



Walt McClure, chair, Center for Policy Studies

Interview with The Civic Caucus

8301 Creekside Circle #920, Bloomington, MN 55437

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Notes of the Discussion

Present : Verne Johnson (chair), Dave Broden, Rick Dornfield, Paul Gilje, Dwight Johnson, Lucas Johnson, Sallie Kemper, Ted Kolderie, Dan Loritz, Tim McDonald

Summary of discussion - One of the original health care market reformers describes Minnesota's position at the cusp of national leadership in health care system reform. The requisite elements are in place for the state to lead in this reform effort: the ability to systematically measure health outcomes and costs, and a system offering incentives for choosing those health care providers that deliver better outcomes at a lower cost. A name suggested for this strategy is *Informed Consumer Choice*. No other state is in such an advanced stage of progress on this strategy as Minnesota. Now the task is to get the elements of the strategy operating maximally and meshing as part of an integrated policy. State leadership, both public and private, is required to complete this job. The role of a health insurance exchange is discussed.

A. Introduction of speaker - Walter McClure received a BA in philosophy and physics from Yale in 1959 and a PhD in theoretical physics from Florida State in 1967. His dissertation research, on nuclear cluster theory, was conducted at the University of Tübingen in Germany, and he co-authored a book on the subject with his professor, Karl Wildermuth.

In 1969 he switched from physics to health care reform policy for reasons, he says, having to do with "relevance". He worked at InterStudy under Paul Ellwood's leadership from 1969 to 1981, at which time he left to start the Center for Policy Studies. He directed the Center until his retirement for medical reasons in 1990. At InterStudy he worked with colleagues on the HMO strategy for health care reform, among other tasks drafting much of the Federal legislation.

At the Center he developed Large System Architecture, a general theory of why organizations do what they do, and a set of methods to strategically redirect their behavior toward the goals society desires of them. With these methods he and his colleagues at the Center developed a health care

system reform strategy to get better care for less, and developed a National Health Insurance proposal consonant with this strategy. He assisted Medicare, Pennsylvania and Cleveland to implement the first step of the strategy, severity-adjusted outcomes assessment of providers, before his reluctant retirement. Named "Buy Right" then, it has since been renamed *Informed Consumer Choice* (ICC) to reflect the nature of the strategy: Provide consumers information about the cost and quality of providers, and provide incentives to choose those that are better for less.

Recently under the leadership of McClure and the Center's President a new project Healthcare|Evolving has emerged to pursue the ICC strategy.

B. Discussion - This month the Supreme Court issued its decision upholding the Affordable Care Act. McClure, with his background in large systems analysis and his work on health system reforms at the Center for Policy Studies, is in a good position to foresee the work ahead.

McClure said Minnesota is close to achieving system reform in health care, changing the incentives of the system to reward quality and cost-effectiveness.

Regardless of what lies ahead with the elections or with the now upheld Affordable Care Act, there are things Minnesota needs to do, he argued. Minnesota has been busy doing system reform in health care "the Minnesota way", and now the task is to finish the job.

The time is right he continued, because all the ingredients are in place to complete the effort. "We've made progress in this field that people in the state have not noticed because it's been gradual and slow," McClure said, "but, in fact, there has been a sea change in health care."

THE PROBLEM: The pieces are in place for a reformed health care system but they risk failing to function properly together.

Minnesota has enormous talent working on different components of health reform, McClure said, but each talent is acutely focused on the tasks they are assigned and do not necessarily realize how their work fits into a larger strategy.

THE GOAL: Leadership gets the pieces of the strategy operating together.

All the key players of the reform strategy need to come together performing as a team.

"We have a public sector and private sector that are presumably on the same page. Getting these to mesh is the critical task." If vision and leadership are not provided, McClure said, there is risk that staffs will succumb to petty bickering, leading to years of delay and decisions being made elsewhere not consonant with the Minnesota approach. If we do it right and lead the way, people will be coming to us to emulate our approach.

STRATEGY: Reform the healthcare system's incentives.

Change incentives to address the core problems.

