



**REFORMING HEALTH CARE DELIVERY THROUGH
PAYMENT CHANGE AND TRANSPARENCY:
MINNESOTA'S INNOVATIONS**

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ABSTRACT: 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.

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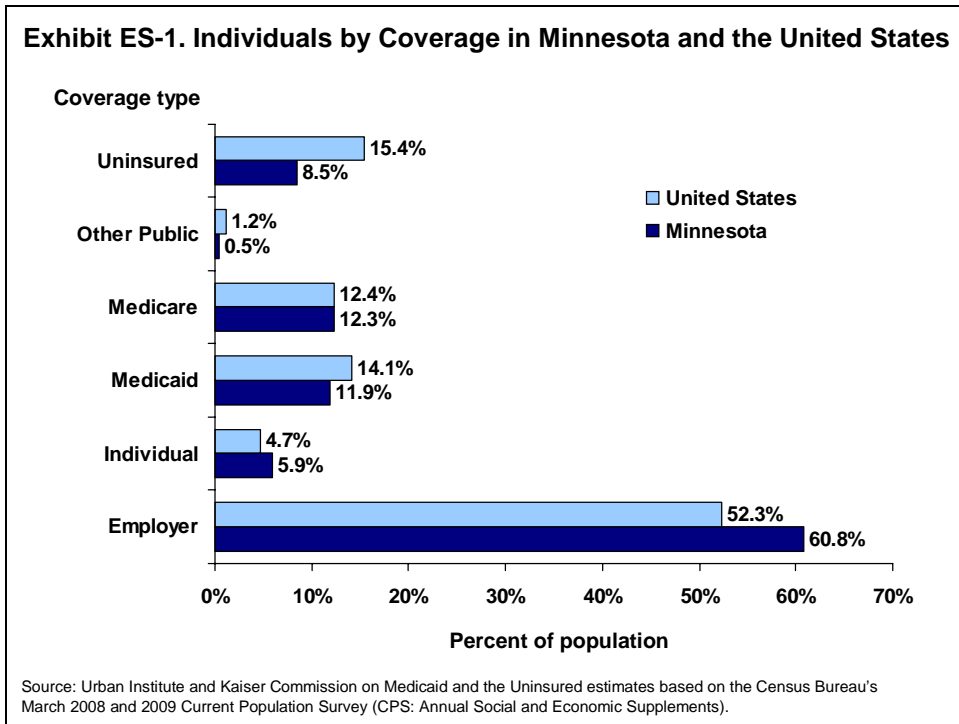
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EXECUTIVE SUMMARY

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	<i>What it is:</i> Standardized set of quality measures for health care providers across the state.
		<i>Progress:</i> 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.
		<i>Implementation challenges:</i> 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	<i>What it is:</i> A method for comparing health care providers based on a combination of risk-adjusted cost and quality.
		<i>Progress:</i> 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.
		<i>Implementation challenges:</i> 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.

**Care Redesign and
Payment Reform**

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.

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.

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.

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.

REFORMING HEALTH CARE DELIVERY THROUGH PAYMENT CHANGE AND TRANSPARENCY: MINNESOTA'S INNOVATIONS

INTRODUCTION

As consensus grows that current health care payment methods work in opposition to efforts to control costs and improve value, the state of Minnesota is implementing a series of reforms aimed at transforming the health care delivery system. Passed in 2008, Minnesota's landmark legislation contained a number of elements to achieve the Institute for Healthcare Improvement's "Triple Aim" goals of simultaneously improving the health of the population, the patient/consumer experience, and the affordability of health care.¹

This report describes Minnesota's experience to date with developing and implementing these reforms. Its purpose is to inform other states' efforts to design strategies for controlling costs and improving value. While implementation is a work in progress, a great deal has been accomplished already, and not surprisingly, new challenges have been uncovered. With the numerous new opportunities for pilot programs in the Patient Protection and Affordable Care Act of 2010, these lessons will also contribute to national policy discussion.

The story is a rich one. Through review of numerous public documents and through structured confidential interviews with 20 key informants—including representatives from the state (executive branch and legislature), plans, providers, business, and consumers—we learned about the policy choices considered and selected, the contributions made by the state and private stakeholders, the key decisions that were made along the way, the plans for implementation, and the lessons learned to date. (See [Appendix A](#) for a list of key informants.) We learned about the unique aspects of Minnesota's environment that affected all of these things. We heard a great deal of consensus, but also differing points of view about how the package came to pass and what the prospects for real impact appear to be. These judgments are presented throughout the report but are especially used in framing the key lessons. Participants were eager to share their experiences and felt officials in other states would benefit from Minnesota's lessons learned and challenges.

In the sections that follow, we first present an overview of the specific elements included in this study. After a short section on the Minnesota context (which refers to

supplemental information in [Appendix B](#)), we lay out the accomplishments to date for each reform and the current implementation issues needing resolution or further work. The key lessons comprise the next section and focus on the process of passing the reforms in addition to observations about the content of what did and did not pass. Throughout, references are included to documents that can be found on the Internet for additional detailed information.

OVERVIEW OF MINNESOTA’S REFORMS

Minnesota’s 2008 legislation contained a number of specific elements with significant potential for overall health care cost savings; reforms that at the time of enactment were estimated to have a potential savings of approximately 12 percent (or \$6.9 billion) by 2015 compared with baseline spending projections.² 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.

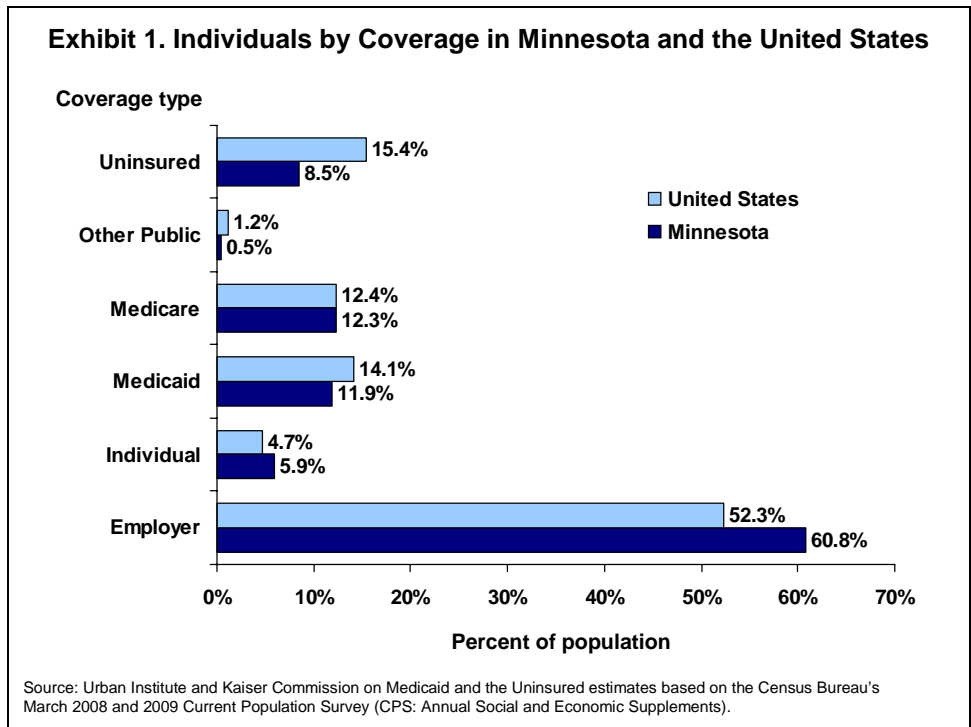
Two important payment reform provisions were discussed during the debate over the legislation, but ultimately they were not included in the final bill. One was the establishment of a single price for provider services across all health insurance plans, which was intended to make it easier for consumers to understand and use cost information and remove plans' ability to compete through discounts they were able to negotiate. The other was a system, known to the health policy community in the state as "Level 3" or "total cost of care," where provider groups and care systems would submit bids for the total cost of care for a given population, and consumers would select systems based on cost and quality. Payments to providers would be risk-adjusted based on the health of the population, and there would be accountability for quality. As will be discussed further, total cost of care was not included in the final bill because of political and provider concerns, but subsequently many providers have developed a more positive view of the concept. In place of this provision, the compromise included the provider peer grouping system and collection of data for the all-payer database, building blocks for reaching the goal of implementing total cost and quality of care payment.

SETTING THE STAGE FOR REFORM

Minnesota has a long history of being at the forefront of health care reform, expanding coverage, using managed care, and encouraging dialogue and collaboration among health care professionals. Despite the problems of too many uninsured, a system where costs were rising unsustainably, and quality was variable and below what could be attained, Minnesota was in a relatively good place when considering the 2008 legislation.

Minnesota's health care environment had numerous strengths as a starting point for reform. The state has a low 8.4 percent of the adult population living without health insurance, ranking third in the country, and has a strong base of employer-provided insurance.³ Exhibit 1 illustrates Minnesota's coverage compared with the nation. For many uninsured Minnesotans, the Medicaid program offers comprehensive benefits with some of the highest standards in the country. According to The Commonwealth Fund's *State Scorecard*, Minnesota leads the nation in indicators of healthy lives.⁴ The health care marketplace, unlike other states, is largely not-for-profit. The health plans that do business in Minnesota report low administrative costs—on average 8 percent, compared with national averages of 16 percent.⁵ The state is also home to some of the most prestigious and progressive medical centers in the country. There is a high concentration

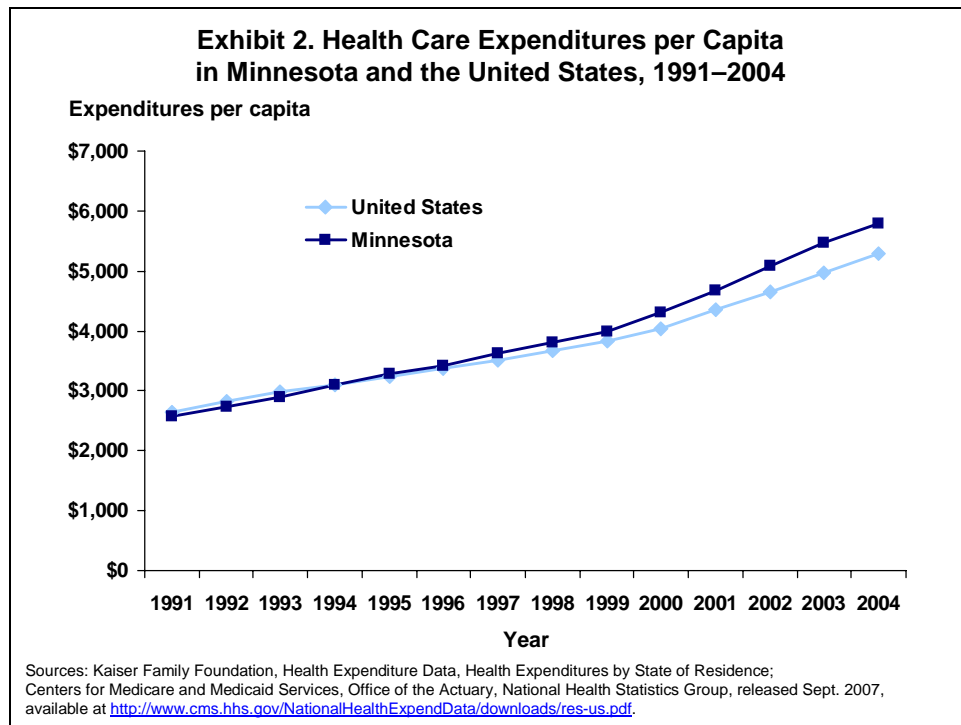
of large, integrated multispecialty practices and hospital systems, and a low level of physicians in solo practice compared with the rest of the nation.



