



# JOURNAL

Expanding the Civic Imagination



## Health care reform: Today's greatest policy challenge?

Reframing the debate while building on success

By Bob DeBoer

As the Citizens League reaches the middle of our 60th anniversary year, we think it is apt to use this issue of the Minnesota Journal to highlight a critical policy area in which we have been involved over several decades and that is perhaps the most contentious and challenging one facing us today: health care reform. Health care spending is already trending at an unsustainable rate. As our population ages, this will only intensify unless we change our system to pay for supporting health rather than reacting to illness.

From the early 1950s through our 2006 report "Developing Informed Decisions" and subsequent reforms that came out of the Transformation Task Force in 2008, the Citizens League has been at the forefront of health care policy change in Minnesota. (See Minnesota Journals from March-April 2012; November-December 2011; March-April 2008).

The term "health care" is on everyone's tongue, but the reality of today's health care system is that most of our resources are spent on medical care that focuses on the treatment of illnesses, and much of that is intensively spent at the end of life and on chronic conditions. Because of this intense concentration of resources, much of this *Minnesota Journal* is focused on the reform path in front of us that begins fundamental changes to the medical care system.

These efforts must reform the payments and incentives in our medical care system so that we actually reward those that provide relatively high-quality and low-cost health care (McClure and McDonald on page 5), but there is also acknowledgement that those incentives must align with and produce major improvements in maintaining health (Benavides on page 9).

The genesis for current reform opportunities took place decades ago (McClure/McDonald), but the most recent opportunities come from the 2008 legislation

passed in Minnesota that resulted from the Transformation Task Force and the more recently passed Affordable Care Act (ACA) at the federal level.

Most of these reforms are meant to help us continue moving in the direction of what is referred to as the Triple Aim in health care (Chase on page 11).

Although the politics of a presidential election year focus on philosophical disagreements about health care reform, Minnesota was already poised to implement many of the measures called for in the ACA from bipartisan agreements in 2008. The Citizens League strongly believes that our current financing system is unsustainable (*Moving Beyond Medicaid*) and we have particularly focused on Medicaid reform, which is a main cost driver in our current system (Leitz on page 14).

These changes will not progress rapidly enough without aggressive leadership from both the public and private sector (Abelson on page 13 and Johnson on page 15).

And although there is much to laud about the leadership that has produced the current reform opportunities, many Minnesotans remain unconvinced that this path of reforms can yield the health care system that we need as a state, and believe they have not seen an inclusive enough process (Hurtado on page 12) to reach our goals.

Ultimately, Minnesota's health care reform track must be looked at in the entire context of how we can all imagine creating a healthier state, including, but also looking beyond, the medical care system (Kershaw on page 4). ●

Bob DeBoer is the Citizens League's director of policy development, managing editor of the Minnesota Journal, and a member. He can be reached at [bdeboer@citizensleague.org](mailto:bdeboer@citizensleague.org) or 651-289-1071.

## INSIDE

- Connections ..... 2
- Get Involved ..... 3
- Viewpoint:  
Ghosts in  
the Machine ..... 4
- Looking back:  
Minnesota's  
growing health  
reform strategy ..... 5
- Outlook on health  
reform efforts ..... 9
- Public reporting  
supports the  
Triple Aim ..... 11
- What's wrong  
with this  
picture? ..... 12
- Tectonic plates  
of health care .... 13
- Medicaid's  
place in  
reform ..... 14
- Perspectives:  
Making Minnesota  
a leading-edge  
state ..... 15

To view the Citizens League reports cited in this issue, visit <http://citizensleague.org/publications/reports>.

# CONNECTIONS

Building a League of Citizens

## INTERN MEMBERS SPOTLIGHT

### ZOEY SLATER

*Zoey Slater is a rising junior at St. Olaf College in Northfield. She is from St. Cloud, and she is studying English and American Studies with a concentration in American Racial and Multicultural Studies. Zoey volunteers to teach English as a Second Language, works in the St. Olaf College Admissions office, and is involved with St. Olaf Leaders for Social Change. Zoey interned at Citizens League this summer, focusing on marketing and communications.*



#### How the Citizens League fits into her academic and career goals:

I'm hoping to go into a career in marketing and communications. Working with various volunteer organizations has prompted me to also consider working with a nonprofit. This internship provides a look into both fields, and I hope to learn more about each career path. As an English and American Studies major, I study the theoretical aspects of social issues. In the future, I hope to learn more about the hands-on side of how communities can enact effective social change, and interning at the Citizens League offers a glimpse of this civic involvement.

#### How she is civically engaged in her life:

In high school I picked up the habit of listening to Minnesota Public Radio every morning. I also try to stay up to date on international news by reading through different online newspapers. I'm also excited to vote for the first time in the upcoming election!

### SALLY COLE

*Sally Cole is a rising senior at St. Olaf College in Northfield. She is originally from Madison, Wis., and she is studying Sociology and Anthropology with a concentration in Management Studies. Sally runs on the St. Olaf cross country team, works with the Special Olympics and is involved with St. Olaf Leaders for Social Change. She interned at the Citizens League this summer, focusing on policy work and the Pathways to Prosperity project.*



#### How the Citizens League fits into her academic and career goals:

I can see myself working in a career that deals with policy change. I've worked with these kinds of issues before in a more hands on way, and it's interesting seeing the "behind the scenes" part of policy work. The Pathways to Prosperity project interested me initially because I've worked directly with people affected by poverty. During this internship, I'm hoping to learn how to navigate policy issues and how to communicate to a wide variety of people with different views. I also hope to learn how to be an effective member of a nonprofit organization like this and how to contribute to the cause.

#### How she is civically engaged in her life:

I vote and I pay attention to politics in the news. I think it's important to be an informed citizen by paying attention to local and global issues. I also volunteer in my community and go on mission trips.

Thank you to our newest sustaining members,  
Troy Davidson & Kate Nelson and Jim McCorkell & Christine Greenhow!

Sustaining members schedule regular monthly or quarterly payments of any amount, or schedule automatic annual donations. Become a sustaining member today at [www.razoo.com/citizensleague](http://www.razoo.com/citizensleague).

Thanks to our new and rejoining members and contributing organizations as of 6/30/12

#### Individual members

Tom P. Abeles  
Alberta Adams  
Ginny Agresti  
Said Ali  
Farouk Althlathini  
Katherine Althlathini  
Brett Baldauf  
Cassandra Berg  
Lee Bizik  
Kimberly Borton  
Ruth Brink  
Matthew Butler  
Rob Colasanti  
Scot Covey  
Eddie Cruz  
Aimee Dayhoff  
David Dayhoff  
Steven D. DeRuyter  
Dirk DeVries  
John F. Driscoll  
Jeff Falk  
Andrea Feshbach  
Greg Filice  
Anna Finnesgard

Matt Finnesgard  
John Flanders  
Randy Fordice  
Rob Fulton  
Dan Grigsby  
Kristy Grigsby  
Kevin Gutknecht  
Carol Halonen  
Marlowe Hamerston  
Susan Hammel-Joyce  
Chad Hegwood  
Wendy Helgeson  
Mary Henschel  
Rick Heydinger  
Kari Hiltner  
Mike Hiltner  
Julie Hoff  
Melissa Hortman  
Christy Hovanetz  
Annie Johnson  
Craig A. Johnson  
Beverly Jones  
Heidinger  
Lauren Juergensen  
Kim Kang  
Michael Kauper

A.M. Sandy Keith  
John Keller  
Kathy Kelly  
Sean Kittridge  
Jacob Knight  
Jen Kohan  
Robert Kowalski  
Joel Kramer  
Laurie Kramer  
Tony Kwilas  
Ron Lattin  
Jenny Lee  
Todd Lee  
Nicole Lehrke  
Joel Lissick  
Bruce Lundeen  
Nick Magrino  
Bryan McCoy  
Tim McDonald  
Daniel C. McElroy  
Christina Melloh  
Lindsey Miller  
Daniel Moore  
Michelle Morocco  
Deborah Moses  
Lauren Nakamura  
Uri Neren

