November 23, 2010

DRAFT -- Payment Reform Working Group Recommendations

A. Background

The U.S. health care system is often criticized for providing care that is fragmented, and for paying many providers for this care under a fee-for-service system that rewards volume, rather than high quality care. This contributes to rapidly increasing health care costs and a system in which the quality of care does not always reflect the high level of expenditure.

In recognition of these concerns, the Minnesota Legislature in 2008 passed legislation that attempts to provide financial and other incentives for the provision of coordinated, high-quality care. These initiatives include provisions to certify health care homes and provide payment for care coordination, make quality incentive payments to providers, and allow consumers to compare providers based on the cost and quality of care (see M.S. chapter 62U). The 2010 Legislature directed the Commissioner of Human Services to implement a demonstration project to test alternative and innovative health care delivery models for Minnesota health care program enrollees, including accountable care organizations that provide services based upon a total cost of care or a risk-gain sharing payment arrangement (see Minnesota Statutes, § 256B.0755).

The federal Patient Protection and Affordable Care Act (ACA) contains many provisions intended to encourage providers to coordinate the care provided to patients and to reward providers for providing care efficiently. One of these provisions establishes a shared savings program under Medicare for accountable care organizations. In addition, the Minnesota Department of Health and the Minnesota Department of Human Services were recently awarded a federal grant under the Multi-Payer Advanced Primary Care Demonstration, to implement health care homes and care coordination payments for both Minnesota health care program enrollees and privately insured enrollees. Finally, many Minnesota health plans, health systems, and health care providers are conducting their own payment reform and care coordination initiatives to reward the provision of efficient, coordinated care and improve health care quality.

Given the interest in, and importance of, payment reform and care coordination initiatives at both the national level and in Minnesota, the Health Care Access Commission convened a Payment Reform Working Group. The membership of the working group consisted of legislators and representatives of various health care and consumer groups (see membership list below).

During the Summer and Fall of 2010, the working group held six meetings (August 18, September 8, September 27, October 14, October 27, and December 2). The meetings included presentations and discussion on: the status of state grant applications related to payment reform, payment reform and care coordination principles, and Minnesota public and private sector payment reform and care coordination initiatives, with a focus on the establishment of accountable care organizations.

The recommendations that follow grew out of the working group discussions of those topics. The goals of the recommendations are to: (1) encourage, and allow the state to facilitate, the

many promising approaches to payment reform and care coordination that are being conducted by Minnesota health plans, health systems, and providers; (2) provide the state with an ongoing means of monitoring payment reform initiatives; and (3) apply promising approaches to state health care programs, in order to improve patient care and to reduce the rate of increase in state health care spending.

B. Membership of Working Group

Senator Tony Lourey, Co-Chair
Senator Rick Olseen
Senator David Senjem
Senator Linda Higgins
Senator Kathy Sheran
Representative Tom Huntley, Co-Chair
Representative Jim Abeler
Representative Julie Bunn
Representative Matt Dean
Representative Maria Ruud

Anne Edwards, Chair of Pediatrics, Park Nicollet Health Services
Charlie Fazio, Chief Medical Officer & Senior Vice President, Medica
Cindy Morrison, Vice President of Health Policy, Sanford Health
Daniel L. Svendsen, Executive Director, Generations Health Care Initiatives, Inc.
Don Jacobs, Chairman & Chief Executive Officer, Hennepin Faculty Associates
Douglas Wood, Chair, Division of Health Care Policy, Mayo Clinic
George Schoephoerster, Geriatrician, Geriatric Services of Minnesota
Heidi Holste, Associate State Director of Advocacy, AARP
James Wuellner, Vice President and Chief Financial Officer, St. Luke's Hospital of Duluth
Jim Przybilla, Chief Executive Officer, PrimeWest Health
Jonathan Watson, Director of Public Policy, Minnesota Association of Community Health Centers
Julie Sonier, Deputy Director, State Health Access Data Assistance Center
Lisa Fink, Staff Attorney, Legal Services Advocacy Project
Meg Hasbrouke, Vice President, Payer Relations and Contracting, Allina Hospitals and Clinics
Michael Scandrett, President LPaC Alliance, Minnesota Safety Net Coalition
Terry Carroll, Senior Vice President, Transformation and CIO, Fairview Health Services
Jim Reimann, Payer Relations Chair, Minnesota Medical Group Management Association
David Abelson, President and Chief Executive Officer, Park Nicollet Health Services

C. Recommendations

1. Develop Standard Criteria for Risk Adjustment and Risk Assessment

Many payment reform initiatives require participating providers to bear some degree of financial risk, as an incentive to efficiently provide high quality services. For example, payments to a provider for a defined set of services provided as needed to a patient may be fixed, or the level of

aggregate payment to a provider may vary with whether the provider meets a target tied to service utilization. In these cases, providers with a patient base that is healthier than average (relative to other providers) will be more likely to benefit financially, since expenditures and service utilization for that patient base will be more likely to be lower than average. This can give providers and health plans and systems a financial incentive to seek healthy enrollees ("cherry-pick"), and a financial disincentive to establish programs that would serve and attract patients with high-cost health care conditions. In addition, small providers may be reluctant to participate in payment systems that involve risk sharing, since any losses on patients with greater than average health care needs must be recouped over a smaller overall patient base.

