Overview

E-Health
Provider Peer Grouping
Health Coverage and Spending

Health & Human Services Finance Committee
February 10, 2011

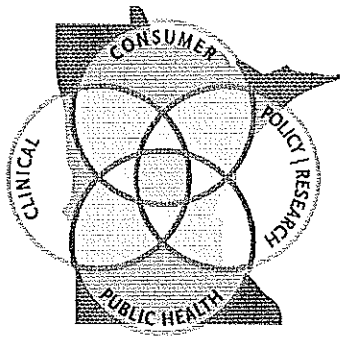
James I. Golden, Ph.D.
Director, Health Policy Division

E-Health

The Minnesota e-Health Initiative

A public-private collaboration established in 2004

- Legislatively chartered
- Coordinates and recommends statewide policy on e-Health
- Develops and acts on statewide e-health priorities
- Reflects the health community's strong commitment to act in a coordinated, systematic and focused way



The Minnesota e-Health Initiative Vision

Accelerate the adoption and effective use of health information technology to improve healthcare quality, increase patient safety, reduce healthcare costs, and enable individuals and communities to make the best possible health decisions.

Legislative Mandates to Advance e-Health

2011 e-Prescribing Mandate

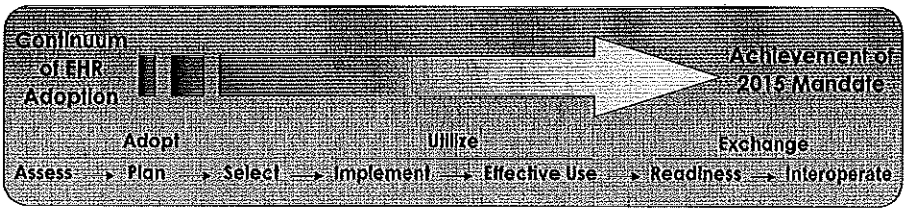
All providers, payers, prescribers, and dispensers must establish and maintain an **electronic prescription drug program** that complies with national standards by January 2011

2015 Interoperable EHR Mandate

All healthcare providers and hospitals must have **interoperable EHRs by 2015**

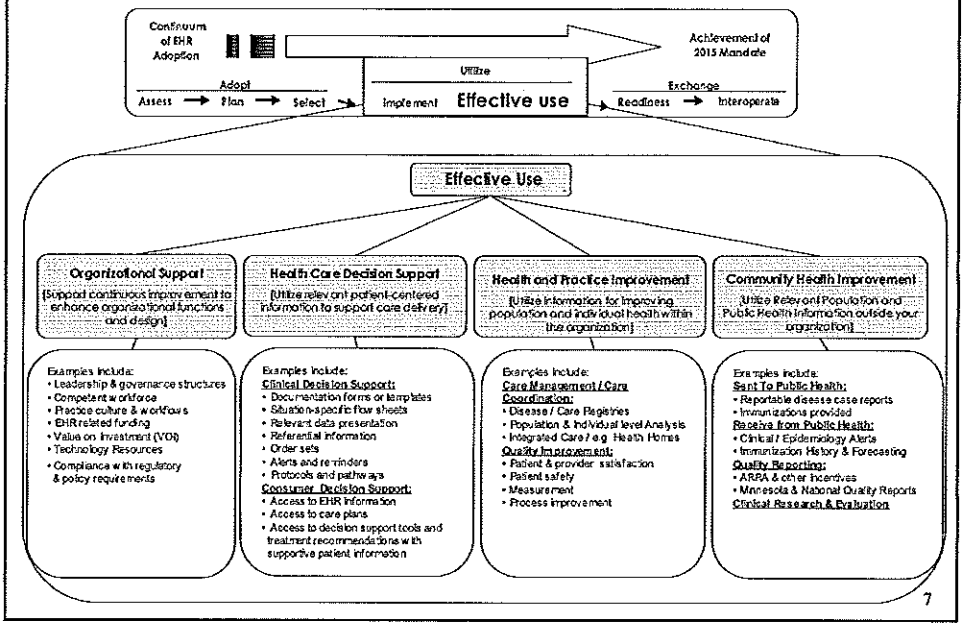
- MDH must develop **statewide plans** to meet the mandates
- Establish **uniform health data standards**
- All EHRs must be **certified**

Minnesota Model for the Adoption and Use of Electronic Health Records



By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. (MS § 62J.495)

Minnesota Model for Effective Use



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Results
EHR Adoption – National Comparisons

- **Guide 1: Addressing Common Barriers to the Adoption of EHRs** - *Released 2008*
- **Guide 2: Standards Recommended to Achieve Interoperability in MN** - *Released 2008, Updated June 2009*
- **Guide 3: A Practical Guide to e-Prescribing** *Released June 2009*
- **Guide 4: A Practical Guide to Effective Use of EHR Systems** - *Released June 2009*
- **MN Strategic and Operational Plans for Health Information Exchange** - *Released July 2010, Updated February 2011*

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Results
EHR Adoption

EHR Adoption in Physician Clinics	% of Clinics (# Clinics)
EHR installed and used by clinic	67% (750)
Purchased/began installation of an EHR	9% (101)
No EHR	24% (270)