Deb Olkon  
Andrea Perzichilli  
Marco Perzichilli  
Neil Peterson  
Maya Petrovic  
Abby Pinto  
Dave Pinto  
Hindolo Pokawa  
Beverly Priebe  
Donald J. Priebe  
Jack Ray  
Brittany Richardson  
Julie Roles  
Jen Rome  
Perry Rutter  
Virginia Rutter  
James Schoettler  
Svetlana Simovic  
Stacy Sinner  
Joseph Sixta  
Jennifer Smith  
Patrick Smith  
Melenie Soucheray  
Ryan Steel  
John Sharsky  
Heidi Storm  
Brian Sweeney

Madeline Tate  
Luisa Tejada  
Saul Theisen  
Michael T'Kach  
Chuck Tombarge  
Patricia Torres Ray  
Peter Truax  
Marian Turner  
Elizabeth Vander Schaaf  
Mark Vander Schaaf  
Jane Vanderpoel  
Tamara Ward  
Ellen Watters  
Zachary Wilson  
Mike Zis  
Jeanne Zlonis  
Jeff Zlonis

#### Organizational members

Maslon Edelman  
Borman & Brand LLP  
Minneapolis  
Regional Chamber of Commerce  
Comcast

CenterPoint Energy  
Minnesota Chamber of Commerce  
Minnesota Private College Council  
Wells Fargo  
Peterson Engberg & Peterson  
Metropolitan Area Agency on Aging  
Minnesota Business Partnership  
Friends of the St. Paul Public Library  
City Academy Charter School  
Presbyterian Homes and Services  
Association of Metropolitan School Districts  
Minnesota Public Radio  
LogIn, Inc.  
Family Housing Fund

Northeast Bank  
The Pohlad Companies  
Minneapolis Public Housing Authority  
Community Action Partnership of Ramsey & Washington Counties  
Workers' Comp Reinsurance Association  
Courage Center  
Office of the Legislative Auditor  
Education Minnesota  
Park Nicollet Health Services  
Medica  
Grassroots Solutions  
U.S. Bancorp  
Dakota County Community Development Agency

Youth Frontiers, Inc.  
Goodwill/Easter Seals Minnesota  
Kowalski's Markets  
Andersen Corporation  
Culligan Water Conditioning Company  
Twin Cities Local Initiatives Support Corporation  
AgeWell Home Care  
Aging Services of Minnesota  
SuperValu  
HealthPartners  
Lindquist & Vennum  
North Central Mineral Ventures  
Saint Paul Area Chamber of Commerce  
City of Edina

# GET INVOLVED

What We're Doing and How You Can Get Involved

## OWN YOUR FUTURE: A FOUNDATION FOR OUR LONG-TERM CARE RECOMMENDATIONS

The Citizens League is participating in the **Own Your Future Advisory Panel** convened by Lt. Gov. Yvonne Prettner Solon, which includes 26 other stakeholders who are engaged in the delivery and policy around long-term care planning. The Minnesota Own Your Future campaign will be planned and implemented over the next 12 months.

The objectives of the campaign are to:

- Raise awareness among Minnesotans of the importance of planning now, so they will have personal and financial options to meet future long-term care needs.
- Increase the number of Minnesotans who have taken action to address and provide for their future long-term care.

The advisory panel will meet quarterly over the next 12 months and members will also participate in working groups to meet the following overall charge:

- Provide oversight and direction for the implementation of Minnesota's Own Your Future campaign.
- Assist with development and review of campaign materials for use by employers, grassroots organizations and stakeholder organizations.
- Act as a liaison between the Own Your Future campaign and employers, grassroots and stakeholder organizations.

Several members of the advisory panel took part in the work of the Citizens League Long-Term Care Collaborative, which issued a report in December 2010 entitled **Moving Beyond Medicaid**.

Public awareness is important, but the Citizens League also believes that other components such as new savings and asset-building tools and Medicaid changes must also be moved forward now to take full advantage of public awareness. If you have connections or ideas regarding those portions of the 2010 work, contact us.

## RECREATING A CULTURE OF SAVINGS

Our current approach to poverty is reactionary. Instead of supporting prosperity, the current public assistance system reacts to poverty and then forces people into navigating a system to prove their neediness, rather than building their capacity to be independent.

Over the past three years, the Citizens League's **Pathways to Prosperity Project** has explored ways in which Minnesota can develop a new approach.

Building off of our 2010 **working document**, the Citizens League is currently advancing a plan to establish Family Independence Demonstrations with five partners across Minnesota. Part of the environment we want to create includes increased tools for asset building. Prize-linked savings (PLS) is one part of the

comprehensive saving and asset-building strategy that is needed to support prosperity for low- and middle-income Minnesotans.

Attracting more people to save is particularly critical when one considers a **2009 study** by Harvard Business Professor Peter Tufano, which found that 46 percent of Americans felt they would be unable to come up with \$2,000 within 30 days if they had an emergency, and another 7 percent were unsure.

By recreating the entertainment and fun that attracts people to the lottery, Prize-linked savings encourages regular savings deposits with the chance to win every month. Participants are able to take a chance on winning without the risk of loss that is included in a typical lottery.

If you are interested in holding a workshop on prize-linked savings or the Pathways to Prosperity project in your community or at your workplace, contact us.

## BRING COMMON CENTS TO YOUR ORGANIZATION

Last year, more than 600 Minnesotans across the state engaged in our **Common Cents** project to discuss: "What values and priorities are important to solving Minnesota's budget challenges?"

This year, we are again partnering with the **Bush Foundation** on a second round of state budget workshops and online activities, and we'd like you (and your elected representatives) to join us.



We're bringing Minnesotans' ideas and values to the Legislature and Gov. Mark Dayton to inform next year's discussion. And this year, we've added a second workshop on tax reform.

Would you like to bring a workshop to your workplace, club, church or other group? We're scheduling them and looking for hosts now.

All workshops are presented free of charge. Hosts will be responsible for meeting logistics and for recruiting at least 20 participants of mixed backgrounds and/or ideologies.

For more information or to schedule a workshop, contact Juve Meza at [jmeza@citizensleague.org](mailto:jmeza@citizensleague.org) or 651-289-1073.

The Citizens League involves people of all backgrounds, parties and ideologies to create and advance solutions for Minnesota. The Citizens League's approach to policy—civic policy making—results in the civic policy agenda, our case for action that is based on the belief that all people and organizations play essential roles in developing the ideas, skills and resources to govern for the common good. Visit [www.citizensleague.org/who/identity](http://www.citizensleague.org/who/identity) to find out more.



Learn more about all of our work at [www.citizensleague.org](http://www.citizensleague.org).

If you have questions about any of these projects or others, contact Policy Manager Annie Levenson-Falk at [alevensonfalk@citizensleague.org](mailto:alevensonfalk@citizensleague.org) or 651-289-1072.



## Ghosts in the Machine:

What's scary—and hopeful—about “health reform”?

by Sean Kershaw

What does it say about our current situation when the most useful analogy about public policy that I've seen in years comes from a horror movie?

“The Others,” a 2001 release starring Nicole Kidman, taps into deep personal and social anxieties. Sense of isolation? Check. Nicole and her children are nearly-alone in a drafty manor home on the island of Jersey following the end of WWII. Fear for our families? Check. Her husband is MIA, and her children have an illness that makes them deathly ill from exposure to sunlight. Fear of others? Check. Strangers show up to help her, but can we trust them? Lack of control? Check.

Nicole's character is paralyzed by fear and an inability to have any impact on the world around her.

Scene by scene, the director slowly ratchets up the audience's anxiety level as we wait for ghosts to suddenly appear from behind drawn curtains.

The film's entire artifice finally falls apart—and back into place—when we realize that Nicole and her family aren't being haunted by ghosts; they are themselves the ghosts and are haunting the real life family that occupies their former home. Nicole's character couldn't let go of her former reality, no matter how much her world had changed. And she couldn't move on until she accepted her new reality.

It's a brilliant movie—and an apt metaphor for why we need a new model for public policy in Minnesota, especially surrounding “health care” and “health reform.”

### THE GHOSTS OF “HEALTH CARE”

The Citizens League's past policy success on issues covered in this Journal were in part due to the fact that we could pull back the curtain, metaphorically, on important policy issues and show people what was really happening. Policy impact and success began with an honest conversation

about the facts and their implications. Without the right definition of a problem, solutions are destined to fail.

One of the ghosts we have to confront is that our entire conversation about “health care” and “health reform” isn't really about creating health. It's about reforming insurance and the delivery of hospital and medical services.

