Health Policy
Quality – Costs – Access
Whose responsibility?

David Durenberger, Chair, NIHP
Senior Health Policy Fellow
University of St. Thomas
February 15, 2005

The National Institute of Health Policy

Senior Health Policy Fellow

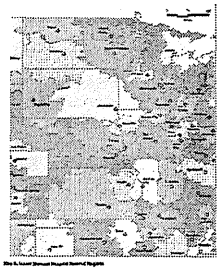
University of St. Thomas' (UST) College of Business

- Chair, National Institute of Health Policy
- Medicare Payment Advisory Committee (MedPAC)
- Kaiser Commission on Medicaid and the Uninsured
- National Committee on Quality Assurance (NCQA)
- National Quality Forum's Commission for Quality Long-term Care
- Medical Technology Leadership Forum (MTLF)

The National Institute of Health Policy

NIHP

- *35-member regional organization*
- *Neutral forum for multi-stakeholder collaboration*
- *Focused on regional health policy*
- *Striving to collectively maximize national impact*



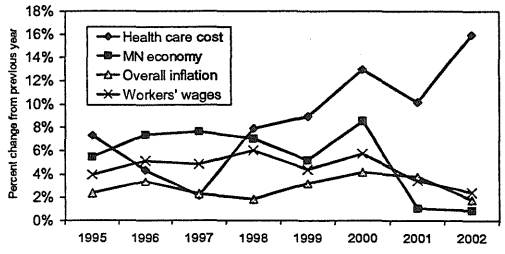
The National Institute of Health Policy

NIHP Members

3M
Allina Health System
Altru Health Systems, Grand Forks
Avera Health, Sioux Falls
Benedictine Health System
BlueCross BlueShield of MN
Buyers Health Care Action Group
Carlson Companies
CentraCare, St. Cloud
Children's Hospitals & Clinics
Courage Center
Fairview Health Services
Gillette Children's Hospital
Good Samaritan Society, Sioux Falls
Group Health Cooperative Care, Eau Claire
Gunderson Lutheran, LaCrosse
Halleland Lewis Nilan Sipkins & Johnson
HealthEast
HealthPartners
Hennepin County
Hennepin Faculty Associates
Institute of Clinical Systems Improvement (ICSI)
Marshfield Clinic
Medica
MeritCare Health System, Fargo
Minnesota Medical Association
Park Nicollet Health Services
PreferredOne
Sacred Heart Hospital, Eau Claire
Sioux Valley Hospitals
Stratis Health
UCare Minnesota
University of Minnesota
VHA – Upper Midwest

The National Institute of Health Policy

Our Problem in a Nutshell



The National Institute of Health Policy

Health Policy

"All American deserve the security of lifelong, affordable access to high-quality healthcare."

- William Frist, M.D., "Healthcare in the 21st Century," The New England Journal of Medicine, January 20, 2005

The National Institute of Health Policy

Policy Priority: Access

- Universal coverage
- Increase supply and demand
- Employer-based health insurance
- Social insurance
- Public assistance

The National Institute of Health Policy

Policy Priority: Affordability (Cost Containment)

- 1970s: Supply regulation
- 1980s: Price regulation
- 1990s: Managed behavior modification
- 2000s: Consumer-driven healthcare, medical liability reform

The National Institute of Health Policy

Policy Priority: Quality

- No national policy or priority
- State regulations and consumer protection
- Pay for volume
- Medical specialization
- Doctors and hospitals
- The "Medical Arms Race"

The National Institute of Health Policy

Quality

"You may believe you've been overcharged, but, remember, you're overmedicated."

The New Yorker, October 27, 2003

The National Institute of Health Policy

Healthcare Non-System

- **Highly fragmented system/cottage industry**
- **Lacks even rudimentary information systems**
- **Unnecessary duplication**
- **Long wait times and delays**
- **Overuse of services**
- **Services delivered where the risk of harm outweighs the benefits**
- **Lacks "value" orientation**

Institute of Medicine 2001 Crossing the Quality Chasm

The National Institute of Health Policy

Is this quality?

Each year between 44,000 and 98,000 American lives are lost due to medical mistakes. *-NCQA*

"HealthPartners refuses to pay for medical errors." *- Pioneer Press*

More people die each year from hospitals than from breast cancer or from automobile accidents.

- Institute of Medicine

The National Institute of Health Policy

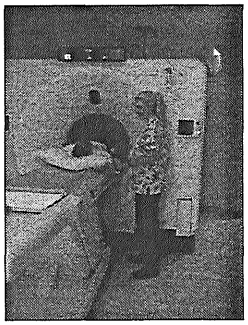
What are we buying?

Lifetime difference in Medicare spending for a 65-year-old in Miami vs. Minneapolis is $50,000.

Lexus GS430 - $50,980

The National Institute of Health Policy

21 CT Scanners within 2.1 miles of Fairview Southdale Hospital



The National Institute of Health Policy

"California Hospitals Open Books, Showing Huge Price Differences"

State law requires disclosing charges for goods and services

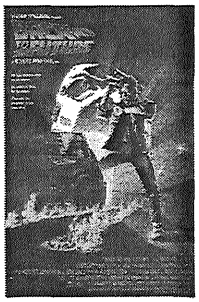
How Much Is That Chest X-Ray?

A new California law allows patients to look up the retail prices of many goods and services at hospitals. A survey of several hospital price lists shows dramatic differences in prices.