Source: MDH Health Information Technology Ambulatory Clinic Survey, 2010.
1121 of 1285 physician clinics responding to survey

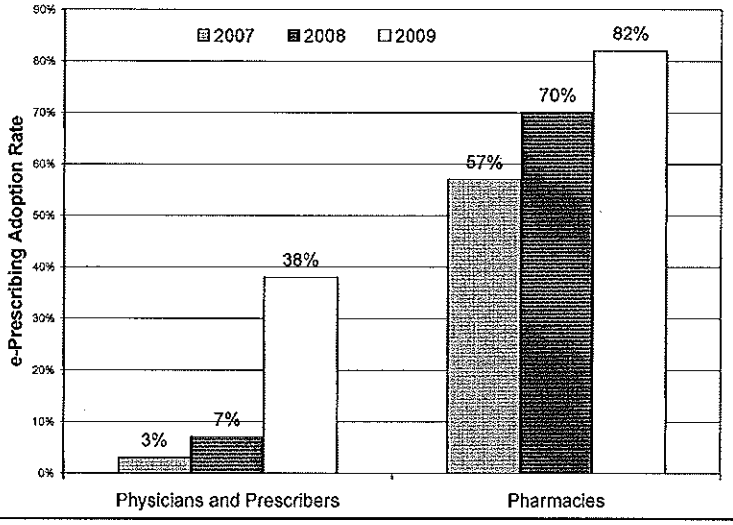
Results
EHR Adoption – National Comparisons

December 2010 – CDC determined Minnesota is leading the nation in adoption and use of EHRs with 80.2% of office-based physicians using an EMR/EHR system

Source: CDC Preliminary 2010 State Estimates, National Ambulatory Medical Care Survey

July 2010 – "The State of Minnesota is perhaps **the most aggressive in promoting the adoption of standards-based electronic health records** to support statewide electronic health information infrastructure." Source: Agency for Healthcare Research and Quality

Results
e-Prescribing Adoption & Use



Provider Peer Grouping

Value and Health Care Spending

- Research has shown that higher health care spending is not associated with better quality of care.
- Consumers need better information on health care costs and quality for more informed decision-making.
- We all need health care payment system reforms that reward value – not volume.

Provider Peer Grouping

- **A system for publicly comparing provider performance on cost and quality**
  - ...a uniform method of calculating providers' relative cost of care, defined as a measure of health care spending including resource use and unit prices, and relative quality of care...
  - a combined measure that incorporates both provider risk-adjusted cost of care and quality of care...

Types of Provider Peer Grouping

1. Total Care – for hospitals and clinics

2. Care for Specific Conditions

- Pneumonia
- Diabetes
- Asthma
- Coronary Artery Disease
- Total Knee Replacement
- Heart Failure

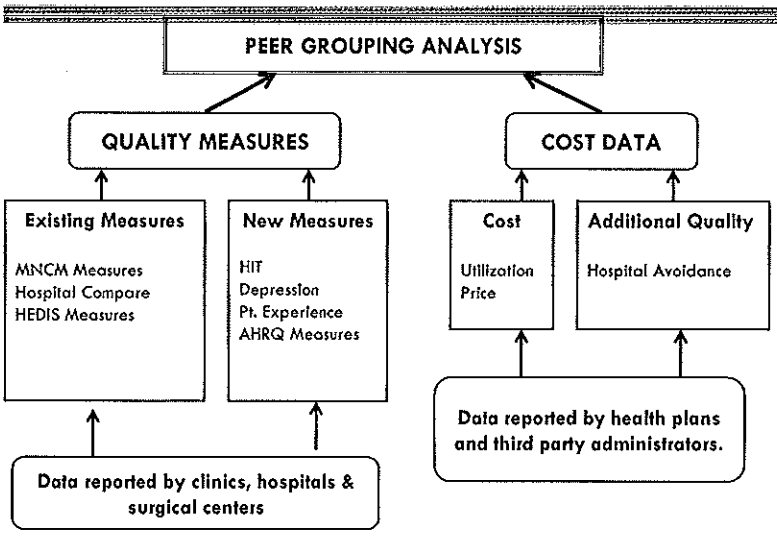
What Data are Needed

- **Quality measures** – e.g., outcomes, processes, structures, patient experience
- **Utilization of health services** – amount and types of services
- **Pricing information** – the amount that a provider was paid from both third-party payers and health plan enrollees

Reporting the Data

- Results are first distributed confidentially to providers
- Providers have opportunity to appeal results based on accuracy of data
- Results will subsequently be publicly reported

Data Sources for Analysis



Timeframe for Releasing Results

	Disseminate to Hospitals	Disseminate to Physician Clinics	Publicly Report Results
Total Care: Hospitals	June 15, 2011	---	September 15, 2011
Total Care: Clinics	---	August 15, 2011	November 15, 2011
Condition-Specific	September 15, 2011	September 15, 2011	December 15, 2011

Uses of Provider Peer Grouping

- **Various payers required to use results** to strengthen incentives for consumers to use high-quality, low-cost providers
  - State Employee Group Insurance Program
  - All political subdivisions that offer health benefits
  - All health plan companies, including those in individual market and small employer market
  - State Medicaid Agency