In addition, the state has a dedicated Health Care Access Fund, supported by a 2 percent tax on providers and a 1 percent tax on fully-insured premiums. Most of the fund's resources help manage the MinnesotaCare program by providing direct appropriations and covering the state and federal share of MinnesotaCare enrollee premiums, though funds also are used to support quality and access initiatives through a number of programs. The fund supports the Office of Rural Health and Primary Care with rural hospital and clinic grants, technical assistance, and health workforce data collection. The Health Care Access Fund further contributes to the Department of Health, Department of Human Services, and the University of Minnesota's data collection, data analysis, policy development, and other health reform analytic work.^{6,7}

Minnesota has a rich history of substantial health reform discussions involving public and private stakeholders, which paved the way for the current reforms. Over the past two decades, the strong collaborative environment has laid the groundwork for public and private leadership toward managed care, early adoption of HIPAA and public reporting on a voluntary basis, health information exchanges, and creating community measurement standards. The issue of health reform has been percolating for a long time in Minnesota. In 1992 the legislature, with the support of

Governor Arne Carlson, passed health care reform known as MinnesotaCare, a government subsidized health plan for Minnesotans with a low to moderate income who are unable to access insurance on their own. Despite the firm groundwork on access and coverage, the rising cost of health care in the state is unsustainable. Serious discussions about cost began early in the decade, when the average total cost of health care for a Minnesota household in 2003 was roughly \$11,000,⁸ and reports projected that this number would double by 2010 if current trends continued. Health expenditures per capita also saw an average annual growth of 6.47 percent, rising faster than national health expenditures⁹ (Exhibit 2). Total health care spending in Minnesota went up 70 percent from 2000 to 2007.¹⁰ The state was looking at a future reduction in access and quality of care, with increased burden on individuals, employers, and the state to cover these cost increases.



In 2005, the Minnesota Medical Association brought together leaders in health care, business, state government, labor, education, and consumer advocacy to develop a comprehensive health care reform plan, and in March 2006 the coalition released *Healthy Minnesota: A Partnership for Reform* to serve as a starting point for developing partnerships. Healthy Minnesota proposed health reform legislation that the legislature considered but did not pass in 2007. The Health Care Transformation Task Force (TTF), created in 2007 by the Minnesota legislature, which required the Governor to convene a Task Force to develop an action plan to improve affordability, access, quality of health

care, and the health status of Minnesotans. To address cost, the TTF made a variety of recommendations in its January 2008 report, many of which were later incorporated in the 2008 reform legislation. At the same time, the Legislative Commission on Health Care Access created work groups to address a continuum of health care issues and its report, issued in February 2008, contained many of the same recommendations. (See [Appendix B](#) for more information on these recommendations.)

Minnesota’s innovations in the private sector and through public–private collaborations paved the way for the current reforms. The private sector was deeply involved in the 2008 payment reform law, building on years of innovation in the marketplace. Without government mandates or legislative action, the business and provider community are 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.

Starting in the early 1990s, there were several movements that built momentum and experience for the current reforms. The Buyers Health Care Action Group (BHCAG) is a 27-member coalition representing 200,000 Minnesotans. The group is composed of some large employers, such as General Mills, Honeywell, 3M, Pillsbury, and American Express, who contracted directly with care systems and structured their benefits to provide patients with incentives to choose systems that demonstrate higher-quality, lower-cost care. Ultimately, BHCAG’s efforts evolved into Patient Choice Healthcare, Inc., formed in 2000, which sorts providers into tiers based on cost and quality standards in their benefit packages. Although the programs are innovative, they serve a small number of self-funded employers. But the focus on consumer choice using both cost and quality measures paved the way for the private marketplace to develop packages of care based on the total cost of care. In 2006, a company called Carol.com was founded by Tony Miller to create 53 packages of care around specific medical issues such as asthma, anesthesia, or pathology. Consumers are able to compare costs, read consumer reviews, and schedule appointments from a single Web site.¹¹ While there was much interest around packaging health care into comparable units, there was little traction in the health care marketplace; nevertheless, the concept found its way into the 2008 legislation as “baskets of care.”

Three additional efforts have played a significant role in the Minnesota reform environment. The Institute for Clinical Systems Improvement (ICSI) was started in 1993 by a major health plan (subsequently joined by others starting in 2001; ICSI is currently supported by six health plans) to develop and disseminate evidence-based clinical

guidelines and support quality improvement collaboration to redesign care. Minnesota Community Measurement (MNCM) was founded in 2000 by the ICSI member health plans (and later joined by the Minnesota Medical Association) to develop joint performance reports on costs and quality at the medical group level. Data are submitted (until the current reforms) voluntarily by most of Minnesota's providers. And the Smart Buy Alliance was formed in 2004 out of a coalition of public and private health care purchasers to have enough combined market power to demand quality and value from health plans and providers. (See [Appendix B](#) for additional information on these efforts.)

CURRENT STATUS: KEY ACCOMPLISHMENTS AND CHALLENGES

Minnesota's reforms are a work in progress. This section provides additional detail about each of the major initiatives and reports on the accomplishments as of late 2009. In each section we discuss the major issues remaining to be resolved, as reported in our interviews. Importantly, while there were varying views about the status of implementation and some of the choices made so far, there is a pervasive public and private commitment to the reform goals.

DATA COLLECTION AND REPORTING

Standardized Statewide Quality Measures and All-Payer Database¹²

The 2008 law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. The measures must be based on medical evidence, must be developed through a process in which health care providers participate, and must be reviewed on at least an annual basis. In addition, the measures must:

- Include uniform definitions, measures, and forms for submission of data, to the extent possible;
- Seek to avoid increasing the administrative burden on health care providers;
- Be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations including, but not limited to, MNCM and specialty societies;
- Place a priority on health care outcomes rather than processes where possible; and
- Incorporate those for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and others as determined by the commissioner.

The commissioner also is required to establish a system for risk-adjusting quality measures, and to issue annual public reports on provider quality beginning July 1, 2010. The specifics of the risk adjustment are still under development. Those reports will comprise a subset of the measures in the standardized set.

The 2008 health reform legislation requires data collection from all payers and providers on all the measures established by the commissioner. These data will be used in all of the initiatives described over time for reporting and payment on quality and value. Physician clinics and hospitals must begin to submit data on the standardized quality measures starting January 1, 2010. For 2010, these quality measures include data on optimal diabetes care and optimal vascular care, as well as a survey on health information technology.¹³ After January 1, 2010, health plans may not require providers to submit data on any measure outside this standardized set. The Minnesota Department of Health, Minnesota Medical Association, and Minnesota Community Care have begun registering medical groups on the data portal, identifying populations, and collecting patient clinical data. The Minnesota Department of Health will publicly report on data in July 2010. Health plans and providers may still voluntarily work on using and/or developing new measures, which can be incorporated through rule-making into the standardized set.

The all-payer electronic database explicitly builds on a number of existing public and private efforts already under way, and the law specified that the commissioner must ensure that any data-reporting obligations established under the new requirements are not duplicative of publicly reported, communitywide quality-reporting activities currently under way in Minnesota.¹⁴

In 2003, Minnesota passed legislation implementing data collection from hospitals and insurers for Minnesota's State Health Database.¹⁵ In addition, the Minnesota Hospital Association acts as the voluntary nonprofit reporting organization for the collection, review, and submission of financial, utilization, and services information of licensed hospitals in the state of Minnesota through the Hospital Annual Report, maintaining these data in the Health Care Cost Information System (HCCIS). There are over 500 data elements in this database.¹⁶ And as described, Minnesota Community Measurement was already voluntarily collecting health care data from physicians and hospitals, achieving an approximately 85 percent reporting rate among providers.¹⁷

In addition, a previous administrative simplification law supports the current data collection and reporting efforts. Passed in 2007, the Uniform Electronic Transaction and Implementation Guide Standards law¹⁸ requires all health care payers and providers to conduct eligibility, claims, and remittance transactions electronically using a single

standard for content and format; the rules took effect July 15, 2009.¹⁹ This change was implemented in part to reduce the administrative costs of processing paper claims, but standardization also benefits data collection for the all-payer claims database. Compliance is being pursued on a voluntary basis at this time.

In 2008, Minnesota Community Measurement was contracted by the Minnesota Department of Health (MDH) to build a unified statewide quality reporting system for health care providers, to expand the number of quality measures for public reporting, to increase the number of physician clinics reporting data, and to enhance consumer access and understanding of the quality measures. Their contract also includes developing the quality incentive payment system, described below. Minnesota Community Measurement first produced a comprehensive national inventory of existing incentive payment systems, pay-for-performance systems, and other payment systems, as well as an inventory of performance measures in current use for pay-for-performance programs, and made recommendations regarding the quality measures for public reporting in their report on February 6, 2009.²⁰ Their plan suggested introducing measures in a staged fashion over four years between 2009 and 2012, in a three-stage process: identifying new measures, collecting the necessary data for the measures, and public reporting on the measures.

On September 8, 2009, MDH published a proposed rule that defines the Minnesota Statewide Quality Reporting and Measurement System, details the initial measures to be collected, establishes the process for adding to the system and refining it over time, and establishes a mandatory reporting framework for the measures.^{21,22} The measures included in the rule were selected based in part on recommendations from work groups that included representation from health care providers, health plans, employers and consumers or from measures that are already reported and available. The Health Care Quality Measures–Hospital Quality Reporting Steering Committee met five times in 2009. The initial proposed physician clinic measures for public reporting are primarily measures that are already being reported on a voluntary basis. The initial proposed hospital measures for public reporting are indicators that are already reported by many hospitals or may be calculated from existing data. The first hospital measures are ones that hospitals already report to the Centers for Medicare and Medicaid Services. The number of measures is expected to expand over time, as noted in department reports and in the Steering Committee minutes.

Implementation Issues

Building on the experience of voluntary data collection has much strength, but the new system has new issues to resolve. Prior to the reform law, health plans and

many providers had extensive experience reporting data to Minnesota Community Measurement. All major plans participate in MNCM, as do the majority of the hospitals and physicians in the state, and because MNCM was developed by plans with a great deal of stakeholder buy-in, numerous observers report that MNCM has provider trust, which mitigates the impetus to submit data that game the system. Several issues arose through the interviews, however:

- Although all physicians are required to report data, there is no straightforward way of knowing that they do so. In Minnesota, as in many states, there is no good list of practicing providers. State medical boards generally know everyone who is licensed to practice, but not whether they are active or not. Under MNCM's voluntary system, with the estimate that 85 percent to 90 percent of providers were submitting data for a particular measure such as diabetes care, there was no good reason to develop a system to ensure 100 percent participation, but such a system will be necessary and more feasible now.
- Despite the reporting challenge noted above, there is no enforcement mechanism for data collection in place or under development. Observers note that the lack of attention to an enforcement mechanism is attributable to the positive experience with voluntary reporting. Indeed, several commented that providers have participated in voluntary data collection and reporting because they see value in doing so. Also, observers argue that a climate of enforcement would lead to gaming the system and poor quality data.
- Mandatory encounter data collection for the all-payer database started before the quality measurement and reporting systems were operational, which was necessary in order for the systems to function. But several observers pointed to technical issues that have arisen because requirements from the all-payer database contractor, Onpoint Health Data (formerly the Maine Health Information Center), differ from what plans had previously been reporting. They comment that these technical issues would best be resolved by knowing specifically what will be needed for the quality measures. Examples of such issues are a request for data in a format that conflicts with Minnesota's standard electronic format or a lack of clarity about whether submitted or adjudicated data are to be reported.

Although the concept of one standard, statewide set of quality measures has appeal in many respects, questions arise about future innovation in developing new measures or reporting mechanisms. The development of Minnesota's statewide quality

measures is necessarily an evolving process. As noted by MNCM, reflecting their experience, it takes roughly three years from conceptualizing a measure to implementing it statewide. Each of three steps takes about a year in an interactive process—a year to identify and define the measure, a year for testing its validity and working with providers on collecting and verifying the data, and a year for developing and testing how it will be publicly reported. Even when using nationally endorsed measures, the implementation process requires collecting and testing data, as well as working with providers to find issues that need correction and correcting them. In addition, providers in Minnesota seek measures that go beyond some of those that are nationally endorsed as they push the envelope to improve quality; a new outcome measure for depression is under development, despite the existence of a national process measure, because Minnesota providers felt that the national measure isn't stringent enough for the standard of care they seek to deliver.

- Under the law, only the measures approved for the statewide standard system will be calculated. While private payers will be able to use others, observers expect that measures not in that system will fall by the wayside for most pay-for-performance contracts. An open question is whether there will continue to be innovation and piloting of new measures by providers. There is clear recognition of the need and desire for the system to evolve; it is designed for such evolution, but whether the pipeline will be strengthened or weakened is unknown.
- As the system evolves and new quality measures are added, it is not known whether the measures will be able to be calculated from the data already collected or if the data collection system will need to change. Also unknown is the administrative burden.

