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# Reforming Health Care Delivery Through Payment Change and Transparency: Minnesota's Innovations

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## Overview

This report summarizes Minnesota's efforts to transform its delivery system, focusing on landmark legislation passed in 2008, but also looking at the many public and private initiatives that preceded its passage. It describes Minnesota's experience to date with developing and implementing these reforms. Minnesota's 2008 legislation contained a number of specific elements with significant potential to achieve overall health care cost savings. In addition to establishing and funding a statewide health improvement program, and enhancements to coverage, the law

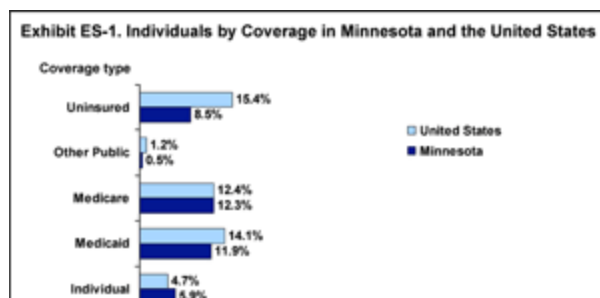
included various provisions to collect and report data to achieve price and quality transparency, as well as provisions to support care redesign and payment reform; these latter provisions are the focus of this report.

## Executive Summary

This report summarizes Minnesota's efforts to transform its health care delivery system. Although the primary focus is on the landmark legislation passed by the state legislature in 2008, we also look at the many public and private initiatives that preceded it. In describing Minnesota's experience to date with developing and implementing these reforms, the report aims to inform other states' efforts to control costs and improve value throughout their health care systems. While implementation is a work in progress, a great deal has been accomplished already, and not surprisingly, new challenges have been uncovered. With numerous new opportunities for pilot initiatives in the Patient Protection and Affordable Care Act of 2010, these lessons will also contribute to national policy discussion.

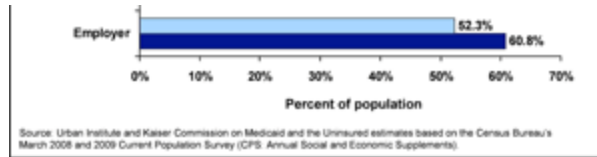
Minnesota's health care environment has numerous strengths as a starting point for reform: a small uninsured population, a strong base of employer-provided insurance, and a history of public-private partnership. Exhibit ES-1 illustrates Minnesota's health coverage compared with the nation. For many uninsured Minnesotans, the Medicaid program offers comprehensive benefits with some of the highest standards in the country. The Health Care Access Fund, a special revenue fund supported by provider and premium taxes, helps manage the MinnesotaCare program for low-income individuals. The private sector was instrumental in creatively piloting data collection on quality and costs, reporting on physician performance, and developing innovative payment methods to reward quality and value for bundled care.

Minnesota's 2008 legislation contained a number of specific elements with significant potential to achieve overall health care cost savings. In addition to establishing and funding a statewide health improvement program, enhancements related to coverage for low-income uninsured people, and steps to increase consumer engagement in all aspects of the system, the law included various provisions to collect and report data to achieve price and quality transparency, and as well as provisions to support care redesign and payment reform; these two sets of initiatives are the focus of this report.



Key legislative provisions to support the collection and reporting of data are:

- Development of a standardized statewide set of quality-of-care measures;
- Collection and use of all-payer encounter data and contracted prices, building on administrative simplification requirements passed in 2007 that call for all health care payers and providers to conduct eligibility, claims, and remittance transactions electronically, with the condition that all plans submit the detailed claims data to a common data aggregator; and
- Transparent ranking of providers based on a combination of risk-adjusted cost and quality (the "provider peer grouping" system, which was modified by legislation passed in 2009).



Key legislative provisions to support care redesign and payment reform are:

- Uniform definitions for at least seven “baskets of care” and standard quality measurements for those baskets;
- A single, statewide system of quality-based incentive payments to providers to be used by public and private payers; and
- Standards of certification for “health care homes” to coordinate care for people with complex or chronic conditions and additional care coordination payments to those homes meeting the standards, with recertification standards based on process, outcomes, and quality measures as well as evaluation of cost impact.

### Exhibit ES-2. Summary of Legislation and Progress as of January 2010

#### Data Collection and Reporting

Statewide measures and all-payer database

*What it is:* Standardized set of quality measures for health care providers across the state.

*Progress:* Uniform definitions and measures have developed. Registration of medical groups in data portal and identification of populations are under way. On January 1, 2010, providers started submitting data on the measures; these will be publicly reported in July 2010.