Chest X-ray	$128.00	$700	$40.150	$720	$1,519	$412.00	$396.72
Complete blood count	$47	$234	$186	$90	$547.50	$185.80	$172.42
Comprehensive metabolic panel	$396.60	$743	$451**	$97	$1,731.95	$375	$387.18
CT scan, head/brain (without contrast)	$821.50	$2,807	$2,593	$850	$6,598	$4,057.61	$2,474.95
Percocet® (oxycodone-acetaminophen) 5/325 mg, 1 pill	$11.44	$76.79	$15	$4.88	$35.90	$6.50	$27.95
Tylenol® (acetaminophen) 500 mg, 2 pills	$7.06	No charge	$1	$5.50	No charge	12 cents	$3.28

The Wall Street Journal, December 27, 2004

The National Institute of Health Policy



<u>Consumer-driven healthcare (CDHC)</u>

The 1970-80s cost containment of increased consumer cost-sharing with major medical

The National Institute of Health Policy

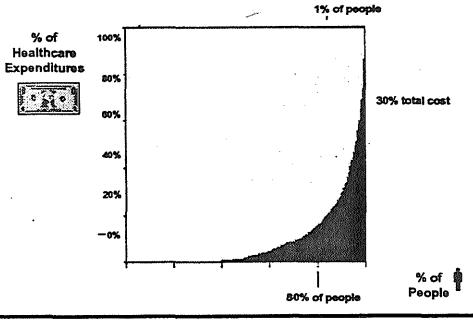
CDHC Problem #1:

No Consumers

- What prices?
- What quality?

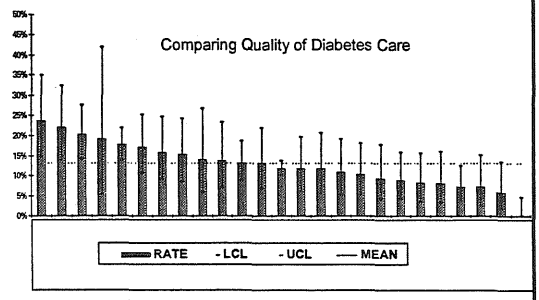
The National Institute of Health Policy

CDHC Problem #2:



The National Institute of Health Policy

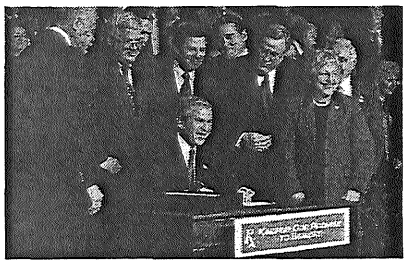
CDHC Problem #3



SOURCE: Sample data from Clinical Quality Report, HealthPartners 1/1/2002-12/31/2002

The National Institute of Health Policy

Medicare Modernization Act 2003



The National Institute of Health Policy

If you had $1.2 trillion, how would you spend it?

- Prescription drugs for all with corporate subsidies for many
  - Donut hole design
  - A drug benefit that drug companies can get out of, but beneficiaries cannot
  - Asking elderly to pioneer "consumer choice:
- Drug company exception to Medicare payment policy
- Pay America's health insurance plans average of $1.10 on traditional Medicare $1.00 to provide drug benefit

The National Institute of Health Policy

The National Institute of Health Policy

If you had $1.2 trillion, how you would spend it?

- Medicare privatization (Medicare Advantage)
- "Clawback" - reverse block grant by states to federal
- Means testing elderly and disabled
- Health Savings Accounts (HSAs)
  - High-deductible major medical
  - Regressive subsidy

The National Institute of Health Policy

"It's a faith-based initiative"

John Rother, Policy Director AARP

AARP
The power to make it better.

The National Institute of Health Policy

And, if you had $12 trillion to spend over 10 years, how would you spend it on 42 million Medicare beneficiaries, 51 million Medicaid beneficiaries including 11 million "dual eligibles"?

We need to ask the right questions.

The National Institute of Health Policy

MEDPAC Medicare Payment Advisory Commission

"Congress must give Medicare the ability to pay providers differently based on performance and funded by a portion of currently budgeted payments."

-MedPAC March 2005 Report

The National Institute of Health Policy

"Incenting consumers to change the system is a displacement of responsibility for changing the system from the stewards who actually have the job of crafting systems to meet the needs of people who come to them for help."

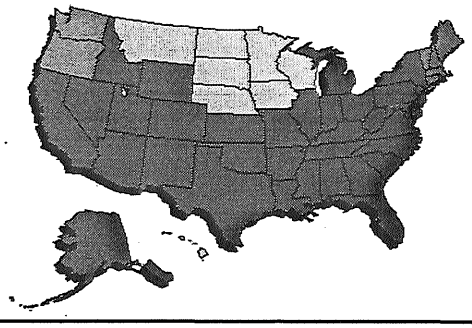
- Don Berwick, MD, MPP, President and CEO of the Institute for Healthcare Improvement

The National Institute of Health Policy

If only I knew then what I know now...

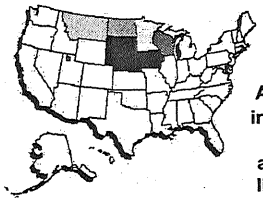
The National Institute of Health Policy

Naturally Occurring Regions



The National Institute of Health Policy

The Upper Midwest



A *naturally occurring region* in which universal access to high quality care at an affordable price is a way of life, with roots in non-profit and faith based associations, held accountable for stewardship.