Methodology & Framework Stakeholder Input

- 2009 - MDH convened an **advisory group to provide advice and recommendations** on overall methodologies
  - Physicians
  - Clinic administrators
  - Hospital administrators
  - Health plans
  - State Medicaid Agency
  - Consumers
  - Purchasers

On-Going Analytical Activities Stakeholder Input

- 2010 - **Contract with Mathematica Policy Research to conduct analysis**
- May 2010 – **Rapid Response Team to provide input** on critical issues:
  - Patient attribution to providers
  - Creation of composite scores from individual quality measures
  - Treatment of non-users and outlier costs
- December 2010 – **Reliability Workgroup** to ensure reliability of peer grouping results
- On-Going – **Monthly Conference Call** to update stakeholders

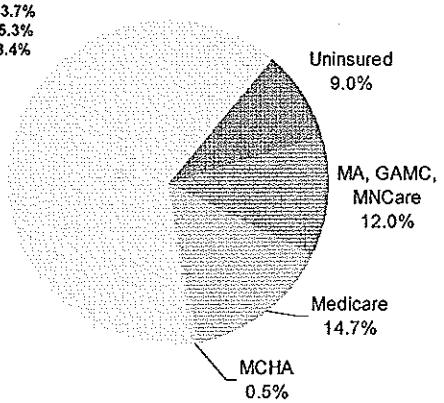
Health Coverage and Spending

Overview

- Sources of health insurance coverage in Minnesota
- Health care spending
- Trends in premiums and cost drivers
- Projections of health care spending

Distribution of Minnesota Population by Primary Source of Insurance Coverage, 2009 (preliminary estimates)

Total Population 5.3 Million



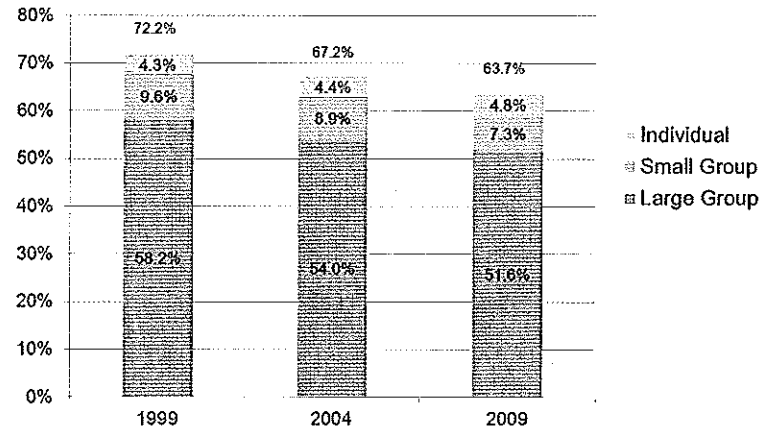
MA is Medical Assistance; MNCare is MinnesotaCare; GAMC is General Assistance Medical Care; MCHA is Minnesota Comprehensive Health Association
Source: MDH, Health Economics Program; population estimates are from the U.S. Bureau of Census, July 2009

Trend in Minnesota's Distribution of Health Insurance Coverage (preliminary estimates)

	1999	2004	2009
Public	**22.4%**	**25.1%**	**27.3%**
Medicare	13.3%	13.5%	14.7%
Medical Assistance	6.0%	7.5%	9.0%
MinnesotaCare	2.2%	2.8%	2.3%
GAMC	0.5%	0.7%	0.7%
MCHA	0.4%	0.6%	0.5%
Private	**72.2%**	**67.2%**	**63.7%**
Fully Insured	34.5%	27.2%	25.3%
Self-Insured	37.7%	40.0%	38.4%
Uninsured	**5.4%**	**7.7%**	**9.0%**
Total	**100%**	**100%**	**100%**

MCHA is Minnesota Comprehensive Health Association; GAMC is General Assistance Medical Care
Source: MDH, Health Economics Program; Population estimates are from the U.S. Bureau of Census, July 2009

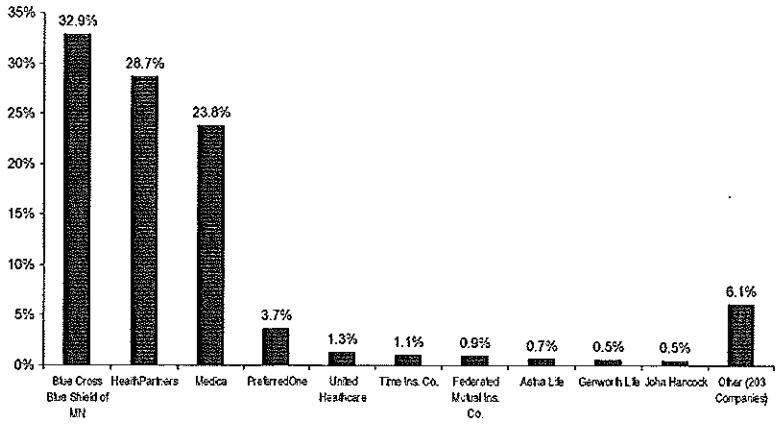
Trend in Minnesota's Distribution of Private Health Insurance Coverage