*Implementation challenges:* There is no enforcement mechanism for data collection in place or under development. Questions arise about future innovation in developing new measures or reporting mechanisms.

Provider peer grouping system

*What it is:* A method for comparing health care providers based on a combination of risk-adjusted cost and quality.

*Progress:* On July 1, 2009, collection of encounter data from health plans and third-party administrators began. Data will be disseminated to providers in June 2010. By January 2011, the state employee health plan, state public insurance programs, local units of government, and private health plans must use these tools to strengthen incentives for consumers to choose high-quality, low-cost providers.

*Implementation challenges:* Though the provider peer grouping system has conceptual support from all stakeholders, the technical details and program’s design are making implementation difficult. Questions also arise about the policy’s potential impact on access.

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## Care Redesign and Payment Reform

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### Baskets of care

*What it is:* A collection of the services, paid separately under a fee-for-service system, but usually combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

*Progress:* Uniform definitions for seven “baskets of care” were established by July 2009, with an eighth basket added later that year. Standard quality measures were established by December 2009. In January 2010, providers offering these baskets were able to establish their own prices for them, and quality information will be publicly available beginning July 2010.

*Implementation challenges:* A number of operational issues still require resolution. A second key question is whether these standard definitions will be used in the market, since their use is entirely voluntary.

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### Quality incentive payments

*What it is:* A statewide system of quality-based incentive payments to health care providers.

*Progress:* Incentive payment design was completed in July 2009, and by July of the following year, the payment system must be implemented for participants in the state employee health plan and enrollees in state public insurance programs.

*Implementation challenges:* Distinguishing the quality incentive payment system from the multiple pay-for-performance programs already in the state is an obstacle.

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### Health care homes

*What it is:* An approach to primary care in which providers, families, and patients work in partnership to improve health outcomes and quality of life for patients.

*Progress:* Standards and procedures for certification and recertification for health care homes were adopted January 11, 2010.

*Implementation challenges:* Despite widespread support for the concept of better coordinated care through a patient-centered health care home, the definition of that home remains controversial. There is also debate over the coordination of payments in this system.

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Although Minnesota has a unique health care environment, the state's experiences with payment and delivery reform illustrate successes and challenges that are applicable to other states wrestling with rising health care costs. Key lessons focus on the process of adopting and then implementing reforms, as it is too early to assess outcomes. Those lessons are:

- Leadership across the public and private sectors at every stage was critical to developing recommendations and passing legislation.
- Stakeholders acknowledged that the issues were complex and required, throughout the development process, vigilant articulation of the goals and willingness to compromise.

- System reform, when framed as controlling costs and improving value, propels bipartisan support.
- Although Minnesota's payment and transparency reforms did not go as far as some proponents wanted, the elements that did pass in 2008 are critical building blocks for future reforms.
- An imperfect package is far preferable to the "do nothing" alternative, but questions remain as to whether it will actually work as expected.
- There are mixed views about the ambitious timetable, but the positive aspects appear to outweigh the negative.
- To transform the system, a majority of the stakeholders must be affected. It is unclear whether the legislation, with voluntary adoption of reforms by the private sector, is sufficient for real reform. Furthermore, it is widely recognized that Medicare's participation in the rest of Minnesota's reforms would truly increase the chances of successfully transforming the delivery system.
- Payment and transparency reforms require an upfront investment; many states are unlikely to be in Minnesota's fiscal position to fund them.

Minnesota's 2008 health reform legislation did not go as far on payment reform as some proponents had wanted, but still puts in place important reforms to change payment mechanisms and care delivery through data collection and reporting, as well as through designing payments to encourage coordination and efficient delivery. Given all the previous activity in the state, the law was perhaps more evolutionary than revolutionary, but the elements needed for real transformation are all there. Notably, there is significant commitment to transformation from every stakeholder group, and all of them will be fully involved with implementation.

Whether the voluntary nature of some of the reforms' adoption will lead to the critical mass of support envisioned—and needed—remains to be seen, but the evident public and private leadership leaves us cautiously optimistic. Were Medicare to join the state's efforts, the chances for success would improve. The opportunities provided by the new Patient Protection and Affordable Care Act of 2010 for states to pilot-test payment reform and transparency initiatives appear to make such collaboration possible.

Currently, the accountable care organization concept has a great deal of traction in the state, with much interest in some kind of better-organized system that can accept bundled payment. The state's reforms are important building blocks for this concept, and Minnesota will be an excellent testing ground.

Finally, this report illustrates that passing legislation is only a first step toward health system reform. It points to the value of assessing early content and process lessons, both to improve what is under way locally and to inform other states seeking to solve the same difficult problems. As Minnesota learns, so will the nation.

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## Citation

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