reform is whether physicians are being held financially responsible for costs beyond their control. He can see the potential for this happening when the "baskets of care" pricing model is implemented.

"If payments get bundled, it is going to be really important, for example, for a family doctor not to be held accountable for consultant choices and costs related to hospitalization issues."

Medical home challenges

The act also advocates a culture shift toward increased focus on

outcomes, preventive care, and medical homes.

Schoephoerster says he wants to make sure that as the medical home model is implemented it supports and bolsters the physician-patient relationship.

"One thing to make sure of is that there is a reasonable and clear definition of medical homes, because that is going to be essential as we begin to think about how to support that structure."

More work to do

Physicians also need to realize that even if all the initiatives in the act come to fruition, Minnesota will still have not achieved all the goals in the MMA's Physicians' Plan for a Healthy Minnesota.

Because of this, Jacobs plans to keep advocating for universal coverage—which this bill does not even attempt to achieve—and larger investments in public health.

Schoephoerster says physicians need to stay connected to this process in any way they can, whether through the MMA, by contacting lawmakers on their own, or by writing letters to the editor of their local newspaper.

"This is going to be a work in progress, so instead of docs being cynical, attacking, or fearful, I hope they give this a little time to develop and continue to provide feedback," Schoephoerster says.

WHAT THE BILL DOES

Medical homes

The new law encourages development of the medical home model—coordinating care primarily for patients with complex, chronic conditions. Both clinics and clinicians (physicians, advanced practice nurses, and physician assistants) can serve in this role with participation being voluntary. Providers that offer the service will receive care coordination payments and initial efforts will focus on patients with chronic diseases.

The medical homes (or health care homes as they are referred to in the new law) will coordinate care. However, they cannot restrict access to specialists, nor can they be held accountable financially for other care the patient might need. Also, the bill does not mandate that certain patients must have a health care home. Instead, the state will encourage patients with chronic diseases who are enrolled in public programs to choose a medical home. The criteria for certifying health care homes must be established by July 2009. The law says they should:

- Enhance the use of primary care
- Be patient-centered
- Maintain care plans
- Provide patients with ongoing access to a clinician or care team
- Have dedicated care coordinators
- Focus on patients with chronic conditions
- Use electronic health records for systematic follow-ups
- Deliver evidence-based care

Fee levels

The actual care coordination payment hasn't been determined yet, but a legislative budget analysis assumes a fee of about \$50 per patient per month. The law says the payments should vary according to the complexity of the patient's care. So on a patient-by-patient basis, the fees could be substantially lower or higher than \$50.

Public health

The health care reform act expands public health improvement efforts by establishing competitive grants for community health boards and tribal governments. The \$47 million earmarked for grants over two years (FY 2010-FY2011) will require a 10 percent local match and can be used for projects focusing on obesity and tobacco use.



MEDICAL HOME TIMELINE

July 1, 2009

- Certification of medical homes, called health care homes in the bill, begins

January 1, 2010

- Payment system to be completed

July 1, 2010

- Private health plans must include medical homes in provider networks
- Private health plans must pay homes a care coordination fee for enrollees who choose health care homes
- Payments to providers for public program enrollees and state employees begins

Increased eligibility

The act expands health insurance coverage to more than 13,000 Minnesotans, adding an estimated 8,700 to MinnesotaCare by 2011. The state hopes that additional tax incentives will encourage 5,000 Minnesotans to buy insurance in the private market. The commissioners of health and human services will also develop a plan for providing affordable health care to all families with incomes at or below 300 percent of poverty (about \$60,000 for a family of four).

MinnesotaCare/Medical Assistance changes

- Increases MinnesotaCare eligibility for individuals and adults without children from 215 percent to 250 percent of poverty
- One month rolling eligibility
- Revised MinnesotaCare sliding scale premium schedule

Payment reforms

The law calls for a standardized statewide system for measuring provider quality by public and private insurers. It also establishes criteria that will allow consumers and health care purchasers to compare providers.

Pay for performance

The Department of Health will develop a standard set of

measures to assess health care quality.

The Department of Health will establish bonus payments for providers who meet targets and improve over time. The payment rates must adjust for variations in patient population. The system will go into effect July 1, 2010, for state programs and state employees. It will not apply to private health plans but private plans will have to use the state's set of measures for their own pay-for-performance programs.