Source: MDH Health Economics Program

Health Plan Market Shares: Total Fully-Insured Private Market, 2009

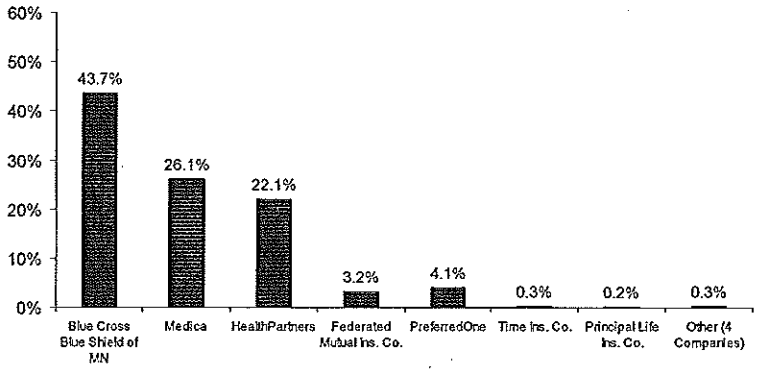
(Premium Volume: $6.0 billion)



Companies with common ownership were treated as one entity. For example, Blue Cross Blue Shield of Minnesota includes BCBSM and Blue Plus. Fully insured market only, market share based on premium volume. Does not total to 100 percent due to rounding.
Source: MDH Health Economics Program, analysis of MCHA Premium Database for 2009.

Health Plan Market Shares: Small Group Market, 2009

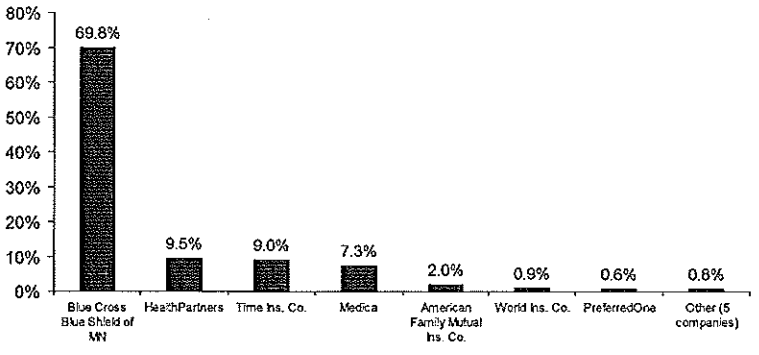
Total Premium Volume in 2009: $1.5 billion



Companies with common ownership were treated as one entity. For example, Blue Cross Blue Shield of Minnesota includes BCBSM and Blue Plus. Market shares based on premium volume; fully insured market only.
Source: Minnesota Department of Commerce, "Report of 2009 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations," June 2010.

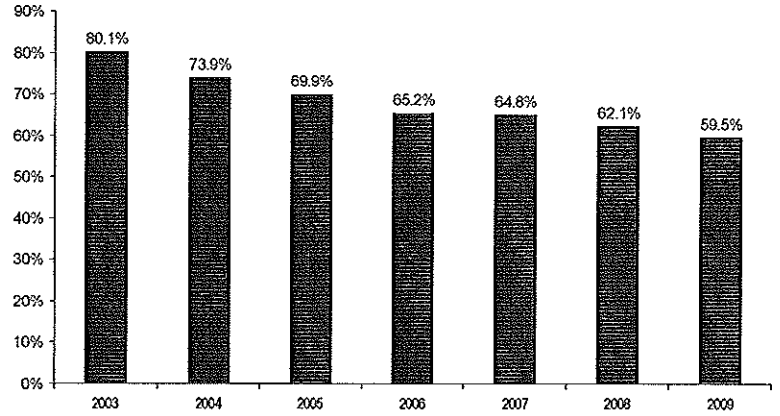
Health Plan Market Shares: Individual Market, 2009

Total Premium Volume in 2009: $626 million



Companies with common ownership were treated as one entity. For example, Time Ins. Co. includes Time Ins. Co. and John Alden Life Ins. Co. Market shares based on premium volume; fully insured market only. Source: Minnesota Department of Commerce, "Report of 2009 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations ," June 2010.

Market Share of Minnesota Non-Profit Health Plans 2003 to 2009



Market share calculated as share of premiums in the fully-insured health insurance market.
Source: MDH analysis of the premium assessment base for the Minnesota Comprehensive Health Association

Minnesota HMO Market Penetration 2003 to 2009

	2003	2004	2005	2006	2007	2008	2009
Total HMO Enrollment	1,236,439	1,092,870	980,374	894,429	869,906	864,119	886,554
Minnesota Population	5,047,862	5,079,344	5,106,560	5,148,346	5,191,206	5,230,567	5,266,214
HMO Enrollment as Percent of Population, by Type of Product							
Commercial	14.3%	11.9%	9.6%	8.1%	7.5%	6.9%	6.0%
Public	10.2%	9.6%	9.6%	9.3%	9.2%	9.6%	10.8%
All Products	24.6%	21.5%	19.2%	17.4%	16.8%	16.5%	16.8%

Source: MDH Health Economics Program analysis of HMO annual report, U.S. Census Bureau

