DRAFT – For Discussion Only

PROPOSAL FOR CREATING THE HEALTH CARE COST, QUALITY AND ACCESS PARTNERSHIP

The Advisory Council supports the appointment of the Health Care Cost, Quality and Access Partnership to handle the inextricably intertwined issues of health care cost containment, quality and access. If Michigan is to extend health insurance to all residents, cost containment strategies must be implemented that do not impact negatively on the quality of care that Michiganians receive, or on their access to health care services. It will take the concerted effort of all interested parties to develop a plan that benefits all stakeholders including consumers, providers, business, and insurers without disproportionately disadvantaging any one group. Consensus can only come over time as stakeholders begin to trust each other and their motives, and learn more about the very complex health care delivery and payment systems. A forum is needed for these issues to be worked out, for opposing positions to be stated and reconciled, and for change to come about. A non-partisan, independent, non-profit, and self -governing Partnership that includes representation from all Michigan stakeholders, and which is staffed sufficiently to assure continuity, could function as a long-term advisor to health policy makers. The Partnership could carry on the work begun by the Advisory Council, using the momentum built up over the past year to extend health insurance to all Michigan residents and to help slow the rate of health care cost increases while maintaining quality and access.

Issues to be Considered by the Partnership

The Partnership would determine which issues strategically present the greatest opportunity for having an impact at any given time and focus on those concerns, but would be charged with considering the following

- Implementation of recommendations of the State Planning Project for the Uninsured.
- Health care cost containment
    - Prescription drug costs
    - Health information technology and electronic payment systems
    - Medical technologies – redundancy, cost/benefit analysis
    - Standards of practice
    - End of life care
    - CON, including supply and costs
    - Utilization of health care services including improper levels of care and ER usage
    - Competition versus collaboration
    - Impact of reimbursement on costs and cost shifting
    - Impact of financial incentives, both intended and unintended
    - Unrealistic consumer expectations
    - Incentive systems for Michigan residents to increase healthy behaviors (a public/private partnership).
    - *Public education/*personal empowerment about the importance of healthy life styles and how to live a healthy life
- Quality
    - Patient Safety including the Keystone project
    - Development of a system of chronic care management (disease management, care management, and case management) and disease and health maintenance protocols that are aligned with evidence-based medicine, along with a pay-for-performance system based on those protocols.
    - Error reduction
    - Health information technology
    - *Public education* about being a wise health care consumer
- Access to health care
    - Statewide
    - Regional differences, especial in very rural and very urban areas
    - Health disparities
    - Workforce issues and shortages
    - Strengthening the health care safety net
    - *Public education* about available health care coverage programs and services
    - *Public education* about the current health care crisis

- Health care policy and coordination of policy

Operational Management

A detailed implementation strategy, including financing, to extend health insurance to all Michigan residents, should be developed. This strategy would include an annual or biennial business plan detailing the steps necessary to implement solutions to meet strategic objectives. The business plan would further operationalize the recommendations from the SPG Advisory Council.

Creation of the Partnership

The current Advisory Council could transition into the Partnership if it is determined that the Partnership should begin its work immediately. The initial Partnership could be supported by DCH, DLEG, OFIS, Medicaid and other state offices as appropriate by Executive Directive. Reasons for the Partnership to begin their work immediately include:

- Keep the momentum created by the SPG Advisory Council and the HRSA grant while seeking enabling legislation, if legislation is desired.
- Begin the public education component and take the issue to the public
- Begin the process of seeking funds to support the Commission and its staff

By 2008 the Health Care Commission could be formally created by statute.

Appointment of Members

If the initial commission were a continuation of the current Advisory Council, appointment of members would entail securing the willingness of each current member to continue to serve on the Partnership, or the Partnership charter could include appointment methodology.