The National Institute of Health Policy

The Minnesota Citizens Forum

Healthy People, Healthy Communities , Healthy System

The National Institute of Health Policy

Minnesota Citizens Forum Seven (7) Principles

- Put Minnesotans in the driver's seat
- Fully disclose costs and quality
- Reduce costs through better quality
- Incentives to encourage health
- Universal participation
- New models of healthcare education
- Overhead and administration

The National Institute of Health Policy

Principle 1:
Put Minnesotans in the Driver's Seat

- **Consumer role in decisions about cost and quality**
- **Patient role in decisions about treatment**
- **Access to preventive care and services to manage chronic illness and disability**
- **Respond to community values**
- **Public participation**

The National Institute of Health Policy

Principle 2:
Fully disclose costs and quality

- **Minnesotans in the dark**
- **Open up the black box:**
  - **Information on cost**
  - **Information on quality**
  - **Information to promote health**
  - **Information to manage health conditions**
  - **Information on health system financing**

The National Institute of Health Policy

Principle 3:
Reduce Costs through Better Quality

*We are currently paying for **VOLUME**, not **VALUE***

- Wide variation in quality
- 30-40% ineffective or unnecessary
- Change payment incentives
- Report quality, safety, efficiency
- Priorities for chronic disease, disparity
- Productivity

The National Institute of Health Policy

Principle 4:
Incentives to Encourage Health

Goal: improve health and behavior

- **Build on community and values**
- **Reward people who live healthy lives**
- **Reward providers who improve health**
- **Home and community support services**
- **Public health and community health**
- **Tobacco user fee**

The National Institute of Health Policy

Principle 5:
Universal Participation

- Continue the commitment of coverage and access for all
- Short-term steps to improve access and prevent cost-shifting
- Participation: medically "lost," new and old cultures
- Mental health, behavioral health, addiction
- Long-term care

The National Institute of Health Policy

Principle 6:
New Models of Healthcare Education

Systems workforce needs:

- Education capacity
- Reform the "guild" approach
- Inadequate preparation:
  - Growing diversity
  - New technology
  - Focus on better health
- New models needed

The National Institute of Health Policy

Principle 7:
Overhead and Administration

- Unnecessary complexity
- Use of electronic technology
- Insurance reform
- Alternative accountabilities
- Role of employers
- Change national payment policies

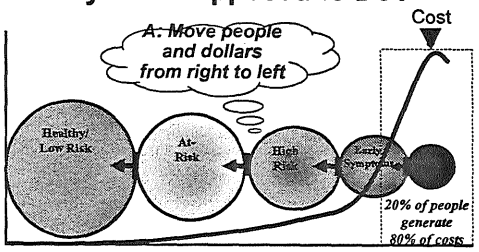
The National Institute of Health Policy

Implementation Strategy

- Leadership from the Governor
- United state purchasing strategy
- Buyers alliance
- Public-private partnership
- Bipartisan legislative work group
- Legislation in 2006 and beyond

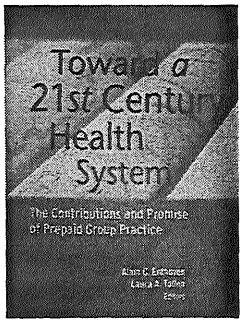
The National Institute of Health Policy

Q: What is the Health Care System Supposed to Do?



A *value-based* health care system

The National Institute of Health Policy



Consumer Choice of Clinical Systems and Performers

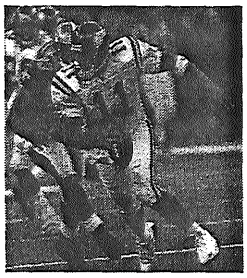
-vs-

Consumer Choice of Insurance and Services

The National Institute of Health Policy

This all requires LEADERSHIP

- Healthy People
- Healthy Communities
- Healthy System
- New Federalism



The National Institute of Health Policy

Governor Pawlenty's Health Cabinet

Four Key Workgroups

1. Health Care Website
2. Health Care Regulation
3. State Health Care Purchasing
4. Budget and Policy

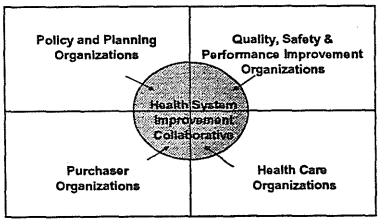
The National Institute of Health Policy

And EXAMPLES

- Institute for Clinical Systems Improvement (ICSI)
- Community Measurement Project
- Wisconsin Collaborative on Healthcare Quality

The National Institute of Health Policy

Collaborating to Improve Minnesota's Healthcare System



"solid performance"

The National Institute of Health Policy

Thank you for your leadership.

ddurenberger@sttthomas.edu
www.nihp.org

LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

Report of the Minnesota Citizens Forum on Health Care Costs

FEBRUARY 23, 2004

LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

Table of Contents

This page is intentionally left blank.