This isn't to say that medical system goals of access, quality and affordability aren't critically important to improving the delivery of these medical services. Lack of access is ultimately unjust. We can significantly improve the value of our already high-quality medical services in Minnesota.

Most of the costs in our current system are wrapped up in five chronic conditions (diabetes, cancer, heart disease, stroke and Chronic Obstructive Pulmonary Disorder) and end-of-life care. Reforms in the delivery of medical services and insurance can improve the treatment and maintenance of these conditions—thereby bending the cost curve—but they can't prevent or avoid these conditions. If we don't reduce the need for these hospital medical services, we won't have any money left for any other public good—from schools to parks to roads.

That's scary. And unsustainable.

### REIMAGINING HEALTH POLICY

The Citizens League is developing a new model for public policy that we call “civic policy making.” As we endeavored to apply this model to “health care,” we realized that, in addition to reforming medical and hospital services, we need to reimagine—and create—a new infrastructure for achieving health.

We have to re-define what we mean by “health.” Is it more than the absence or maintenance of disease? Luckily, dozens of conversations we've had throughout

Minnesota, sponsored by the Bush Foundation and reporting to the Bipartisan Commission on Health Reform, confirm that there is surprising agreement by the public (across partisan differences) on what we mean by “health.”

It involves an inherent sense of balance in our lives. Minnesotans agree that we have a role in co-producing our own health and an obligation to improve our health.

How can health be the default opportunity in our daily lives, rather than something we have to go out of our way to achieve? What is the role of creating health within families, workplaces, neighborhoods and schools? Are we putting too much responsibility for this on medical service organizations and government?

As it turns out, the quality delivery of medical services accounts for approximately 10 percent of longevity gains and healthy aging. Environmental and social circumstances and individual choices affect 60 percent of these outcomes, and genetics are another 30 percent. We spend most of our time and resources on 10 percent of the problem.

This conversation is both new, with profound implications for all individuals and organizations, and one that the public wants to have. It's also an example of why we need a new model for policy making that recognizes the roles we all have in achieving policy outcomes.

When it comes to imagining and creating new systems of health, we first must realize that “the others” aren't someone else, somewhere else. They're all of us.

Only then will we be able to create the infrastructure for everyone, everywhere to achieve healthier outcomes. Only then will we have truly exorcised our health care reform ghosts. ●

Sean Kershaw is the executive director of the Citizens League and a member. He can be reached at [skershaw@citizensleague.org](mailto:skershaw@citizensleague.org), 651-289-1070, @seankershaw (Twitter), or Facebook.



# Looking back: Minnesota's growing health reform strategy

A history of health care system reform in Minnesota

By Walter McClure and Tim McDonald

Minnesota's focus on incentive-based reform of the health care system dates back to the 1970s, when Excelsior-based InterStudy, under the direction of Paul Ellwood, began developing what came to be the Health Maintenance Strategy for federal policy. The objective of the strategy was to foster Health Maintenance Organizations (HMOs): prepaid, integrated, managed comprehensive-care organizations, which presumably had internal incentives to reduce unnecessary services and costs. By 1980 it became clear that, with some heartening exceptions, true HMOs were not catching on widely and were not making a dent on cost escalation.

By 1981 Walter McClure (senior author), part of Ellwood's team at InterStudy, had concluded the HMO strategy was aimed at the wrong level: It was addressing symptoms and not the underlying cause of the health care system's variable quality and runaway cost. Instead of looking at incentives within organizations, one had to look above the organizations to the level of the system itself and the incentives the system placed upon the organizations within it, including HMOs. It became clear the system punished providers who were better for less and rewarded costly providers, independent of their quality. Even an HMO could not pursue efficient practice if it were punished for it. McClure founded the Center for Policy Studies to design a system reform strategy that would reverse these pernicious incentives and to assist people in positions of leadership who wished to implement it.

The Center concluded that a strategy to reward providers who were better for less would have to:

- Identify who those providers are, and
- Reward providers by giving consumers objective ratings of provider quality and cost and placing incentives in their health insurance plans to choose providers who are better for less.

The name we suggest in this article for this strategy is Informed Consumer Choice, or ICC (at its origins, it was given the uninspired and now abandoned name Buy Right). Thirty years ago, these policy ideas, originating in Minnesota, were considered radical and impractical. Nevertheless, enough progress was made nationally that they are now becoming mainstream around the country—and nowhere more so than here in Minnesota.

As the state considers the next steps in its ongoing reform of the health care system, it can be helpful to take a look back at how we got to where we are, and the private and public sector

leadership that has brought Minnesota to a position where it can step out and lead the nation on reform at this important time.

## THE INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI)

Measurement of quality took a giant leap forward in the '90s due to two developments here in Minnesota. The first was when our two HMOs, Group Health and MedCenters, merged to form HealthPartners. This led Dr. Jim Reinertsen, CEO of Park Nicollet and George Halvorson, CEO of the old Group Health and now of the new HealthPartners to the inspired idea to use the clinical expertise of all three medical groups to develop and publicly release a new common set of improved quality measures for themselves and the medical community at large.

At about the same time, a group of large employers, represented by their business coalition, Buyers Health Care Action Group (BHCAG), sought a single health plan and put it out for bids. The group of three, led by HealthPartners, submitted a bid and won. Thus in 1993, from all this imaginative forward thinking, was born ICSI, the Institute for Clinical Systems Improvement: the first independent agency continuously developing, and updating in light of new evidence, quality guidelines for practicing providers—not a limited research project but a practical, operating program.

Dr. Gordon Mosser, formerly head of quality at Group Health, was brought in to head ICSI. He had the relevant clinical experts from HealthPartners, Park Nicollet and Mayo work through the medical literature and arrive at consensus on the best protocols. The work has proven outstanding, and ICSI protocols are achieving increasing recognition and endorsement around the country. Each protocol was accompanied by a set of patient outcome objectives, and the program called for each provider group to audit its records and report on the percentage of its patients achieving the desired outcome for each protocol. These reports were kept confidential and shared only among the participating providers. Mosser's consensual, confidential process won provider trust, and more and more provider groups joined ICSI and used its protocols and confidential reporting. They all discovered that while some were better than others on this condition or that, they were all far from where they wanted to be on patient outcomes and they could learn from each other to improve their care.

The second key development came in 1995. HealthPartners under its new medical quality director, Dr. Gail Amundson, developed a set of "patient-centered" quality measures aligned with

### Minnesota's growing health reform strategy

InterStudy begins as part of Sister Kenny Hospital by its director Paul Ellwood to work on health policy. Becomes independent under Ellwood's direction in 1975 when the hospital merges with Lutheran Deaconess, now part of Allina.

Federal HMO statutes are enacted with key assistance from Interstudy. Aim is to control cost to system; they fail to do so.

Walter McClure, formerly with Interstudy, concludes the HMO strategy is treating symptoms but not the underlying cause of health care system quality and cost problems and founds the Center for Policy Studies (CPS) to develop a new strategy for incentive-based system-level reform. (Ted Kolderie later joins CPS to develop an incentive-based system reform strategy for public education.)



ICSI guidelines for monitoring not just HealthPartners' own medical group but participating groups in its network such as Park Nicollet and Fairview. She proposed and got strong support from HealthPartners leadership that these measures be released publicly for each participating provider group, essentially putting the groups in competition with each other publicly on quality. HealthPartners leadership believed not only that patients deserved this information, but also that it would strongly motivate all provider groups including their own to improve lest the others get ahead of them (and so it proved).

All the pieces to complete the job are in place and under development.

By the end of the '90s, many of the state's providers were participating in ICSI's confidential but objective quality assessment; those participating in HealthPartners' plans were having their quality reported publically. This was an enormous accomplishment, an unheard-of, giant stride forward in quality assessment. It was not just the development of sophisticated new evidence-based quality measures; the major advance was the landmark shift in physician culture—from unease and opposition at objective external measurement of their quality (let alone public release of the results), to recognition that when done competently and transparently, assessment is a powerful tool to improve their quality of care and the right thing to do for their patients.

The skill and patience with which this culture shift was brought about offers an important lesson. One cannot impose external assessment on providers in a day or year and expect cooperation; the impatient advocate or policy will fail. Physicians are smart, independent thinkers—experts in their field. They will not accept things on others' say-so; they must work through the matter themselves until persuaded of the merits. Moreover, their training drills them in autonomy, and even when persuaded that competent external assessment is a powerful tool to improve quality, it takes them some getting used to. ICSI gave physicians years of experience via confidential processes, in which they themselves came to consensus on well-validated measures, to see the value of assessment for improving care.

