



Minnesota Hospital Association

Starting the Health-Care Reform Journey

May 2008

Overview

The passage of health-care reform legislation was clearly one of the highest legislative priorities for the 2008 Legislature. After countless hours serving on both the Governor's Transformation Task Force and the Legislature's Health Care Access Commission, health-care leaders seemed bound and determined to pass some form of health-care reform legislation, even if it meant compromising much of the proposed MinnesotaCare eligibility expansion in order to get Governor Pawlenty's approval. Despite the scaled-back provisions, an additional 7,000 individuals will be eligible for MinnesotaCare under the new health-care reform bill, S.F. 3780. The expansion comes primarily through raising the income limit to 250 percent of federal poverty guidelines for adults without children and through raising the family income limit to \$57,500.

After Governor Pawlenty vetoed the first health-care reform bill, H.F. 3391, bill authors Sen. Linda Berglin (DFL-Minneapolis) and Rep. Tom Huntley (DFL-Duluth) spent the next couple of days negotiating with Administration officials. Huntley had an especially challenging task of reaching out to a coalition of single-payer DFL legislators, who wanted more eligibility expansion without getting locked into a specific payment methodology. At the same time, Huntley had to try to convince House Republicans, who had overwhelmingly voted against the original bill, that the new bill contained many worthwhile reform measures at a significantly reduced price tag. In addition, House Republicans wanted inclusion of tax credits and resources for Section 125 tax plans for small businesses. The negotiations must have produced the right balance because the final bill passed with only five "no" votes in the Senate and seven in the House.

Throughout the legislative process the bill continued to be amended to address concerns raised by the health-care provider community. The final legislation, which puts into place a process for more significant reform, is in the words of Senator Berglin a "mere shadow" of its original content.

The Minnesota Hospital Association (MHA) was opposed to the proposed hospital tax to pay for the new public-health initiative. In the end, the final bill had no new hospital tax and called for the public health initiative to be paid for with money from the Health Care Access Fund. The payment reform section is also significantly different. The bill now authorizes uniform definitions to be created for a minimum of seven baskets of care that

providers can voluntarily submit bids for in 2010. Previous versions of the bill required participation in this bidding approach. The single pricing language, which was also of concern to many health-care providers, will apply exclusively to these voluntary baskets of care.

In the end, the benefits of moving forward with even a scaled-back health-care reform bill outweighed any remaining policy or political concerns. An estimated 12,000 individuals will have access to health-care coverage, either through expanded eligibility in MinnesotaCare or through tax credits provided through the Section 125 plans. The bill seeks to empower consumers with greater transparency around both provider price and quality, provide better coordination of care through the creation of medical homes and establishes a framework for moving forward with payment reform ideas.

Highlights of the Health-Care Reform Bill, S.F. 3780

Statewide Health Improvement Program

This section of the bill includes a competitive grant program for which community health boards can apply. Grants are to be aimed at reducing the percentage of Minnesotans who are obese and reducing the use of tobacco. Local communities will be required to provide a minimum of 10 percent matching funds to qualify for grants. The grants will be paid for through the Health Care Access Fund. Through MHA's advocacy efforts, the original funding source of a new hospital/health plan tax was not adopted.

Health-Care Homes

One of the ideas discussed throughout the summer and fall by both the Health Care Transformation Commission as well as the Health Care Access Commission was the creation of "Health-Care Homes."

A health-care home is to provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition. Legislators embraced the idea that health-care homes will provide better outcomes for individuals, particularly those with chronic conditions. Some legislators also believe the model will result in cost savings.

The State will establish a certification program for health-care providers seeking to be designated as a health-care home. Certification is voluntary. Beginning July 1, 2009, state health plan enrollees shall be encouraged to select a primary-care clinic that has been certified as a health-care home.

The legislation also calls for care coordination payments. Certified health-care homes are eligible for per-person payments for providing care coordination services and directly managing onsite or employing care coordinators. Payments are to be based on the complexity of the patient's needs. Development of the payment system must be completed by Jan. 1, 2010 with the goal of implementation by July 1, 2010.

By Jan. 1, 2010, health-plan companies shall include health-care homes in their provider networks and, by July 1, 2010, shall pay a care coordination fee for their members who enroll in health-care homes. By July 1, 2010, the commissioner of finance shall implement this incentive payment system for all participants in the state employee group insurance program.

The Commissioners of Health and Human Services shall provide to the Legislature comprehensive evaluations of the health-care home model three and five years after implementation.

Increasing Access

It is estimated that, through this legislation, an additional 12,000 Minnesotans will now have health insurance. Approximately 7,000 individuals will now be eligible for MinnesotaCare, and 5,000 individuals will get coverage through enhanced affordability of private insurance.