Having trusted implementation agencies that can step forward is extremely useful for implementation. Although there was debate in the various bodies making reform recommendations as to whether to include Minnesota Community Measurement by name in the reform law or to refer to its characteristics more generically, there is no question that MNCM's track record for collecting and reporting data contributed positively to the state's ability to implement the law on an ambitious timetable.

Comparing Providers: The Provider Peer Grouping System

The 2008 health reform bill required Minnesota's Commissioner of Health to develop by January 1, 2010, a method for comparing health care providers based on a combination of risk-adjusted cost and quality. Called provider peer grouping (PPG), the system includes:

- A uniform method of calculating cost of care and relative quality of care;
- A combined measure that includes provider risk-adjusted cost of care and quality of care to get a value measure that combines cost and quality; and
- Use of encounter data and statewide quality measures to provide quality information and use of paid claims amounts to account for the true cost of services.

On July 1, 2009, Minnesota began encounter data collection from health plans and third-party administrators. Information on relative cost and quality will be disseminated to health care providers beginning June 1, 2010, and will be reported publicly beginning in September 2010. By January 1, 2011, the state employee health plan, state public insurance programs, local units of government, and health plan companies must use these tools to strengthen incentives for consumers to choose high-quality, low-cost health care providers.

A provider peer grouping advisory group was charged with providing recommendations to the commissioner on creating a methodology to be used for comparing health care providers on a composite measure of risk-adjusted cost and quality. The group was composed of members appointed by a broad cross-section of stakeholder organizations and was led by cochairs Jan Malcolm and Dr. Charlie Fazio. Ann Robinow and Andrea Kao facilitated the group. Information gathered from responses to a request for information (RFI) in spring 2009 was synthesized into a set of issue papers that served as a starting point for discussions by the advisory group. The method for comparing providers on cost and quality was developed in consultation with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. The advisory group submitted its final recommendations on the provider peer grouping methodology in mid-October, and the Minnesota Department of Health accepted comments and concerns on the recommendations through December 1, 2009.

The law specified several ways that the PPG is to be used, primarily by public payers.²³ By January 1, 2011, state employee insurance groups will use rankings of providers to strengthen incentives for members to use high-quality/low-cost providers and to arrange providers in tiers based on cost and quality. Political subdivisions that offer health care benefits will sort providers based on their cost and quality performance. Minnesota's Medicaid agency will establish performance thresholds for the PPG, and Medicaid and state-only subsidized insurance carriers will be prohibited from contracting

with the lowest 10 percent of providers. This is envisioned as a message to the system to improve cost and quality indicators. Providers and plans will have a year—until January 1, 2012—before the lowest performers become ineligible to receive payments. Providers who are deemed necessary to ensure access to care for patients may be allowed to continue providing medical care and receiving payments under these programs. The legislation also states that providers who score in the lowest decile in any given year may resume participation on January 1 of the following year if their most recent combined cost and quality score exceeds the threshold determined by the Minnesota Department of Health Services (DHS). DHS has not yet developed rules for implementation, but informants interpret this as setting a one-time threshold; in the following year providers could get beyond that threshold and not be excluded. The legislation itself does not address the possibility of raising the lowest threshold for participation over time, but this concept was discussed during the debate.

The law anticipates that private health plans will develop and use products and plan options that include PPG, such as selective provider networks, to encourage members to use high-quality/low-cost providers. In addition, health plans in the individual or small-employer market must offer at least one product that establishes financial incentives for consumers to choose higher-quality/lower-cost providers through enrollee cost-sharing or selective provider networks.

Implementation Issues

The PPG has conceptual support from all stakeholders but the proverbial “devil is in the details” arises across all aspects of the program’s design. The PPG advisory group and the commissioner have numerous issues, both technical and policy, to resolve in implementing this system. As one observer noted, “Can you implement this with standardization that holds up and is consistent and cannot be challenged in court as inconsistent and not meaningful?” While the technical issues are challenging, it is the policy issues that are likely to be most daunting going forward. Examples of both were readily reported by observers:

- The first step in the process was to make specific recommendations in nine methodological categories, and these were done in relatively short order.²⁴ The challenge on the technical side was to be detailed but not so detailed that the recommendations are not used. They covered such topics as: attributing care given to specific providers, risk adjustment, use of quality measures, outlier adjustment, how to categorize (group) providers, determining appropriate

provider level for analysis, how to adjust for variations in payment levels, adjusting for payer mix, and types of services included.

- Near the top of the challenges is how to combine the cost and quality information. There's a technical side, which arguably is easiest—the cost measures come from the all-payer claims database while the quality measures come from clinical and administrative data. But more challenging is how the cost and quality measures are weighted in the system. How do you score low-cost/low-quality versus high-cost/high-quality providers? How much weight should process measures be given versus outcome measures (which are scarce to date)? If, as is generally believed, quality measures are less developed than cost measures, why should they be given equal value to cost?
- How should “like” organizations be grouped? How many levels make sense? How should location (i.e., rural versus urban) be taken into account? What happens if a particular provider doesn't have patients that are covered by the quality measures used? One observer questioned whether the groupings would be meaningful to providers, something that would be important to spur improvement.

The 2009 requirement that the lowest decile providers will be eliminated from participating/getting paid under state plans raised technical questions about the ability to define that decile with validity but even more questions about the policy's potential impact on access, especially in rural areas. The definition is still a work in progress. There were two clear and opposing points of view about this provision:

- One camp's view centers on the fact that the provision sends a strong signal to the lowest-tier providers that state-served beneficiaries and employees deserve better. They note that the state cannot afford to do business with the lowest-tier providers. They also point to the provision that allows those providers to reenter into contracts with the state the following year, after achieving concrete improvement and meeting the prior year's bar (even if the decile cut-off changes that next year). They note that there is an exception for providers deemed necessary to ensure access to state beneficiaries.
- The other camp views the policy as misguided for technical and policy reasons. In small hospitals, for example, there isn't always patient sample size to ensure that the cost or quality measures are representative of the provider. Worries about

access to care, especially in rural areas, were raised, as were concerns that some rural providers would need more time to come up to the standards of urban providers and would be unfairly penalized by the policy while they were working on improvement. Access concerns are particularly strong for Medicaid, where there is already a provider shortage. On the policy side, observers asked: Is 10 percent the right cut-off? What if the lowest decile falls in the middle of a peer group? Some suggested that a better policy would be to collect the data first and see how the rankings play out, and before eliminating payment for the lowest decile, pay them differentially from the higher performers.

Will the PPG effect change? The law specifies that the state and municipalities must use the PPG system to offer plan options that allow consumers to select higher-value providers. Health plans must offer at least one such option in the small-group and individual markets. But whether the market will follow suit, or use a different system (as noted above, there is already a great deal of activity in Minnesota) remains to be seen. Will it lead to new forms of competition and the payment reform envisioned by the Transformation Task Force and many stakeholders? And an even bigger question is whether such competition and payment change will yield the cost savings and quality improvement desired.

CARE REDESIGN AND PAYMENT REFORM

“Baskets of Care”

The 2008 legislation required Minnesota’s Commissioner of Health to establish uniform definitions for at least seven “baskets of care” by July 1, 2009, and to establish standard quality measurements for them by December 31, 2009. A basket of care is a collection of the services that are paid separately under a fee-for-service system, but which are usually combined by a provider in delivering a full diagnostic or treatment procedure to a patient—for example, all the services needed for knee surgery. (See [Appendix C](#) for additional information on and an example of the services comprising a basket of care.) Under this concept, plans will bundle payments for a set of health care services in ways that will create incentives for health care providers to cooperate and innovate on approaches to improving health care quality and reducing cost.²⁵ Each basket then is the new “product” consumers can purchase, allowing providers, payers, and consumers to rethink the organization of health care service delivery.

Bundling payments in this way and publicly disseminating the cost and quality information about each provider’s basket is expected to make it easier for consumers to find and compare cost information on the baskets of care, but their use in private

insurance is entirely voluntary. Beginning January 1, 2010, health care providers that offer these baskets of care will be able to establish their own prices for the baskets. Quality information on the baskets will be publicly available beginning July 1, 2010.

The implementation and coordination of baskets of care were not specifically defined in legislation because the baskets concept was seen as a market tool to address episodes of care and to stimulate competition with an innovative way for providers and consumers to think about discrete care packages. With the inclusion in the final legislation, some felt that baskets of care would be challenging to implement, absent total cost and quality-of-care models. Others felt baskets were an innovative approach for the marketplace to spur redesign of care and payment.

The Minnesota Department of Health awarded a contract to the Institute for Clinical Systems Improvement (ICSI) to facilitate a steering committee process to define the baskets of care. The steering committee held four meetings in 2009, and was led by Dr. George Isham, Chief Health Officer and Plan Medical Director, HealthPartners, representing the Minnesota Council of Health Plans; and Dr. Douglas L. Wood, cardiologist, representing the Mayo Clinic. The committee work groups consisted of health care providers, health plan companies, employers, patients, and organizations that work to improve health care quality in Minnesota. Their work was to define the specific services that are included in the initial baskets, and they completed these definitions. The initial baskets of care are:

- Asthma (children)—management of asthma as a chronic disease;
- Diabetes—without comorbidities (does include hypertension and hyperlipidemia);
- Low Back Pain—management of acute episode of low back pain;
- Obstetric Care—prenatal care, uncomplicated vaginal delivery or cesarean section delivery;
- Preventive Care (adults);
- Preventive Care (children)—well-child care, preventive care, normal newborn care; and
- Total Knee Replacement—inclusive management from preoperative phase through rehabilitation phase.

An eighth basket—pre-diabetes—was added by the work group during the year.

Implementation Issues

Challenges in designing the baskets of care—including balancing the breadth of the basket and the resultant heterogeneity on the one hand with simplicity for consumers and risk for providers on the other—led to narrower definitions than some originally envisioned. While all observers commended the concept as a step in moving toward more-defined episodes of care and bundled payment, only a few were enthusiastic about the resulting definitions. Questions and problems raised by observers have outnumbered kudos so far:

- Chronic care baskets are arguably the most challenging to define, and as a result, were noted by some to have been winnowed down in the legislation to the lowest common denominator—something stakeholders could agree that, for a particular patient population, would be considered appropriate medical care that could then be predicted and priced. Because preventive care is fairly specific, with established guidelines for periodicity by population, baskets for preventive care are relatively easy to delineate. But for a chronic disease like diabetes, boundary issues are prevalent. For example, if a consumer is covered for a year of diabetes care, is care for a stubbed toe included? Risk-averse providers would naturally prefer anything outside their immediate control that might drive up costs be excluded, while consumers would find a broader and simpler package easier to understand and potentially more desirable. Narrowing the basket and leaving ongoing preventive services out, as in the case of the pre-diabetes basket of care, provides little incentive or pressure to be proactive in preventing hospitalization.
- One of the biggest barriers for chronic and preventive baskets of care was benefit design and the lack of flexibility with payment structures. How to handle prescription drugs was another big issue. While it is true that chronic care baskets were the most challenging to define, all of them had challenges.
- The definitions of the baskets are built on current clinical practice and do not inherently contain incentives for lower-cost treatment. For example, the total knee replacement basket starts with the decision that the knee will be replaced, not the decision about whether or not it should be.

There are a number of operational issues that still need resolution:

- Who will receive the payments for the baskets—hospitals, physicians, health plans, other providers, et al.? Several observers reported volatile discussions over

this issue around the total knee replacement basket in particular. Beyond this important question are technical issues such as: How will payment systems need to change? Who will administer the payments? How will the payments get to various providers that do not receive the initial sum? How will the billing office determine when to bill a basket and which basket to bill?

- The asthma basket, considered by some to be the most innovative because it covers diagnosis through treatment—including drugs and equipment, as well as assessment of the home environment—raises the following issue: Physicians are currently paid in one way for office visits, pharmacists and drugs are paid in another, and environmental assessments generally aren't covered at all. How will the asthma basket work?
- How will complications be handled? For example, with diabetes, will the basket cover care for open wounds or sinus care that is more complicated because of the diabetes?
- How will the baskets relate to the rest of an individual's benefit package? How will the transition occur from fee-for-service care for individual procedures and visits to baskets of care? And from the private employer perspective, if baskets are offered in the health plan, should every eligible employee be required to participate? How will the two systems mesh?
- How will this system fit with the health care home coordination payment (see below)? Several noted that it is important not to pay twice for the same thing, but it is not yet clear whether coordination of care is included in the baskets. For some, such as diabetes, it seems that care coordination will be part of the basket; whereas, for knee replacement, overall care coordination may not be included. Coordination of care was identified as one of the core components necessary for the success of care delivery in each basket of care.
- The next step in the design process will be to select standard quality measures for each basket of care from the standardized statewide set of measures; this has yet to be done, although recommendations have been submitted. Observers noted that for some of the baskets, valid quality measures do not yet exist.