## MINNESOTA COMMUNITY MEASUREMENT (MNCM)

The second great leap forward began quietly in the early 2000s. Blue Cross Blue Shield of Minnesota, Medica, PreferredOne, UCare and Metro Health Plan had joined as sponsors of ICSI, and Mary Brainerd had succeeded Halvorson as CEO of HealthPartners. Brainerd proved as strong a proponent of provider assessment as her predecessor, if not more. At this time, each of the health plans was using its own confidential internal measures for assessing provider quality. HealthPartners proposed to the two other largest plans, the Blues and Medica, that it would be better and easier on plans and providers alike to come to a common set of measures, so that providers reporting on this one set would satisfy all plans. The three plans came to a landmark agreement to aggregate the common measures by provider group and make the results public as soon as there was confidence in the process. Since these plans covered most of the state, this meant most provider groups would now be publicly assessed on their quality.

It was thought at first that ICSI should perform this assessment, but Mosser advised that this should be done by a separate organization. ICSI had promised its provider participants confidentiality and should not betray this trust; moreover, acting as a public quality auditor would conflict with its role of quietly helping provider groups to improve. So the three plans (joined later by PreferredOne and UCare) set up and funded a separate pilot project headed by Amundson with 50 participating provider groups covering most of the state.

There was some initial unrest among providers in some of the groups, but most bought into the concept when they saw the assessment was valid, fair and transparent. In 2004, results for the first patient condition—diabetes—were publicly released with each provider identified. The pilot was deemed a success and a nonprofit organization, Minnesota Community Measurement (MNCM), under the direction of Jim Chase was created to continue assessment and expand the quality measures. Like Mosser at ICSI, Chase proved patient and skillful in setting up an open participative process to earn provider consensus and approval on all quality measures as they developed. MNCM has grown in provider participation and the range of patient conditions assessed for quality. The board has been broadened well beyond the initial plan and provider group leaders to include a balanced set of representatives from labor and business, as well as plans and providers, with none dominant.

Medicare begins releasing patient outcome data for hospitals nationally, and Pennsylvania and Cleveland pilot the CPS incentive-based health care system reform strategy (named buy right and recently renamed informed consumer choice), with CPS advice and assistance.

Federal policy greatly expands size and number of medical schools. Aim is to reduce cost by ending a supposed shortage of physicians; with cost-increasing incentives still in place, this instead aggravates cost increases.

Institute for Clinical Systems Improvement (ICSI) is founded by HealthPartners and Park Nicollet, soon joined by Mayo Clinic, to collaborate on standardized evidence-based clinical guidelines.

Leading health plans collaborate to launch the Minnesota Community Measurement pilot project (MNCM) to measure provider performance across the state based on ICSI guidelines. Guidelines are reoriented from plan-centered to patient- and provider-centered so providers can use them to improve quality of care. Project releases the first public report of comparative quality measures of provider groups, for diabetes care.

1984-9

1980s

1993

2002

## INCENTIVE-BASED SYSTEM REFORM BECOMES STATE POLICY

The final great leap forward came in 2008. In an exemplary demonstration of bipartisan collaboration, Gov. Tim Pawlenty signed into law a series of reforms arrived at with the Democratic-controlled Legislature that for the first time made assessing and buying “better for less” state policy. The 2008 reforms had their origins in a failed attempt in 2007 to pass a health insurance exchange bill Pawlenty proposed that led to an end-of-session compromise to create a Health Care Transformation Task Force on which the Citizens League served. Its role was to “advise and assist the governor regarding activities to transform the health care system” to improve affordability, quality and access. It reported in 2008.

The essences of the task force’s recommendations were four-fold:

- Use aggressive public health programs and education to curb unhealthy consumer behavior.
- Measure all providers on quality and cost and publish the results to consumers, so they can act accordingly.
- Change payment to reward those providers who are better for less.
- Assure all Minnesotans basic health insurance at an affordable price.

The second and third recommendations were revolutionary; no state had ever based its policy on this kind of dramatic system reform.

These recommendations could not have been contemplated—indeed would be politically unthinkable—had Minnesota’s private stakeholders not brought the state to such a forward position. Their long, hard collaborative effort had proven that provider quality assessment was practicable, had built the culture shift that made it acceptable and persuasive to most providers and was presently gift-giving the state with an operating quality assessor.

The legislative architects of the 2008 reform bill included Democrats, Republicans and appointed and career staff. After many fits and starts, the first and last recommendations went by the wayside as too costly, and the core team crafted a tighter package that placed emphasis on assessing provider quality and cost, publishing the results for consumers, and on bonus payments rewarding providers who were better for less. A bill with these components sailed through the Legislature in two hearings and passed quickly, and Pawlenty signed it.

## PROVIDER PEER GROUPING

Since 2008, officials across multiple private and public agencies, and through two administrations, have been diligently implementing the statute. In the process, some challenges and new opportunities have emerged.

The first and most difficult task was to arrive at a practical method to assess providers for quality and cost, and under direction of Scott Leitz, the Minnesota Department of Health set to work with a will. MNCM had a well-developed methodology for assessing provider quality, and the department borrowed heavily from it with MNCM’s full cooperation and assistance. But at the time, there was no method for the task of accurately assessing provider costliness, which the statute directed had to be measured as well.

Any cost methodology has to assess a provider’s “total cost of care”—a technically daunting exercise. Not only service prices must be measured (those actually paid the provider, not billed charges), but also how efficiently the provider uses services to achieve its contribution to a given patient outcome, which can involve multiple providers. Like outcomes-based quality assessment, it has to be risk-adjusted for the patient population served.

The department, after considering proposals from multiple bidders, hired Mathematica to work with providers, plans and community stakeholders to develop such a cost assessment method and combine it with quality assessment to rate each provider grouping’s quality and efficiency. The department and Mathematica chose an approach called Provider Peer Grouping (PPG), and it appeared to have considerable promise but would require lengthy and challenging development.

In 2011 the department issued its first preliminary report (released only to the hospitals for review) rating hospitals based on cost and quality—hot-housed to this stage of development in a remarkable four years. These early results appeared rather off the mark, and shortcomings in technical methods became evident to both private and department participants. The department has aggressively set to work to iron out these deficiencies. Despite the department’s considerable effort soliciting provider input, technical experts among providers and plans presently appear to feel the process has been too piecemeal, and the methods too incompletely published, to understand or feel comfortable with the PPG methodology yet. The preliminary results alarmed some providers, who argued assessment should be stopped. But wiser provider leaders, such as Dr. David Abelson, CEO of Park Nicollet, publicly stated that assessment development should not be stopped; providers simply

MNCM incorporates; broadens its board to include providers, employers, labor and government; and steadily expands the scope of conditions being measured for quality of care. Providers are found to steadily and measurably improve their quality in response.

A health insurance exchange bill proposed by Gov. Tim Pawlenty fails to pass. A compromise at the end of session creates a Health Care Transformation Task Force to advise the governor and Legislature on the creation of a plan for reforming the health care system to improve affordability, quality and access.

Task force releases recommendations, makes proposals to Legislature. Legislature enacts health reforms drawing on the recommendations. Makes pursuit of better quality at lower cost the state policy.

In absence of any available reliable metric to measure cost and efficiency by provider, the state initiates development of Provider Peer Grouping (PPG), a new metric for this purpose.

2004

2007

2008

2009

want methods that are accurate and transparent, totally open to all for scrutiny of validity.

### AN NQF-ENDORSED TOTAL COST OF CARE METRIC

Just this past January, a totally new and unexpected opportunity has emerged. The National Quality Forum (NQF), the pre-eminent body that rigorously examines provider quality assessment methods, has endorsed its first Total Cost of Care metric. In the past few years, the quality of care movement has embraced cost as part of provider and health plan assessment on grounds that excessive cost denies too many patients coverage and access to quality health care. The combination of patient outcome, patient satisfaction and lower cost has come to be known in this movement as the Triple Aim. But no accepted rigorous method for cost assessment had come out until this year. As it turns out, the newly endorsed metric is also of Minnesota origin (perhaps we should not be surprised).