MinnesotaCare expansion is done primarily through four provisions:

- ▶ Raise the eligibility restrictions for adults without children from 215 percent to 250 percent of federal poverty guidelines;
- ▶ Raise the current family income limit from \$50,000 to \$57,500;
- ▶ Establish a 30-day grace period for the processing of re-enrollment paperwork or instances of a missed payment; and
- ▶ Increase the current \$20 application assistance bonus to \$25.

Private coverage is expanded primarily through tax incentives for small businesses to establish Section 125 plans for their employees. By July 2009, all employers with 11 or more employees will be required to establish Section 125 plans, which allow employees to purchase individual market or employer-based insurance with pre-tax dollars. Employers may opt out of this requirement by appealing to the Department of Commerce. (Detailed implementation language regarding Section 125 plans is contained in both S.F. 3780 and in the Omnibus Tax Bill.)

Electronic Prescription Drug Program

Any organization (providers, insurers, etc.) that uses e-prescribing must, by 2011, establish an electronic prescription drug program that uses either HL7 messages or the NCPDP SCRIPT Standard for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

Interoperable Electronic Health Record Requirements

Electronic medical records must be certified by the Certification Commission for Healthcare Information Technology, or its successor. This criterion shall be considered met if a hospital or health-care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period. As included in last year's legislation, this requirement goes into effect in 2015. Health-care providers who are prescribers or dispensers of controlled substances must have a certified electronic health record system.

Payment Restructuring, Incentive Payments Based on Quality of Care

The Commissioner of Health shall develop a standardized set of measures by which to assess the quality of health-care services offered by health-care providers. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The

measures will be developed by July 1, 2009 and used for the quality incentive payment system for state health-care programs. Payments are to be based upon a comparison of provider performance against specific targets, and improvement over time.

Quality Transparency

The Commissioner of Health shall establish standards for measuring health outcomes; establish a system for risk adjusting quality measures and issue annual reports on provider quality beginning July 1, 2010. By Jan. 1, 2010, physician clinics and hospitals shall submit to the commissioner standardized electronic information on the outcomes and processes associated with patient care. (The measures must be initially based on existing quality indicators for physicians and hospital services, which are measured and reported publicly by quality measurement organizations.) The commissioner may contract with a private entity or consortium of private entities to complete these tasks. By Jan. 1, 2010, health-plan companies shall use the standardized quality measures established and shall not require providers to report any other specific quality and outcome measures.

Payment Reform to Reduce Health-Care Costs and Improve Quality

The Commissioner of Health is instructed to develop a plan to create transparent prices, encourage provider innovation, reduce the administrative burden associated with processing claims and provide comparative information to consumers on variations in health-care cost and quality across providers. (This plan is to be complete by Jan. 1, 2010.) Specifically, the commissioner is to develop a uniform method of calculating providers' relative costs of care, defined as a measure of health-care spending including resource use and unit prices, and relative quality of care. In developing this method, the commissioner will be required to address a number of issues including provider attribution of cost and quality, appropriate adjustment for catastrophic cases, patient demographics and health status, specific types of providers and services and a variety of other factors in calculating the relative cost of care.

Beginning January 2009 and every six months thereafter, health plans and third-party administrators will be required to submit encounter data to a private entity designated by the Commissioner of Health. This data will be used to help the Commissioner of Health develop a peer grouping system for providers based on a combined measure that incorporates risk-adjusted cost of care and quality of care. Also beginning Jan. 1, 2009 and annually thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health-care providers to the selected private entity for the purposes of performing the analysis necessary to develop a peer-grouping system. The law calls for the commissioner to consult and coordinate with health-care providers on establishing the peer-group system.

Beginning July 1, 2010, the commissioner shall disseminate information to providers on their cost of care, quality of care and the results of the grouping based on the health-plan and provider data collected. Providers will have 21 days to appeal if they do not agree with the findings.

This information will be used to do the following by Jan. 1, 2011:

- ▶ The Commissioner of Finance shall use this information to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

- ▶ All units of government (city, county and school district) must offer plans that differentiate providers on cost and quality;
- ▶ All health-plan companies shall develop products that encourage consumers to use high-quality, low-cost providers and must offer at least one plan that uses the information to establish incentives for consumers to choose high-quality, low-cost providers.

Provider Pricing for Baskets of Care

The Commissioner of Health must establish a workgroup with members appointed by statewide health-care associations. The group will advise the commissioner in order to meet a July 1, 2009 deadline of establishing uniform definitions of services within each basket of care. The law calls for a minimum of seven baskets of care with a focus on chronic conditions.