Peer grouping

The state will replace its current Minnesota Advantage tiering plan with a peer-grouping system. The commissioner of health will begin collecting data on cost and pricing from health plans for the purpose of developing a uniform method

of calculating providers' costs of care and quality of care by July 1, 2009. Then the commissioner will develop a method of comparing peer groups, which can be used by consumers and purchasers. Annual publication of this data begins September 1, 2010. The state will integrate the peer-grouping systems into its benefits for state employees starting January 1, 2011, and private plans must develop products using the same data.

Baskets of care

The act also directs the commissioner of health to establish definitions for at least seven "baskets of care," or sets of related services. Conditions for which baskets of care may be developed include coronary artery and heart disease, diabetes, asthma, and depression. Providers may establish baskets

of care by January 1, 2010.

Providers may then choose to establish a price for each basket, and payers must pay the set price. Once a basket price is established, providers cannot vary the amount they charge for each basket of care provided to Minnesota residents or nonresidents covered by Minnesota employers. State programs and Medicare are excluded.

Essential benefit set

The law calls for a work group to design an essential benefit set that includes coverage for a broad range of services and technologies that are determined to be clinically effective and cost-efficient. A work group will draft a report by October 2009 that will be presented to the Legislature by January 15, 2010.

Initial areas for baskets of care

- Initial measures for primary care
- Preventive services
- Coronary artery and heart disease
- Diabetes
- Asthma
- Depression
- Others as deemed appropriate

History of Health Care Legislation in Minnesota

1973	The Health Maintenance Organization Act, which allows the creation of HMOs, passes.	2005	The MMA showcases its Physicians' Plan for a Healthy Minnesota. A copy of the plan is sent to all members. At legislators' urging, the MMA drafts a bill that is introduced and sparks community-wide debate and media coverage.
1976	Minnesota Comprehensive Healthcare Association is created for high-risk patients denied coverage.	2006/2007	The MMA forms Healthy Minnesota: A Partnership for Reform, which has a 26-member steering committee composed of leaders from health care, government, business, labor, education, and patient advocacy groups.
1987	The Children's Health Plan, which provides some coverage to low-income children and pregnant women not eligible for Medicaid, is established.	2007	Legislation is introduced based on Healthy Minnesota recommendations. A law is signed that creates legislative and gubernatorial commissions.
1992/1993	The HealthRight Act establishes MinnesotaCare, the provider tax, and a Health Care Reform Commission that proposes market reforms that the legislature abandons in 1997.	2008	S.F 3780, passed the house 127 to 7 and the Senate 62 to 5. Gov. Pawlenty signs it May 29.
2004	The MMA forms the 21-member Health Care Reform Task Force to develop a reform plan.		

A PHYSICIAN AT THE FOREFRONT



Sanne Magnan, M.D.
Minnesota Commissioner of Health

No one has more health care reform work to do than Minnesota's Commissioner of Health Sanne Magnan, M.D. The new law charges her with about a dozen tough jobs to manage. Here are her thoughts on how she plans to get the work done.

Can this effort succeed?

Implementing these ambitious ideas means we are going to have to work through a lot of details, and we don't always agree on details. But we have good processes and communications. I'm confident we can work through any conflicts.

What's the hardest part?

The hardest task will be to keep all the elements together and find the right synergy. For example, there are measures that will be used in health care homes [a.k.a. medical homes], baskets of care, and quality incentives, and we need to find the right connection between those measures and other initiatives, such as ehealth.

How will you ensure the fairness of cost and quality reports?

There is not going to be a black box. We will choose evidence-based quality measures. We'll risk-adjust those measures to account for patient populations, and then we'll have a way for providers to appeal.

What's your approach to developing an essential benefit set?

We are increasingly paying more for services, whether they are clinically effective, cost-effective, or add any value. When developing an essential benefit set, we will want to use science to help distinguish services that are clinically effective and cost-effective.

For example, in the past, prevention has been excluded from coverage. If you want to get upstream from problems and address chronic health issues, do you really want to exclude prevention? I don't think so.

How will you define peer groupings—by groups? individual doctors? specialty?

That's a level of detail to be decided, but I know providers from the MMA and others will have input.

What is the purpose of the peer groupings?

We know that there is tremendous variation in cost and quality among providers. Peer grouping is a way to convey to providers, consumers, and purchasers where some of it is.