Distribution of Minnesota HMO Enrollment* by Product Line and Age, 2009

	<15	15-29	30-44	45-54	55-64	65+	
Commercial	20.1%	20.1%	23.0%	19.8%	15.0%	2.0%	100.0%
Medicare Advantage	0.0%	0.1%	0.3%	0.9%	2.5%	96.3%	100.0%
Other Medicare	0.0%	0.9%	1.7%	2.2%	4.8%	90.4%	100.0%
General Assistance Medical Care (GAMC)	0.0%	22.3%	31.0%	30.5%	16.2%	0.0%	100.0%
Prepaid Medical Assistance Program (PMAP)	58.3%	24.6%	12.1%	2.5%	0.4%	2.1%	100.0%
MinnesotaCare	21.8%	28.8%	21.3%	17.4%	10.6%	0.1%	100.0%
All Products	28.8%	19.6%	16.0%	11.4%	8.0%	16.2%	100.0%

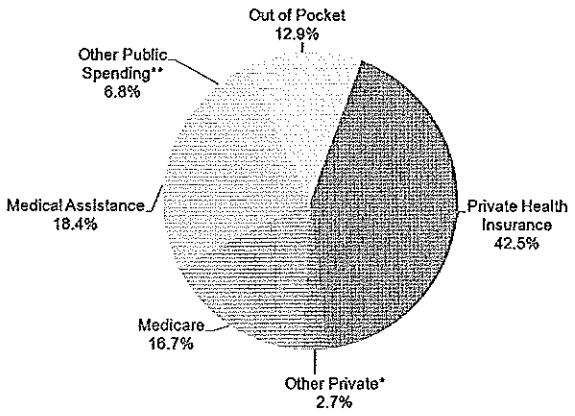
*Includes health plan members that are non-Minnesota residents.
Source: MDH Health Economics Program analysis of HMO annual reports

Prepaid Medical Assistance Program Enrollment in MN HMOs - 2003 to 2009

	2003	2004	2005	2006	2007	2008	2009
Blue Plus	58,003	53,331	56,792	48,242	49,873	52,162	61,445
FirstPlan	3,250	3,472	4,257	4,338	7,055	7,692	5,334
Group Health	0	0	0	0	0	0	0
HealthPartners	30,735	32,233	33,520	30,616	31,653	32,282	36,325
Medica	83,706	91,760	92,343	86,618	85,891	87,680	97,039
MHP	22,423	13,496	13,333	12,209	12,567	12,851	13,537
PreferredOne	0	0	0	0	0	0	0
Sanford	0	0	0	0	0	0	0
UCare	49,640	56,118	58,237	58,230	58,040	62,462	73,064
All HMOs	247,757	250,410	258,482	238,253	245,079	255,129	286,744
Change from previous year		1.1%	3.2%	-7.8%	2.9%	4.1%	12.4%

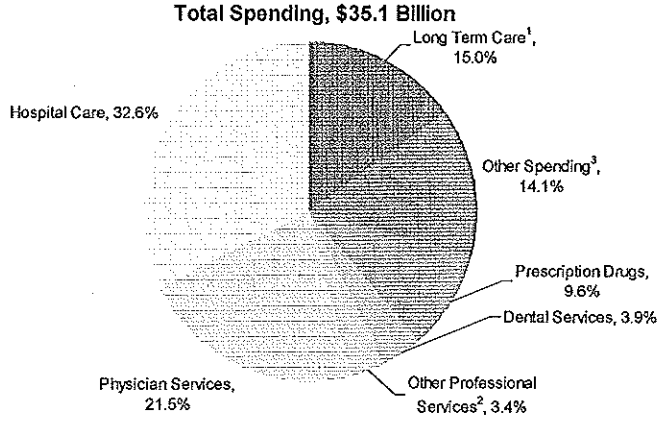
Source: MDH Health Economics Program Analysis of HMO Annual Report

Minnesota Health Care Spending by Source of Funds, 2008



*Other major private payers include, private worker's compensation and auto medical insurance.
**Major components of other public spending are MinnesotaCare, General Assistance Medical Care, government worker's compensation, Veteran Administration and Minnesota Comprehensive Health Association.
Source: MDH Health Economics Program

Minnesota Health Care Spending by Type of Service, 2008



[1] Includes home health care
[2] Includes services provided by health practitioners who are not physicians or dentists
[3] All other spending, including chemical dependency and mental health services, durable medical goods, and non-medical health care spending
Source: MDH Health Economics Program

Medical Assistance Enrollment and Spending History, 1999 to 2009

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending per Enrollee
1999	370,054	$2,997	$675	-4.6%	2.7%	7.7%
2000	367,737	$3,233	$733	-0.6%	7.9%	8.5%
2001	378,884	$3,582	$788	3.0%	10.8%	7.5%
2002	403,668	$4,136	$854	6.5%	15.5%	8.4%
2003	442,585	$4,740	$892	9.6%	14.6%	4.5%
2004	463,650	$4,991	$897	4.8%	5.3%	0.5%
2005	482,861	$5,224	$902	4.1%	4.7%	0.5%
2006	498,406	$5,462	$913	3.2%	4.6%	1.3%
2007	510,155	$5,846	$955	2.4%	7.0%	4.6%
2008	527,001	$6,268	$991	3.3%	7.2%	3.8%
2009	557,337	$6,775	$1,013	5.8%	8.1%	2.2%