McClure outlined the nature of the state's strategy to bring about healthcare system reform. First, he defined what he means by "system reform." In this context, "system reform" means changing the structure of a system in such a way as to correct its inherent incentives that perversely reward problem behaviors. In health care, quality and cost are symptoms of an underlying condition: bad incentives. He argues that an effective reform strategy needs to cure this underlying cause of unfavorable results; it must restructure the system to replace the bad incentives with proper incentives.

The incentives in the health care system today are very bad. They reward cost regardless of quality, McClure said. Under today's system, efficient providers that get better patient health results with fewer, more efficiently produced services earn less on each patient, yet gain not a single additional patient for their pains. No one, not patients, not even providers, knows who these high quality, efficient providers are because we don't keep score.

McClure contends that if all providers were to practice a style of medicine that is reflective of the best providers, then Minnesota would have overall better quality of care with 20-30 percent fewer providers. The question is, how we can get the system's incentives right to make that happen?

Informed Consumer Choice can change consumer behavior.

There is a strategy to accomplish this end that evolved in Minnesota. The basic notion began with Dr. Paul Ellwood in the 1970's. Ellwood realized that incentives are critical to the behavior of a market and the performance of a system. He was running a rehab hospital, and realized the faster he got people rehabbed and back to work, the less money he made. So he had an idea to create the HMO, the Health Maintenance Organization. McClure was part of Ellwood's team that worked on the HMO strategy at Ellwood's Minnesota-based policy studies organization, Interstudy. This Interstudy team drafted much of the federal HMO legislation.

By 1980 Interstudy found that, with some heartening exceptions, HMO's generally had made no dent in healthcare costs. McClure left in 1981 to form the Center for Policy Studies (CPS) and continue work on this problem. His CPS team found that the HMO strategy was targeted at the wrong level. The healthcare organization itself is the wrong focus - it doesn't do any good, McClure said, to be an efficient HMO if you don't get additional patients, that is, increased volume and hence adequate revenue for all your efforts at achieving quality and efficiency. The correct focus became clear. "It was the system's *incentives* that had to be changed."

To change the incentives affecting providers CSC came up with a strategy: Measure quality and cost of care, then use pricing incentives in insurance plans to encourage people to choose those health care providers that are better for less.

McClure gave the strategy a name, originally *Buy Right*, and more recently, *Informed Consumer Choice*. With Informed Consumer Choice, assessors get information on healthcare providers' quality and cost; that information is then given to consumers, and incentives are built into their health insurance plans to encourage consumers to choose providers with better quality care for less cost. Not just better care, but better care *for less*.

Measuring healthcare quality and cost is key to the strategy.

If you wish to substantially contain cost, assessing health care quality is the first, if perhaps not obvious, place to start in any healthcare system reform strategy. The only way to have an understanding of healthcare quality is to have someone measure it, and McClure likened this to baseball: you have no idea who is a good hitter by going to a game; a hitter might be lucky that day or unlucky - you know only his past record of success because someone measures and tells you his batting average. When you go to a doctor, what you want to know - what we mean by quality - is the doctor's batting average, the quantification of his/her success in getting good health results for comparably sick patients compared with other providers. The measure of provider quality is a measure of both patient health results and patient satisfaction, McClure said, not the quality of services per se. A provider's batting average on health outcomes and patient satisfaction for comparably sick patients are what tell us whether this particular provider's care is "better" (i.e. higher quality) than others.

The second component critical to this strategy is to assess the efficiency of each provider, i.e., the efficiency of each provider's contribution to the total cost of care (not just the cost of each service but the number and type of services used) to achieve the health outcomes for a given population. This is a formidable technical task since any particular patient may have seen multiple providers for a given health result, but adequate statistical methods are now available.

McClure pointed out that studies indicate that the variance among providers in death and complication rates for comparably sick patients varies almost two-fold, as does cost, and the two are largely unrelated. Indeed, it is not uncommon that those healthcare providers with the worst outcomes actually cost the most. Unfortunately, the healthcare consumer today scarcely knows that such poor quality providers exist and certainly is unaware of who they are. This is the perverse situation that Informed Consumer Choice is designed to remedy.

Minnesota has an opportunity to lead the country.

Despite popular focus on the federal government's role, medical care is essentially a local product, McClure said, created by local people. And our state abounds with strong local resources in this field. Few people know just how good and efficient Minnesota's healthcare system really is, but the fact is well documented if not well publicized.