Partnership Membership

The Partnership could have representatives from the following broad categories - specific organizations within those broad categories have been included as possible options:

- Business (Big Three, Chambers of Commerce, SBAM, MMA, Economic Alliance)
- Unions (Teamsters, SEIU)
- Seniors (AARP)
- Health Insurers/Plans (BCBSM, Michigan Association of Health Plans)
- Hospitals (Michigan Health & Hospital Association)
- Physicians (Michigan State Medical Society, Michigan Osteopathic Association)
- Other Providers (Michigan Primary Care Association, Free Clinics of Michigan)
- Local/Regional (Detroit-Wayne County Health Authority, GFHC, GDAHC, Alliance for Health)
- Advocacy Groups (League for Human Services, Consumer Health Care Coalition, MichUHCAN)
- University (MSU School of Medicine, U of M SPH)
- Local Government (MALPH, MAC)
- State Government (DCH, OFIS, Medicaid, DLEG)
- Elected Officials/Legislators (Governor's Office, Bi-partisan, Bi-cameral)

Terms of Office

Each member could be appointed for a three-year term, with staggered appointments to provide for continuity of leadership and membership.

Staffing and Funding

To foster the mission and objectives of the Partnership, adequate initial financing for staff and operational costs should be sought from the Michigan Council of Foundations to provide a three-year development and operations launch window. Over the longer term, the Partnership should be supported by financing mechanisms that allow it to maintain its objectivity and independence and which provide a stable base of support for staff and activities necessary to accomplish the goals of the Partnership.

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VARIOUS COMMISSION/COUNCIL STRUCTURES

Congressional Budget Office – is a federal agency within the legislative branch of government, created in 1974 by statute. Their main goal is to provide Congress with objective, timely, nonpartisan analyses needed for economic and budget decisions and with information and estimates required for the budget process.

Government Accounting Office, now the Government Accountability Office (GAO) – investigative arm of Congress, is independent and nonpartisan. Called the Congressional watchdog, it studies how the federal government spends taxpayer dollars. GAO advises Congress and the heads of executive agencies about ways to make government more effective and responsive, it evaluates federal programs, audits federal expenditures and issues legal opinions. When GAO reports its findings to Congress, it recommends action. Its work leads to laws and acts that improve government operations and save billions of dollars. It was created by statute and has auditing responsibilities, accounting, and claims functions from the Treasury Department. It is independent of the Executive Branch. It is headed by a Comptroller General who is appointed to a 15-year term to give the GAO a continuity of leadership. Its workforce is comprised almost exclusively of career employees who have been hired on the basis of skill and experience. During the last 20 years, GAO has sought to improve accountability by alerting policymakers and the public to emerging problems throughout government.

Pennsylvania Health Care Cost Containment Council – is an independent state agency formed under statute to address rapidly growing health care costs. Their strategy is to contain costs by stimulating competition in the health care market by providing comparative information about providers to consumers and group purchasers for health services and giving information to providers so they can identify opportunities to contain costs and improve the quality of care they deliver. Pursuant to statute the Pennsylvania Council has three responsibilities: to collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania; to study, upon request, the issue of access to care for the uninsured; and to review and make recommendations about proposed or existing mandated benefits upon request of the legislative or executive branches of government. The Council is funded through the state budget and receives revenue through the sale of data. The membership of the Council and their terms of office are specified in the statute.

Washington State – has a Gubernatorially-appointed inter-agency work group charged with developing strategies from which specific operational programs can be developed. The legislature set goals of building public/private options and linking children with medical homes. The workgroup has on-going discussion with the Governor's staff, legislators and their staff, community and advocacy groups, and labor and business.

Rhode Island – created the Directors Health Care Group made up of key state department directors with various groups under it including: Wellness Issue Group, Balanced Health Care System Issue Group, State Health Care Purchasing Issue Group, Affordable Health Insurance for Small Employers Issue Group, and Health Information Issue Group. The Affordable Health Insurance for Small Employers Issue Group has three teams: a Core Implementation Team that is involved in day-to-day activities and actively implements the strategies. This team meets once a week and communicates regularly. The Advisory Group includes people from a variety of different functional areas who have valuable expertise, who meet once a month. The Small Employer Advisory Group is an informal group of employers who are interested and engage in the issue of health insurance and provide ideas and feedback.