If we build it, will they come? And will it matter? A key question is whether these standard definitions will in fact be used in the market, since their use is entirely

voluntary. The state employee plan is required to consider implementation in their benefits, but even they are not mandated to use the definitions. While only time will tell, informants varied in their predictions. Some pointed to use of the definitions by the members of the Smart Buy Alliance (SBA) as a potential driver. One observer noted that the SBA employers and their employees constitute about 50 percent of Minnesota patients, which affects many providers. Although adoption is voluntary by each SBA participant, if they adopt the baskets of care when purchasing, even with imperfections, they could drive change in the market. Others discounted the impact of the SBA entirely given that its large-employer participants mostly purchase independently. Some large employers are actually proponents of the baskets of care concept, but they have been working on different definitions separately. For example, General Mills already offers baskets of care to its employees, working with Tony Miller and Carol.com. While these have provided a concrete model for the state process and are touted by the company and others, the question remains open as to whether the standard state baskets will be successful. Several informants, all from the private sector but from very different organizational perspectives, commented that there is a strong belief that payment system change is necessary, as quickly as is feasible, and if the state system isn't right, the private sector will continue to experiment on its own.

Supporters of the baskets of care concept recognize readily that even if fully adopted, baskets are only one small piece of a larger set of strategies to control costs and improve value. They are a building block for one type of bundled payment, and if used in that way, they can reward quality and efficiency of care over volume. Even when adopted by purchasers, they are not designed to save money initially (although for certain conditions, savings on hospital admissions over time should occur). Some of those involved in developing the baskets believe patient outcomes will improve and have a favorable impact on costs over time. Importantly, they are viewed as a means to drive change in consumer behavior. Proponents argue that baskets of care are condition-focused and therefore target more-expensive patients where costs can be saved with better care; those who are less supportive note that baskets do nothing at all for consumer behavior if the medical conditions are not present. Others find the jury still out on consumer behavior but expect that, as with other forms of public reporting, it will be the providers who change their practices to compete with each other on price and reputation. Most participants in the subcommittees felt baskets of care offer an opportunity to enhance patient-provider relationships as well. They are also seen as a way to drive care delivery innovation because they provide a new payment model.

Perhaps the most significant potential impact reported is that purchasing on the basis of baskets will lead some providers to bid, and some purchasers to buy, on the basis

of a population's total cost and quality of care. Although "total cost of care" payment (with quality measures) was not included in the 2008 reform legislation, it is uniformly recognized by the key public and private officials interviewed as the direction Minnesota (and others) should be heading; several hold hope that baskets of care will increase public and stakeholder support for the change.

Statewide Quality Incentive Payment System

The 2008 legislation called for a statewide system of quality-based incentive payments to health care providers, using a subset of the standardized set of quality measures for health care providers. Use by public payers is required, but the payments are intended to be used by private health care purchasers as well. The contract with Minnesota Community Measurement to develop the measurement and reporting system also included the statewide Quality Incentive Payment System. By July 1, 2010, the payment system must be implemented for participants in the state employee health plan and enrollees in state public insurance programs.²⁶

Under this incentive payment system, payment will be based on providers achieving target levels of performance or improvement over time, as shown by the reported quality measures. MNCM recommended a methodology for the quality incentive payment system that rewards providers who attain a defined benchmark performance level determined by reviewing historical data, or rewards those providers who reach a defined improvement goal designed to close the gap between prior performance and 100 percent. They also recommended calculating a stretch goal of 4 percent to 5 percent average improvement over the previous year, and designing a reward for the top 20 percent of providers.^{27,28} In future years, MNCM recommended evaluating additional risk-adjustment models and considering a more complex measure-weighting system.²⁹

A summary of the selected measures, data collection processes, and reporting timelines will be available to providers well in advance of reporting. For the first year of the incentive program, Minnesota Community Measurement suggested the following initial measures be used to initiate the incentive program:

- Ambulatory Care Measures (collected directly from providers):
 - Comprehensive Diabetes Care (care meeting selected outcome and process measures³⁰)
 - Optimal Vascular Care
 - Depression PHQ-9 Six-Month Remission

- Hospital Care Measures (reported by providers and externally validated— includes Appropriate Care Measures, a patient-centered all-or-none approach to measurement that recognizes when a patient receives all of the evidence-based care for which they were eligible, and gives no “credit” when all care is not given):³¹
 - Acute Myocardial Infarction (AMI)/Heart Attack
 - Heart Failure
 - Pneumonia

Quality measures to be added in 2010 have already been recommended, and MNMCM will continue to recommend ambulatory incentive measures on an annual basis.

Implementation Issues

Because the Quality Incentive Payment System applies to state programs only, most informants had little comment on it; rather, they viewed it as another of the many pay-for-performance programs already in place in Minnesota. There were several comments about the decisions so far:

- With respect to risk adjustment for the payments, one observer noted that the method chosen weighed feasibility highly, and the result is probably more than most employers and less than most providers would prefer. Employers value a mechanism that is simpler and less costly to apply, but providers worry about being held accountable for risk not under their control and favor more sophisticated and costly methods.
- With respect to whether the payments will support quality improvement or quality attainment—a core conceptual issue in pay-for-performance—the current thinking is that they will pay for both, a choice that appears to have reasonable support.
- Will the state system align with existing pay-for-performance initiatives? This is yet to be known, but from the state perspective, there is a reasonable chance that it will, and from all perspectives, this will be a positive step if it occurs. The state is already using pay-for-performance through the Bridges to Excellence program; the new incentive payments are expected to be slightly different.³² The Buyers Health Care Action Group, involving private and public health care purchasers, is leading Minnesota’s Bridges to Excellence program. Participating employers include 3M, Carlson Companies, General Electric, Health Partners, Honeywell,

Medtronic, Resource Training and Solutions, State of Minnesota Department of Employee Relations, Minnesota Department of Human Services, Target Corporation, University of Minnesota, and Wells Fargo. Plans are to take the state quality measures to the locally governed Bridges to Excellence steering committee and work to align the payments, using the state's large group of beneficiaries and employees as the impetus to send a unified signal to providers.

Health Care Homes

A “health care home,” also called a “medical home,” is an approach to primary care in which primary care providers, families, and patients work in partnership to improve health outcomes and quality of life for patients. The development of health care homes in Minnesota is part of the health reform legislation passed in May 2008. The Minnesota program starts with individuals with chronic health conditions and disabilities. The legislation directed the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) to develop and implement standards of certification for health care homes, develop a certification process, develop a payment methodology for publicly insured patients, use a collaborative learning model to spread the program, and evaluate outcomes.

The criteria are required to promote use of health care homes to coordinate care for people with complex and/or chronic conditions. They were developed over a series of meetings with all constituencies in the health care system—patients, providers, health plans, purchasers, and community organizations. Multiple informal and formal (rule-making) structures were used to gain feedback. Input included recommendations by the Institute for Clinical Systems Improvement (ICSI) on the outcomes and goals also to be used to guide the evaluation of health care homes.

A proposed rule for health care home state certification was adopted by the Commissioner of Health in November 2009. It is in the final stage of enactment. The rule includes criteria for:

- access and communication;
- use of registries;
- care coordination
- care planning; and
- practice-level quality improvement.

Mechanisms to allow variances for innovative models and to lower the criteria burden for practices achieving high outcomes are included in the rule. The rule also spells out the procedures for certification and recertification of health care homes. Minnesota worked with experts from the Centers for Medicare and Medicaid Services, the National Committee for Quality Assurance (NCQA), and the Center for Medical Home Improvement in designing standards and criteria. As with many state medical home programs, the definition includes some elements of the NCQA standard and adds others; it is unique to Minnesota.

The 2008 legislation includes a payment to primary care providers for coordination of care consistent with the patient- and family-centered model envisioned in the rule. A steering committee and several work groups met seven times in 2008 and 2009 to develop a system of per-person care coordination payments to certified health care homes. Minnesota's health reform legislation requires DHS, in coordination with MDH, to develop the patient complexity-adjusted payment system by January 1, 2010.³³

The Health Care Homes Outcomes Measurement Work Group is charged with developing outcomes measurement implementation strategies and making recommendations on how health care homes outcomes measurement can work within the broader statewide reporting structure. This work group will receive reports from the health care homes team and respond to the progress of outcomes measurement, ongoing identification of outcomes, and evaluation of the progress of health care homes measurement over time.³⁴ This work group began with three meetings, held in August, September, and November 2009. The group will meet quarterly through 2010.

Implementation Issues

There is widespread support for the concept of better-coordinated care through a patient-centered health care home, but the definition of that home remains controversial. Observers noted a conceptual difference among supporters; some see the health care home as a physician's practice, while others see it as the set of services and supports that facilitate coordination to improve outcomes and lower utilization of unnecessary services, such as avoidable hospitalization. The certification standards in the proposed rule sets the bar high for practices and anticipates payments only when there is real transformation at the practice level, including having a quality improvement team that comprises patients and their families. Variation to accommodate alternative models is permitted with commissioner approval. The certification standards build on known successes in the pediatric community, and emphasize the role of patients and families. One informant commented that it is not clear whether the design and

operation will work well for adults with chronic conditions. In addition, whether certified homes will have the opportunity or even the requirement to prospectively identify patients they care for is under discussion, although favored by the state.

Although the payment system is still under construction, there is already debate over the coordination payments, especially where they will come from and how they will be applied. The concept of increasing payments for better primary care is straightforward, but the details are not:

- A key point of contention is over whether the legislation requires private health plans to make care coordination payments for all certified health care homes in their networks. It is not surprising that health plans and the state take different sides on this issue, and it is under discussion.
- The legislation says that the coordination payment must be financed by the savings anticipated from implementing the system of health care homes, and there is no additional appropriation to date. Many observers question where the state funding for the payments will come from and note that, in particular, Medicaid is already a low payer. Aside from the payment level, some question whether there will be enough patients in the program from which to generate savings. This is partly because of the different readings of the statute noted above with respect to whether private plans are required to make the payments. Another reason is that the program begins with patients with complex medical conditions or chronic conditions. While these are arguably the most expensive, it is unclear whether the numbers of patients who will be eligible for the pilots may be too limited to realize actual savings in the pilot phase that might otherwise occur with full implementation of the program for more patients and conditions.
- As noted earlier, it remains to be worked out how this program will intersect with the quality incentive payment system and with payments for baskets of care (which are optional). Where is the coordination paid so that it is not done twice? This is an example of an implementation issue that still needs to be resolved before the program is operational.
- Other details, such as the risk-adjustment mechanism for patient medical and nonmedical complexity, are under development. Current thinking for state programs is that there will be four levels of payment based on patient complexity; these decisions will be made in 2010 before implementation.