To illustrate, the Commonwealth Fund, a nationally eminent foundation, ranks regions on comprehensive healthcare measures in its report "Rising to the Challenge". The top four regions in its healthcare ranking are: 1) Saint Paul, 2) Des Moines, 3) Rochester, and 4) Minneapolis. The nationally eminent Institute for Healthcare Improvement in its book "The Triple Aim" reports Medicare costs per elder in Minnesota run about 30 percent lower than the national average despite our outstanding quality, and it further reports that Minnesota's HealthPartners is among the nation's foremost innovators in quality and efficiency and runs 10 percent less cost per elder than the state average. Both are must reading for anyone concerned with health care delivery and financing.

Expansion of access to care, as the Affordable Care Act has set in motion, must also be accompanied by careful attention to cost. The country learned from Medicare and recently from Massachusetts' experience that in the present healthcare system if you expand coverage without first having an adequate cost containment strategy, you are pouring gasoline on a fire and costs will run away unrestrained.

However, Minnesota is now going at this problem in an entirely opposite fashion: Change the incentives to reward both improvements in quality and lower cost *before* the exchanges are formed, and then universal access will not break the bank. In fact universal access can then positively further proper system reform and help steadily reduce cost.

"Regardless of what the federal actors do or anyone else does, we are doing this the Minnesota way. We don't need to wait for the federal government; we don't need to wait for anybody. We can just go ahead, starting with our commercial and public assistance health insurance sectors. The Feds are begging states to lead the way. No other state is in so advanced a position to do that."

Minnesota health reform precedents lead the way.

In 2007, then-Governor Pawlenty worked with legislators to introduce a health exchange bill. It did not pass, but from this effort came a task force. Pawlenty was hoping to decrease health care cost by 20 percent in five years. That was a short time frame - perhaps too short even if the strategy were fully in place - but the goal of a 20 percent reduction is eventually more than possible, McClure said.

The Pawlenty task force made four recommendations to the legislature:

1. Launch aggressive public health measures.
2. Assess provider quality and cost and inform consumers of the results.
3. Reward those providers that are better for less.*
4. Provide universal coverage.

(* McClure noted a missing component is disincentives penalizing those that *aren't* better for less).

In the 2008 legislative session, the first and last recommendations were dropped by the legislature as too expensive, but the second and third were enacted with strong bipartisan support. "We are the first state in the country to legislate a market-based, consumer-choice-driven system as state policy," McClure said.

Minnesota can lead the nation, he said, but there are two important tasks facing the state right now: First, getting assessment right, and second, reforming the insurance market to ban uncompetitive behaviors.

Quality and cost assessment movements led from Minnesota.

That quality and cost assessment are now in place in Minnesota is an amazing fact, McClure said. When his team started on assessment in the 1980's the idea that someone would be looking over a

physician's shoulder was considered communism. Physicians were convinced of their right to autonomy.

However, by 2008 Minnesota's private and voluntary sector had accomplished a sea change in this culture with 85 percent of providers in the state participating in having their outcomes measured. Over the course of 20 years, the world's experts in assessing health care outcomes have emerged here in Minnesota.

In 1992 HealthPartners, Park-Nicollet, and Mayo Clinic set up the non-profit Institute for Clinical Systems Improvement (ICSI) to go through the literature and develop evidence-based clinical protocols. Representatives of employers, providers and health plans were included on the board. Participating providers who assessed their outcomes by these protocols were assured confidentiality, and more and more began participating voluntarily. These providers learned that while some were ahead on this illness or that, all were far from where they wished to be, and measurement led to notable steady improvement on outcomes by all.

In 1996 HealthPartners began publicly reporting these outcomes not only for its own provider group but all provider groups participating in its network. It was believed that making outcomes public would seriously motivate all these providers to improve outcomes, and so it proved. This is the first time outcomes by provider group were made public, and providers found the world did not collapse as a result. Indeed, participating providers gained respect while those *not* publicly reporting outcomes were viewed as perhaps hiding quality shortcomings.

