MINNESOTA ASSOCIATION OF
County Health Plans

October 13, 2010

Rep. Thomas Huntley
Minnesota House of Representatives
585 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1206

Sen. Tony Lourey
Minnesota Senate
75 Rev. Dr. Martin Luther King Jr. Blvd.
Capitol Building, Room 303
St. Paul, MN 55155-1606

RE: County-based Purchasing and Payment Reform

Gentlemen:

At the first Payment Reform working group meeting, you asked members to share information regarding payment reform models and issues of interest and importance to the group. Representatives from the Minnesota Association of County Health Plans ("MACHP") suggested that County-based Purchasing ("CBP)" is a good example of payment reform, which is especially well-suited for rural communities but would work well in metropolitan areas as well. CBP plans bear risk, coordinate care, and promote better health of patients and the community in partnership with rural providers who often do not have the infrastructure, systems or expertise to implement payment reform pilot projects, such as an Accountable Care Organization ("ACO"), on their own. In addition, CBP plans are able to coordinate medical services with social services, public health, housing, and other county services that have a direct impact on patients' health.

At the last working group meeting, Brett Skyles, CEO of f Itasca Medical Care ("IMCare") in Itasca County, presented to the committee about CBP and about IMCare's long-standing approach to gain-and loss-sharing with providers. We appreciated the opportunity to share this information with you and are now following up to suggest some guiding principles for consideration by the working group.

MACHP suggests the following payment reform principles for consideration by the working group and policymakers:

1. Health care is local. Payment reform models and requirements should be flexible enough to be adaptable to local conditions. Not every community is the same. A single, standardized form of payment reform will not be as effective as a general payment reform framework that focuses on the desired outcomes in terms of costs and quality, rather than prescribing the process for achieving the outcomes, and that allows substantial local flexibility and engages local communities and stakeholders in developing the local model and strategy.
2. Special models and networks are needed for rural areas. Health care reforms are often designed with metropolitan areas in mind, where there are many competing providers and health plans, large integrated health systems, and a comprehensive array of services available

that are not available in rural communities. Different models for addressing health issues and controlling costs are necessary for rural areas because of the different provider sizes and types, different relationships and communication channels and a different array of resources available in the community. For example, rural health care systems are already predominantly primary care-based and make greater use of mid-level practitioners, which is a goal of urban health systems. Another example is 24-hour urgent care centers, which generally do not exist in rural communities because they are not economically viable alternatives to hospital emergency rooms. Further, accountability often takes on a different aspect in rural communities, where patients may personally know the local hospital administrator, county commissioner, public health staff and other persons in the community whose decisions affect that patient's health care. For these reasons, payment and delivery models and performance measures for rural health systems should be appropriate for rural areas.

3. Payment strategies should be comprehensive and pay adequate rates. Payment rates should be adequate to cover the costs of services provided and to allow appropriate investment in the system changes that are necessary to reduce costs in the future. Payment strategies also should be comprehensive and take into consideration all areas where health and treatment decisions affect costs. Without a comprehensive approach, payment reforms are likely to simply shift costs from one level of government to another, from one provider to another, from one set of purchasers to another, or from the public sector to the private sector. CBP plans are acutely aware that decisions made by providers, health plans and patients have a direct and substantial impact on county services and budgets. Counties are ultimately responsible for dealing with needs and costs that are the result of cutbacks and program and services changes made by the federal government, state, health plans and providers. Finally, payment strategies should differentiate for the unique needs of, and costs of services for, patient populations with special needs, including disability, mental illness, multiple complex co-occurring medical conditions, and other chronic diseases.

4. Health care treatment and services should be coordinated with public health, social services and other local services affecting health. Providers play a role in improving patients' health, but changes to provider payment arrangements, alone, will not address the major population-health issues such as obesity, poor nutrition and chemical dependency that are major drivers of cost. In addition, many non-clinical factors directly affect patients' health, access to services, compliance with treatment plans and outcomes of treatment. Services provided by counties and community nonprofits are also vital to the success of payment reforms and should be closely coordinated with medical services. This type of health plan and county service coordination is inherent in the CBP model.

Brian Nasi – CEO, South Country Health Alliance
Jim Przybilla – CEO, PrimeWest Health
Brett Skyles – CEO, Itasca Medical Care