HealthPartners has continued to steadfastly champion more and better public assessment. To advance pursuit of the triple aim nationally and to help MNMCM in particular add cost assessment to its repertoire, Sue Knudson, vice president of HealthPartners' informatics group, was given the task of generalizing, for use by others, HealthPartners' own internal Total Cost of Care metric, used and refined over a decade of work. This generalized Total Cost of Care metric was to be submitted to the NQF evaluation process, and made available for free and in the public domain if endorsed, as a major advance and contribution to the field. The metric was put through NQF's technical wringer and it passed and was then endorsed with flying colors—a truly major accomplishment. It is the first and only Total Cost of Care metric to meet any such rigorous and public test. It is now being put through the careful consensus examination process at MNMCM to win provider and board approval for its use in provider assessment.

### RESURFACING OF A MINNESOTA HEALTH INSURANCE EXCHANGE

Pawlenty was not the only one who believed a health insurance exchange was a smart idea, and it has walked in through another door. Congress incorporated a mandate for state health insurance exchanges in the new federal Affordable Care Act. The State Department of Commerce is now leading a process to design Minnesota's exchange.

A critical role for the exchange can be setting of rules for effective competition. At present, health plans can—and many do—compete in highly undesirable ways. The most flagrant is

cherry-picking—that is, keeping premiums low by excluding employer groups and individuals who are sick, or segregating them into prohibitively expensive policies. But there are many other undesirable competitive practices.

Ideally, we suggest cost competition among health plans should be limited to just five legitimate objectives, and all other means forbidden by appropriate law and regulation:

- Financial protection.
- Encouraging healthy behavior and preventive care among their insured.
- Incenting the insured toward providers who are better for less.
- Administrative cost efficiency.
- Consumer satisfaction.

An ideal place to begin such regulation is a Minnesota-based exchange, designed for this purpose.

### MOVING FORWARD

Over the past 20 years, innovative private and public sector leadership has built the capacity to put Minnesota in a position to lead the nation on system reform in health care. This brief look back is based on individuals' recollections and, while generally accurate, would benefit from a more rigorous historical study. Others might have somewhat different recollections, and we apologize that in this brief review we could not mention the many others who also played important roles.

Due to the uncommon vision of so many of its private and public leaders over the past two decades, Minnesota now finds itself in a remarkably advanced stage on health care system reform. All the pieces to complete the job are in place and under development. But the most crucial accomplishment that puts Minnesota ahead has been the growing understanding (and subsequent culture shift) among all the stakeholders that tinkering isn't enough and redesign of the health care system is necessary, and that redesign must include objective assessment to publicly rate providers on quality and cost and incentives to reward providers who are better for less. ●

Walter McClure, PhD., is chairman and senior fellow at the Center for Policy Studies, a nonprofit, nonpartisan policy design organization based in St. Paul. Tim McDonald is a fellow at the Center. Both are Citizens League members.

This article is abridged. The full article, including a discussion of next steps for the state, may be found on the web site of the Center's health care project, [www.HealthcareEvolving.org](http://www.HealthcareEvolving.org).

McClure describes a general theory for system reform titled Large System Architecture, distilled from lessons in health care from 1970s and '80s. The Informed Consumer Choice strategy (ICC) is presented as the theory's practical application to health care system reform.

Preliminary results with the PPG metric are released; problems arise from inaccuracy of results and nontransparency of methods. Recognizing PPG is not yet ready, Legislature removes 2008 law's requirement that everyone must use it.

After a grueling months-long assessment by technical experts, a new Total Cost of Care metric developed and submitted by Sue Knudson of HealthPartners and her team becomes the first and to-date only such measure of provider cost to win official endorsement by the eminent National Quality Forum.





# Outlook on Minnesota's health reform efforts

The Minnesota Department of Health's multi-phase effort

By Ellen Benavides

Minnesota has been working on health care reform for years to achieve the long-term goals of better health care, lower costs and healthier communities. Our landmark 2008 legislation was passed as a bipartisan effort supported by DFL lawmakers and Gov. Tim Pawlenty. Lawmakers recognized that although Minnesota's health care system was one of the best in the country, it still confronted uneven quality, a void of information for consumers and unsustainable cost increases for state government and the private sector. Lawmakers concluded that the solution was to prevent disease through increased public health investments and to transform the health care system into one that ultimately would pay for value (health at an affordable cost) instead of volume (number of doctor visits or procedures). This led to the implementation of several initiatives including:

- The Statewide Health Improvement Program (SHIP)
- Health Care Homes
- Statewide Quality Measurement System
- Provider Peer Grouping

At about the same time, Minnesota also passed legislation designed to move providers from paper to electronic health records. In 2009, an e-prescribing mandate was passed that required providers, purchasers and pharmacies to prescribe medications electronically by Jan. 1, 2011. The state also passed a health records interoperability mandate that calls for all hospitals and health care providers to have in place a statewide system by 2015 that will allow them to exchange medical information.

The Affordable Care Act, passed in March 2010, complemented Minnesota's own reforms. Minnesota's efforts focused primarily on controlling costs through preventing illness and reforming the care delivery system, whereas the federal act placed more emphasis on reforming the health insurance market and providing insurance to Americans.

The federal reforms have allowed Minnesota to start building a health insurance exchange, shift about 100,000 Minnesotans from exclusively state-funded programs to Medicaid and test new ways to compensate providers for caring for Medicaid enrollees, through the Accountable Care Organization demonstration project. Here is a look at how some of Minnesota's specific reform efforts have matured since 2008 and will continue to converge with federal efforts.

## HEALTH CARE HOMES

The state's health care home initiative is having a significant impact on primary care delivery in Minnesota with about 20 percent of the state's clinics being certified health care homes and

about 2 million Minnesotans (38 percent) receiving care at a certified health care home clinic.

A health care home is a primary care clinic or provider offering personalized care in partnership with a team of providers and specialists to improve health and meet the needs of a patient. To be certified, a health care home must meet criteria such as offering 24-hour access to care, care coordination services, a team-based approach and the ability to track patients and provide health

reminders. The goal of the health care home program is to transform Minnesota's primary care clinics so they have the resources to help patients meet their health goals. A health care home usually has a care coordinator, a social worker or another staff member who helps the patient create a care plan and shares information and coordinates activities with specialists. A

health care home also has the technical expertise to track patients and follow up with them as they attempt to reach goals such as losing weight or quitting smoking.

The program has made great progress, but the model still faces financial challenges. The Minnesota Department of Health (MDH) certifies clinics as health care homes, and the Department of Human Services reimburses clinics an additional \$10 to \$60 a month per patient with a chronic condition who is insured through a public program and declares the clinic a health care home. Minnesota's health care home efforts have also been expanded to include Medicare recipients. However, there is need for more financial support from private payers and a simplified payment method. Some insurers are pursuing creative ways to fund health care homes through contracts where the clinics are responsible for managing the health of patients with diabetes, for example. The insurer and the clinic then share any savings that accrue from keeping patients healthy and out of the hospital. We at MDH believe that the health care home program will serve as the foundation upon which providers can build Accountable Care Organizations.

## STATEWIDE HEALTH IMPROVEMENT PROGRAM

If we think of health care costs as a river that flows downstream to primary care clinics and eventually hospitalization, the goal of the Statewide Health Improvement Program (SHIP) is to keep Minnesotans from ever falling into that river by improving the health of the population by lowering tobacco use and fighting obesity.

SHIP does this by working with schools, communities, businesses and clinics to implement proven strategies that help Minnesotans avoid tobacco use or obesity. An example from the smoking front is that SHIP works with colleges or apartment buildings interested in becoming smoke-free. To combat childhood obesity, SHIP works with schools to improve nutrition by serving

A key goal is making sure everyone can afford to see a doctor or nurse and have access to preventive services.

more fruits and vegetables and to increase physical activity through efforts such as creating safe routes for biking or walking to school.

SHIP recently released impressive results from its first two years of operation. During the program's first round of funding in 2009, every county received part of the \$47 million investment. However, in 2011, the program's funding was significantly reduced to \$15 million, and it no longer has statewide reach. MDH will recommend increased funding and returning SHIP to a program with statewide impact in 2013, when the Legislature will debate whether to authorize additional funding for the program.

We also need to better integrate clinics and hospitals with traditional social services offered by communities, such as mental health, housing, transportation, food, training and employment assistance.