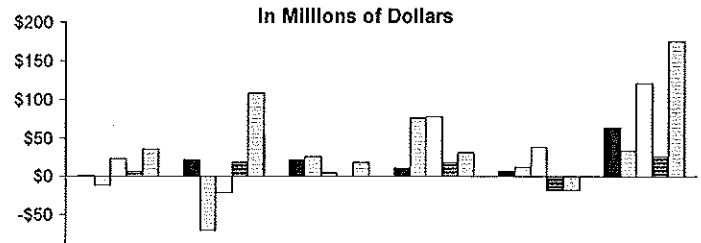
Source: Minnesota Department of Human Services, data for state fiscal years

Minnesota Health Plan Spending on Public Health Insurance Programs

Expenditure Summary (in millions)	2004	2005	2006	2007	2008	2009
Physician	341	370	511	526	567	637
Other Professional	73	93	143	179	233	263
Inpatient	283	385	531	560	608	681
Outpatient	199	223	330	378	477	493
Skilled Nursing	21	26	75	96	113	143
Home Health Care	66	91	106	122	125	167
Emergency Room	48	59	83	100	114	147
Prescription Drugs	315	344	310	321	348	392
Durable Goods	27	32	40	44	54	63
Chemical Dependency	83	118	136	144	190	276
Dental	56	62	54	61	78	96
Indirect (Admin)	133	147	179	211	235	245
Not Itemized	32	18	53	59	64	81
Total	**1,678**	**1,968**	**2,550**	**2,801**	**3,206**	**3,684**

Source: Health Economics Program analysis of health plan reports submitted as of Feb. 4, 2011.

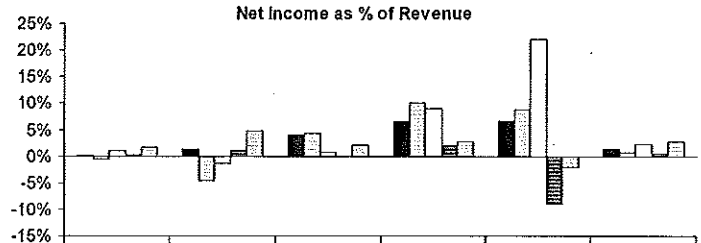
Minnesota HMO Net Income by Product Line, 2005 to 2009



	Commercial	PMAP, PGAMC, MNCare	Medicare	MSHO	All Other	Total
■ 2005	$1.2	$22.1	$22.1	$10.8	$7.2	$63.6
□ 2006	($11.1)	($70.0)	$26.1	$75.7	$12.6	$33.2
□ 2007	$23.0	($21.3)	$4.6	$76.9	$38.1	$121.2
■ 2008	$7.0	$18.7	($0.1)	$18.1	($17.7)	$26.0
□ 2009	$35.2	$108.1	$18.6	$31.4	($17.9)	$175.5

PMAP is Prepaid Medical Assistance Program; PGAMC is Prepaid General Assistance Medical Care; MSHO is Minnesota Senior Health Options; All Other includes: Medicare Supplemental, Dental and Minnesota Disability Health Options
Source: MDH Health Economics Program analysis of HMO annual reports

Minnesota HMO Profitability by Product Line, 2005 to 2009



	Commercial	PMAP, PGAMC, MNCare	Medicare	MSHO	All Other	Total
■ 2005	0.1%	1.3%	4.0%	6.5%	6.7%	1.4%
□ 2006	-0.6%	-4.6%	4.4%	10.0%	8.8%	0.7%
□ 2007	1.1%	-1.3%	0.7%	9.0%	22.1%	2.3%
■ 2008	0.3%	1.0%	0.0%	2.0%	-8.9%	0.4%
□ 2009	1.6%	4.8%	2.1%	2.8%	-2.1%	2.7%

PMAP is Prepaid Medical Assistance Program; PGAMC is Prepaid General Assistance Medical Care; MSHO is Minnesota Senior Health Options; All Other includes: Medicare Supplemental, Dental and Minnesota Disability Health Options
Source: MDH Health Economics Program analysis of HMO annual reports

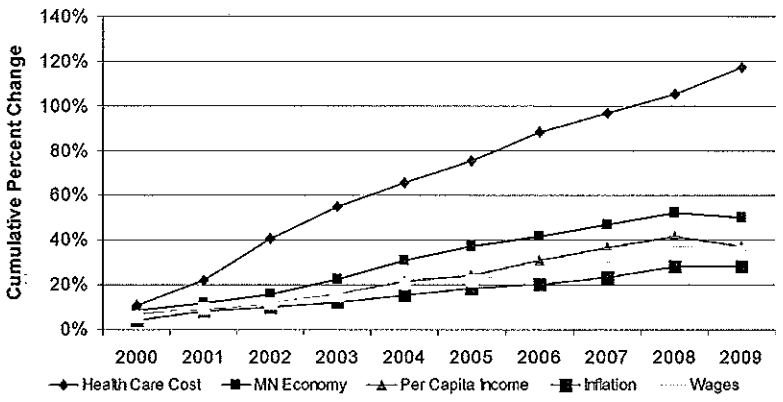
Sources of HMO Net Income 2005 to 2009

In Millions of Dollars

	2005	2006	2007	2008	2009
Sources of Net Income:					
Net underwriting gain/loss	($5.2)	($43.8)	$26.8	$31.3	$123.1
Investment Income	$68.9	$78.9	$93.3	($5.5)	$52.4
Other	($0.1)	($1.9)	$1.2	$0.2	$0.0
Net Income	$63.6	$33.2	$121.2	$26.0	$175.5
Investment income as % of net income	108.3%	237.6%	77.0%	-21.2%	29.8%

