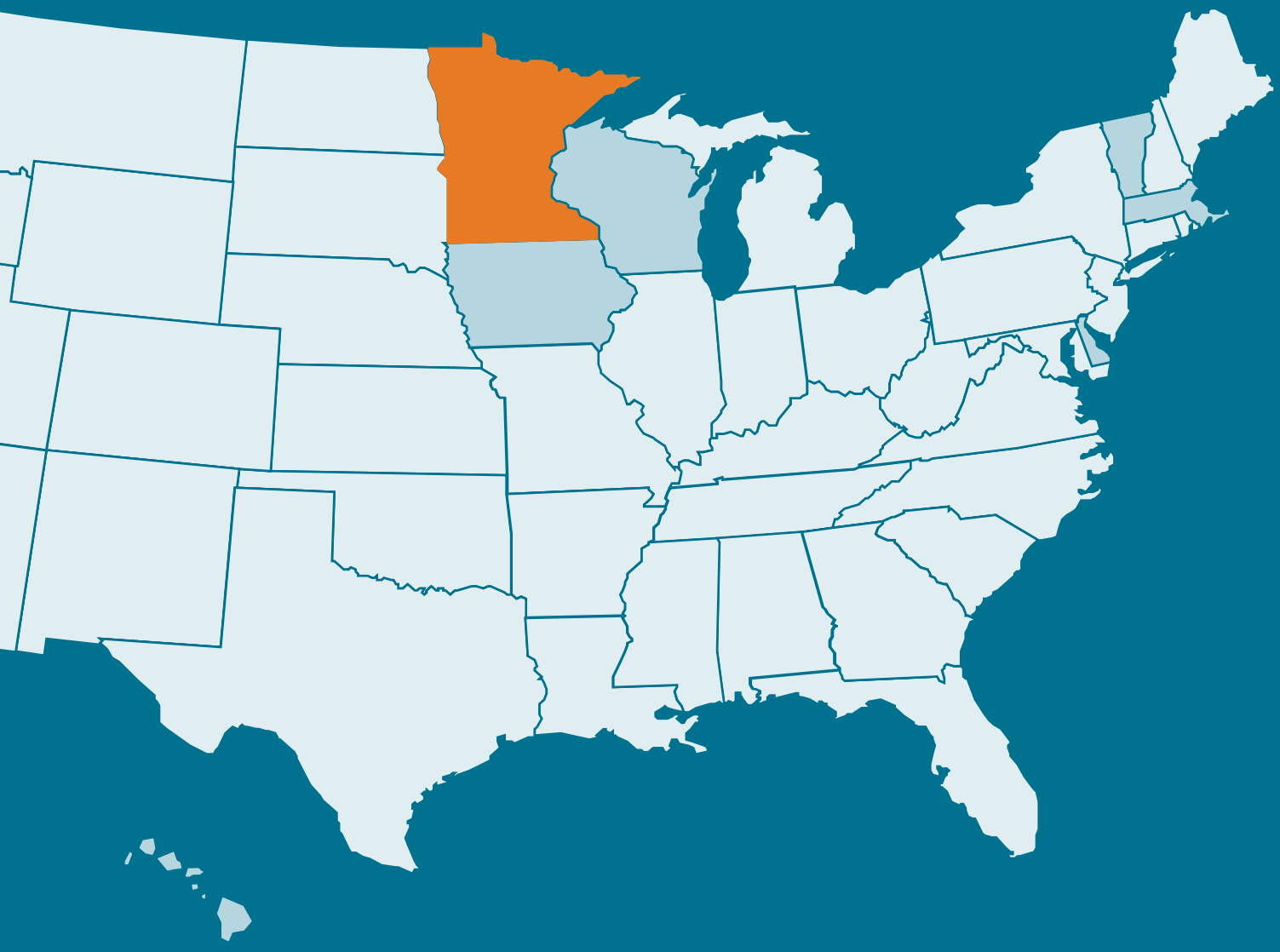
AIMING HIGHER FOR HEALTH SYSTEM PERFORMANCE

A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard: Minnesota



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Aiming Higher for Health System Performance: *A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009* State Scorecard: Minnesota

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Minnesota: Land of 10,000 Collaborations

Minnesota has the nation's healthiest population, according to the *State Scorecard,* and a historically strong and inclusive health insurance system, both through employers and public programs. The health care marketplace in Minnesota is characterized by its nonprofit health plans and physician-led, integrated group practices, both of which seem naturally oriented toward collaboration. Over the past two decades, numerous coalitions have emerged to improve health system performance: government took the lead in the early 1990s to expand coverage, employers focused on value-purchasing, providers refined well-organized systems of care, and health plans developed community measures of health system performance. These efforts have contributed to very high health system performance. Minnesota outperforms most states on 2009 *State Scorecard* measures related to access, prevention and treatment, and healthy lives (Table 7).