#### QUALITY REPORTING, PEER GROUPING AND PAY-FOR-PERFORMANCE

The 2008 law created the Statewide Quality Reporting and Measurement System that requires clinics and hospitals to provide the state with data about the quality of care they are providing to patients. This has resulted in the creation of a set of statewide measures for patient experience, health information technology (HIT), diabetes, heart disease, asthma, colorectal cancer screening, and cesarean sections. Minnesota's insurers can only require providers to submit data for those measures that are part of the statewide reporting system. MDH contracts with Minnesota Community Measurement to collect data. Minnesota issued its first report about the quality of care in hospitals and clinics in 2010.

This quality data is then used by Minnesota's Quality Incentive Payment System to create a pay-for-performance framework for clinics and doctors. The state employee health plan and state health insurance programs, Medical Assistance and MinnesotaCare, have used this pay-for-performance program since 2010. Clinics and hospitals receive additional payments depending on the quality of care they are providing related to conditions such as diabetes, depression and heart disease. MDH also encourages private insurers to use Minnesota's Quality Improvement System.

The state health department has also been developing a system, known as Provider Peer Grouping, for publicly comparing the cost

and quality performance of Minnesota's clinics and hospitals. To do this, MDH will provide this data to the public, through the Minnesota health insurance exchange and other means, to allow them to make smarter health care decisions when choosing an insurer or a clinic or hospital.

#### E-HEALTH

Around the same time that health reform passed, Minnesota passed significant e-health measures including a mandate that doctors, hospitals, other providers and pharmacies have systems in place by 2011 allowing them to write and fulfill prescriptions electronically. The state also passed a mandate requiring the creation of a system that would allow providers to exchange health records information electronically by 2015.

Minnesota has made great progress meeting the e-prescribing mandate. For example, 90 percent of pharmacies and 68 percent of clinics were e-prescribing in 2011, though only 39 percent of hospitals and 3 percent of nursing homes have achieved the goal. MDH continues to pursue the e-prescribing goal through a collaborative, rather than punitive, approach to working with providers.

Progress has also been made with partners to achieve the state-wide interoperability mandate by 2015. MDH has been supporting an open market strategy for a secure health information exchange that allows for private sector innovation and initiative and uses government oversight to assure fair practices and compliance with state privacy protections.

These efforts have contributed to Minnesota becoming a leader in the move from paper to electronic health records (EHRs). An EHR is defined as a real-time patient record with access to information that can be used to aid clinicians in decision making. In 2011, EHR adoption rates were 69 percent for nursing homes, 72 percent for clinics and 93 percent for hospitals.

#### HEALTHY COMMUNITIES AND PRACTICES

Moving forward, MDH will continue to focus its reform efforts on improving clinical care and the health of our communities. A key goal is making sure everyone can afford to see a doctor or nurse and have access to preventive services. We will provide quality data to providers and consumers, promote e-health and continue to lead the transformation of primary care by advocating for effective team-care approaches such as health care homes. As part of these efforts, we will promote a significant shift in clinical care that invests more in primary care. We also need to better integrate clinics and hospitals with traditional social services offered by communities, such as mental health, housing, transportation, food, training and employment assistance. ●

Ellen Benavides is an assistant commissioner at the Minnesota Department of Health.



## Supporting the Triple Aim through public reporting

Tracking the progress of health care reform

By Jim Chase

There is an old saying: If you don't know where you are going, any road will get you there. As we seek to reform our health care system, we need to track our progress in three essential aspects, known as the Triple Aim: cost, quality and patient experience of care.

True health care reform cannot occur without addressing all three elements of the Triple Aim, as noted by those who coined the phrase:

"The United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the 'Triple Aim': improving the individual experience of care; improving the health of populations; and reducing the per-capita cost of care," wrote Donald M. Berwick, Thomas W. Nolan and John Wittington in the journal *Health Affairs* in 2008.

Minnesota is fortunate to have such a broad base of engaged organizations and the right tools to pursue reform across all elements of the Triple Aim.

It's easy to see the importance of balancing those three elements. High-quality care that improves community health must be affordable and delivered in a way that meets patients' needs, fostering trust and increasing engagement in their health. But achieving these aims requires more than technical solutions; it won't come from fancier electronic records or new medical devices. The biggest challenge will be to motivate everyone to change while staying focused on what is important for patients and the public.

Minnesotans are well-positioned to lead the way because we have a history of working together. Transparency, such as that provided by Minnesota Community Measurement's public reporting initiatives, can help ensure that everyone has the information needed to advance reform. It is only through agreeing on how to measure our progress and comparing where we are to where we have been that we can continue to improve.

In Minnesota, we have pioneered collaborative health care quality reporting: building a set of 76 measures that are widely accepted and aligned across all payers and providers; establishing a process that allows efficient collection of quality and cost data for measures from hospitals, medical groups and health plans; and reporting the results to health care providers and the public on more than 672 sites of care. Our measures have received national endorsement from the National Quality Forum, and Medicare now

uses our measures nationwide for its value-based purchasing initiatives. As importantly, our measures allow Minnesotans to make apples-to-apples comparisons about quality at the clinic level and they are used by providers to improve care and by payers to reward better results.

An important aspect of supporting reform in Minnesota is publicly reporting on the elements of the Triple Aim. We have seen the steady quality improvements that are possible through collaboratively developing and publicly reporting information on the quality of care. We now have the opportunity to provide more robust information on other aspects of the Triple Aim by enhancing our patient-experience and cost-of-care reporting.

In 2010, 110 clinics reported on patient experience of care in Minnesota; by next year, that number will be more than 850 clinics. This information is essential not only to improving patient experiences, but also to ensure that changes affecting cost and quality of care take patient needs into account.

We are also developing a standardized method for measuring the total cost of care for patients treated by each provider group. As the number of high-deductible plans grow, consumers are recognizing the need for better information on all of their costs of care, not just their copayments, in order to make better choices about their care options and find better value for each health care dollar they spend.

This commitment to public reporting of the Triple Aim can contribute significantly to Minnesota's reform efforts because:

- Patients need better information to choose and achieve optimal care.
- Providers benefit from comparing their performance to others. Indeed, it is an important factor driving the consistent increase in performance MN Community Measurement has observed in the quality measures.
- Purchasers are using measures to recognize and reward providers that achieve better results for their patients.
- Policy makers need this information to understand what works for people. For example, evaluating options that would expand access to health care homes or foster patient engagement through electronic means requires data on cost, quality and patient experience.

Minnesota is fortunate to have such a broad base of engaged organizations and the right tools to pursue reform across all elements of the Triple Aim. MN Community Measurement is proud to contribute to the effort. We know that this process will require the commitment and drive of a broad group of Minnesotans, but it will benefit all of us. Why? With a high-value health system, everyone wins. ●

Jim Chase is president of Minnesota Community Measurement, a collaborative effort to accelerate the improvement of health by publicly reporting health care information.



# Health care reform in Minnesota: What's wrong with this picture?

Why new voices are needed to achieve equitable reform

By Monica Hurtado

**W**e know health care reform is not going to solve all the challenges of our system, but we also know it is a step in the right direction. People are now paying more attention to the fact that some patients receive much lower-quality care than others—and often the difference is due to race or poverty. Despite the additional attention, something remains wrong with the health care reform picture, and I hope that it is not too late to fix it.

Health care reform is about power and control. We all want power in our lives, but what happens when those in power want to stay in power and keep control of the things that affect them? When it comes to our health care system, the differences in power and control are striking. Whether you're talking about lobbyists at the Capitol, members of state government advisory

Imagine the difference in patient outcomes between a diabetic who is homeless, has no place to keep diabetic supplies and has no money to buy healthy food, compared with “mainstream” patients.

committees or people who contribute to political campaigns, the dominance of a few large health care corporations and special interests is overwhelming.

Take a look at the representation on the current state advisory committees on health care reform and you will find many representatives of a few large health care corporations and special interests and only a handful of people representing the interests of the general consumer or of smaller nonprofit organizations that specialize in working with patients of color and people living in poverty.

The dominant theme in the current health care reform efforts is accountability—the admirable goal of measuring the quality and cost of care provided by doctors, clinics and hospitals and then tying payment (profit) to achieving quality and cost goals. This is a great goal! Wouldn't it be wonderful if, rather than competing to make more money by providing expensive care to treat preventable illnesses, health care providers competed to keep their patients healthy at the lowest possible cost?