Beginning Jan. 1, 2010, health-care providers may establish package prices for the baskets of care. Providers must accept their single price as payment in full when voluntarily submitting bids for these baskets. This single pricing will not apply to services paid for by Medicare, state public health-care programs, workers' compensation or no-fault automobile insurance.

Health-Care Reform Review Council

The bill authorizes a Health-Care Reform Review Council be established to review the progress of implementation of this legislation. Specifically, two members of the council are to be appointed by the Minnesota Hospital Association, with at least one being a rural hospital administrator. Other stakeholder groups include Minnesota Medical Association, Minnesota Medical Group Managers Association, as well as business and labor organizations.

Additional Studies:

- ▶ A workforce shortage study;
- ▶ A study of the uniform claims review process;
- ▶ A work group will also be created to make recommendations for the design of a health benefit set that provides coverage for a broad range of services and technologies;
- ▶ A study will look at ways to provide health coverage to employees at long-term care-facilities; and
- ▶ Recommendations to the Legislature on community benefit standards for nonprofit health plans doing business in the state.

Where Do We Go From Here?

This year's legislation has been characterized as an incremental step toward a larger objective. For the foreseeable future, it appears the Legislature will be divided between those who want to expand access to coverage and those who are more concerned with cutting health-care expenditures. Regardless of how this debate unfolds, there will unquestionably be increasing calls for more transparency around provider pricing and quality measures. The legislation passed this year has ample opportunity for the hospital community and other health-care providers to be involved in the reform process going forward.

Health-Care Reform Timeline 2008-2012

| Date | Description |
|---|--|
| Dec. 15, 2008 | Commissioner of Human Services reports to Legislature with recommendations for a rate increase to long-term care employers for purchase of employee health insurance. |
| Jan. 1, 2009 or upon federal approval, whichever is later | MinnesotaCare expansions increasing income threshold for adults with no children to 250 percent of federal poverty guidelines, and allowing enrollees to remain on MinnesotaCare for an additional month after failing to submit renewal forms or make final month's premium payment. |
| On or before Jan. 15, 2009 | Commissioner of Health convenes first meeting of Health-Care Reform Review Council. |
| Jan. 15, 2009 | Commissioner of Human Services shall report on ways to improve coordination between state health-care programs and social-service programs to identify and enroll MinnesotaCare-eligible residents. |
| Jan. 15, 2009 | Commissioner of Health submits report to Health Care Access Commission regarding payment restructuring progress. |
| Jan. 15, 2009 | Commissioner of Health makes recommendations to the Legislature for changes necessary in health licensure and regulation related to scope of practice of advanced practice nurses, physician assistants, and other health-care professionals in the health-care home and primary-care delivery system. |
| Jan. 15, 2009 | Commissioner of Health submits report and recommendations to the Legislature regarding affordability proposal for individuals with access to employer-subsidized health coverage. |
| April 1, 2009 | Commissioner of Commerce makes form for opting out of Section 125 requirement available on its Web site. |
| July 1, 2009 | Commissioner of Health awards grants to community-health boards for public health initiatives. |
| July 1, 2009 | Employers with 11 or more FTEs must establish Section 125 plans or opt out. |
| July 1, 2009 | Commissioners of Health and Human Services develop and implement certification standards for health-care homes for state health-care programs. |
| July 1, 2009 | Commissioners of Health and Human Services establish a health-care home collaborative. |
| July 1, 2009 | Commissioner of Human Services begins encouraging state health-care program enrollees with complex or chronic conditions to select primary care clinics with health-care home-certified clinicians. |
| July 1, 2009 | Commissioner of Health establishes uniform definitions for baskets of care. |
| July 1, 2009 | Commissioner of Health develops a system of quality incentive payments for providers. |