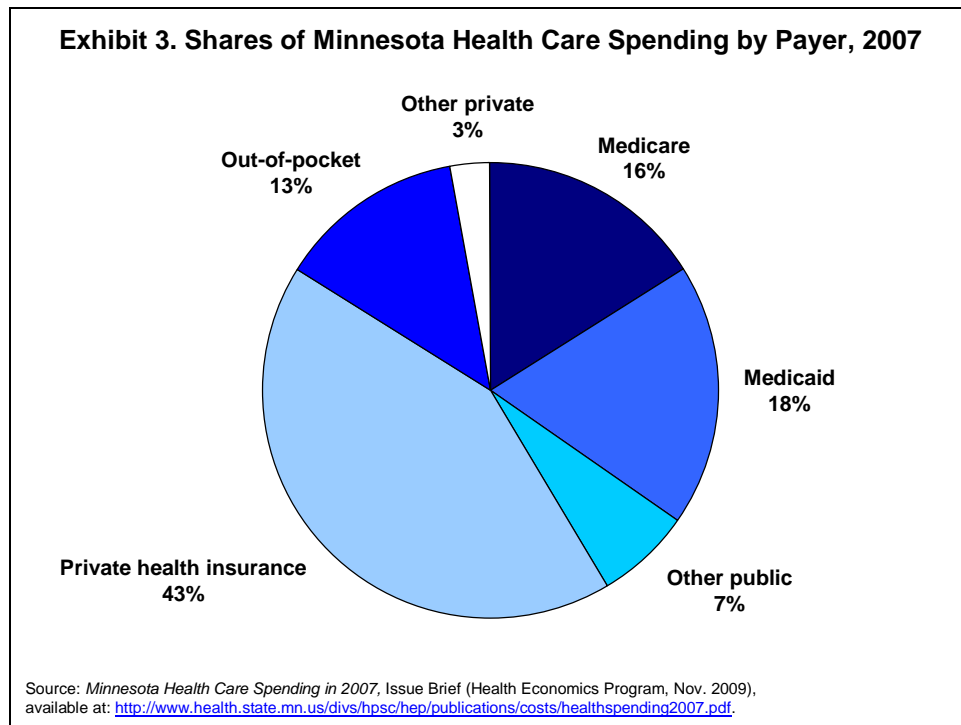
CROSS-CUTTING IMPLEMENTATION ISSUES

The Minnesota Department of Health (MDH) has primary responsibility for implementing many aspects of the reform law, including all of the pieces discussed here with the exception of the health care homes, which is jointly implemented by MDH and the Minnesota Department of Human Services (DHS). Given the law's explicit commitment to a strong public/private partnership, and with a practical dose of capacity issues for the tight implementation timeframe, MDH used a Request for Proposal (RFP) process to work with private sector organizations with specific expertise in the various areas of the bill. In this way MDH would provide coordination and oversight, but the private sector would do much of the substantive work. In the first year, 12 RFPs were issued and contracts were awarded to 20 organizations and individuals.³⁵

Although each one expressed high respect for the state staff running the process, many private sector informants expressed concern that different reforms were under development in separate processes led by separate organizations on different time frames. The concerns were partially about the lack of an apparent road map to bring the pieces together, although it was noted that the law itself is not one cohesive plan. There were also concerns about how the individual decisions, measures, and payments would work and whether the things measured and the methods of payment were different in each program, they would then work at cross purposes and undermine the goals. As noted earlier, it is unclear how payments for health care homes will interact with payments for baskets of care or the statewide quality incentive payment system. Another example cited by the key informants is that the provider peer grouping work group that defined the PPG methodology recommended the key quality measures to be used, but a separate group is developing the standardized statewide set of quality measures, and a third is developing the health care home quality measures.

Even as the individual implementation issues are resolved, separately or together, several informants lamented that because so much is occurring simultaneously, it will be difficult to attribute which reform or set of reforms affect future performance. It is unlikely that any one action will be the key; in most cases it will be some set, but the composition of that set will vary depending on the different starting points of the different providers. Will there be missed learning opportunities about what specifically led to improved quality scores for a particular practice site? Perhaps, say others, but they perceive the more important question to be whether a voluntary approach in the private sector to payment reform—albeit with uniform data and transparency—will result in a critical mass adopting the reforms. They differ on predictions about whether or not this will happen. Without it, however, all agree that the system transformation sought will not occur.

Finally, as Exhibit 3 illustrates, even in Minnesota’s fairly consolidated market, no payer has influence over even a majority of the dollars. While Medicare is only 16 percent of spending (less than in some other states), the other payers have similar minority segments; private insurance is divided among the different plans, including state employees. Observers commented that Medicare’s participation would be extremely desirable even more for its national leadership than its market share. Still, having the rest of the market adopt the voluntary reforms could go a long way if it occurs in a coordinated fashion.



LESSONS FROM MINNESOTA

Even at this early stage, Minnesota’s experience to date can provide some useful lessons for other states, and even for federal and state officials charged with implementing the recently enacted health reform legislation. The key informants for this study had a great deal to say about the process of getting the legislation passed, the content of the package, its potential impact, and its replicability elsewhere (summarized below). Not surprisingly, different stakeholders offered different perspectives on what matters most, as well as the degree of agreement or contention that existed in passing the law and exists now in its implementation. Yet taken together, there was a fair amount of consensus about these lessons. We stress, however, that this is an unfinished story: because the implementation is still a work in progress, there is more that can be said now about the passage of reforms than about their results. And as such, there are still more questions than answers.

PASSING REFORM

- **Leadership, leadership, leadership.** The overarching lesson in passing Minnesota's reforms is a familiar cry, but its importance cannot be overemphasized: leadership was critical at every stage, and still is. Minnesota's leadership came in many forms, and each was essential to the final package. There was leadership from state officials—first in terms of developing the recommendations (through the Transformation Task Force [TTF] and in the Legislative Commission on Health Care Access [LCHA]) and then in terms of passing the bill. But equally crucial were the private sector leaders, including business, integrated delivery systems, health plans, and the leaders of the hospital and medical associations. For the various provider groups, the rank-and-file general membership did not readily follow the group's official position put forth by its leaders, but leadership prevailed.
- **System reform is a bipartisan issue, especially when framed as controlling costs and improving value.** With a Democratic legislature and a Republican governor, the decision to focus on cost control before access was critical to the bill's passage. Unlike Massachusetts, which did the opposite, the joint decision of the Senate and House to address costs first and access second was heralded by several as a key strategic move in Minnesota. The debated provisions, many of which ultimately passed, were derived from two bipartisan processes (the TTF and the LCHA) that came up with similar recommendations. Observers commented that both the legislature and the governor agreed that they could share credit for the bill, although there was certainly partisan posturing in the throes of the debate.
- **Articulation and rearticulation of clear goals for reform throughout the process motivates action—and compromise when necessary.** Early in the reform implementation process, all participants agreed to the triple aim of improving the health of the population, enhancing the patient experience of care (including quality, access, and reliability), and reducing (or at least controlling) the per capita cost of care.³⁶ Stakeholders were concerned that legislation might not pass, so the state applied to participate in the State Quality Improvement Institute³⁷ as a back-up plan. When legislation did pass, the state used its participation in the Institute to focus on what goals it wanted to accomplish with the legislation and to articulate them clearly and persuasively. Several informants emphasized the importance of the goal as a motivator at various tough times. In

addition, the TTF's goal of reducing health care spending by 20 percent was reportedly a key driver of the specific payment reforms that were deliberated (including the total cost and quality-of-care provision that did not pass). Finally, including population health in the legislation was important on a practical level. By including the statewide health improvement plan in the cost estimates for the bill, which showed savings over time from public health measures, the plan was not only included but its upfront investment was funded for two years.

- **Good data on variation in quality and cost coupled with concrete personal stories were instrumental in building a shared sense that such variation is unacceptable and that incentives have to be changed.** Multiple informants recalled specific instances of testimony presented that resonated with legislators and other stakeholders. For example, data showing that most providers give optimal diabetes care for only 50 percent of their patients, and some providers do not give optimal diabetes care for any of their patients, generated outrage and built support for payment and transparency reforms. Another example was a report on obesity in Minnesota that helped legislators understand that money was being spent without a resulting improvement in health. And in the two years leading up to the legislation's passage, new research became available which showed that there are interventions that can improve care for people with chronic illness, but financial incentives worked against their adoption. Legislators began to understand that with reform, it is possible to improve health and health care and save money at the same time.
- **The shared experience of a long-standing public-private partnership and multiple reform discussions, coupled with a shared sense that the status quo is untenable, moves mountains, or at least hills.** The years of stakeholder engagement and experience through the Minnesota Medical Home Learning Collaborative, Smart Buy Alliance, ICSI, Minnesota Community Measurement, and private sector experience such as the Buyers Health Care Action Group—as well as multiple and improving iterations of pay-for-performance—were explicit precursors to the 2008 law. In addition, the agreements reached in developing various comprehensive reform plans through processes, such as the Minnesota Medical Association's health reform task force, the TTF, and the LCHA, meant that in some respects the landmark legislation was the next logical step in a continuous process. When asked about the key decisions made in passing the 2008 law, one observer noted that it was hard to say because the process was evolutionary. Many involved in these efforts were not only from the same

organizations over time, but they were the same individuals, allowing relationships and shared respect to grow even when points of view differed.

- **“Level 3” or “total cost of care” payment was introduced too late in the process to win passage; its inclusion in the package set the stage for a next round.** The TTF included total cost of care (and quality) payment prominently in its recommendations. It was introduced into the legislation, but unlike some of the reforms, there was no real vetting of the total cost of care idea before the legislative session. Multiple observers noted that there was no time to obtain the support of the trade groups (especially the hospital and medical associations) or the public. Others reported that the language in the final bill was neither well crafted nor well understood. For example, although the intention of the reform was to create an innovative total accountability option for organizations, it was interpreted as individual physician capitation, which raised immediate concern and opposition. Many reported, however, that there has been significant progress since the 2008 debate, including progress on developmental models for appropriate risk-/gain-sharing and accountable care organizations. Organizations opposed at the time of passage, including some major provider systems, are actively seeking such payment in their contracts voluntarily.

CONTENT OF REFORM PACKAGE

- **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.** The all-payer data collection and the standardized set of quality measures clearly support payment that rewards value over volume. The definitions of baskets of care must be coupled with benefit package incentives for measurable impact, but even with that limitation, the implementation process has helped to build broader understanding among stakeholders about the benefits of moving to more bundled payment, and also helped to develop some practical illustrations and raise issues. No matter what the next evolution is in Minnesota’s health care reform, the implementation of the 2008 legislation has focused on care coordination, episodes of care, and value-based payments as important attributes.
- **The reform package includes elements and a process that will align reporting, analysis, and payment pilots already under way, potentially leading to a greater overall impact.** Observers commented that the community-

wide database will be valuable for everyone. Although most plans already were conducting analyses like the provider peer grouping system, they were doing so with different methods and for their own patients only. The combined data will be more robust and send a consistent message. As subsets of the purchasing population move to use the system, there should be increasing numbers of providers with increasing portions of their patients affected by efforts to improve what is being measured.

- **An imperfect package is far preferable to a “do nothing” alternative, but questions remain as to whether it will actually work as a package.** To be sure, there are questions about how the various components will fit together (e.g., the payments for health care homes and baskets of care), and several informants decried the lack of a road map for doing so. Several stakeholders commented that as a result, compliance will increase complexity rather than decrease it. But doing nothing was not acceptable from any perspective.
- **There are mixed views about the ambitious timetable, but the positive aspects appear to outweigh the negative.** The ambitious implementation timetable continues the public–private dialogue and momentum that led to the legislation’s passage. Perhaps even more important is that there are numerous, difficult choices left to the implementation phase; having a shorter timeframe to debate them can be useful for taking action rather than drawing out the discussion. Some legislators viewed the time frame as a way to save money earlier rather than later, although several observers worried that those expectations are unrealistic. Still, most agreed that because many concepts are untested, it is critical to get pilots in place as soon as possible to learn what does and does not work. Critics noted that the short time table resulted in a missed opportunity to simplify the system and ensure that the package works better as a whole.

POTENTIAL IMPACT

- **Despite the significant public–private and private–private collaboration already in place in Minnesota, the legislation has the potential for significant acceleration of efforts that otherwise would take much longer.** In addition to establishing a more coherent environment for quality measurement and payment so that various players will use the same methods, the legislation provides impetus and resources to expedite improvement. A few observers pointed to the danger that the work could instead be slowed or get bogged down in political

fighting, but the stakes are high enough to engender cautious optimism. In addition, the state involvement and funding brings all insurance markets except Medicare to the table, and this was generally seen as positive by the private sector. Many further commented that the law gives the public–private and private–private partnerships sanction and support.

- **To transform the system, a majority of stakeholders must be affected. Is the legislation, with voluntary adoption of reforms by the private sector, sufficient for real reform?** There was clear agreement that for significant impact, payment and transparency reforms must be pervasive. It remains to be seen whether reforms like paying for baskets of care will be widely adopted without a mandate on private payers to use them. Some observers commented that if the participants in the Smart Buy Alliance were to use the baskets, there would be significant impact, but others noted that large-employer support for that coalition doesn't translate into purchasing jointly.
- **Where is Medicare?** Without exception, informants recognized that without Medicare, Minnesota's reforms will not affect 16 percent of health care dollars. There was clear interest in getting Medicare data for the all-payer system, but the interest went quite a bit further. One observer called the recent announcement by the U.S. Secretary of Health and Human Services to establish Medicare's participation in multipayer medical home demonstrations a "huge step," but it was widely recognized that Medicare's participation in the rest of Minnesota's reforms would truly increase the chances of success in transforming the delivery system. The new health reform legislation includes provisions for pilot initiatives that would include Medicare; Minnesota appears poised to be an early adopter.