Setting the Stage for High Performance

Minnesota's modern health reform efforts began in 1992, with an emphasis on coverage. The stage had been set for reform when Gov. Arne Carlson (Independent-Republican) vetoed a more extensive health care reform bill a year earlier but, in his veto message, signaled that he was willing to work with the legislature on a more targeted plan. State Senator Linda Berglin (Democrat-Farmer-Labor) and others in the legislature worked with the administration to develop the plan that became MinnesotaCare, a subsidized health insurance program for low- and moderate-income Minnesota residents who are unable to access affordable insurance on their own.

Since 1992, different sectors have emerged at different times to provide leadership for health system change. There has not been a formal structure in place for health system reform, but rather informal and organic "coalitions of coalitions" that emerge, and work, and disband as the situation requires. The glue that holds the coalitions together, as some describe the process, is the progressive and neighborly outlook of the Upper Midwest. Occasionally, coalition activities reach a critical mass and need to be organized into structured reform, as they were in 1992. The most recent Minnesota health reforms, which were signed into law by Gov. Tim Pawlenty (R) in May 2008, invest in public health, modernize health system infrastructure, and propose new provider payment incentives to improve health care value.[22]

Coverage

Minnesota ranks very high (third) among states in the percent of insured nonelderly adults; only Massachusetts and Hawaii have higher rates of adult coverage. And it continues to rank among the top quartile of states for children's coverage. Minnesota also scores very high on other access measures, including adults receiving routine checkups and cost not being a barrier to care.

Minnesota has a historically strong and inclusive health insurance system. The state's rate of coverage through private insurance is very high (67.5 percent) and publicly funded programs cover another one-quarter (25.2 percent) of the population, resulting in one of the lowest uninsured rates in the nation (7.4 percent).[23] Minnesota's public officials have provided consistent leadership over the past two decades to expand and sustain coverage options through three publicly funded health insurance programs: 1) Medicaid Medical Assistance (MA), 2) state-funded General Assistance Medical Care (GAMC) for low-income individuals (primarily adult men) not eligible for Medicaid, and 3) MinnesotaCare. "These programs are critically important to close the coverage gap between Medicaid and private insurance," says

Cal Ludeman, commissioner of the Minnesota Department of Human Services, "but we never lose sight that Medicaid is the public program that is doing the heavy lifting in terms of coverage."

MinnesotaCare

MinnesotaCare is a state and federally subsidized health care program created in 1992 to provide health care to Minnesota children and adults who do not have health insurance coverage. The state made its financial commitment to the MinnesotaCare expansion *before* it was certain of federal support, by enacting a significant provider tax. Today, MinnesotaCare covers children and parents, legal guardians, foster parents, or relative caretakers up to 275 percent of the federal poverty level (Medicaid covers most children up to 170 percent of poverty and parents and caretakers up to 100 percent), and single adults and households without children up to 250 percent of poverty, some of whom are enrolled in MinnesotaCare through the GMAC program. As of April 2008, 115,000 residents (2.4 percent of Minnesota's population) received health insurance through MinnesotaCare.

MinnesotaCare enrollees are covered by several different benefit sets and all receive services through managed care. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents and adults without children are covered for most services, but are subject to benefit limitations and copayments. Premiums for children up to 150 percent of poverty are $4 per child per month. Children above 150 percent of poverty and adults pay a premium based on family size and income (the average monthly premium is $24).