Risk adjustment is one method of reducing the likelihood of providers being penalized for serving a greater-than-average proportion of patients with significant health care needs. Risk adjustment is the process of adjusting payments to health plans, health care providers, and other entities, to reflect differences in the risk characteristics of enrollees or patients. Risk adjustment can also be used to control for patient characteristics as part of measuring and comparing quality of care. Minnesota rules governing the statewide quality reporting and measurement system define risk adjustment in this context as "a process that adjusts the analysis of quality measurement by accounting for those patient-population characteristics that may independently affect results of a given measure and are not randomly distributed across all providers submitting quality measures. Risk adjustment characteristics include severity of illness, patient demographics, or payer mix" (Minnesota Rules, part 4654.0200, subpart 17).

Risk adjustment usually relies on a risk-assessment model to compare the risk characteristics of individuals or groups to a population average. These characteristics can include demographic factors such as age and gender, health status information, payor information, and information on medical condition and treatment. Risk assessment can be used to risk-adjust payments to health plans and providers when they are paid through capitation or some other non-fee-for-service payment method. Risk assessment can also be used to identify high-cost patients for purposes of disease management or care coordination, measure provider efficiency, and compare provider performance while controlling for patient health status and other relevant characteristics.

Recommendation: The working group recommends that the state work with the private health care sector in developing standard criteria for risk adjustment and risk assessment models. The criteria could, for example, address issues such as: the demographic and health-related factors that should be included in a risk-assessment model; the extent to which health indicators should be based on diagnosis or treatment; and the extent to which a risk adjustment model should be prospective (based on health spending indicators from a previous period) or concurrent (based on health spending indicators from the current period).

These criteria should, among other things, encourage smaller health care providers and health plans to participate in payment reform initiatives that require some risk-sharing. An effective risk adjustment method for small providers may require special features given their small patient base, since risk assessment tends to do a better job of explaining variations in health care costs between larger groups, as opposed to smaller groups or individuals.

In developing the standard criteria, the state should evaluate and consider incorporating the risk adjustment criteria and methods to be established by the Secretary of Health and Human Services, following consultation by the Secretary with the states, as part of implementing the ACA.

2. Provide Technical Support for Small Providers

Payment reform initiatives may require providers to contract with other health care organizations, modify their organizational procedures, and adopt new payment systems. Payment reform initiatives may also require coordinating health care services provided by different providers, and monitoring and comparing the cost and quality of these services across providers. These initiatives may also require providers to adopt and maintain sophisticated health information technology and/or use electronic health records.

Small providers, such as solo-practitioners, very small group practices, and community clinics, may not have the staff expertise necessary to evaluate whether to participate in a payment reform initiative, contract successfully with health plans or health systems, and redesign their organizational procedures and payment systems. Any required health information technology and electronic health record systems may be unaffordable to small provider groups. In addition, small provider groups may require technical assistance in developing and maintaining these systems.

Recommendation: The working group recommends that the state encourage the private health care sector to provide technical and financial assistance to small providers, to enable them to evaluate and participate in payment reform initiatives, make necessary changes in organizational procedures and payment systems, and develop and maintain any health information technology and electronic health record systems required for participation. The working group also recommends that the state assist in these efforts, by coordinating private sector technical assistance efforts and seeking any applicable federal grants that would support infrastructure development by small providers.

3. Facilitate Transparency and Coordination

Many payment reform initiatives require increased transparency – i.e. greater sharing of price and quality information between health care providers, and with consumers. Effective implementation of payment reform initiatives may also require health care providers and health plans to work together to coordinate care using uniform procedures. State and federal data privacy, antitrust, and fraud and abuse laws may limit the extent to which information can be shared, and the ability of providers to work together to establish uniform procedures for care coordination. These laws may also hinder efforts to allow consumers to choose providers or health care systems based on comparisons of cost and quality.

The ACA, in order to promote the development of Medicare accountable care organizations, provides federal agencies with waiver authority related to fraud and abuse laws, and also gives those agencies the authority to designate new regulatory exceptions and safe harbors.

Recommendation: The working group recommends that the state assist efforts by the private health sector to cooperatively develop uniform procedures for payment reform initiatives, by convening groups of patients rights and consumer protection organizations, health care providers, and health plans when some form of state protection from antitrust laws is necessary. The working group also recommends that the state monitor the extent to which data privacy and anti-fraud laws hinder the implementation of payment reform, and when necessary recommend appropriate changes in state and federal laws and any necessary federal waivers.

[Question for working group: What are areas related to payment reform for which state protection from antitrust laws would be useful?]

4. Maintain a State Focus on Payment Reform and Cost Containment

The development and implementation of payment reform initiatives is an ongoing process. Many payment reform models have only recently been implemented and have not been fully evaluated. The state should continue to maintain a means of reviewing the progress of payment reform and a forum for discussing relevant issues with stakeholders.

Recommendation: The working group recommends the state continue to focus on payment reform and cost containment, whether through a working group of the Health Care Access Commission, a commission appointed by the governor (perhaps similar to the Governor's Health Care Transformation Task Force of 2007), or by another means. Membership in the working group should continue to be bipartisan and represent a broad cross-section of stakeholders. In addition to focusing on the recommendations above, the working group may also want to consider:

1. promoting and further developing the health care payment and quality reforms authorized by the 2008 Legislature, e.g. by continuing to transition payment reform from bundled payments and shared savings approaches to total cost of care models;

2. continuing to promote the development of health care homes, in both private and public sector programs, and monitoring health care home initiatives such as the Medicare Multi-Payer Advanced Primary Care Practice Demonstration, for which Minnesota was recently awarded a federal grant to implement;

3. monitoring the development of ACOs in Minnesota, including the health care delivery systems demonstration project authorized under Minnesota Statutes, § 256B.0755, and based upon this monitoring, determining whether state regulation of ACOs is necessary; and

4. evaluating the effectiveness of private sector payment reform models, and considering whether successful private sector initiatives should be incorporated into state health care programs.