Minnesota Citizens Forum on Health Care Costs

LEADERSHIP PANEL MEMBERS

David Durenberger, Chair

Chair
National Institute of Health Policy

Peter Benner

Executive Director
Minnesota State Employees Union, AFSCME Council 6

Duane Benson

Former Executive Director
Minnesota Business Partnership

Jesse Bethke Gomez

President
Chicano-Latinos Unidos En Servicios (CLUES)

Ray Christensen, MD

Assistant Dean for Rural Health
School of Medicine, University of Minnesota-Duluth

Joanne Disch, PhD, RN, FAAN

Professor and Director of the
Katharine J. Densford International Center for Nursing Leadership
School of Nursing, University of Minnesota

Al Fallenstein*

Executive Vice President
Taylor Corporation

Frances Gardeski

Former CEO
University Medical Center-Mesabi

Jeanne Lally

Former President
Fairview Northland Regional Health Care
Fairview Health Services

Roger Moe

Business and Policy Consultant

Glen Nelson, MD

Chairman
GDN Holdings

Karl Self, DDS

Executive Director
Community-University Health Center

Bob Senkler

Chairman, President and
Chief Executive Officer
Minnesota Life Insurance Company

Tom Swain

Former Executive Vice President
St. Paul Companies

Chris Twomey

President and Chairman of the Board
Arctic Cat

Pamela Wheelock

Senior Vice President and
Chief Financial Officer
Minnesota Sports and Entertainment Group

Colleen Wieck

Executive Director
Governor's Council on Developmental Disabilities

Douglas Wood, MD, FACP, FACC

Vice Chair
Department of Medicine
Mayo Clinic and Mayo Foundation

*Al Fallenstein was tragically taken from us in an automobile accident in December. He remains with us in spirit.

STAFF ACKNOWLEDGEMENTS

Michael Scandrett served as the staff director, with assistance from **Mona Peterson Rosow** of Halleland Health Consulting, but many others made important contributions, including **Scott Leitz** and **Julie Sonier** of the Minnesota Department of Health, **Barbara Vaughan** and **Sheila Moroney** of the National Institute of Health Policy, and **Susan Heegaard** of Governor Tim Pawlenty's office. Thanks to **Mary Jo O'Brien** for her substantial contributions and assistance in working with the Governor's office. Thanks also to **Jill Caruth** and **Kate Schlauch** who did a lot of heavy lifting to provide administrative support and to **Bonny Belgum** and **Bekah Orr** for their research support. Many others contributed as well, most without compensation.

MINNESOTA CITIZENS FORUM ON HEALTH CARE COSTS
220 South Sixth Street, 600 Pillsbury Center South
Minneapolis, Minnesota 55402

February 23, 2004

Dear Governor Pawlenty:

On behalf of the Leadership Panel members of the Minnesota Citizens Forum on Health Care Costs and the many Minnesotans who have shared their ideas, concerns and values through our Minnesota Dialogues process, I am pleased to submit to you this report, "Listening to Minnesotans: Transforming Minnesota's Health Care System."

The report reflects not only an enormous amount of work by all those involved, but a deep-seated desire by many Minnesotans to work together to create a better system of health care. The findings and conclusions in this report are a consensus not just of the Leadership Panel, but of Minnesotans from across our state.

I submit this report with some personal observations:

First, Minnesota is in the enviable position of being able to build on some enormous strengths in our health care system. Our state's uninsured rate of 5.4 percent is one of the lowest in the nation. Minnesotans consistently have ranked among the healthiest people in the country. Dramatic and immediate change is needed, but we start our journey in far better shape than many other states.

Second, many of the recommendations in this report call for partnerships – between government and employers, between purchasers and payers, between providers and consumers and on and on. Collaboration is a great Minnesota tradition. We can look at many of the strengths of our health system and see at their beginning an innovative partnership. How much more of a challenge would we face today if employers, government, payers and providers hadn't worked together in the late 1980s and early 1990s to make it easier and more affordable for small business to obtain health coverage for their workers or to create MinnesotaCare?

Third, the report cites many barriers to an affordable, accessible health system. One barrier is not mentioned, however, even though it may be the largest of them all. Too often, important reforms are stymied by the barrier of false choices. We pit individual privacy against the need to collect data about public health, even though we can do both. Tort reform is constructed as a choice between safeguards on an error-prone system and the ability of providers to practice cost-effective, evidence-based medicine. We demand controls over rising health insurance premiums, yet reward political intervention in mandating benefits and treatments. Certainly, there will be difficult trade-offs and challenging choices as we take on the task of reforming the

health system. But we are in this together. We need to frame choices in ways that reflect the common good.

Fourth, some will take the easy way out and dismiss the recommendations in this report by saying they are nothing new. In one sense, they are right. There is no one magic answer. We have known for years that greater consumer involvement in health care purchasing decisions, universal coverage and many of the other recommendations are essential to reforming the health system. As is so often the case in life, we know the right thing to do; the difficulty is in doing it. So it is with health care.

Having said that though, this report is new on two important fronts. First, it is the most comprehensive set of recommendations ever offered for reform. It connects the actions in a cohesive and clear action plan. Second, the recommendations are borne of public involvement. The recommendations aren't the work of those with a special-interest agenda to pursue. They are based on the values and principles of Minnesotans.

And that gets me to my fifth and most important observation. Minnesotans are ready for change. In many ways, the people of Minnesota are ahead of policy makers on health care reform. Minnesotans need more tools (especially information) to be full partners in health care reform, but they are ready for the challenge. They know change will be difficult and will require contributions from everyone, but they also know that we no longer can just tinker around the edges.