Eventually, in 2004, the three big health plans (HealthPartners, the Blues, and Medica, set up and financed an independent non-profit, Minnesota Community Measurement (MNCM), to assess and publicly report on a uniform basis the comparative outcomes of all providers covered under these plans. The other Minnesota-based health plans soon joined. This greatly expanded the number of provider groups being publicly assessed. The MNCM board was broadened to include a balance of representatives from employers, labor and government, as well as providers and plans, with none dominant. While not all providers are comfortable with public assessment, the majority were by now sufficiently accustomed to realize how a powerful a tool and incentive it was to improve their quality. And few wished to appear to be hiding their quality from patients, employers and other providers. By 2008 more than 85 percent of Minnesota provider groups were participating in MNCM's public assessment.

"While the development of excellent assessment methods, receiving endorsement around the country, was amazing, the more epic change was the transformation in physician culture where doctors were now seeing the demonstrable value of public assessment to improving their quality of care," McClure said. This was truly a sea change here that was not happening in the rest of the country.

At the time of the 2008 legislation there was only technology for measuring quality - not yet cost. While MNCM did not measure cost, the legislation required the state to measure quality and cost both. So the State set out to do this through the Department of Health, which contracted with Mathematica, a consulting firm with expertise in data collection and statistical analysis. The Department and Mathematica worked admirably hard and produced a preliminary report in 2012. However, the results had shortcomings recognized by both providers and the State, and the

Department and its contractor have gone back to work on their methods. It is uncertain when, and if, the State's current methods for measuring cost and quality will be perfected. This has created a potential delay, as there is insufficient confidence in the State's method of quality and cost assessment.

This year, however, there is a new and promising development. The National Quality Forum (NQF), an eminent national organization, which rigorously tests and endorses measures of provider quality, has for the first time endorsed a method to measure provider cost and efficiency. The method was developed and submitted to NQF by Minnesota's own HealthPartners. "NQF sent it through the technical wringer," McClure said, "and all the various experts took their shots at it. It is the only provider cost assessment method that has been publicly vetted like this. It's public, it's open, it's free, and available for immediate use."

MNCM is now working to add this NQF-endorsed cost assessment method to their quality measures, working with providers to let them see the merits of the method, just as they have with all their quality measures. "Perhaps the most important lesson we've learned from the impressive accomplishments of ICSI and MNMCM," McClure said, "is that you don't slam-dunk physicians. They are smart independent thinkers and need to review, understand, and be persuaded of the merits. If you have that process, if you know how to work with doctors in a respectful way and bring them along, you get buy-in from doctors."

Next steps for Minnesota outlined.

There are three demanding tasks facing Minnesota to complete system reform underway. If meshed together properly and done well, in one to three years Minnesota could have the nation's first health care system restructured to reward high quality care and coverage and declining cost escalation.

Presently, McClure said, four different parties are laboring mightily on various parts of these three tasks: the Department of Health, the Department of Human Services, the Department of Commerce, and the private non-profit organization Minnesota Community Measurement.

A key factor for those laboring on these tasks is to see themselves as part of a team, and their task as part of a larger strategy. The goal is not each piece in isolation, but all of them properly meshed.

The three tasks he described are:

Task 1. Decide on the methods for assessing providers, and decide on the arrangements for who should best perform such assessment.

Task 2. Arrive at simplified reports, readily understandable by consumers, on the value (quality and efficiency) of providers, and decide how these can best be distributed and freely available to consumers. Then, encourage or require appropriate incentives in health plans for consumers to choose efficient providers through consumer-directed payments (payments follow the consumer), not through bonus-payments to providers that do well. The bonus payments, McClure said, are currently

in statute but have not been shown to work in any scientific studies. The strongest incentive on health care providers, he said - like that on schools - is the gain or loss of patients based upon provider performance.

Task 3. Correct the unsound insurance market, either by legislation or by appropriate design of the new State health insurance exchange to reflect the new incentives.

"The State's success and credibility do not depend on the success or failure of Provider Peer Grouping," he said, "they depend on accomplishing the goal of implementing system reform soundly and expeditiously."

In 2008 there was no accurate, rigorous cost assessment metric, he added, and so the state moved ahead as best it could, contracting with a consultancy to come up with a cost metric. Now with the National Quality Forum endorsed metric there is such an accredited cost measure, and it could be paired with the provider quality assessment of an organization like Community Measurement.