How will medical homes be certified?

I'm saying start with the end in mind. Let's talk about what we are trying to accomplish with health care homes, what are the outcomes, what will success look like, and then decide what the criteria ought to be, and give providers the flexibility to achieve those outcomes.

Any idea what the care coordination payments will be?

We're not there yet. What is clear is that those payments will be risk-adjusted to account for the health care needs of the populations served.

Are medical homes gatekeepers?

No, not at all. The use of health care homes is voluntary. This is really about giving patients a better care experience and enabling clinics to invest in systems, such as registries, so they can more easily take care of patients. It also allows clinics to be reimbursed for things such as phone calls and emails that historically haven't been seen as part of care.

What role can physicians play?

Physicians are clearly central to our success. They will be represented on the review council and hopefully will volunteer for many of the workgroups. I'm committed to keeping an open line of communication. I've met with the MMA, and we'll keep meeting with physicians and other providers in formal and informal ways.

Will the private sector adopt this?

We want a public-private collaboration that builds systems and design elements that will make sense market wide.

Not all of these reforms are mandated. How will you get private sector buy-in?

In Minnesota, we start by trying to figure out how to do the right thing. For example, look at the DIAMOND [Depression Improvement Across Minnesota Offering a New Direction] project. Did anyone make the health plans and others do the DIAMOND project? No. The state, the health plans, the providers, the purchasers, and the consumers all came together and said let's do this because it will be better—better outcomes for the dollars spent. Or look at what the MMA is doing about credentialing. Everyone is coming together because it makes sense. If this is about improving health and value, then why wouldn't everyone want to do it?

Closing thoughts?

What the MMA did and physicians did in the last few years, working on the Minnesota Legislature's Health Care Access Commission, the Governor's Transformation Task Force, and Healthy Minnesota, all helped to form the solid basis for this legislation. We applaud physicians, and we know we can count on them to help create a better health care system for the people of Minnesota.

Huntley on Reform

Rep. Thomas Huntley, DFL-Duluth, served on Healthy Minnesota and was the reform bill's chief author in the House. He worked closely with the MMA to pass legislation that would benefit patients. Here are some of his comments at the bill's signing on May 29.



Rep. Thomas Huntley

“I will say that this started with us about two years ago, but prior to that it was the Minnesota Medical Association and their report that actually led to what we’re discussing today.”

“I personally think that this is the biggest thing that has happened in Minnesota health care since the passage of MinnesotaCare in 1992, and I would argue that it is more important because this attempt is to fix the entire health care system, not just for the 7 percent that doesn’t have insurance.”