A MODEL TO REPLICATE?

As noted throughout this report, Minnesota's reforms are a work in progress. By passing their reforms first, Minnesota's ability to overcome many political and policy challenges in order to enact the legislation can serve as a model for other states. Under the new Patient Protection and Affordable Care Act of 2010, states have numerous opportunities to pilot payment reform and transparency initiatives in partnership with the federal government. As other states consider similar activities, they can understand better how similar reforms would affect key stakeholders and devise strategies to overcome political and technical issues.

- **Many of the elements in Minnesota’s reforms could be replicated in other states, although Minnesota’s prior voluntary experience provided a significant boost to adoption and, now, to implementation.** The data collection and reporting reforms were thought by all to be readily adoptable by other states. This was also true for the care redesign and payment reforms, but here observers noted that the form of bundled payment might look different in markets with other types of health plans and a lesser degree of delivery-system integration. Given that there is still much to learn about what works best, innovators in Minnesota would welcome the opportunity to see different models in operation while they implement their own.
- **While national standards for quality measurement are helpful, payment reform and transparency need to be implemented in different ways at the state or local level.** The implementation process—including the accomplishments to date and the challenges remaining—points to the clear role for state or local implementation. Examples abound of the desirability of local innovation within a standard framework, from the standardized statewide quality measures system, the all-payer database, and the need to work with providers to get useful data, to the provider peer grouping system and the challenges to seeking improvement while preserving access, to the questions about how to support real primary care transformation in the health care home. For example, local providers often want measures that they believe are more clinically meaningful than national metrics. As long as the results of innovation are measured and reported, the best means to improvement can be learned and taught to others.
- **Payment and transparency reforms require an upfront investment; many states are unlikely to be in Minnesota’s fiscal position to fund them.** While observers expect the savings to greatly exceed the investment, Minnesota’s legislation did include a \$12 million expenditure to implement the transparency and payment reforms, a sum made possible by the state’s Health Care Access Fund. Few states have such a dedicated source of funding. In addition, the political will to make an investment for future savings doesn’t come readily, although observers noted that the climate is perhaps more ripe for such discussions given the passage of national health reform legislation.

CONCLUSION

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.

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.

APPENDIX A. LIST OF KEY INFORMANTS

Matthew Anderson
Vice President of Regulatory/
Strategic Affairs
Minnesota Hospital Association

Carol Backstrom
Assistant to the Commissioner for
Health Reform
Minnesota Department of Health

Senator Linda Berglin
Minnesota Senate

Kent Bottles
President and CEO
Institute for Clinical Systems Improvement

Julie Brunner
Executive Director
Minnesota Council of Health Plans

Jim Chase
President
Minnesota Community Measurement

Tom Forsythe
Vice President
Corporate Communications
General Mills Inc.

Representative Thomas Huntley
Minnesota House of Representatives

Carolyn Jones
Senior Director, Policy
Express-Scripts, Inc.

Scott Leitz (*until November 20, 2009*)
Assistant Commissioner
Minnesota Department of Health

Cal Ludeman
Commissioner
Minnesota Department of Human Services

Sanne Magnan
Commissioner
Minnesota Department of Health

Lawrence Massa
President
Minnesota Hospital Association

Harold Miller
President and CEO
The Network for Regional Healthcare
Improvement
Executive Director
Center for Healthcare Quality & Payment
Reform
Adjunct Professor of Public Policy and
Management
Heinz School of Public Policy and
Management
Carnegie Mellon University

Ann Robinow
Healthcare Consultant
Founder and Former President
Patient Choice Healthcare, Inc.

Jeff Schiff
Medical Director
Minnesota Health Care Programs
Minnesota Department of Human Services

Eileen Smith
Minnesota Council of Health Plans

Mark Sonneborn
Vice President of Information Services
Minnesota Hospital Association

Dave Wessner
Chief Executive Officer
Park Nicollet Foundation

Doug Wood
Cardiologist
Division of Health Care Policy Research
Department of Health Sciences Research
Mayo Clinic

APPENDIX B. ADDITIONAL INFORMATION ON KEY ORGANIZATIONS AND HEALTH REFORM EFFORTS

Patient Choice Health Care Model (as evolved from the Buyers Health Care Action Group, BHCAG) <http://www.patientchoicehealthcare.com>

The Patient Choice Health Care model evolved out of the activities of the Buyer's Health Care Action Group (BHCAG). BHCAG was created by business leaders in 1988 to address escalating health care costs in Minnesota by using value-based purchasing predicated on principles that improve health care quality, promote provider competition in the health care market, create efficiencies in health care delivery, and enhance consumer choice and knowledge.³⁸ The model was developed to use market forces to encourage consumer demand for value, which spurs providers to improve quality and manage total costs.³⁹ A unique feature of this approach was to drive competition among providers on cost and quality rather than competition among health plans and payments were designed to address the "total cost of care."⁴⁰

The Patient Choice Health Care model uses global payment incentives in a fashion distinct from traditional capitation, in an attempt to prevent providers from gaming the system to maximize their global payment. Under total cost of care, providers are encouraged to take responsibility for the total population cost while working with multiple plan designs and provider structures. Key to this development is encouraging providers to organize into multispecialty systems (virtually or vertically integrated) to create economies of structure that facilitate provider groups developing and bidding on total cost of care. Another key to this approach is transparency of information on provider performance, cost, and quality, by organizing provider bids into a tiered system that allows consumers to make their health care choices based on relative cost and quality. The expectation is that as consumers select providers based on value, the health care market as a whole will improve performance and quality to attract these value-conscious consumers.

In 1997, BHCAG used this concept to develop the nation's first tiered health care delivery model, Choice Plus, designed to promote competition among provider groups through consumer choice: Choice Plus faced some growth challenges, including the withdrawal of two of its largest employer members from BHCAG. In response, BHCAG formed the for-profit Patient Choice Health Care, Inc., in 2000 to assume management of the Choice Plus program (now the Patient Choice Care System Program) and to build on its success. Medica acquired the Minnesota and Dakota operations of Patient Choice in the spring of 2004. Operating as a business segment within Medica, Patient Choice continues to develop programs that lead the market toward value-based health care

purchasing—differentiating provider performance and giving consumers the information they need to evaluate cost and quality.⁴¹

Minnesota Community Measurement (MNCM) <http://www.mncm.org>

The idea behind Minnesota Community Measurement was developed in 2000 by medical directors of three of Minnesota's largest health plans, who were also members of the Institute for Clinical Systems Improvement (ICSI). Their impetus was to improve the quality of care in Minnesota by developing joint performance reports at the medical group level by developing and using standard measurement and transparent reporting, with the additional aims of reducing system costs and improving value. They were rapidly joined by other health plans and the Minnesota Medical Association, all of whom participate by supplying data and paying membership fees. MNCM is also supported through grants from organizations such as the Robert Wood Johnson Foundation Aligning Forces for Quality project.

By 2003, Minnesota Community Measurement released its first performance report on diabetes care, and in 2004 released its first report on medical group performance measures. By 2008, 67 participating medical groups, representing over 350 sites, directly submitted data on two measures. Also in 2008, MNCM released its first annual disparities report using data derived from health plan claims and medical records. MNCM data are used to support the Bridges to Excellence Pay for Performance program. This partnership has promoted measure alignment among Minnesota health plans.

In addition to publishing and disseminating condition-specific performance reports to participating clinics, Minnesota Community Measurement disseminates health scores at the clinic level via its Web site, www.mnhealthscores.org. Data are provided by Minnesota health plans as well as submitted directly by more than 300 medical clinics statewide, and are organized by condition—such as diabetes, depression, vascular disease—as well as by patient experience and by use of health information technology. Users can search the Web site by location, clinic name, or health condition. MNCM also supports the D5 for Diabetes project. This project and Web site, www.thed5.org, are targeted to diabetes patients to encourage them and their caregivers to learn about and achieve the D5, a set of five treatment goals that, when achieved, reduce the risk of heart attack or stroke. The Web site also reports Minnesota Community Measurement's clinic results for this diabetes measure. MNCM is the contractor with the state for developing quality measures for the 2008 legislative reforms.

The Institute for Clinical Systems Improvement (ICSI) <http://www.icsi.org>

The Institute for Clinical Systems Improvement is a nonprofit regional health care collaborative that develops and disseminates evidence-based clinical guidelines for the prevention, diagnosis, treatment, and management of numerous diseases and health conditions, in an effort to improve the quality and value of health care in Minnesota. ICSI was started in 1993 by HealthPartners, Mayo Clinic, and Park Nicollet Health Services. In 2001, four more large health plans joined HealthPartners as ICSI sponsors. Health plan sponsors provide a portion of ICSI's funding. Currently ICSI has seven sponsors, 57 medical groups participate, and it represents more than 85 percent of physicians in Minnesota (more than 9,000 individual providers).

Because of ICSI's efforts, Minnesota became the first state in the nation where medical care was built around the systematic use of science-based best medical practices developed by physicians and sponsored by major health plans. Its health care guidelines are widely recognized as the standard of practice in Minnesota and beyond. ICSI's collaborative work has become the model for other U.S. regional care improvement collaboratives. As the leading collaborative, ICSI has recently expanded the scope of its work to help lead the transformation of Minnesota's health care system.

ICSI tackled major health issues like diabetes across all member organizations. It recently broadened its support for improvement to address member organizational infrastructure and culture. One current undertaking involves developing a diagnostic imaging project that saved an estimated 20 lives through reduced exposure to unnecessary radiation in a year-long pilot project and \$50 million in health care costs in Minnesota in 2010 by allowing providers to use, as an option to health plan prior notification, appropriateness criteria to order high-technology diagnostic imaging scans at the point of care. The DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) initiative is a project to improve treatment for depression by changing the way care is delivered, requiring medical groups and health plans to collaboratively develop new care practice and payment models. In addition, ICSI is working on two fundamental elements of Minnesota's 2008 health care reform legislation: 1) developing a sustainable model for health care homes and facilitating a Minnesota Department of Health project to define eight baskets of care meant to help consumers compare the value of services offered by different providers, and 2) educating providers on baskets of care.

Smart Buy Alliance (SBA) www.smartbuyalliance.com

The Smart Buy Alliance formed in 2004 out of a coalition of public and private health care purchasers, of which the Buyer's Health Care Action Group (BHCAG) was a key

organizer. The goal of the coalition was to grow large enough to have the combined market power to demand quality and value from health plans and medical providers, and no longer simply purchase health care based on cost.⁴² The inclusion of large state health purchasers such as the Department of Employee Relations (DOER), Minnesota's employee benefit agency, and the Department of Human Services, which oversees Minnesota Medicaid, allowed the purchaser coalition to represent about three-fifths of Minnesota's population, giving it large influence in the health care market.

The Smart Buy Alliance developed a set of common principles to guide its activities: to identify and reward provider quality, to adopt uniform measures of quality, to empower consumers with easy access to information, and to accelerate the use of health information technology. The Smart Buy Alliance Web site, www.smartbuyalliance.com, provides consumers with information to compare the cost and quality of physicians and medical groups, hospitals, health plans, nursing homes, and home health care, as well as online tools to calculate the cost of health care. It also provides links to the Minnesota Department of Health (MDH) Web site, which is designed to help consumers and health care providers learn more about evidence-based medicine, demonstrated best practices, and patient safety.

The Alliance promotes the adoption and use of tools such as: the Bridges to Excellence (BTE) pay-for-performance model, which in Minnesota uses standardized ICSI clinical measures and data collected by Minnesota Community Measurement; the QCare (Quality Care and Reward Excellence) plan to include incentives in health care contracts to improve reporting of cost and quality information (among other improvements and accountability measures); eValue8, a Web-based tool that allows health care purchasers to compare health plans; and the Patient Advocacy Best in Class Program (PA-BIC), a voluntary evaluation of provider programs addressing high-cost specialty care.