Change will be difficult. It will require hard work, political courage and a faith in the people of Minnesota. Taking on this challenge may seem overwhelming. Ignoring this challenge will be devastating. Delay no longer is an option. The time to act is now.

With that, it is great privilege to have been part of this process and a great honor to submit this report, "Listening to Minnesotans: Transforming Minnesota's Health Care System."

Sincerely,

David Durenberger, Chair

Executive Summary

A CRISIS OF AFFORDABILITY. The average Minnesota household pays $11,000 per year for health care in taxes, premiums, and out-of-pocket costs for themselves and others. If health care costs continue to grow at the current rate, the cost per household will reach $22,000 by the year 2010. Without a change, our health care system will be priced out of reach of most Minnesotans. Businesses are also being hit hard by the increasing health care costs. In the past four years, insurance premiums have grown 3½ times faster than the state's economy and workers' wages. As health care costs continue to grow, employers have less money to spend on wage increases and other benefits for employees. Rising health care costs are also breaking the back of state and local governments. The relentless rise in health care costs has forced the Minnesota Legislature to divert millions of dollars away from education, roads, and the environment. Based on a three percent growth rate each year in the state's total health care spending and no reduction in the monthly cost of the average enrollee, by the year 2007, lawmakers will be faced with a decision of whether to cut another 104,000 low income Minnesotans from government health care programs.

PEOPLE PAY FOR HEALTH CARE. In our current financing system, people are in the dark about health care costs and excluded from most decisions about coverage and financing. Most Minnesota households pay less than a third of the cost of health care directly out of their own pockets. The rest is paid by employers and government in ways that are hidden from view. Even this money is actually coming out of people's pockets, they just don't realize it. Government uses our tax dollars for government programs and for health insurance for public employees. Employers pay their share of the health insurance premium using employee benefit dollars that might otherwise be paid to workers in additional wages or other benefits. Businesses build the cost of their share of health care premiums into the price of goods and services we purchase every day. Ultimately, people, not government or insurance companies, pay for everything and they should be fully informed and involved in decisions affecting their pocketbooks.

SERVING THE PEOPLE. Past efforts to keep health care affordable – from government price controls to managed care – have had at best only temporary success because they did not have public support. People felt the changes were forced on them by outside forces in a health care system they did not trust. To have lasting success, control of the health care system must be given back to the people who use and pay for it. Minnesota has earned a national reputation for leadership and innovation in health care. That success has always come from the ability to listen to citizens and to trust their collective judgment. The starting point must be the shared community values of Minnesotans and the goal must be a health care system where the individual is in control of his or her own care and coverage.

LISTENING TO PEOPLE. At the request of Governor Tim Pawlenty, the Minnesota Citizens Forum on Health Care Costs (Minnesota Citizens Forum) spent November and December, 2003 listening to Minnesotans. Town hall meetings and informal listening sessions were held across the state. An online survey was developed to solicit information from those who were not able to attend the town hall meetings. Ideas sent

by Minnesotans through the mail and the Internet were read. Surveys and other research on public opinion in Minnesota were studied. The Minnesota Citizens Forum worked with the Minnesota Board on Aging and the Minnesota Governor's Council on Developmental Disabilities to conduct a survey of a representative sample of 800 Minnesotans. In the end, a surprising amount of agreement was found about what Minnesotans expect from the health care system and what they think should be done about rising costs. Our first report, "*Listening to Minnesotans: the First Step towards Building a Better Health Care System,*" describes the results of the dialogue with Minnesotans in detail.

In addition to talking with the public, we also sought the ideas and advice of experts and leaders from health care, business and government. We were impressed. Most major business and health care trade associations submitted detailed proposals for improving health care. We found that they, like the general public, agree about more things than they disagree about. They know major changes are needed and are ready and willing to work together. Our recommendations are built on the large expanse of common ground that exists among Minnesota citizens and leaders from health care, business and government.

MAJOR CHANGE IS NEEDED. There is a big gap between what people want and what the current system delivers. Many Minnesotans said we will not be able to fix the health care system without making major changes. Isolated, band-aid approaches will not have a lasting effect. They may even have the unintended effect of increasing health care costs further. Minnesotans are ready for change and are willing to do their part.

WE ARE ALL IN THIS TOGETHER. Few of us can afford to pay the costs of a serious illness without insurance. We use a health insurance model to share the risk with others. In any given year, 20 percent of us will use no health care services while one percent will consume 27 percent of all health care dollars. By sharing the risk through insurance, we can afford health care when we need it. We count on the system to balance individual needs with the needs of others. The Minnesota Citizens Forum discovered Minnesotans understand this concept and embrace it, but they have lost faith in the system's ability to do this fairly. They lack trust because they are left in the dark and do not have a say in important decisions. Restoring trust in the system is the key to making sustainable improvements Minnesotans can support.

BUILDING ON EXISTING EFFORTS. We were very impressed with the commitment and leadership shown by Minnesota's health care community, business community and public officials. Minnesota is a hotbed of nationally recognized leadership and innovation in health care. Our health care system has a strong climate of creativity, collaboration and commitment. Activities are already underway that take us halfway to our vision of how Minnesota's health care system should work. Our goal is to build on these existing efforts rather than create new ones. We want to foster an environment that encourages collaboration among existing efforts, eliminates redundancies and capitalizes on the ability to create successful new models for health care delivery.