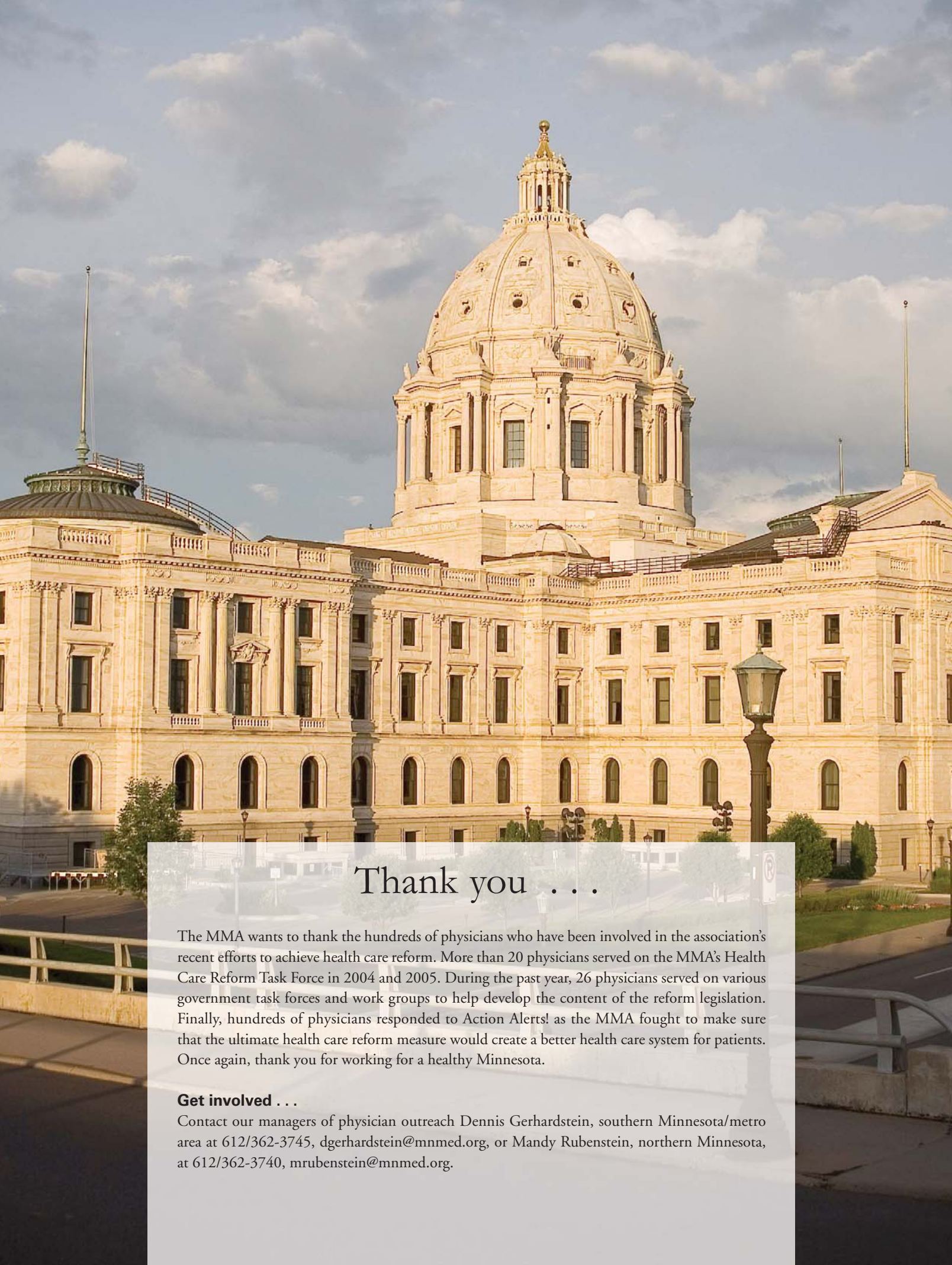
Plenty of Work Groups

The MMA plans to include as many physicians as possible on workgroups being formed by the Department of Health and the Department of Human Services.

- **The Health Care Reform Review Council** is a 14-member council overseeing the process. The first meeting will be held in September.
- **The workforce shortage** study group will study the need to change health professional licensure and regulation. Recommendations will be presented to the Legislature by January 2009.
- **The baskets of care** group will establish definitions for baskets of care and complete its work by July 2009.
- **The health care homes** group will develop and implement standards of certification for health care homes for state health care programs by July 2009.
- **The essential benefit set** group will make recommendations on the design of an essential health benefit set by October 2009.
- **The consumer engagement** group will develop strategies for engaging consumers in understanding the importance of health care cost and quality by January 2010.
- **The uniform claims work** group will make recommendations on the potential for reducing claims costs of health care providers and health plan companies by January 2010.
- **A provider peer grouping** group will develop a peer-grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care.
- **A quality measure development** group will develop standard measures by which to assess the quality of health care services offered by health care providers.

Reform Fast Facts

- Key timelines start after the 2009 session
- Numerous changes take effect after the 2010 session
- The bulk of implementation authority rests with the commissioner of health
- The Legislation calls for creation of 10 different work groups
- The Legislation provides the Minnesota Department of Health with authority to contract with private entities to complete some of the work



Thank you . . .

The MMA wants to thank the hundreds of physicians who have been involved in the association's recent efforts to achieve health care reform. More than 20 physicians served on the MMA's Health Care Reform Task Force in 2004 and 2005. During the past year, 26 physicians served on various government task forces and work groups to help develop the content of the reform legislation. Finally, hundreds of physicians responded to Action Alerts! as the MMA fought to make sure that the ultimate health care reform measure would create a better health care system for patients. Once again, thank you for working for a healthy Minnesota.

Get involved . . .

Contact our managers of physician outreach Dennis Gerhardstein, southern Minnesota/metro area at 612/362-3745, dgerhardstein@mnmed.org, or Mandy Rubenstein, northern Minnesota, at 612/362-3740, mrubenstein@mnmed.org.