Minnesota Medical Association Health Care Reform Task Force and Healthy Minnesota

In 2004 the Minnesota Medical Association (MMA) created a Health Care Reform Task Force to develop a plan for health reform. The goal of the task force was to recommend bold and fundamental changes for Minnesota's system of health care. The 21-member task force met 11 times during a nine-month period and published its recommendations in 2005 as the *Physicians' Plan for a Healthy Minnesota*.⁴³ This document outlined a long-term goal of achieving universal coverage by requiring citizens to have insurance, and the following short-term goals to transform Minnesota's health care system to make this possible:

- Advocate for stronger public health policies and systems;
- Help physicians deliver evidence-based care;
- Support a medical home for every Minnesotan through changes in administrative and payment policies;
- Support efforts to improve care delivery and payment for patients with chronic and complex conditions;
- Advocate for including behavioral health care as part of basic medical benefits;
- Support an information infrastructure that would allow collection, reporting, and dissemination of the information needed to measure and improve quality and help patients make choices about cost and quality;
- Advocate for reductions in administrative complexity;
- Support a \$1 per pack increase in the tobacco tax to help preserve Minnesota's health care programs and move toward universal insurance coverage;
- Advocate for a statewide ban on smoking in bars and restaurants; and
- Explore legislative options regarding specific reforms such as an individual insurance requirement, an essential benefit set, and insurance market reform.

The MMA's reform plan served as the starting point for the partnership, *Healthy Minnesota: A Partnership for Reform*,⁴⁴ brought together by the MMA in March 2006. Healthy Minnesota consisted of an independent group of influential leaders in health care, business, state government, labor, education, and consumer advocacy with a goal to recommend and implement strategies for health care reform. Healthy Minnesota proposed health reform legislation that was considered but did not pass in 2007.⁴⁵ The goal of this legislation was for the state to achieve universal coverage by 2011. Interim steps toward that goal included:

- Requiring every Minnesotan to have health insurance;
- Requiring health plans to offer insurance for the minimum benefit set to all applicants;
- Reforming the payment system by creating medical home pilot projects that coordinate care; and
- Strengthening the public health system.

That 2007 legislation and the relationships developed by the Healthy Minnesota Partnership for Reform laid the groundwork for the development of the Legislative Commission on Health Care Access, the Health Care Transformation Task Force, and ultimately, passage of the 2008 reform bill.⁴⁶

Health Care Transformation Task Force

The Health Care Transformation Task Force was created in 2007 by the Minnesota legislature, which required the governor to convene a task force to develop an action plan to improve affordability, access, quality of health care, and the health status of Minnesotans. The task force had 13 members appointed by the governor, four members appointed by the legislature, and one ex officio member.

The Task Force was charged to:

- Reduce health care expenditures by 20 percent by January 2011, and limit the rate of growth in health care spending to no greater than the percentage increase in the Consumer Price Index plus two percentage points each year thereafter;
- Increase affordable health coverage options for all Minnesotans and ensure all Minnesotans will have health coverage by January 2011;
- Improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;
- Improve the health status of Minnesotans and reduce the rate of preventable chronic illness;
- Propose changes to state health care purchasing and payment strategies that promote higher-quality, lower-cost health care;
- Promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;
- Create options for serving small employers and their employees, and self-employed individuals; and
- Reduce administrative costs.

The Health Care Transformation Task Force report, issued in January 2008, recommended transforming health care in Minnesota by addressing five core principles:⁴⁷

- Improving the health of Minnesota's population (individual wellness);

- Improving quality, cost, and patient-centeredness using both collaboration and competition (improving system quality);
- Restructuring the health care payment system to support and encourage evidence-based, high-value health care (payment reform);
- Reducing the overall size of the health care system (reduce overuse of health care, new technologies, and administrative costs); and
- Providing necessary health care to all Minnesotans at an affordable cost (change function of individual and small-group insurance market and develop a health insurance exchange).

The Task Force recommended that the payment system hold providers accountable for quality, efficiency, care coordination, and the total cost of care. They felt that this could be best achieved in three stages. Large integrated practices systems could be ready to participate in Level 3; others might only be ready for Level 1. There was the expectation that hospitals, physicians, clinics, and other providers would move to Level 3 by 2012.

Level 1 involved making payments to providers dependent upon on the quality and efficiency of care provided. Providers that would meet targets for improvement would be eligible for quality/efficiency-based payments. Specific indicators and measures of quality and efficiency were recommended based on the provider's setting. The indicators measured provider outcomes rather than process.

Level 2 involved providers taking on greater responsibility for care coordination, particularly for patients with chronic conditions. Providers serving as a medical home or health care home would receive care management fees for monitoring and managing care. Payments would be adjusted for the complexity of the patients served. Initially, payments based on process would be phased out in replacement of cost and quality results. Providers would need to have care management systems in place to be eligible to receive the additional payment. The additional care management fee creates an additional payment on top of the total cost of care. This cost would be offset by lower utilization of acute care services.

Level 3 involved providers and care systems assuming responsibility for the total cost of care as well as the quality of care provided for patients. Providers would not be responsible for higher costs of care that result from caring for sicker people, not preventable through the actions of the provider. Providers and care systems would submit

bids to health plans and other purchasers to provide care under a standardized benefit. The total cost of care would include anything under the standard benefit, but nothing outside the benefit set. Bids would be based on value, not just cost, and must decrease costs over current levels. A mechanism for soliciting and accepting bids would ensure that bids from different providers could be compared by consumers based on relative value. Payments to providers for the cost of care would be risk/complexity adjusted based on the health and special needs of the population they manage. Providers would be rewarded for keeping patients healthy. Level 3 is different than a traditional capitation system, as providers would be responsible for managing the cost of care, but would be paid additional monies for patients with complex health needs.

Legislative Commission on Health Care Access

The Legislative Commission on Health Care Access was established in 1992, and in 2007 was required by the Minnesota legislature to convene a task force to make recommendations to the legislature on how to achieve the goal of universal health coverage. The legislature's goal was to ensure that all Minnesota residents have access to affordable health care by January 1, 2011.

Membership of the commission consists of five members of the Senate and five members of the House of Representatives. Working groups of stakeholders were formed by the commission to address the following areas:

- public health
- insurance market reform
- cost containment
- health care for long-term care workers
- single-payer health care, and
- bridging the health care continuum.

Each working group was composed of House and Senate members of both parties, as well as representatives of health plans, health care providers, labor unions, counties, employers and other organizations, and consumers. The working groups met over several months, resulting in each working group developing a prioritized list of recommendations that was presented to the commission. The commission then reviewed the resulting recommendations and developed and adopted the recommendations contained in the final

report, “Recommendations Submitted to the Minnesota State Legislature,” which the committee submitted in February 2008.

The commission developed detailed recommendations that were grouped into the following sections:

- **Public Health**—Develop and implement a comprehensive health promotion program, including a statewide educational curriculum on health, nutrition, and physical education, and monitor and report childhood obesity using body mass index (BMI) measures.
- **Health Care Homes**—Establish health care homes and require participation of all state health care program enrollees, integrate pharmacy with primary care, and encourage changes in scope of practice and licensure necessary to implement the health care home model.
- **Affordability**—Establish a health insurance exchange, require employers to establish section 125 plans, provide premium subsidies, and raise the MinnesotaCare income limit.
- **Continuity of Care**—Eliminate the MinnesotaCare four-month uninsured requirement and streamline enrollment.
- **Health Insurance Reform**—Establish statewide health improvement and outcome measurement and reporting goals, and adopt a modified community rating system in health insurance, among other recommendations.
- **Cost Recapturing Mechanisms**—Establish a savings recapture assessment, increasing tobacco fees, creating a community benefit pool, and aggressively negotiating growth limits and cost controls in managed care contracts with health plans.
- **New Cost Containment Initiatives**—Develop an evidence-based benefit set, an evaluation process for new procedures, medications, and technologies, and a midlevel dental practitioner to work with licensed dentists.
- **Health Care for Long-Term Care Workers**—Determine the cost of a future rate increase to long-term care employers that would be dedicated to the purchase of employee health insurance.
- **Universal Coverage**—Continue to study the option of the state transitioning to a single-payer style health care delivery system, and review existing occupational licensure requirements and the scope of practice identify situations in which health care professionals could provide an expanded level of care.

- Payment Reform—Implement Payment Reform Levels 1 and 2, as developed by the Transformation Task Force.
- Universal Coverage—Require all Minnesota residents to have health coverage, a requirement triggered if a recommended phase-in schedule of interim goals for fiscal years 2009–2013 is not met.

APPENDIX C. AN EXAMPLE OF BASKETS OF CARE

Total Knee Replacement Basket of Care

The components of the Total Knee Replacement¹ basket of care are highlighted below.

Description	Timeframe / Frequency
Preoperative Phase: ²	Prior to procedure
<ul style="list-style-type: none"> • Pre-surgery education including: <ul style="list-style-type: none"> – Procedure education – Physical therapy education & exercises – Deep vein thrombosis prophylaxis (mechanical & chemical) – Nutrition discussion (referral if indicated) – Smoking identification (referral if indicated) • Case management for planning post-hospital discharge³ 	Prior to procedure
Operative / Acute Care Phase:	
<ul style="list-style-type: none"> • Anesthesia services / Operating room services • Professional fees⁴ • Knee prosthesis⁵ • Imaging 	<ul style="list-style-type: none"> As required for surgical procedure As required for care within the basket Per clinical indications Minimum of 1 set postoperative films and other imaging as clinically indicated
<ul style="list-style-type: none"> • Laboratory <ul style="list-style-type: none"> – Postoperative hemoglobin and other laboratory studies as indicated 	Per clinical indications
<ul style="list-style-type: none"> • Deep vein thrombosis prophylaxis⁶ <ul style="list-style-type: none"> – Mechanical compression devices – Chemical (anticoagulation medications) – Laboratory tests as indicated; international normalized ratio (INR) if on Coumadin 	Per clinical indications
<ul style="list-style-type: none"> • Post-procedure facility services (hospital days, transitional care unit), home health, alternative sites⁷ 	Per patient requirements
<ul style="list-style-type: none"> • Medications⁸ <ul style="list-style-type: none"> – Prophylactic antibiotics – Continuation of home medications during the inpatient stay 	Per clinical indications
<ul style="list-style-type: none"> • Pain management⁹ • Physical therapy • Durable medical equipment 	<ul style="list-style-type: none"> Per patient requirements Per patient requirements Per patient requirements
<ul style="list-style-type: none"> • Occupational therapy (if indicated for discharge to home) • Medicine consultation¹⁰ <ul style="list-style-type: none"> – Follow-up visits as needed • Case management (inpatient)¹¹ 	<ul style="list-style-type: none"> Per patient requirements Per clinical indications Per patient requirements

Description	Timeframe / Frequency
Post-Hospital Phase —90 days after procedure	
• Postoperative follow-up surgical visits ¹²	Per clinical indications
• Physical therapy ¹³	Per patient requirements
• Durable medical equipment	Per patient requirements
• Occupational therapy (if indicated for discharge)	Per patient requirements
• Deep vein prophylaxis <ul style="list-style-type: none"> – Mechanical compression devices – Chemical (anticoagulation medications) – Laboratory tests as indicated; international normalized ratio (INR) if on Coumadin 	Per clinical indications
• Pain management	Per patient requirements
• Imaging ¹⁴	1 plain film of knee postoperatively
• Home health	Per patient requirements
• Transitional care unit ¹⁵	Per patient requirements
• Inpatient care for readmission within 90 days after procedure resulting from complications related to the surgical site, assuming care delivered by the same provider group	Per clinical indications

¹ **Scope:** The subcommittee, as part of this explorative step in creating a TKR basket, elected to maintain a narrow scope opting to put together a package of services, without significant implementation barriers, that has the potential for market place adoption. While the scope of this basket does not include the more complex or higher risk patient, the objective is that this basket incents providers to cooperate and develop innovative ways to deliver this care while improving health care quality and reducing costs. With the proposed scope, the subcommittee attempted to capture the average patient and therefore average associated costs. The subcommittee engaged in extensive discussion, including literature review regarding the use of a classification that would be useful for providers and understandable by patients in determining eligibility for this basket. Originally, the subcommittee considered the use of an ASA score of 3 or below; however, acknowledging some limitations for use with the ASA classification for this purpose, the subcommittee elected to use language in the scope that is consistent with an ASA score of 2 and below, described as follows: "...and determined to have mild or no systemic disease..." Additionally, the subcommittee discussed that ideally a mechanism would exist to support a provider/patient discussion to jointly determine whether the Basket of Care is appropriate to meet an individual's needs. The subcommittee acknowledges that the criteria of BMI less than 35 is not evidence-based, but rather represents subcommittee consensus and addresses those patients most likely to benefit from this Basket of Care. Furthermore in considering the scope, the subcommittee elected to limit the upper age to 64 recognizing that the 2008 health care reform law does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. A preoperative history and physical is required prior to the surgical procedure, and encouraged to be performed at the patient's health care home for purposes of continuity, but is not included in the basket in order to avoid anticipated administrative challenges the subcommittee considered. With regard to the scope end point (90 days after the procedure), the subcommittee added clarifying language to indicate that hospital readmissions within that timeframe applicable to this basket, would be limited to those resulting from complications involving the surgical site assuming care delivered by the same provider. Lastly, the subcommittee acknowledged that while some individuals will not be eligible to receive care within the basket, the care components within the basket may guide other's care as well.