CHARGED WORDS. Because the health care reform discussion is so politically charged, some words have become associated with a particular political or philosophical agenda or mean different things to different people. We tried to avoid loaded terms such

as "universal coverage," "free market system," "consumer-driven health care," "evidence-based medicine," "personal responsibility" and "single-payer health care system." When we used these terms, we tried to explain what we meant. For example, when we use the term "health care" in this report, we are using it in its broadest sense – to include mental health, dental health, and long-term care – even though we have not developed specific recommendations in these areas.

COMPETITION IN A WELL-FUNCTIONING HEALTH CARE SYSTEM. The polarized, political debate between a "single-payer" system (a universal, government-financed health insurance plan that covers everyone) and a "free market" health care system (where government plays a minimal role in regulating or managing health care) continues. In the mean time, nothing changes and we slip deeper into the health care cost crisis. The Minnesota Citizens Forum looked to Minnesotans for the answer. We found that almost all Minnesotans agree on two fundamental principles: (1) they want a responsive system where everyone gets the health care they need, and (2) they want a privately-based health care system that offers as much choice as possible. Our recommendations will lead to a uniquely Minnesotan universal health care system that promotes healthy private sector competition while assuring the overall system serves the best interests of all Minnesotans.

A VISION FOR THE FUTURE. We believe Minnesotans deserve a health care system that delivers better health and equitable to safe, high quality treatment at an affordable price. Everyone must do their part to realize the vision, including individuals, communities, those who work in the system and those who finance it. Some of these changes can be implemented immediately; many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals.

GENERAL RECOMMENDATIONS

The current health system is very complex, but it is simple to describe what needs to change. We can drive a car without knowing exactly how the engine works. The following recommendations require major changes, but by working together and building on existing efforts already underway, the job will get done. For each recommendation, we have identified actions that should be taken to implement the recommendation. Time is essential, we must act now.

1. **PUT MINNESOTANS IN THE DRIVER'S SEAT.** Minnesotans should make the decisions about health care, both individually and collectively. This is a paradigm shift from the current system where many of the most important decisions are made by employers, health plans, health care professionals and government. Minnesotans need to define what the health care system should do as opposed to the system defining itself. There also needs to be a collective discussion on how to fund the system and what affordability means. Employers, HMOs, and health insurance companies should play a supportive role, but not the lead role. This means we will have to rethink what the marketplace should look like.

    a. **Give individuals more choices and control of their health care treatment, with incentives for choosing higher quality, lower cost providers; however, consumer-centered health care should**

not create financial barriers that prevent people from getting preventive care and cost-effective services.

b. **Give individuals the opportunity to choose from a full array of health plan choices ranging from low-cost to high-cost, while preserving the basic concept of insurance which uses money from the currently healthy to subsidize the currently sick.**

c. **Make sure individuals with a chronic disease or disability can afford to receive the care they need to avoid preventable complications of disease.**

d. **Establish a permanent process for a continuing dialogue with the public and for conducting research on Minnesotans needs, values and preferences.**

2. **FULLY DISCLOSE COSTS AND QUALITY.** Minnesotans should be fully informed about health care costs and quality and able to compare the price and quality of health care providers and health plans in order to make informed decisions. This will be eye-opening for the public. Most people have no idea how much variation exists in quality and price. As members of a community, they should know where the money goes, how it is used, who profits from it, and what quality and outcomes they are getting for their money.

a. **Give Minnesotans detailed information on prices costs and financing in the current system.**

b. **Create a health care information web site with comprehensive information about health care costs and quality in Minnesota (see recommendation 3 on quality).**

c. **Implement a public awareness campaign to increase the public's knowledge of the costs of health care.**

3. **REDUCE COSTS THROUGH BETTER QUALITY.** During the dialogue with Minnesotans, many examples were given of how health care dollars are often wasted on ineffective treatments, mistakes and poor quality care. By some estimates, 30 to 40 percent of health care dollars are spent on ineffective and unnecessary care. Health care costs can be reduced by improving quality of care and eliminating health disparities.

a. **Change payment systems to reward better quality and effectiveness.**

b. **Standardize methods of measuring and reporting quality.**

c. **Give Minnesotans quality information about health plans and health care providers.**

d. **Bring together existing quality initiatives in a state forum to coordinate existing quality improvement efforts and develop a**

statewide quality plan that will achieve specific quality improvement goals.

e. **Test new improvements in care for persons with chronic disease and disability.**

f. **Define "quality" to include cultural competence and no disparities in health status, access and quality.**

4. **CHANGE INCENTIVES TO ENCOURAGE HEALTH.** The current system does not reward individuals for healthy lifestyles, nor does it reward health care providers for improving a patient's health. The broader environment, too, does not encourage good health. Super-sized, caloric, high-fat fast food has replaced home-cooked meals. Poor diet, lack of exercise, high stress lifestyles, and smoking result in higher rates of obesity, heart disease, cancer and mental illness. Incentives in the health care system should be changed to produce better health and outcomes, and together we should seek to create healthier communities.

a. **Change payment systems across the entire health care system so that incentives produce better health.**

b. **Reward people who maintain good health with discounts on health care, lower premiums, or other benefits.**

c. **Encourage employers and communities to provide programs and incentives to influence individuals to adopt healthier behaviors.**

d. **Strengthen the state's efforts to reduce tobacco use, with a special focus on youth smoking.**

e. **Add a $1.00 per pack user fee on cigarettes to reduce smoking rates and raise revenue for state efforts to reduce smoking, improve health and provide access to uninsured Minnesotans.**

f. **Launch an aggressive campaign to reduce obesity, especially among children.**

g. **Strengthen the public health system through community partnerships and adequate funding.**