Massachusetts – created the Health Insurance Exchange, a quasi-independent entity governed by a nine-member board to facilitate the purchase of health insurance by certifying insurance products.

Georgia – (as written by a staff person in Georgia) – "had a Georgia Healthcare Coalition (GHC) made up of 32 members representing government, the business community, providers, and consumers. It existed for some time before dissolving. Originally, the GHC members had to pay a membership fee to be members of the coalition, which included provider trade groups and the business community leaders. They met to discuss different health care policies and tried to come to consensus on policies that they could all support. Apparently they had luck on some insurance market reforms. When they agreed on something, all the members went back to their

organizations and used their organization's lobbying powers to educate the policy makers/legislators with a uniform voice. Their meetings were closed meetings and no one really knew that the coalition existed.

The governor decided to use the coalition to be his advisory counsel on Medicaid Reform. He gave the Coalition funding to become his advisory body, so they agreed. This made the coalition a public group with public meetings etc. (There were some who didn't like the idea of this becoming an advisory group since members had "paid" and self-selected to join originally). They had a lot of trouble coming to consensus on Medicaid reform. Problems arose around the provider trade organizations because they felt most of the reforms would impact them financially, so consensus was hard to come by...also add in the public meeting component. . These were the main reasons for the coalition's demise.

In summary, the policy problem the coalition was asked to address was too tied to the members' pocketbooks and the solutions too short-term to be viable. Providers have said that if they had discussed longer-term solutions there may have been a way to get more buy-in. It is very difficult for a commission to have a voice in policy without government involvement, you need to be specific about the clout of people on the commission and you also need to be specific about the purpose of the commission (Is it an advisory body to the governor or something else). Folks here have also said that it will be difficult to have an objective commission if they receive any government funding."

Utah - has an Uninsured Working Group created at the request of the Governor with no specific budget. Membership includes: Commissioner of Insurance, Executive Director of Health, University of Utah, Governor's Offices of Planning and Budget, and Economic Development, Small and Large Employers, Actuary and CEO of an insurer, Office of Rural Affairs, Utah Hospital Assn, Department of Community and Culture, Utah Medical Assn, Salt Lake Chamber of Commerce, with the Governor and his Chief of Staff.

Wyoming – established the Wyoming Healthcare Commission within the Governor's office. It is charged with examining a wide range of healthcare issues and drafting specific recommendations designed to improve access to, and quality of, healthcare in Wyoming. Tasks assigned to the WHCC by the Legislature include suggesting solutions for reducing medical liability insurance costs, decreasing medical errors, addressing health-related workforce shortages, and compensating injured patients. Commissioners, who are appointed by the Governor, are charged with looking at the following issues: access to affordable, effective and quality health care, including the rural areas of the state; wellness and individual responsibility for personal health; disease prevention and management; liability insurance reform, provider workforce shortages; cost shifting that results from low public reimbursement; long term care; medical errors and other issues deemed appropriate.

The Models Development Workgroup envisioned a commission as follows:
"A health care commission would develop implementation strategies to insure that all Michigan residents are covered. The commission would also develop on-going strategies for continuous improvement in the areas of cost containment, quality, and access. Some of the Commission's initiatives should include the following.

- A system of chronic care management (disease management, care management, and case management) and disease and health maintenance protocols that are aligned with evidence-based medicine.
- A pay-for-performance system based on the above protocols.
- Incentive systems for Michigan residents to increase healthy behaviors (a public/private partnership).
- A single unified billing and service authorization system for providers, including medical claims such as Workers' Compensation, auto insurance reimbursement, health insurance claims, etc.
- A strategy to maximize the efficiency and cost savings from full implementation of an electronic system for submitting provider claims, service authorization, and accessing medical records.
- A mechanism/fund to capture savings that may result from simplification of administrative processes, as well as other savings that may be realized as health care becomes universally available.
- A detailed implementation strategy, including financing, to extend health insurance to Michiganians."