² **Preoperative phase:** A rationale for including pre-surgery education in the basket is the association between decreased length of stay and patients understanding expectations prior to admission.

³ **Case management:** A rationale for including case management in the basket is the ability for preplanning to reduce unnecessary hospital days.

⁴ **Professional fees:** As the basket price is intended to cover a collection of health care services ordinarily combined by a provider in delivering a full diagnostic or treatment procedure, it is anticipated that surgeon fees would be included in the basket. The basket component includes all of professional fees.

⁵ **Knee prosthesis:** The subcommittee discussed implant cost variation at length. The subcommittee supported the prosthesis cost being in the basket believing most patients would expect this to be included in the basket price; however, the subcommittee acknowledged that further strategies, such as specific tiering, related to such pricing were beyond the scope of the subcommittee. Additionally, the subcommittee acknowledged that the discussion about which prosthesis to use usually occurs as part of the orthopedic consultation prior to the start of this basket.

⁶ **Deep-vein thrombosis prophylaxis:** Deep-vein thrombosis prophylaxis significantly reduces the risk of postoperative thromboembolism; options include mechanical and/or chemical. Additionally, compression devices can control pain and reduce edema.

⁷ **Facilities:** The subcommittee acknowledges the challenge of balancing component specificity against allowing for innovation. The subcommittee elected to list components by general categories versus being more prescriptive, allowing for innovation. The subcommittee believes strongly that many opportunities exist for innovation in this particular area.

⁸ **Medications:** Prophylactic antibiotics should be limited to 24 hours post procedure.

⁹ **Pain management:** The subcommittee acknowledged the opportunities for innovation as it relates to management of patient immediately post-operatively.

¹⁰ **Medication consultation:** This is intended to describe medical management for medications/conditions not related to the surgery.

¹¹ **Case management:** This is included for the purpose of mobilizing the preoperative plan for disposition or responding to any necessary changes.

¹² **Postoperative follow-up surgical visits:** No specific frequency of visits or modality is defined, allowing for provider determination.

¹³ **Physical therapy:** No specific frequency or length of physical therapy is defined, allowing for provider determination.

¹⁴ **Imaging:** One outpatient knee film is included as the immediate postoperative film at the hospital may not be of required quality.

¹⁵ **Transitional care unit:** No specific length of stay or care at a transitional care unit is defined allowing for provider determination. The subcommittee believes strongly that many opportunities exist for innovation in this area.

Source: Total Knee Replacement Basket of Care Subcommittee (St. Paul, Minn.: Minnesota Department of Health, June 22, 2009), available at http://www.health.state.mn.us/healthreform/baskets/TotalKnee090622_FinalReport.pdf.

NOTES

¹ The Institute for Healthcare Improvement’s “Triple Aim” initiative helps organizations achieve improvements in these three areas simultaneously. See “Minnesota Health Reform Implementation Update” (St. Paul, Minn.: Minnesota Department of Health, 2009), available at <http://www.health.state.mn.us/healthreform/implementation/index.html>.

² “Administrative Costs at Minnesota Health Plans in 2007” (St. Paul, Minn.: Minnesota Department of Health, Dec. 2008, available at <http://h1n1resource.net/divs/hpsc/dap/cdireports/grppurch/admn2007.pdf>).

³ Current Population Survey, “2006 to 2009 Annual Social and Economic Supplements,” (Washington, D.C.: U.S. Census Bureau, 2009).

⁴ D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, and D. Belloff, *Aiming Higher Results from a State Scorecard on Health System Performance, 2009* (New York: The Commonwealth Fund, Oct. 2009).

⁵ “Administrative Costs in 2007,” 2008.

⁶ “Health Care Access Fund (HCAF) Transfer Issues” (St. Paul, Minn.: Fiscal Analysis Department, Minnesota House of Representatives, Jan. 2004).

⁷ Rural Health Advisory Committee, “The Health Care Access Fund and Provider Tax: A Rural Perspective” (St. Paul, Minn.: Office of Rural Health and Primary Care, Minnesota Department of Health, Nov. 2000), available at <http://www.health.state.mn.us/divs/orhpc/pubs/hcaccess.pdf>.

⁸ Includes premiums, out-of-pocket expenses, and taxes.

⁹ “Health Expenditure Data, Health Expenditures by State of Residence” (Washington, D.C.: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released Sept. 2007), available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-us.pdf>.

¹⁰ J. Sonier, “Health Reform: Minnesota and the Nations,” presentation for the Minnesota Department of Health, Sept. 22, 2009.

¹¹ The specific information about the packages and prices on Carol.com is proprietary, accessible only to employers and employees who purchase the service.

¹² “Health Care Quality Measures” (St. Paul, Minn.: Minnesota Department of Health, 2009), available at <http://www.health.state.mn.us/healthreform/measurement/index.html>; and “Health Care Quality Measures—Proposed Rule” (St. Paul, Minn.: Minnesota Department of Health, 2009), available at <http://www.health.state.mn.us/healthreform/measurement/drafrule.html>.

¹³ Minnesota Medical Association, Minnesota Department of Health, and Minnesota Community Measurement, “Quality Measurement and Reporting Web Conference,” Dec. 2009, available at <http://www.house.leg.state.mn.us/fiscal/files/ibhctxfr.PDF>.

¹⁴ Laws of Minnesota for 2008, Ch. 358, Art. 1, Chapter 358–S.F.No. 3780.

¹⁵ http://www.cchconline.org/pdfs/MN_data_elements.pdf.

¹⁶ <http://www.mnhospitals.org/index/aboutosp2>.

¹⁷ Interview with Jim Chase, President, Minnesota Community Measurement.

¹⁸ Minnesota Statute § 623.536.

¹⁹ “Administrative Simplification—The New Minnesota Standards,” presentation by the Minnesota Administrative Uniformity Committee, available at <http://www.mnhima.org/smart05-bin/public/downloadlibrary?&itemid=86114174841847227467>.

²⁰ “Minnesota’s Statewide Quality Reporting and Incentive Payment Program: Final Recommendations to the Minnesota Department of Health” (St. Paul, Minn.: Minnesota Department of Health, March 2009), available at <http://www.health.state.mn.us/healthreform/measurement/FinalRecs.pdf>.

²¹ <http://www.health.state.mn.us/healthreform/measurement/qualityrulesrevisor082509.pdf>.

²² Minnesota’s Vision for Health: Quality Measures, “A Guide to the Proposed Rule” (St. Paul, Minn.: Minnesota Department of Health, Sept. 2009), available at <http://www.health.state.mn.us/healthreform/measurement/GuideToProposedRule.pdf>.

²³ This description includes a provision passed in 2009 regarding the Medicaid performance thresholds. See 2009 Minnesota Statutes 256B.032, Eligible Vendors of Medical Care, available at <https://www.revisor.mn.gov/statutes/?id=256B.032>.

²⁴ “Provider Peer Grouping Recommendations” (St. Paul, Minn.: Minnesota Department of Health, Provider Peer Grouping Advisory Group, Oct. 23, 2009), available at http://www.health.state.mn.us/healthreform/peer/advisory_finalreport.pdf.

²⁵ “Baskets of Care,” (St. Paul, Minn.: Minnesota Department of Health, March 2009), available at <http://www.health.state.mn.us/healthreform/baskets.html>.

²⁶ “Minnesota’s Statewide Quality Reporting and Incentive Payment Program: Final Recommendations to the Minnesota Department of Health,” (St. Paul, Minn.: Minnesota Department of Health, March 2009), available at <http://www.health.state.mn.us/healthreform/measurement/FinalRecs.pdf>; and “Health Care Quality Measures—Quality Incentive Payment System,” (St. Paul, Minn.: Minnesota Department of Health, 2009), available at <http://www.health.state.mn.us/healthreform/measurement/qips.html>.

²⁷ “Minnesota’s Statewide Quality Reporting,” 2009.

²⁸ Detailed information on why this is a stretch goal, and what the spread is, is not available in the final report, but it reported as such.

²⁹ “Minnesota’s Statewide Quality Reporting,” 2009.

³⁰ The diabetes measures include the percentage of patients ages 18–75 with diabetes (Types 1 and 2) who reached all five treatment goals:

- a. HbA1c < 8
- b. Blood pressure < 130/80
- c. Low-density lipoprotein (LDL) < 100
- d. Daily aspirin use
- e. Documented tobacco-free

³¹ Measures include heart attack (acute myocardial infarction) care:

- a. Eight measures (seven process measures, plus mortality rates)
- b. Heart failure care: five measures (four process measures, plus mortality rates)
- c. Pneumonia care: eight measures (seven process measures, plus mortality rates)

³² Bridges to Excellence is a national pay-for-performance program that participating states have tailored for their unique regions. The program brings together employers, coalitions, health plans, and physician associations.

³³ Chapter 358—S.F. No. 3780, Article 2, “Health Care Homes,” (St. Paul, Minn.: Minnesota Department of Health, Sept. 2009), available at: <http://www.health.state.mn.us/healthreform/homes/documents/HCHLegislation.pdf>; and “Health Care Homes (aka Medical Homes)—Payment Methodology Development,” Minnesota Department of Health, Sept. 2009, available at <http://www.health.state.mn.us/healthreform/homes/payment/index.html>.

³⁴ “Health Care Homes (aka Medical Homes),” 2009.

³⁵ Health Reform Requests for Proposals (RFPs) (St. Paul, Minn.: Minnesota Department of Health), available at <http://www.health.state.mn.us/healthreform/rfp/index.html>.

³⁶ The Institute for Healthcare Improvement (IHI) believes that new designs can and must be developed to simultaneously accomplish three critical objectives, or what we call the “Triple Aim”:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

See: <http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>.

³⁷ A partnership of The Commonwealth Fund and AcademyHealth, announced in January 2008.

³⁸ S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Case Study of Minnesota’s Smart Buy Alliance* (New York: The Commonwealth Fund, Aug. 2007).

³⁹ A. Robinow. “Patient Choice Health Care Model Case Study,” presentation at the Pay for Performance Summit, March 13, 2009, available at http://www.mass.gov/EeoHhs2/docs/dhcfp/pc/2009_03_13_Global_Payments_Patient_Choice_Robinow.ppt.

⁴⁰ J, Christianson and R. Feldman. “Evolution in the Buyers Health Care Action Group Purchasing Initiative,” *Health Affairs*, Jan/Feb 2002 21(1):76–88.

⁴¹ Patient Choice, “About Us: Overview,” (Minnetonka, Minn.: Medica, 2007), available at <http://www.patientchoicehealthcare.com/aboutus/index.html>.

⁴² Silow-Carroll and Alteras, *Value-Driven Health Care Purchasing*, 2007.

⁴³ Minnesota Medical Association. *Physician’s Plan for a Healthy Minnesota* (Minneapolis, Minn.: Minnesota Medical Association), available at <http://www.mmaonline.net/KeyIssues/HealthCareReform/tabid/90/Default.aspx>.

⁴⁴ “Healthy Minnesota: A Partnership for Reform,” Healthy Minnesota, available at <http://www.healthyminnesota.org>. [Web site no longer active.]

⁴⁵ Healthy Minnesota bill, SF1689/HF1856, available at <https://www.revisor.mn.gov/bin/bldbill.php?bill=S1689.0.html&session=ls85>.

⁴⁶ “Health Care Reform in Minnesota” (Minneapolis, Minn.: Minnesota Medical Association), available at <http://www.mmaonline.net/KeyIssues/HealthCareReform/tabid/90/Default.aspx>.

⁴⁷ Minnesota Health Care Transformation Task Force, Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature (St. Paul, Minn.: Minnesota Department of Health, Minnesota Health Care Transformation Task Force, Jan. 2008), available at <http://www.health.state.mn.us/divs/hpsc/hep/transform/tfreportfinal.pdf>.