Unfortunately, the disparity in power and representation will perpetuate or even increase health disparities for people and providers who do not have power and money. What's wrong with this picture is that the same people who have controlled our health care system in the past are designing the reforms that are

supposed to rectify the problems and reduce the health disparities that are part of our current system. Even though the goals of health care reform are laudable, will things really change for the better if the same people continue to make decisions affecting us all?

Imagine the difference in patient outcomes between a diabetic who is homeless, has no place to keep diabetic supplies and has no money to buy healthy food, compared with “mainstream” patients. Imagine the difference if this same diabetic only recently immigrated to the U.S. as a refugee from a war-torn country and does not speak English. Is it lower-quality care if the clinics who choose to serve these patients—and also who choose to provide additional services such as arranging housing or interpreters—have patients whose treatment outcomes are not as optimal as “mainstream” patients? Should they receive lower quality scores and be penalized financially because they serve these patients?

This can happen. Take a look at who serves on the committees and work groups that are designing our new system. Of 112 seats on 10 different state health care reform task forces, working groups and advisory committees, only five persons represent consumers, and of these, only two represent racial or ethnic minorities. Only two of the 44 health care provider slots are safety net-providers who serve primarily low-income and diverse populations, even though this population is the primary focus of the state's health care programs and services. Only six out of 112 seats are held by people of color.

Despite the minimal representation of consumers, people of color and safety net providers, several large providers and interests that dominate our current system have three or more representatives each. Those who are designing health care reforms that are supposed to fix our ailing system are the same corporations and special interests who control the current system.

If we want a health care system that works for everyone and if we truly want to eliminate the inequities that exist in our current health care system, it is essential that the patients, communities and health care providers who are discriminated against in the current system have the opportunity to share their knowledge and expertise and be part of the decision-making body that is shaping the future health care system.

If this is not the case, then the decisions made by the people designing our new health care system, defining quality, dividing up the money and control, and making decisions that will affect our health care for decades into the future, will have a discriminatory impact, even if there is no discriminatory intent.

Avoiding this requires new terms of engagement in health care reform that can overcome the formidable barriers of poverty, language, race and culture that make it so difficult for those with less power to have an impact. It takes extra effort, but the result will be worth it. ●

Monica Hurtado is executive director of ARCHÉ, the Alliance for Racial and Cultural Health Equity.



# “Reform” and the tectonic plates of health care

Why reform must continue regardless of political posturing

By David J. Abelson, MD

The outer crust of the earth consists of continent-size plates approximately 60 miles thick. From day to day, we consider these massive earthen plates as our bedrock, providing the illusion of an unmoving and unchanging foundation upon which we build our lives. In truth, these plates float, move and bump against each other, resulting in sudden shifts that release pent-up energy, such as earthquakes or volcanoes.

There are tectonic plates in health care, and they are sending out tremors right now warning us of instability and change.

Spiraling health care costs fuel the tremors that threaten the foundation of household, state and national budgets. Health and Human Services (HHS) currently makes up a third of Minnesota’s budget, its fastest-growing segment. Nationally, Medicare and

Illness or medical bills contributed to 62.1 percent of personal bankruptcies in 2007, up from 8 percent in 1981.

Medicaid cost \$826 billion per year and are the largest items in the federal budget. Medicare and Medicaid also are projected to grow faster than the gross domestic product (GDP) and will make up a larger share of projected future deficits and public debt.

Total health care costs are projected to grow from 17 percent of GDP in 2012 to 25 percent by 2025, jeopardizing our ability to fund other social needs including military, education and infrastructure while driving public debt to unsustainable levels. Health care expenses are also the most common contributing causes of individual bankruptcy in the United States. According to a study in the American Journal of Medicine, illness or medical bills contributed to 62.1 percent of personal bankruptcies in 2007, up from 8 percent in 1981.

Making matters worse, it is hard to discuss reform in our volcanic political environment when the word itself has become a trigger for toxic partisan argument. Using reform as a noun (think “Obamacare” or “Romneycare”) instead of a verb (“to improve through change”) goes beyond mere linguistics when reform is used as a metaphor to lull people into believing that change in health care is a political process that can be stopped by a court decision or an election. It cannot. Historic and transformational changes in health care delivery are already here (e.g., shared savings, assumption of risk). More are coming.

There are many entities involved in the health care process, each inhabiting their own tectonic plates: individuals, families, employers, health plans, pharmaceutical companies, medical device manufacturers, providers and health care delivery systems. Each entity has incentives that conflict with the other entities. None is rewarded for simultaneously achieving the goals of the

Triple Aim: healthy communities with great experiences and outcomes for individuals provided at a sustainable cost.

We must move to a system that aligns incentives for all entities to work toward and achieve the common goals of the Triple Aim. Although health care competition is fierce, competition is around the wrong things—providing more services (regardless of benefit) in increasingly expensive facilities. For example, hospitals are rewarded for filling beds when their incentive should be to keep people healthy and in their own homes.

Here is a starter list of where we need to provide the right kind of health care incentives:

- Universal access to care is necessary to achieve healthy communities and prevent pricing failures. Otherwise, competition is focused on treating those with excellent coverage and avoiding coverage for those in poor health that need it most, such as people with cancer.
- Government must invest more in public health for healthy communities and create incentives for healthy behavior and disincentives for non-healthy behavior (e.g., cigarette taxes).
- Individuals need to participate more in the cost of care, as they are currently with large deductibles and with those that pay directly for insurance premiums.
- Payers (government, insurers and employers) need to reward health care providers based on the value they bring to achieving the three goals, not on the number of services they generate.
- We need a transparent marketplace that rewards entities with more business when they compete around the three goals. In other words, we must align doing well with doing right.

In order to fully meet consumer needs, the health care marketplace must be subject to a uniform set of market rules that hold every entity accountable. Health care is a unique market where its products and services are critical for quality of life (and, in some instances, life itself). Yet no marketplace provides as little transparency as health care. As more costs are shifted to individual consumers, transparency will become increasingly important.

None of these component strategies of reform will succeed unless patients are kept at the center of everything we do. All the players (and payers) in the health care marketplace must collaborate to arrive at the same destination of quality care at affordable prices with an optimal experience. If we can’t bring quality up, prices down and meet the expectations of our patients, then we all fail.

The health care industry spends too much time, energy and resources worrying about the potential impact of health care reform rather than preparing for it. If we wait until tremors turn into earthquakes, the challenge only becomes worse. Reform by any other name is still inevitable. Let’s embrace effective change and improve the health care experience for everyone. ●

David J. Abelson, MD, is president and chief executive officer of Park Nicollet Health Services. You can read more of Dr. Abelson’s views on health care at his blog site, [DrAbelsonConnects.tumblr.com](http://DrAbelsonConnects.tumblr.com).



## Medicaid's place in health care reform

Better outcomes for more people at a lower cost

By Scott Leitz

Minnesota has a long and proud history of health reform. From the groundbreaking MinnesotaCare reforms of the 1990s to the landmark 2008 health care reform law, these reforms have led to Minnesota having an uninsured rate among the nation's lowest and a health system that has lower costs compared with many states.

Medicaid, the federal and state program designed to ensure coverage for those with low incomes, has played a key part in these successes in Minnesota. In 2014, Medicaid's role in Minnesota's health care system will expand substantially, as full implementation of the Affordable Care Act (ACA) will increase the number of Minnesotans eligible for Medicaid.

The Dayton administration has set two key objectives as it relates to health care under the Medicaid program: First, we want to ensure that health coverage and access for those in need is preserved and expanded, and second, we want to improve and reform how we pay for health care services to achieve enhanced outcomes for Medicaid enrollees at lower costs.

### EXPANDING ACCESS

Minnesota's history of ensuring access to coverage is impressive. Through a series of incremental expansions, eligibility for parents and children in Minnesota's public insurance programs goes up to 275 percent of the federal poverty guidelines. Gov. Mark Dayton continued this tradition when he signed an executive order shortly after taking office extending Medicaid coverage to childless adults under 75 percent of poverty, bringing coverage to an estimated additional 100,000 people.

Under the ACA, coverage will be expanded through the Medicaid program and through subsidies to individuals to purchase coverage through the newly established Health Insurance Exchanges. Adults without children will be eligible for Medicaid coverage up to 133 percent of poverty, while those with incomes between 133 percent and 400 percent of poverty will have subsidies available to them to purchase coverage in the exchange.

