

MINUTES
POLICY ADVISORY COMMITTEE

Tuesday, June 10, 2008

555 N. Wabasha Street

4th Floor Boardroom

St. Paul, Minnesota 55102

8:00 a.m. to 9:30 a.m.

Members present: John Adams, David Alden, Duane Benson, Jim Boyle, Carrie Coleman, Bright Dornblaser, Kevin Goodno, Scott Halstead, Dave Hutcheson, Scott McMahon, Ed Oliver, Paul Taylor, Maureen Reed, Linda Stone, Barbara VanDrasek, Donna Zimmerman

Speakers present: Cal Ludeman

Staff present: Bob DeBoer, Victoria Ford, Jim Horan, Annie Levenson-Falk, Rebecca McDonald, Fiorella Ormeño Incio

Outcomes:

- Decide next steps on medical care policy advancement
- Keep members informed and involved in ongoing policy work.

1. Introductions

2. Review and approve agenda and outcomes

Approved with no changes

3. Medical care advancement discussion

Duane Benson: The core finding of the Medical Facilities Study Committee was that there is not enough information available for a regulatory or competitive model to be effective at reforming health care. A market requires knowledgeable consumers interacting with ample producers. Without good information, consumers cannot be knowledgeable.

Cal Ludeman:

- The reforms that passed in this legislative session are not as broad as the Transformation Task Force recommendations, but are still significant.
- The reforms dig into health care delivery models. What should health care look like? How should we pay for it? Transparency will increase value.
- The reforms are based on the idea that we need to change health care or costs will increase, the number of uninsured will increase.
- Over time, these reforms will reduce costs.

Public Health

- The legislation includes one of the most substantial investments in public health in Minnesota, including \$47 million for community-level grants for public health. The grants will

be distributed to communities. The intention is to change community design and behavior to improve health: walkability, green space, better information for consumers, etc.

Increased Coverage

- The legislation included small improvements in coverage, mostly through MinnesotaCare. Approximately 12,000 – 13,000 more Minnesotans will be able to receive coverage:
 - Increased eligibility to 250% of poverty level for individuals
 - Incentives for employers to enroll with the IRS for Section 125
 - Grant program to help employees enroll in Section 125
- 60% of uninsured Minnesotans are eligible for public programs. The legislation includes new dollars for outreach to enroll more people. It is difficult to enroll these people: have to go to health care providers, counties, schools, etc. to find people who are eligible and help them enroll.

Medical/Health Care Home

- Rigorous certification process to providers to establish themselves as a “health care home”. They must have the ability to manage health instead of looking at procedures individually.
- Medical homes have been in the literature of health care for almost 20 years. It was a response to managed care.
- Medical homes assume some loyalty between patient and provider.

Care Management/Care Coordination

- Dept. of Health/Dept. of Human Services/Dept. of Finance and Employee Relations to pay care coordination fees for medical homes for people with chronic diseases.
- Based on results – evidence based medicine.
- Ready in 2010.

Packages of Care

- Providers are asked to package care for certain conditions and advertise those to the marketplace.
- Health plans can respond to the packages: “We will buy these packages this way.”
- This will take some time to be successful but there is considerable interest, especially for diabetes.

Price Transparency

- Dept. of Human Services will contract to examine claims and data, to get to the point where consumers can judge the efficiency and quality of care.
- The contracts will be let by DHS by late summer 2008. Providers are required to make their data available.

Other Elements

- Legislation requires e-prescribing by a certain date. This should reduce medication errors.
- Working toward administrative/coding uniformity. Currently, medical coding is very complex. A knee replacement, for example, requires approximately 170 codes.

What Didn't Get Done

- Level 3 payment reform
- Insurance exchange: a place for individuals and small group coverage consumers to shop for insurance

Conclusion

- These changes should change the marketplace quickly, because of the availability of information to the public.
- There will be some discomfort to providers but the Minnesota Medical Association endorsed these changes. Providers will have the right to appeal the peer group into which they are placed. Peer groups will be risk-adjusted based on patient population. How to make those adjustments will be an important decision.
- The legislation capitalizes on what Minnesota already has going for it:
 - The Institute of Clinical Systems Improvement. Physicians have already reached some common guidelines on good practices.
 - Minnesota Community Measures – quality measures that no other states have.

Bob DeBoer:

- Article 4 of the legislation: Government structure to balance a provider-driven market.
- The legislation creates a Health Care Reform Review Council. The council is mostly a provider group, but it is responsible for monitoring how reform is going. It is a quasi-public body, as recommended in the Citizens League report, but we wanted a consumer-dominated group.
- There is always a question of how much to depend on regulatory authorities to do this. The Department of Health gets a lot of responsibility.
- Walt McClure quote from Medical Facilities report (page 12):

“A regulatory agency may be considered a referee between legitimate consumer interests and legitimate producer interests. But consumer interests are broad and diffuse and therefore difficult to mobilize through a regulatory process; whereas producer interests are sharp, concentrated and, ironically, more easily mobilized in a regulatory process than in a market. Thus, a purely regulatory process unbalances the respective leverage of consumers and producers in favor of the producers. This is a central, almost inherent structural defect of command and control regulation that is extremely difficult to remedy.”

Discussion

Framing questions:

- Can a critical mass of change be achieved through this legislation?
 - How much of the health care market will this get into, and in how long?
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Citizens League Role

- Member: There is a lot of focus on transparency and getting information to consumers. What role can the Citizens League play in building consumer interest and appetite for this information?