Medical payments for MinnesotaCare totaled $463 million in 2008, or about $338 per enrollee per month.[24] The state covers 61 percent of MinnesotaCare program costs with revenue generated from various provider taxes on health maintenance organizations, hospitals, and other health care providers.[25] Enrollee premiums and cost-sharing cover 8 percent of program costs. The remaining 31

Table 7. State Scorecard on Health System Performance: Minnesota

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	9	4	25	11	15
Access	5	2	4	1	0
Prevention & Treatment	13	8	7	5	8
Avoidable Hospital Use & Costs of Care	10	12	6	1	3
Equity	27	17	*	*	*
Healthy Lives	5	1	8	4	4

Note: Data were available to rank Minnesota on all 38 *State Scorecard* indicators in 2009. Trend data were available for 35 indicators.
* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.
Source: The Commonwealth Fund, Oct. 2009.

percent of costs are paid by the federal government through a Medicaid Section 1115 demonstration waiver, called Prepaid Medical Assistance Project Plus (PMAP+). Minnesota was one of the early states to use an 1115 waiver to cover uninsured populations. The federal waiver, which is approved through June 2011, is a critical source of funding to sustain MinnesotaCare, worth $144 million in federal contributions annually.

Prevention and Treatment

Minnesota has made recent gains in the quality of preventive care and treatment relative to other states, improving its State Scorecard *rank to eighth in 2009 with substantial improvement on half of the indicators in this performance dimension.*

Minnesota's employers were among the first in the nation to identify great variation in health plan and provider quality. In 1988, General Mills, 3M, and other large self-insured employers in the state created a Buyer's Health Care Action Group (BHCAG) to create balance in a health care market they perceived as primarily influenced by health plans and medical providers. BHCAG challenged the state's health plans and providers to publish quality results so that consumers and employers would have the information they needed to reward optimal health plan and provider performance.

Despite some initial tension, Minnesota's health plan and provider community embraced market transparency and enhanced information as a strategy to drive quality.[26] Several factors made this possible. For example, the majority of care in Minnesota is provided through well-organized, physician-led group medical practices, most of which are fully integrated or closely aligned with a nonprofit hospital. (Several of these integrated systems, such as the Mayo Clinic, have national reputations for high performance.[27]) Strong physician leaders emerged in these practices to embrace evidence-based practice and quality reporting as the right thing to do for patients.[28] In addition, Minnesota's health plans are required by law to be nonprofit, so they have remained local entities with leaders who are in touch with community objectives. In response to BHCAG's challenge to report quality, the physicians and health plans created the Institute for Clinical Systems Improvement and MN Community Measurement.

Institute for Clinical Systems Improvement

The Institute for Clinical Systems Improvement (ICSI) was established in 1993 by HealthPartners, Mayo Clinic, and Park Nicollet Health Services to improve patient care in Minnesota through innovations in evidence-based medicine. As an independent, nonprofit organization, ICSI develops evidence-based health care guidelines and helps its members implement best clinical practices for their patients. Most Minnesota physicians (85 percent) participate in ICSI through 57 group practices, all of the health plans are involved, and business representatives also are involved in the decision-making process. ICSI is currently focused on redesigning outpatient care and exploring new methods for improving the patient-centeredness and value of care. For example, ICSI is developing recommendations for health care homes in response to 2008 health reforms, bringing medical groups and health plans together to improve care in the primary care setting for patients with depression, and launching a high-tech diagnostic imaging project that is expected to save lives and $50 million in health care costs annually.

MN Community Measurement

MN Community Measurement (MNCM) was created by Minnesota's health plans in 2004 to report statewide health care quality measures across medical groups. Using ICSI guidelines and data supplied by the health plans, MNCM measures, compares, and reports "HealthScores" for over 700 provider groups and clinics across the state. MNCM HealthScores is a community asset, used by medical groups and clinics to improve patient care, by employers and patients as information about the cost and quality of health care services, and by health plans for their pay-for-performance programs. As a result of 2008 health reforms, MNCM is working with the Minnesota Department of Health to accelerate and expand existing quality measures and to establish a state system of pay-for-performance.

Other Quality Initiatives

ICSI and MNCM put Minnesota ahead of most states in its capacity to understand what contributes to health care value and health system performance. These organizations also create a forum to discuss, test, and act on new ideas. Minnesota is famously active in national quality initiatives, including the Quality Alliance Steering Committee (QASC), Network for Regional Healthcare Improvement (NRHI), Aligning Forces for Quality (AF4Q), Bridges to Excellence, and The Leapfrog Group for Hospital Patient Safety. Also, the state has implemented a policy to not pay for certain medical mistakes, and follows pay-for-performance standards for diabetes, hospital stays, preventive care, and cardiac care. In 2008, the U.S. Department of Health and Human Services designated Minnesota a Chartered Value Exchange, a special federal distinction for strong commitment to improving quality and value in health care.