With the coming Medicaid expansions, there is a strong desire for Medicaid to become a wiser purchaser of health care services to ensure the expansions are sustainable. To do that, The Department of Human Services has focused on reforming and improving how we purchase health care for Medicaid. We've done that by improving how we contract for managed care plans and by working with providers on payment and care delivery reforms.

### CREATING COMPETITION

Our initial focus upon taking office was on changing methods of procurement for managed care contracts. Most Minnesotans on Medicaid receive their coverage through managed care plans, a method that has worked well to ensure access to care. However, our methods of contracting with managed care plans had not kept up with recent developments, using an administrative rate-setting process that didn't allow for competition among plans.

We changed this process for 2012 by moving to a system where plans competitively bid against each other. This bidding process resulted in nearly \$200 million in budgetary savings while also preserving access to services for Minnesotans.

### ACCOUNTABLE CARE

We have also moved rapidly to adopt and implement accountable care for providers in Minnesota's Medicaid program. Today, providers are paid primarily based on the volume of services they provide, rather than the cost and quality outcomes they achieve.

Starting this summer, under our Health Care Delivery System Demonstration program, this will change. Providers and Medicaid will mutually agree upon quality and cost targets, and if providers are able to meet or beat those targets (bringing better health outcomes at lower cost), they will share in the cost savings. This allows them to implement care delivery innovations that lower health care costs and improve outcomes, while being able to benefit financially from those innovations. The state and Medicaid enrollees benefit with lower health care costs and better patient health outcomes. There are nine provider organizations serving more than 150,000 Medicaid enrollees taking part in this three-year demonstration.

### COORDINATED CARE

We have also entered into a program with Hennepin County called Hennepin Health. Under this program, DHS pays Hennepin County a monthly per-enrollee capitation payment the same way it pays managed care organizations. The county in return enrolls very low income Medicaid enrollees (below 75 percent of poverty) in a network of services designed to meet their physical health, mental health and social service needs. By integrating the payment and delivery of services across the spectrum of Medicaid enrollees' needs, we anticipate both improved health and social outcomes, with lower costs to both DHS and the county.

We intend to expand these models into the future. Many of Minnesota's Medicaid enrollees are elderly or disabled and require not just acute care services but also long-term care and other supportive services. They frequently also need mental health services. As we look to the future, we will be exploring ways to ensure that financing and delivery models for acute and long-term care services are better coordinated, and that we successfully integrate mental health with primary care.

Minnesota needs to continue to forge our path on health reform, and Medicaid intends to be a key partner and driver of reforms. ●

Scott Leitz is assistant commissioner of health care at the Minnesota Department of Human Services. He oversees Minnesota's Medicaid program.

# PERSPECTIVES

Expanding Minnesota's Conversation



## Making Minnesota a leading-edge state

A call for civic leadership

By Verne Johnson

The 60th anniversary of the Citizens League is an opportunity to look to the future. We cannot rest on what we have, because times are changing.

Since my time as director of the Citizens League, politics have grown more confrontational. I think this is in part because we don't have a clear idea about our direction. We lack a vision, and without a vision you can't know where you are going.

Our concept for the future should include making Minnesota a leading-edge state. This will not happen through our taxing or spending—the most common topics that divide us—but by what we do and how we do it. We must strive for the opportunity to change, recognizing now that we cannot cut or tax our way to greatness. We need to redesign.

Leadership must be shown by the executive, term after term. Gov. Mark Dayton demonstrated with the recent stadium debate what vision and leadership from the state's executive can do. The Legislature is an essential and important partner, but nothing in government surpasses the capacity of the position of governor to set a vision and drive it.

But leadership also needs to come from business. When former Citizens League

president and board member Jim Hetland passed this spring, Minnesota lost a brilliant man, and I lost a friend and colleague of 50 years. Reflecting on his life, I was reminded about the nature of civic leadership and my days at the League: It is about professionals and executives getting involved themselves, not relegating “community involvement” to public relations or making donations and ending their commitment there.

When I decided at age 55 to retire as vice president at General Mills, they asked me to identify a project for the public good and direct it for one year. The company had done this before with Stevens Court, a successful housing project in Minneapolis that empowered people to live with dignity, improved a neighborhood and was financially self-sustaining. Our CEO was proud of what they had accomplished with Stevens Court in applying business principles to doing public good.

The project we agreed upon was to provide care options for older citizens who were no longer able to live on their own but did not yet need a nursing home. This was a present and growing problem for families and the government. General Mills made the project a priority among its executive leadership, and professionals

within the company made it part of their portfolios. What emerged was Elder Homestead and the organization Altcare—the first of what came to be known as assisted living facilities. I stayed for 10 years as CEO, and by the end it was in the black and sustainable. People's lives improved, families and taxpayers saved money, and Minnesota again—as it has in so many areas—led the nation in the development of a new theme.

We need new generations to come in to redesign, to find creative ideas for organizations or for policy. Education and health care provide two of the most pressing opportunities. They are two prime examples of areas where Minnesota is already No. 1, but not as good as we can be or need to be. We can lead the country, and people will follow.

We need to recognize that the future is full of opportunity and we need to seize it. Minnesota needs leadership and vision if it is to continue to be a leading-edge state. Without leadership, the politicians dither. It's time that business leadership, foundations and other civic organizations re-engage in the work of redesign. ●

Verne Johnson was the executive director of the Citizens League from 1958-1967 and is a member.

## 60 years of impact through innovation

A former state legislator, Verne Johnson led the Citizens League as executive director from 1958 to 1967 and subsequently served as board president. During Johnson's tenure, the Citizens League's ability to positively influence policy in the state grew immensely, and it broadened its focus to affect the entire state of Minnesota.

In the early days of the Citizens League, Verne Johnson and his contemporaries imagined new roles for citizens, and generated innovative and seemingly impossible policy ideas. Johnson passed along a knack for innovative thinking to his son, Ron, who will be the featured speaker at the Citizens League's Civic Celebration event this October. Now CEO of J. C. Penney, Ron Johnson has created some of the most significant retail concepts in a generation.

He is recognized for bringing affordable versions of designer products into Target Stores and pioneered the concept of the Apple Stores and their Genius Bars.

On Oct. 25, Ron Johnson will share lessons on innovation and imagination he learned from his father and from his retail successes. He will also describe how, as the Citizens League believes, all individuals and all organizations can and must be involved in innovating and generating new policy solutions. This is what we call civic policy making.

Join us to celebrate the Citizens League's 60 years of accomplishments for Minnesota, and to look ahead to a new generation of policy innovation.

# Celebrate 60 years of impact through innovation!

How can successful retail concepts introduced at Apple and Target involve citizens in generating solutions to public problems?

**Find out on Oct. 25 at the Civic Celebration**

**Doors 5:30 PM | Program 6:30 PM**

**Nicollet Island Pavilion**

**40 Power Street, Minneapolis, MN 55401**

Keynote: Ron Johnson, CEO of J.C. Penney, and creator of some of the most significant retail concepts in a generation.

***Register now [civiccelebration.eventbrite.com](http://civiccelebration.eventbrite.com).***

PERIODICALS



213 Fourth Street East, Suite 425  
St. Paul, MN 55101

**The Minnesota Journal**  
Publisher – Sean Kershaw  
Editor – Larry Schumacher  
Managing Editor – Bob DeBoer  
Board Chair – Nena Street

The Minnesota Journal (ISSN 0741-9449) is a publication of the Citizens League, a nonprofit nonpartisan Twin Cities public affairs organization.

213 Fourth Street East, Suite 425, St. Paul, MN 55101.  
Phone: (651) 293-0575, Fax: (651) 293-0576.  
Email: [info@citizensleague.org](mailto:info@citizensleague.org).

Articles and commentary are drawn from a broad range of perspectives and do not necessarily reflect Citizens League positions.

The Minnesota Journal is published six times a year. Periodicals postage paid at Saint Paul, MN and additional offices.

Annual subscription rate for nonmembers is \$25. To order call 651-293-0575 or email [info@citizensleague.org](mailto:info@citizensleague.org).

Postmaster: Send address changes to the Minnesota Journal, 213 Fourth Street East, Suite 425, St. Paul, MN 55101.