| Date | Description |
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| July 1, 2009 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| July 1, 2009 | Health plans and third-party administrators submit data on their contracted prices with providers to Commissioner of Health. |
| Oct. 15, 2009 | Benefit Set Work Group submits report to Commissioner of Health on an initial essential benefit set and design. |
| Dec. 15, 2009 | Commissioners of Health and Human Services report on implementation and administration of health-care home model for state health-care program enrollees. |
| Dec. 31, 2009 | Commissioner of Health establishes quality measures for the baskets of care. |
| Jan. 15, 2010 | Commissioner of Health reports on public health improvement program, including recommendations on sustainable funding source other than the Health Care Access Fund. |
| Jan. 1, 2010 | Commissioner of Human Services develops payment system for care coordination fees. |
| Jan. 1, 2010 | State employee insurance plans include options for high-deductible health plans. |
| Jan. 1, 2010 | Hospitals and physician clinics submit standardized electronic information on outcomes and processes associated with patient care. |
| Jan. 1, 2010 | Health plan companies required to use standardized quality measures developed by Commissioner of Health. |
| Jan. 1, 2010 | Commissioner of Health develops plan to create transparent prices, encourage provider innovation and collaboration in cost-effective care delivery, reduce administrative burden on providers and plans associated with processing claims, and provide consumers with comparative information on health-care cost and quality. |
| Jan. 1, 2010 | Health plans required to include health-care homes in provider networks. |
| Jan. 1, 2010 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| Jan. 1, 2010 | Health plans and third-party administrators submit data on contracted prices with providers. |
| Jan. 1, 2010 | Consumer Engagement Work Group makes recommendations to Commissioner of Health and Legislature. |
| Jan. 1, 2010 | Health-care providers may establish package prices for baskets of care. |
| Jan. 1, 2010 | Uniform Claims Review Process Work Group makes recommendations to Commissioner of Health regarding potential for reducing claims and adjudication costs by adopting more uniform payment methods. |
| Jan. 15, 2010 | Commissioner of Health reports on recommendations of Essential Benefit Set Work Group to Legislature. |
| June 1, 2010 | Commissioner of Health disseminates information to providers on their cost of care, resource use, quality of care, and the results of peer grouping. |

| Date | Description |
|---|---|
| June 22, 2010 | Deadline for providers to review accuracy of Commissioner of Health's data based on cost of care, resource use, quality of care, and peer grouping. |
| July 1, 2010 | Comparative price and quality information on baskets of care is published by Commissioner of Health for consumer use. |
| July 1, 2010 | Commissioner of Finance implements quality incentive payment system for state employees. |
| July 1, 2010 | Health plans required to pay care coordination fee for members enrolled in health-care homes. |
| July 1, 2010 | Commissioner of Finance implements care coordination payments for participants in state employee insurance plan. |
| July 1, 2010 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| July 1, 2010 | Commissioner of Human Services implements quality incentive payments for state health-care program enrollees. |
| July 1, 2010 | Commissioner of Health establishes standards for measuring health outcomes and issues annual public reports on provider quality. |
| July 1, 2010 or upon federal approval, whichever is later | Commissioner of Human Services implements care coordination payment system. |
| July 1, 2010 or upon federal approval, whichever is later | Expansions of MinnesotaCare become effective allowing children to remain eligible for MinnesotaCare immediately after exceeding medical assistance's income limits and increasing total family income limits to \$57,500. |
| Sept. 1, 2010 | Commissioner of Health publishes information on providers' cost, quality, and peer grouping for public use. |
| Dec. 15, 2010 | Commissioners of Health and Human Services report on implementation and administration of health-care home model for state health-care program enrollees. |
| Jan. 1, 2011 | Commissioner of Human Services develops payment system to reward high-quality, low-cost providers; creates incentives for public health-care program enrollees to choose high-quality, low-cost providers; and fosters collaboration among providers to reduce cost shifting. |
| Jan. 1, 2011 | Providers, group purchasers, prescribers, and dispensers of controlled substances must establish and maintain an electronic prescription program. |
| Jan. 1, 2011 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| Jan. 1, 2011 | Health plans and third-party administrators submit data on contracted prices with providers. |

| Date | Description |
|---------------|---|
| Jan. 1, 2011 | Commissioner of Finance, political subdivisions, and health plans develop incentives or products to encourage consumers to use high-quality, low-cost providers. |
| Jan. 1, 2011 | Commissioner of Health reports to governor and Legislature on recommendations to encourage health plans to promote wide-spread adoption of insurance products that encourage the use of high-quality, low-cost providers. |
| Jan. 15, 2011 | Commissioner of Health reports on public health improvement program and makes recommendations regarding whether future program funding should be distributed based on health disparities. |
| July 1, 2011 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| Sept. 1, 2011 | Commissioner of Health publishes information on providers' cost, quality, and peer grouping. |
| Dec.15, 2011 | Commissioners of Health and Human Services report on implementation and administration of health-care home model for state health-care program enrollees. |
| Jan. 1, 2012 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| Jan. 15, 2012 | Commissioner of Health reports on public health improvement program. |
| Jan. 1, 2012 | Health plans and third-party administrators submit data on contracted prices with providers. |
| July 1, 2012 | Health plans and third-party administrators submit encounter data to Commissioner of Health. |
| Sept. 1, 2012 | Commissioner of Health publishes information on providers' cost, quality, and peer grouping. |
| Dec. 15, 2012 | Commissioners of Health and Human Services report on implementation and administration of health-care home model for state health-care program enrollees. |