Potentially Avoidable Use of Hospitals and Costs of Care

Minnesota is among the top fifteen states on most measures related to hospital admissions and readmissions and the top state on avoiding admissions among long-stay nursing home residents. It was among the least-costly states in terms of Medicare spending per beneficiary in 2006. Employer-sponsored health insurance premiums were near the national median rate for employed individuals in 2008.

The same coalitions described above that are working to improve quality also are focused on cost control. To them, quality and cost are two sides of the same health care coin, and the goal is to strike a balance that delivers the best possible value for health care purchasers and consumers. In addition, other groups have formed specifically to focus on value purchasing. The Smart Buy Alliance, for example, is a group of public and private health care purchasers in Minnesota working together to drive greater quality and value in the market. The state also plays a major role. "We sit alongside our private sector counterparts," says Cal Ludeman, "first and foremost as a purchaser of health services." The Department of Management and Budget purchases care for about 120,000 state employees and their families through the Minnesota Advantage health benefits plan, and is ahead of most health care purchasers in using value-driven purchasing mechanisms.[29] Recently, the various coalitions that focus on both quality and cost have turned their attention to achieving better value through payment reform.

Payment Reform

Minnesota was an early leader in using payment reform to achieve better health outcomes. In 1997, for example, the state implemented Minnesota Senior Health Options (MSHO), a special managed care program that blends funds from the Medicare and Medicaid programs to improve the delivery and coordination of all Medicare and Medicaid services received by seniors who are eligible for coverage under both programs. MSHO has simplified and increased access to a broad range of services for dually eligible seniors, and resulted in significantly fewer hospital days and preventable hospitalizations compared with the traditional Medicare and Medicaid programs.[30]

Minnesota's health policy leaders generally agree that health care payment reform is the next big step to further improvement in system performance. "The system will continue to reward quantity over quality," says Scott Leitz, M.P.H., Minnesota's Assistant Commissioner of Health, "until we fix the currently dysfunctional payment system." The current federal debate about "accountable care organizations" is in part inspired by Minnesota's well-organized group medical practices. In 2008, there were efforts to move from the current fee-for-service system to one in which providers were held accountable for the total cost of care. Ultimately, however, this approach was not approved and the state's 2008 reforms took a more modest—but still important—approach to payment reform.

Minnesota's 2008 health reform establishes a single comprehensive set of provider quality metrics, requires a statewide system of quality-based incentive payments to be used by public and private health care purchasers, creates payments for care coordination to support "health care homes," and sets up a process to define "baskets of care" to bundle services together in a way that creates incentives for health care providers to cooperate and innovate to improve health care quality and reduce cost.[31] The 2008 reform also establishes a process to group providers based on their total cost of care and quality of care to develop a value index for providers that will be transparent to the public and health care purchasers. Minnesota's health experts believe Provider Peer Grouping, a common set of information about cost and quality, is an essential first step toward achieving additional payment reforms and is the powerful strategy in the short term to improve health system performance and influence redesign.

Minnesota e-Health Initiative

Minnesota is the first state in the nation to require all health care providers and group purchasers to exchange common health care business transactions electronically starting in 2009. The new requirement, which is expected to reduce health care administrative costs by more than $60 million a year, applies not only to the conventional list of health plans and providers, but also to auto insurers, chiropractors, dentists, pharmacists, workers compensation insurers, and others. In addition, the 2008 health reform requires all health care providers and payers to use an electronic prescribing system by 2011, and requires all providers to have "interoperable" electronic health records by 2015. Also, the Governor announced a goal that all Minnesota residents have the option of an online personal health portfolio by 2011, and that all state employees have this choice by the end of 2009.

Healthy Lives

Minnesota ranks among the top 12 states on all eight healthy lives indicators in the State Scorecard. *It ranks first in mortality amenable to health care and has the lowest percentage of children who are overweight or*

obese. It also has made significant strides in reducing adult smoking and is one of the few states to experience improvement (reduction) in adults reporting activity limitations.

