



Scott Leitz, Assistant Commissioner, Minnesota Department of Human Services

Interview with The Civic Caucus

8301 Creekside Circle #920, Bloomington, MN 55437

February 24, 2012

Notes of the Discussion

Present : Verne Johnson (chair), David Broden, Janis Clay, Steve Dahl, Pat Davies, Bryan Dowd (phone), Paul Gilje, Jim Hetland (phone), Curt Johnson, Sallie Kemper, Ted Kolderie, Dan Loritz, Walt McClure, Tim McDonald, Wayne Popham (phone), Clarence Schallbetter, Steve Wander

Summary : For the interests of the state - government, business, and individuals alike - the rapid growth in cost of health care must be contained, Scott Leitz, assistant commissioner, Minnesota Department of Human Services, said. Aging is a particular challenge, teamed with the decreased fiscal resources available to spend on rapidly increasing costs. "When you pair information on the quality and the total cost of care," Leitz said, "with incentives for consumers to choose based on that information, you begin to see the elements of a solution."

Background : Traditionally Minnesota is a state that's had high rates of employer-based health care - highest in the country. At start of last decade 68 percent of people had health care through their employer. That has since dropped to 57 percent.

During that time those without health care coverage rose from 6 percent to 9 percent. 5 percent of population are self-employed and purchase own care.

Health care expenditures are the largest and the fastest growing area of the state budget. This past year the portion of the state general fund classified as Health and Human Services, the majority of which is related to health care services and care for the elderly, is projected to grow at an annual rate of approximately 8 percent, according to estimations by State Economist Tom Stinson and former State Demographer Tom Gillaspy. That is enough to hold all other areas of general fund spending increases- including K-12, higher education, and transportation - at zero.

Against this backdrop of financing, Minnesota has emerged as a potential leader in health care policy. Already the leading state in the quality of medical care, Minnesota organizations in the health care

industry - such as Minnesota Community Measurement, Health Partners, and Mayo Clinic - are nation-leading innovators in their fields.

In 2008 Governor Pawlenty signed into a law a series of health care reforms developed with cooperation of providers, other interested groups, and a Democratic legislature. The reforms sought to improve the quality of care in the state and lower its cost by, in part, evaluating and making public the outcomes and relative costs of providers.

Implementation of the 2008 reforms is presently under way. Scott Leitz, assistant commissioner in the Department of Human Services, will visit with the Civic Caucus on February 24 to provide an update.

Meanwhile information on quality and cost is being gathered in the non-governmental sector. Minnesota Community Measurement, a non-profit, has developed ways to assess quality of services that are open for public review, and continually vetted and improved.

A non-governmental organization has also made progress in the assessment of the cost of care amongst providers. In February a tool that Bloomington-based Health Partners has used to determine the cost of care became the first to be endorsed by the National Quality Forum following a lengthy process of reviews. Like MNCM's assessment of outcomes information, this tool is open and available for public view and use.

Meanwhile Governor Dayton and the Republican-controlled legislature are deadlocked on the topic of creating a state health exchange, the first stage of implementation of the 2009 federal health reforms.

The Civic Caucus became interested in health care because of its significance in terms of cost and the burden it is placing on individuals and business, and to explore whether reform of the health care system is an area that Minnesota could lead the nation.

For past interviews on related health care topics see the notes from Sue Knudson of Health Partners, (<http://tinyurl.com/6qmlzrq>), Sanne Magnan, former Commissioner of Health (<http://tinyurl.com/7veboxl>), and Steve Dahl of Deloitte Consulting (<http://tinyurl.com/6tx849q>).

A. Introduction of interviewee - Scott Leitz is Assistant Commissioner of Health Care at the Minnesota Department of Human Services (DHS). Working with a budget of more than \$5 billion, he oversees Minnesota Health Care Programs, which include Medical Assistance, MinnesotaCare, and General Assistance Medical Care. DHS is one of the largest health care purchasers in the state serving more than 700,000 program enrollees. Leitz is responsible for eligibility and benefit policy, state MinnesotaCare operations, provider contracts and payment systems, and health reform initiatives in publicly funded programs. He was appointed to his post in January 2011.

Leitz has 16 years experience in the health care and public health fields. Prior to this position, he was director of public policy for Children's Hospitals and Clinics of Minnesota. Leitz has also held several positions at the Minnesota Department of Health over the course of his career, most recently serving as Assistant Commissioner where he oversaw the development, passage, and implementation of Minnesota's landmark 2008 health reform act. He previously served as health policy division director, health economics program director, federal relations coordinator and research economist.

Scott has a bachelor's degree in economics and mathematics from the University of Wisconsin-Eau Claire and a master's in public affairs from the University of Minnesota's Humphrey School of Public Affairs.

B. Discussion -

THE PROBLEM: Minnesota's health care system is not yet operating at full effectiveness

Looking back to MinnesotaCare and its coverage of the poor, Leitz observed the problems they were trying to solve then are problems we still have today. Meanwhile, the challenges have multiplied.

Aging is a particular challenge, teamed with the decreased fiscal resources available to spend on rapidly increasing costs. Data also shows the state and country have an increasingly chronically ill patient population.

Since 2000 cumulative health care costs in the state have increased over three times faster than incomes, at a rate of 127 percent vs. 40 percent.