Minnesota products only
Source: MDH Health Economics Program analysis of HMO annual reports

Trends in MN Private Health Care Cost and Economic Indicators
(preliminary estimates)

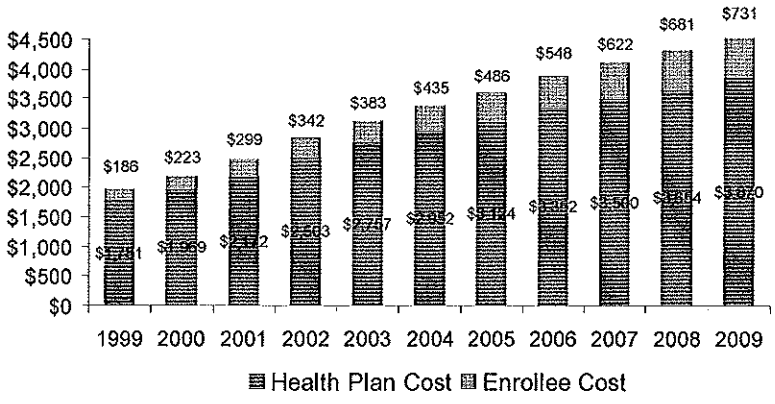


Health care cost is MN privately insured spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; per capita personal income from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (consumer price index); workers' wages from MN Department of Employment and Economic Development

Total Cost Per Person and Health Plan/Enrollee Shares, 1999 to 2009
(preliminary estimates)

Minnesota Fully-Insured Private Market



Source: MDH, Health Economics Program.

Contacts & Additional Information

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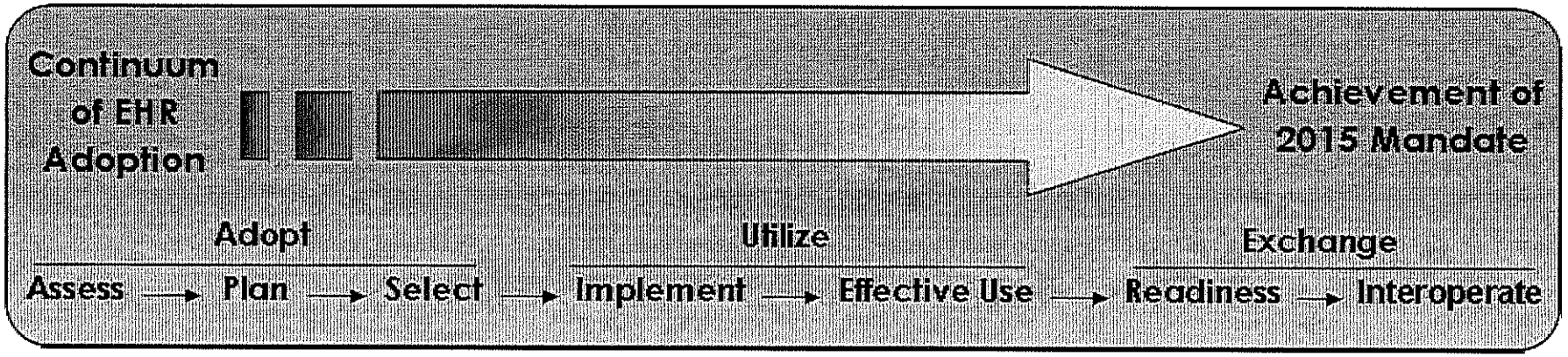
- Health Care Market Statistics (Chartbook Updates)
  - http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html

Minnesota e-Health Initiative

The Minnesota e-Health Initiative vision is to accelerate the use of health information technology to improve healthcare quality, increase patient safety, reduce healthcare costs and enable individuals and communities to make the best possible health decisions.

