December 14, 2010

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 selected to participate in the federal 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 and evaluating the success of payment reform initiatives; and (3) apply promising initiatives 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, University of Minnesota
Lisa Fink, Staff Attorney, Legal Services Advocacy Project
Meg Hasbrouck, 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 Improved Methods of 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 the cost and 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, which are typically obtained from enrollment or claims data, 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.

The working group discussed the limitations of current methods of risk assessment. Several working group members raised concerns about the fact that current methods do not generally incorporate factors such as race/ethnicity, language, or income/poverty that may influence health outcomes and health care utilization independently of other factors included in the models (e.g. age, gender, diagnoses).

Assessing the need for improvements to risk adjustment is a necessary and important step for implementing payment reform for two reasons. First, if providers do not trust the risk adjustment methods, many of them – especially small providers – will be reluctant to participate in payment reform initiatives. Second, inadequate risk adjustment could lead to financial incentives that penalize providers serving higher-risk populations and reward providers that serve lower-risk populations. This could ultimately reduce access to care for higher-risk populations.

Recommendation: The working group recommends that the state work with the private health care sector to assess the need for improvements in risk adjustment models, to develop the necessary data infrastructure (e.g. data collection on additional factors to be included in risk adjustment), and to develop and implement improved methods of risk adjustment. This process should result in a set of agree upon standards for risk adjustment and risk assessment models. The standards 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).

The standards should, among other things, encourage smaller or specialized health care providers and health plans to participate in payment reform initiatives that require some risk-sharing. An appropriate risk adjustment method for these providers will likely require special features given the small patient base of these providers, since current risk assessment tools tend to do a better job of explaining variations in health care costs between larger patient populations, as opposed to smaller ones. An appropriate risk adjustment method for these providers would also likely require including in the risk assessment model a wide range of variables, including non-clinical, socio-economic factors related to race, ethnicity, language, and poverty and homelessness.

2. Ensure the Full Participation of All Provider Types in Payment Reform

In order to have a significant effect statewide in reducing health care spending and improving the quality of care, payment reform and care coordination initiatives must include participation by a wide range of providers, who in the aggregate serve a large and diverse patient population across all areas of the state, both rural and urban. Participation in payment reform initiatives should be feasible and attractive not only for large, urban group practices but also for solo-practitioners and other small (often rural) providers, safety net providers such as community clinics, and specialty providers that serve defined populations, such as those with specific health conditions or certain cultural, ethnic, or socio-economic groups.

These small, safety net, and specialty providers may not have the resources necessary to evaluate whether to participate in a payment reform initiative, negotiate successfully with health plans and health systems, and modify their organizational procedures and payment systems as necessary to allow them to participate in payment reform initiatives. The health information technology and electronic health record systems required to participate in payment reform initiatives may be unaffordable to these providers, and these providers may require technical assistance in selecting

and maintaining these systems. Finally, these providers may only be able to accept limited financial risk as part of a payment reform initiative.

At the same time, many of these providers have experience in providing care to hard to serve populations using cost-effective and innovative payment and care delivery methods. This specialized expertise may be useful to health plans and large health care providers as they develop payment initiatives to serve low-income or culturally diverse or specialized populations.

Recommendation: The working group recommends that the state take steps to ensure that private sector payment reform initiatives, and those administered by the state for state health care program enrollees, are flexible in design and include a range of models, in order to incorporate the full range of health care providers and serve a diverse patient base. These steps could include, but are not limited to:

1. encouraging and coordinating efforts to provide technical and financial assistance to small, safety net, and specialty providers, to allow them to evaluate and participate in payment reform initiatives;

2. seeking any applicable federal grants that would support infrastructure development by small, safety net, and specialty providers, and assisting these providers in applying for relevant grants;

3. providing a means of communicating best practices to all providers, including but not limited to those best practices used by small, safety net, and specialty providers to reach hard-to-serve populations;

4. ensuring that financial risk arrangements do not preclude participation by small, safety net, and specialized providers; and

5. ensuring that risk adjustment methods are appropriate for small, safety net, and specialized providers (see also recommendation #1).

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:

1. the state assist efforts by the private health sector to cooperatively develop uniform procedures and standards 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;

2. state agencies assist provider groups and health plans interested in developing payment reform initiatives, by issuing timely decisions or issuing advisory opinions, after input from consumers, and when necessary, assisting providers and plans in obtaining clarification from the federal government;

3. 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; and

4. the Minnesota Department of Health, in consultation with the Department of Human Services and providers and plans, develop improved patient reported outcome measures that can be used to measure delivery system performance and the effectiveness of payment reform initiatives.

4. Design and Implement Payment Reform in the Broader Context of Societal Determinants of Health

While much of the discussion of payment reform focuses on the actual provision of and payment for health care services, other factors also have a significant impact on population health outcomes. For example, the county health rankings model assigns weights to the various health factors that influence health outcomes. The model assigns a weight of 20 percent to clinical care, with the remaining 80 percent assigned to three sets of non-clinical factors – health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent). [Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, County Health Rankings: 2010 Minnesota, www.countyhealthrankings.org/minnesota]

Since the ultimate goal of the health care system is good health and positive health outcomes, payment reform initiatives should be developed in the context of these broader societal determinants of health, and in coordination with the public health system.

Recommendation: The working group recommends that payment reform initiatives for enrollees of state health care programs:

1. incorporate preventive services;
2. provide incentives for patients to adopt and maintain healthy lifestyles;
3. take into account racial, ethnic, and cultural factors;
4. respect patient preferences and decision-making; and
5. use measures of population health status as well as individual health status, including the health status of specific racial, ethnic, and low-income populations, when evaluating effectiveness.

The working group also recommends that the state encourage private sector payment reform initiatives to satisfy these criteria.

5. Continue the State's 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. Given the potential impact of payment reform on health care costs and quality, the state should maintain a means of reviewing the progress of payment reform, evaluating the effectiveness of payment reform initiatives in lowering health care costs, and providing a forum for discussing relevant issues with stakeholders.

Recommendation: The working group recommends that 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 listed in this report, the working group or other entity 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 Multi-Payer Advanced Primary Care Practice Demonstration for which participation by Minnesota was recently approved;

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;

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

5. evaluating what an appropriate definition and level of reimbursement should be for total cost of care, in order to both evaluate the effectiveness of payment reform and obtain a baseline for assessing ongoing provider concerns about the adequacy of reimbursement. In defining total cost of care, the working group should consider not just medical costs incurred by a provider for the provision of patient services but also the impact on costs (cost-shifting) for other providers, payers, government entities, and nonprofit organizations; and

6. promoting state collaboration with the newly established Center for Medicare and Medicaid Innovation, through communicating effective strategies to the center and seeking any necessary federal approval for state payment reform initiatives.