In 2014 a wave of more people will be coming into the health care system as the federal mandate for universal coverage kicks in. We're likely to see more people using services.

THE GOAL: Lower growth in costs while improving quality

For the interests of the state - government, business, and individuals alike - the rapid growth in cost of health care must be contained, Leitz said. From the perspective of public budgets, given present growth of health care increases in all other areas of state spending will be stressed given the growth in health care spending. Many areas of the state budget, as higher education has been experiencing, will see continued decreases.

THE STRATEGY: Leverage federal reforms into a state-based market strategy that will build on the best of Minnesota's health system

Before looking to the future, understand the 2008 reforms

Many of the elements of the 2008 law were first-of-their kind Leitz said, and much has been learned during their implementation.

Five things were contained in the law.

1. Statewide Health Improvement Program (SHIP): The largest investment (\$47 million) of its kind by a state for promoting healthy behavior, particularly around obesity and tobacco cessation

2. Electronic health record mandate: Seek to improve the quality and availability of electronic medical records, to ensure clinicians have the best possible information at the time of care.

3. Statewide quality measurement system: Measuring quality of care and outcomes is critical to ensuring that we, as we lower the trajectory of health care cost growth, we are not putting quality of care at risk. However, providers have traditionally been frustrated by being measured on quality of care for a given health condition multiple different ways by different insurance companies. The law required the establishment of a single core set of quality measures, measured uniformly at the state level, and a requirement that plans use this common core set.

4. Health care homes: As more people have become chronically ill, a more cost effective means must be found for providing care, particularly later in life. The goal with health care homes is to compensate primary care physicians and nurse practitioners so they have more time to spend time with person, and better coordinate care. In the past, efforts by providers to coordinate care has resulted in losses for the providers. Under health care homes, these providers are rewarded for coordinated care provision.

5. Provider Peer Grouping (PPG): The most challenging part of the law, and perhaps the most game-changing Leitz said, is PPG. PPG includes gathering information on quality and cost of services, and comparing providers with each other. The measures are risk-adjusted and done for the total cost to deliver care for a population. From this information, PPG calls for the creation of an index or value for each health care provider, to create a ranking and publish those rankings. As PPG is developed and made publicly available, insurance incentives would be tied to the best performers.

All five measures are currently being implemented, Leitz said. The PPG is controversial by its nature, because it involves a new process and public reporting, and has run into questions about methodology.

The components to a state strategy moving forward

Minnesota's 2008 reform law sought to put in place the necessary components to improve value, Leitz said: Information on the quality and cost of care, the publication of that information, and payment incentives that reward quality at lower costs. While each must be implemented and improved on its own, they fit into a larger strategy.

The reforms in 2008 were driven by a feeling that with the increases in cost the state was not getting better value- in fact the opposite. Yet there was lack of information to know whether we were getting good value. From the data of MNCM, state leaders know there is wide variance in quality. Knowledge about cost now is also required.

Moving forward however, Leitz said a third component - payment reform - is necessary to create an effective market.

Even with information on cost and quality, if you continue to pay people on a fee for service basis, the system will reward cost, not efficiency, he said. In such a system the more efficient a hospital is the more money it loses.

The state is moving rapidly to models of payment that provide new flexibility for providers to deliver and design care to reduce costs and improve quality, while also holding those providers accountable for costs and quality outcomes, Leitz said. Another area of opportunity will be linking insurance design

to encourage the use of high quality, low cost providers by enrollees. As the state constructs an insurance exchange, it will provide an opportunity to build in incentives for patients to choose better quality at lower cost. Types of incentives might include co-pays, deductibles, or tiering.

"When you pair information on the quality and the total cost of care," Leitz said, "with incentives for consumers to choose based on that information, you begin to see the elements of a solution."

Opportunity for leadership by the Governor

Leitz was asked about the role of Gubernatorial leadership in advancing health reform. Leitz said that in 2008, Governor Pawlenty was very favorable of reforms, Leitz said, as is the current Governor. "Governor Dayton understands we operate from a perspective of a marketplace, yet has his firm beliefs about equity and ensuring access." Those are compatible with a well functioning public-private marketplace Leitz added - in fact may stand their best chance with such a model.

Implementation of Federal and State Reforms

Leitz indicated there is opportunity to build on the 2008 reforms because the state has learned from their implementation, and now is faced with implementation of the federal health bill.

The Health Department undertook a major effort after 2008 when it began to implement the quality and cost assessment. The task was and remains very big, and the MDH has done a good job of dealing with the challenge of implementation. While there is a healthy discussion among stakeholders and the legislature surrounding PPG, it is a statute that the MDH remains committed to moving forward with towards full implementation.

A key consideration moving forward is ensuring whatever systems of measurement are built, that they are ones that are trusted by providers and stakeholders. This will be a critical part of the implementation for PPG and other initiatives looking forward.

Leading the nation, with new potential

When asked whether other states are pursuing strategies similar to Minnesota's market reform Leitz said the state appears to be way out front, but a lot of elements in Minnesota's 2008 reform Oregon ended up adopting in reforms in 2009.

C. Closing - The parallel with education is remarkable, a participant observed. Motivation is necessary, but teachers don't see motivation as their job - instead providing content. In health care the system does not yet reward efficiency.

A member asked Leitz where he learned to design markets - Humphrey Institute? "Yes - John Brandl."

The chair thanked Leitz for the visit.