5. **ASSURE UNIVERSAL PARTICIPATION IN THE HEALTH CARE SYSTEM.** Minnesotans are strongly in support of a health care system where everyone has access to needed health care. Access to health care may be limited by financial, geographic, linguistic or cultural barriers. These barriers result in poorer health, lack of preventive care and delays in needed treatment, all of which add cost to the system. We must work together to eliminate barriers so that everyone has health care coverage and is able to get the services they need. However, a universal system is not <u>just</u> about access and coverage, it is also about meaningful participation by individuals so we have a health care system

in which everyone receives needed health care, including preventive care, at a cost they can afford and everyone contributes to better health. We share the financial risk of medical expenses through insurance so that we can afford health care when we need it. If everyone is not paying in, especially when healthy, we run the risk that others will not receive care when they need it.

a. **Set a goal of "universal participation" in the health care system, which is broader than just universal access or coverage.**

b. **Continue the state's commitment to the goal of health coverage for all Minnesotans, with a priority for covering children.**

c. **Give uninsured Minnesotans access to affordable basic preventive care and other cost-effective services that will improve their health and reduce the need for more costly treatment.**

d. **Require participation in the health care system by uninsured Minnesotans who can afford to buy health coverage but choose not to.**

e. **Change the current system of financing uncompensated care for the uninsured to eliminate cost-shifting and spread the burden more equitably.**

f. **Eliminate non-economic barriers to access for needed health care services.**

g. **Reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses.**

6. **SUPPORT NEW MODELS FOR HEALTH CARE EDUCATION.** Minnesota is facing a growing shortage of health care workers even in areas typically not affected by worker shortages. The existing workforce cannot keep up with current demand, nor is it adequately prepared for the rapid changes that are taking place in our state's demographic makeup and the revolution of medical technology treatment. **Support new models for health care education to meet Minnesota's changing health care needs.**

7. **REDUCE THE COST OF OVERHEAD AND ADMINISTRATION.** The complexity, duplication, and lack of accountability in the current system results in unnecessary costs for overhead and administration. Significant savings can be achieved by streamlining and standardizing administrative procedures and government regulations. New electronic technology offers an opportunity for further savings.

a. **Establish uniform health care industry standards for electronic billing, electronic medical records, reports and other administrative procedures.**

b. **Use health care industry partnerships to facilitate the rapid adoption of new electronic technologies that will improve efficiency and service and reduce administrative costs.**

c. **Adopt a new approach to state health care regulation.**

d. **Reform health care taxes.**

HOW TO GET THERE

A major effort is needed to make the transformational changes recommended above. The good news is that much agreement exists about the direction we need to go; everyone seems ready to do their part, and leaders are stepping forward to spearhead the effort. These three ingredients – vision, commitment and leadership – will get us to our goal. We suggest the following specific steps to get started, but all should be done in a way that is open to the public and maximizes participation of Minnesotans to assure that the changes truly serve the needs of Minnesotans.

8. **STATE LEADERSHIP.** The State of Minnesota will lead the way by changing the way the state carries out its role as purchaser, regulator and provider of health care services. On Friday, February 6, 2004, Governor Pawlenty announced that the State of Minnesota will develop a **united state health care purchasing and regulatory strategy** that will set an example for the entire state.

9. **BUYERS ALLIANCE.** With state leadership, consumers, employers and other buyers can be brought together to form a **united buyers alliance** to get the leverage needed to drive major changes in the health care delivery system. Governor Pawlenty and some of the state's largest employers and business organizations have agreed to provide leadership.

10. **PUBLIC/PRIVATE PARTNERSHIP.** Once consumers and buyers make it clear what is expected from their health care system, the health care industry will respond. An action-oriented, **public/private partnership** is needed to help the health care industry retool and work together to manage a seamless transition from the old way to the new way of doing things. Private leaders from health care and business will work with Governor Pawlenty to organize this activity.

11. **BIPARTISAN LEGISLATIVE WORK GROUP.** While much can be accomplished through public and private collaboration without the need for legislation, the Minnesota Legislature will play an important role in changing the state's public policy to support improvements in health care. Health care leaders in the House and Senate from both parties have agreed to work together and with the Governor, in a bipartisan way, to agree on public policies and draft legislation for the 2005 legislative session.

This page is intentionally left blank.

LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

Report of the Minnesota Citizens Forum on Health Care Costs

Introduction

In September 2003, Governor Tim Pawlenty announced the formation of the Minnesota Citizens Forum on Health Care Costs (Minnesota Citizens Forum.) Under the leadership of former U.S. Senator David Durenberger, an 18-member Leadership Panel comprised of respected citizen leaders was convened to lead a statewide, public discussion on how to keep health care affordable. Their charge was

> *To engage Minnesotans in a public dialogue about the causes and consequences of rising health care costs, and possible solutions, and to recommend both short and long-term actions for controlling costs that are grounded in community values.*

The Leadership Panel sought to develop a set of recommendations for changing the way health care is delivered in Minnesota, a plan based on Minnesotan community values. Beginning in October 2003, the Leadership Panel began meeting each month to discuss the current health care system and aspects of the system that were driving up costs. After defining the problem, the Leadership Panel began focusing on the vision for the future of Minnesota's health care system. As part of this process, the Leadership Panel formed four small groups around health, access, quality and affordability to discuss in depth the goals for Minnesota's health care system and to make recommendations on how to meet those goals. These groups presented their recommendations to the panel for approval.