If the Department does decide to go with the MNMCM quality measures coupled with the new NQF cost metric, it needs to decide the best arrangements to operate it. One option would be to perform the assessment itself, as it is attempting now with PPG.

A second option would be to take advantage of MNMCM's experience, provider acceptance, and proven track record, and rather than duplicate their activity, designate them as the assessor agency at the pleasure of the Department. McClure recommended the second option as more effective.

The health exchange can be an important tool to complete system reform.

At present health plans can, and many do, compete in highly undesirable ways, McClure said. A health insurance exchange can help with the second major part of the strategy - insurance reform.

The most flagrant and easily understood adverse practice, McClure explained, is cherry-picking, that is, keeping premiums low by excluding coverage to employer groups and individuals who are sick, or segregating them into prohibitively expensive policies. But there are, he asserted, many other undesirable competitive practices that can and should be eliminated by proper regulation.

McClure proposed that cost competition among health plans should be limited to just five legitimate objectives, and all other means forbidden by appropriate law and rules. Those five legitimate objectives should be:

- Assuring financial protection
- Encouraging healthy behavior and preventive care among members
- Incenting members to use providers who are better for less.
- Achieving administrative cost efficiency
- Realizing consumer satisfaction

An ideal place to begin such regulation of health plans is Minnesota's new health insurance exchange. The State is presently designing a so-called "exchange" specified under the new federal Affordable Care Act. But as Governor Pawlenty recognized, such an exchange seems a smart idea

for Minnesota independent of any federal mandate. By writing the rules for the kind of plans that can be offered through the exchange, undesired competitive practices can be prohibited, and competition on the five legitimate goals can be fostered.

If the exchange doesn't construct effective rules the legislature can move to write the rules for all the insurance in the state.

Questions and Answers

Who opposes this? WM: "Some providers will oppose assessment, and will work through professional associations to raise issues. They'll try to stall it. But if labor and provider leaders are pressing, with political leadership, the work will get done. The Minnesota Medical Association (MMA) represents 30 percent of physicians in the state; the leading providers are separate.

Dr. David Abelson, President and C.E.O. of Park Nicollet Health Services in St. Louis Park, said it all during the debate this year about the Physician Group Demonstration Project (PGP). Park Nicollet is a founding participant in PGP, the nation's first pay-for-performance Medicare shared savings program. Abelson said the provider leaders don't want assessment to stop; they just want it to be open. If leaders understand the strategy it will move forward - if they don't understand it, then the discontents might stall it.

Institutionally how can a state government make the change happen? WM: " This is an idea coming in from outside state government, so it has to be picked up on the inside of state government. The idea of the exchange has been around a long time. So the question for Minnesota is, can the state actually do this? In order for the exchanges to work and be done right people need information.

How does the Governor mobilize action? WM: "The Planning agency, when it was around, was a group the governor could use for such a project. Without that now, the Governor could get a new deputy chief of staff for this purpose. We see an example right now with the *Better Minnesota* initiative, which was given to a team. I don't know that that's succeeding with its charge. It's hard to get a group like that to execute a strategy. Without having a group within the planning agency, you need to bring in somebody from the outside, and say 'this is the task; it needs to get done; get to work on it.' There are people with the capacity for doing this working for the state already.

What should be done right now? WM: " The most important thing for the exchange is to focus on rules that will forbid bad competitive processes."

What is the role of Medicare? WM: "The issue is not what the Feds are doing, but the wellbeing of Minnesota. If it makes sense to have Medicare involved to carry this out, then that's what we should do. We don't need Medicare to do anything to succeed here. We can do it all in our commercial and state sectors. Then again, Medicare is begging for demonstrations of successful cost-containment efforts."

Governor Dayton has the potential to do for health care what Perpich did in education? WM: " We're so close. It's so ripe, and so right, that it can be a real winner for this governor."

C. Conclusion - time for leadership

McClure concluded, "Minnesota is at an extremely promising juncture, and the time has come for expanded leadership. If the thought and action leaders of the community and state can do some adept directing here, we could have a total system reform in health care in 2-3 years.

"Wiser heads higher up need to get up to speed and understand that the state and MNCM are not rivals; they are partners in this effort.

"Achieving culture change: that's what leadership does."

The chair thanked McClure for the visit.