Minnesota Model for Adoption and Use of Electronic Health Records



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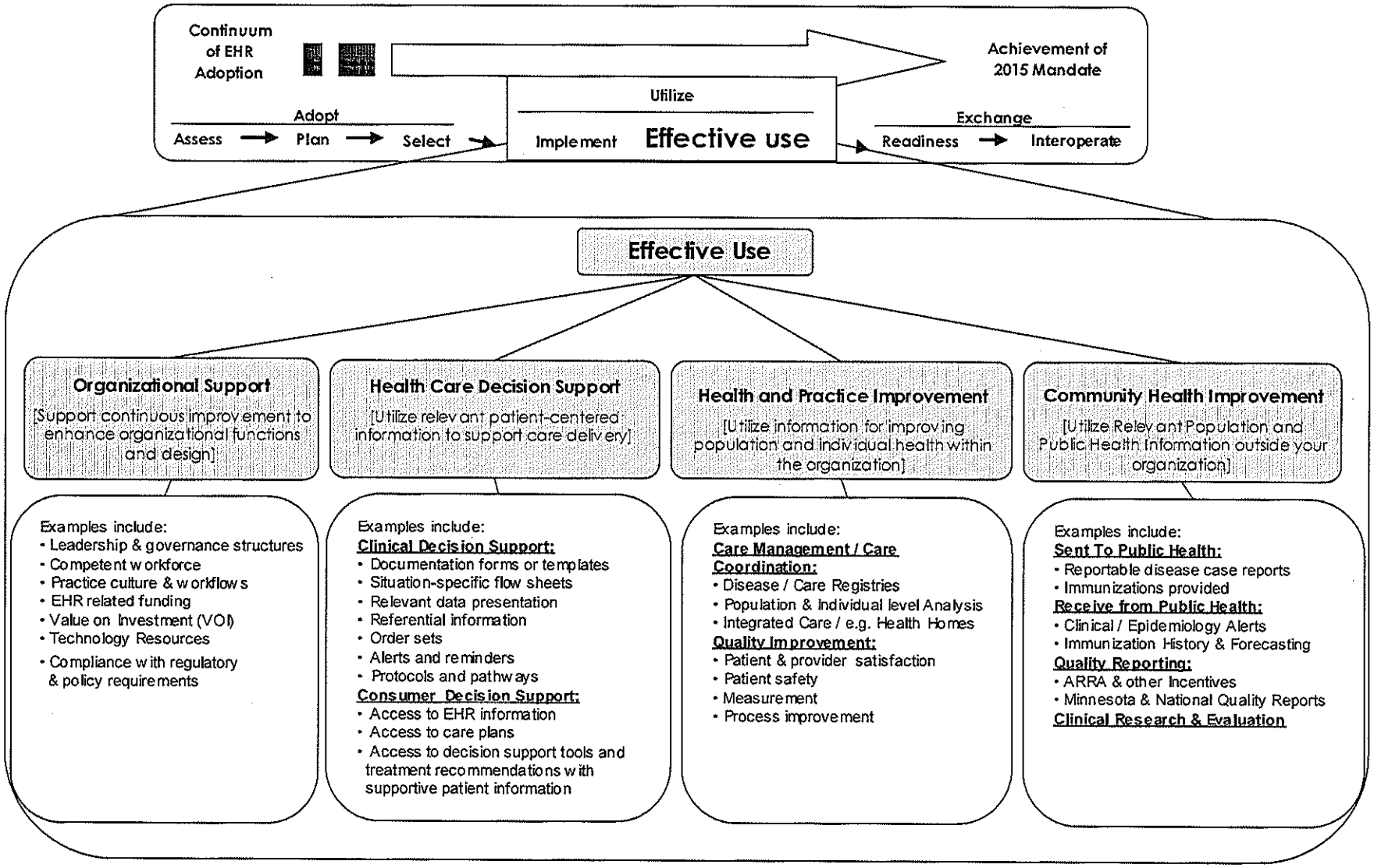
Minnesota e-Health

Minnesota Framework for Effective Use of Electronic Health Records



Minnesota's Vision: Value Information January 2011

Provider Peer Grouping: Health Care Value

Background

In 2008 Minnesota enacted a major bipartisan health reform law to improve health care access and quality and to contain the rising cost of health care. This health reform initiative – Minnesota's Vision for a Better State of Health – aims to help curtail unsustainable cost growth while simultaneously improving the quality of care and the health of all Minnesotans. A cornerstone of the law provides for the development of tools to promote quality and transparency in the health care market.

Minnesota leads the nation

Minnesota is the first state in the nation to develop a comprehensive system that provides information about health care *value* – both cost *and* quality. The Minnesota Department of Health (MDH) is developing a "provider peer grouping" system that will compare physician clinics and hospitals based on a combined measure of risk-adjusted cost and quality to offer a clearer picture of each provider's value.

Uses for the information

Employers and health plans will be required to use it to develop products that encourage consumers to use high-quality, low-cost providers. Providers can use it to improve their quality and reduce costs. Consumers can use it to make more informed health care choices.

Alignment with national efforts

The goal of comparing providers based on value is in keeping with national efforts. Value-based purchasing, accountable care organizations, payment reform demonstration and pilot programs, the National Quality Strategy and exchanges strive to link payment more directly to quality. Value measurements include both quality and cost information.

A strong product in Minnesota

Minnesota's goal is to create a credible analysis that will be considered a community asset. MDH has taken a thoughtful approach to the development of this system, building on related efforts in the state. Cost data will include information related to both pricing and resource use. Quality data will include information reported directly from physician clinics and hospitals on outcomes and processes, as well as measures calculated from administrative data.

Timeline for results

The results of the analysis will first be distributed to providers beginning in summer 2011 and reported publicly during fall 2011 as information that can be easily used by payers and consumers.

Community collaboration

- An advisory group met in 2009 to develop a framework and recommendations for implementing provider peer grouping.
- MDH awarded an implementation contract to Mathematica Policy Research.
- MDH created a Rapid Response Team of stakeholder representatives. This group provides input on more detailed methodological issues.
- MDH has also convened a Reliability Work Group of stakeholders to help the department ensure the reliability and usefulness of peer grouping results.
- MDH holds monthly conference calls to update stakeholders on peer grouping activities.

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota's Vision: A Better State of Health
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MINNESOTA'S VISION
A Better State of Health