The Minnesota Department of Health has compiled detailed reports of public health data for Minnesota and each of the state's 87 counties since 1996, and uses that information to plan prevention and wellness initiatives. In 2004, Minnesota was allocated $2.5 million annually through 2009 from the federal government's Steps to a HealthierUS program to implement chronic disease prevention efforts in Minneapolis, St. Paul, Rochester, and Willmar. Minnesota's Steps to a HealthierMN program has focused on reducing the burden of diabetes, obesity, and asthma and encouraging physical activity, good nutrition, and tobacco cessation. In 2008, HealthierMN served as the model for a new Statewide Health Improvement Program.

Statewide Health Improvement Program

While all of Minnesota's 2008 health reforms strive to improve health outcomes, an integral part of the health reform law is its public health component, the Statewide Health Improvement Program (SHIP). SHIP is a community-based effort to help Minnesota residents live longer, better, healthier lives by reducing the burden of chronic disease. In July 2009, the Minnesota Department of Health awarded $47 million over two years through SHIP to 52 community health boards and eight tribal governments across the state. Local grantees are required to create community action plans, assemble community leadership teams and partnerships, and implement interventions from a menu of proven choices to reduce the burden of obesity and tobacco use in four settings: schools, work sites, health care settings, and the community.

Conclusion

Minnesota's "coalitions of coalitions" in health care have resulted in hundreds (one state official said "thousands") of individual health care providers, business leaders, and state officials being "trained up" to wrestle with the complexities of health system change. There is not a dominant, central organization that determines health system performance or sets reform priorities. "It's all a bit messy," confides one state official. But consistently the right leaders emerge at the right time to meet specific health system challenges and, when new ideas arise, there are hundreds, perhaps thousands, of potential health policy leaders ready to step up, make sense of the issue and, working together, act to improve the system.

Notes

[22] Governor Tim Pawlenty, "The Minnesota Way," *Modern Healthcare* and The Commonwealth Fund (Jan. 2009).

[23] Minnesota Health Department Health Economics Program ("Distribution of Minnesota Population by Primary Source of Insurance Coverage, 1998 to 2006" (updated July 2009).

[24] Minnesota Department of Human Services, "Minnesota Health Care Programs" (Dec. 2008).

[25] Minnesota levies a 2 percent provider tax on physicians, hospitals, surgical centers, and wholesale drug distributors; and a 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.

[26] For one example, see D. McCarthy, K. Mueller, and I. Tillman, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda* (New York: The Commonwealth Fund, June 2009).

[27] D. McCarthy, K. Mueller, and J. Wrenn, *Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care* (New York: The Commonwealth Fund, Aug. 2009).

[28] There is growing evidence that the physician-led, integrated group practice model is particularly effective in achieving high value in terms of improving quality and controlling costs. The Commonwealth Fund recently highlighted high-performing health system sin the Midwest, including two integrated systems of care serving patients in Minnesota: Gundersen Lutheran Health System, a physician-led integrated system; and the Mayo Clinic, the world's oldest and largest integrated multispecialty group medical practice. (These case studies are available on The Commonwealth Fund's Web site.)

[29] Minnesota Advantage organizes primary care clinics into risk-adjusted cost tiers and provides financial incentives for employees to choose lower-cost providers; reduces office visit copayments if an employee participates in a health assessment; provides disease management programs; reports MN Community Measurement quality information; and participates in the Bridges to Excellence physician pay-for-performance program.

[30] R. L. Kane, P. Homyak, B. Bershadsky et al., "Patterns of Utilization for the Minnesota Senior Health Options Program," *Journal of the American Geriatrics Society,* Dec. 2004 52(12):2039–44.

[31] The initial seven payment baskets include diabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain, and total knee replacement. The Institute for Clinical Systems Improvement is working with the Minnesota Department of Health to facilitate seven working groups that will recommend detailed definitions for each basket of care.

Sources

Minnesota

HMA interviews with Cal Ludeman, chairman of the Minnesota Governor's Health Cabinet and Commissioner of Human Services; George Isham, M.D., M.S., chief health officer and Plan medical director for HealthPartners; and Scott Leitz, M.P.A., Assistant Commissioner of Health (Aug. 2009).

Sharon Silow-Carroll and Tanya Alteras, Health Management Associates, "*Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance*" (New York: The Commonwealth Fund, Aug. 2007).

Minnesota Department of Human Services, "Minnesota Health Care Programs" and "Minnesota's Health Reform Initiative" accessed online (Aug. 2009): http://www.health.state.mn.us.