- Bob DeBoer: Should the Citizens League consider being directly involved with the consumer engagement portion of this legislation?
- Member: I'm more excited about this legislation for the mindset change that I think it has created in the marketplace. Though there were some movements toward payment reform, they are very small steps compared to where we have to get. In my opinion, the cost is the problem in health care. If costs were lower, more people would be incurred and quality would have to be better, because right now we're paying for poor quality. Recommendations for the Citizens League:
 1. Consider how the Citizens League might bolster efforts at real payment reform. Absent comprehensive payment reform, we won't get costs under control.
 2. Consider how to engage and energize the things in prevention that are known to pay off. Energize individuals to take individual responsibility for their health at early stages. As a society we need to think preventative, not curative.
 3. Engage consumers to demand health care interests. More than half of the oversight group are vested interest. You can't overstate the tenacity with which vested interests hang on to the status quo. The Citizens League needs to figure out how to engage the citizenry. It's much harder than engaging vested interests.
- Donna Zimmerman: How do you create the demand for payment reform? It is difficult for consumers to understand. There is a role for the Citizens League in helping create this demand. It's not intuitive that less care can be better, on an individual level. People don't want fewer tests. How do we use this information to create a demand for supply-sensitive care?
- Member: Consumers prefer to get information from their doctors, not from their health care plan. If the Citizens League is going to try to create demand for payment reform, we need to work with providers.
- Member: There are two different kinds of consumers:
 1. Human Resources staff at employers. They are better informed. Maybe the Citizens League should target this group.
 2. Individuals buying health plans, etc.

Information

- Duane Benson: The similarities between the legislation and the Medical Facilities report are around information. What we didn't spend time on is: Who is the information for? The legislation is focused on providers. The Citizens League report focused on payers. The general population is disengaged around this issue. The Citizens League should consider this like a Constitutional amendment question: how do you engage the average Minnesotan around this, outside of when they go to the doctor and when they pay their insurance.
- Cal Ludeman: A truly owned, personalized health record is probably the best place we can go for consumers to start to learn about how to engage on health issues.
- Member: To engage consumers, you have to provide information and then require them to pay.
- Kevin Goodno: It's also about frequency. You'd know what a colonoscopy cost if you had to buy it as often as you buy gas.
- Member: There is a lot of information available. The insurers have it. They done a good job of getting information to policy holders and employees.

- Member: It is available for discrete services, but not for the cost drivers – comprehensive care for chronic conditions.

Medical Records & Privacy Issues

- Kevin Goodno: A question for Commissioner Ludeman: Is there any thought to the right of individuals to have timely access to their own medical records?
- Cal Ludeman: Minnesota was the first state to engagement in public-private partnership, the Health Information Exchange. This will accelerate this work. 50%-60% of Minnesotans have access to systems that has or will soon have electronic personal medical records.
- Member: Do you have the right to modify the information? Because your record can affect your insurance rates and job applications, etc. Who else has access to the information? There are important privacy issues.
- Cal Ludeman: Google, Microsoft, etc. are building platforms. They are tested for privacy, records can be certified haven't been altered in any way.
- Member: There needs to be a way to have an easy exchange of information between providers. This is related to payment reform. Currently, providers get paid for every duplicated test, all the extra days you sit in a facility even if nothing is done, etc. As long as pay for piecemeal work, we'll get piecemeal results.

Public Input

- Kevin Goodno: I don't see in the legislation how the Department of Health will get information from the public as these elements are being developed.
- Cal Ludeman: The review council will be convened this summer. Interested people would be welcome to be a part of the discussion of how reform will be carried out. The process is not specifically prescribed in the legislation.
- Kevin Goodno: The Citizens League wouldn't want to name a person to the board. The focus should be broad participation. We're willing to work with Commissioner Ludeman to make this work so it doesn't appear to be constructed by people with vested interests.

Misc.

- Bob DeBoer:
 1. The Citizens League hasn't made strong comments on this legislation yet. It sounds like we're not sure the Review Council will be able to effectively make sure the reform is going to right way for consumers – something the Citizens League will want to work.
 2. The information pieces seem to be all in the right direction. There are a lot of questions for how far they can take us and how fast. We may be able to find ways to be involved.
 3. Question: How much of the health care delivered in the state will be taking part in these reforms?
 4. Total Cost of Care didn't happen in this legislation.

- Member: The challenge: This is complex to understand. If/when we ask providers to take responsibility for the outcomes of care they've delivered that's a totally different economic dynamic.
- Member: The Office of Personnel Management used to have a health assessment. You'd talk to a nurse, be weighed, etc. If you could do that on a large scale people could have a better idea of their health. There could be tiered pricing based on behaviors.
- Member: I agree that this is a cost-driven system. If we want to see reform that puts consumers at the center we need to drive toward rewarding providers based on good outcomes not procedures done.

Summary

The Citizens League could get involved by:

- Taking a position on the legislation.
- Offering to help improve the elements of reform in the legislation.
- Engaging consumers in health care reform more generally.

What kind of response should we have to the legislation?

- Ask for input. Use web forums, etc. to discuss.
- Bob DeBoer: On a high level, staff could put together a statement. For more detail, we would need more member involvement.
- Kevin Goodno: Unless we ask specific questions, electronic means might not be the best way to develop position. We could suggest to the Board that staff spend time on developing a statement and getting input, and that the Citizens League could offer assistance in advancing the legislation that was passed. This would have to go to the Executive Committee and then come back to the Policy Advisory Committee.

Cal Ludeman: I suggest that you laser in on working with the Consumer Engagement Working Group & Essential Benefits Set Working Group.

4. Updates

No updates.

5. Evaluate whether outcomes were achieved

Evaluations: 4-5