Over the same period of time, the Leadership Panel went to Minnesotans, both the general public and health care experts, to learn what Minnesotans believed was the problem, the solution and the vision of Minnesota's health care system in the future. Over the course of this process, the Leadership Panel received input from:

- Twelve town hall meetings, including 4 meetings with special invitations extended to the Latino, American Indian, African American, and Asian American communities - over 500 people participated in the town hall meeting process.
- 800 randomized participants in a telephone survey.
- 108 respondents to an online survey.
- 94 proposals from both individuals and stakeholder organizations.
- 158 individual emails and letters.
- Numerous listening sessions with local chambers, trade associations, business groups, health educators and others.

Based on this information and their discussions, the Leadership Panel developed recommendations that are contained in this report, the second report issued by the Leadership Panel. The first report, "*Listening to Minnesotans: the First Step towards Building a Better Health Care System*," describes the results of our dialogue with Minnesotans. This report uses what was learned through our conversations with Minnesotans to recommend changes to Minnesota's health care system that will keep health care accessible and affordable, using methods that the public will consider fair and reasonable.

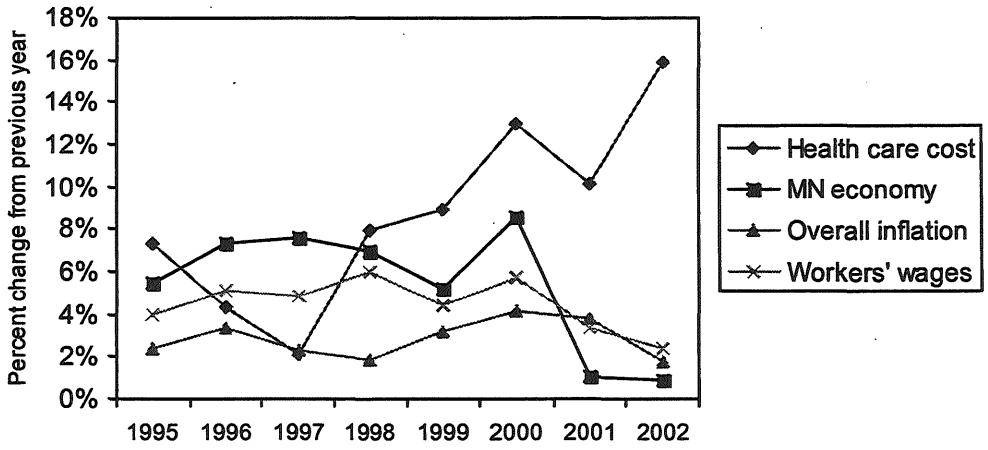
Chapter One

MINNESOTA'S HEALTH CARE CRISIS

The rising cost of health care is a serious threat to Minnesota's business climate, the state budget and citizens' well-being and standard of living. In 2001 alone, $21.6 billion was spent on health care (over 11 percent of Minnesota's economy), and the costs are rising faster than economic growth, personal income and general inflation. In the past four years:

- Medical costs for insured Minnesotans have grown by 57 percent.
- The cost of health insurance has grown 3½ times faster than the state's economy and workers' wages.
- The cost of health insurance has grown over 4 times faster than the rate of inflation.

Diagram 1: Key Minnesota Health Care Cost and Economic Indicators



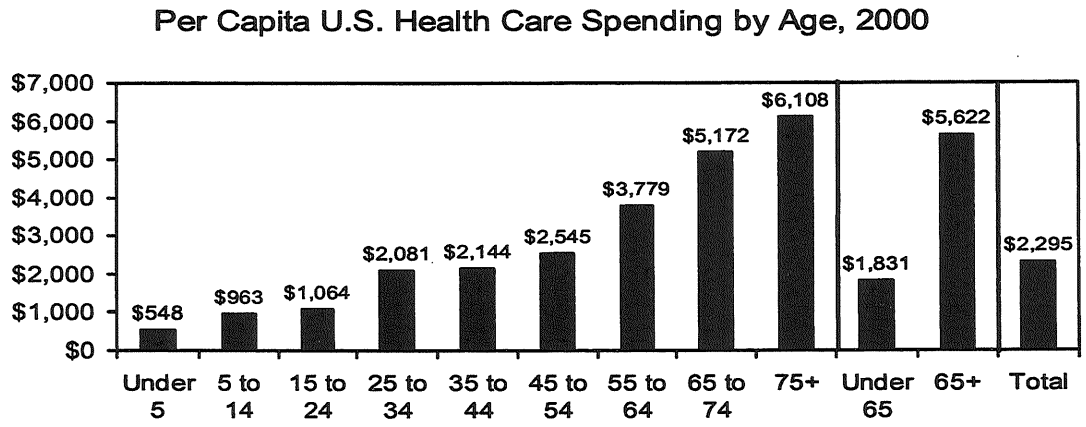
SOURCE: Minnesota Department of Health, Health Economics Program (HEP)
* Note- Health care cost is Minnesota privately insured spending on health care services per person; MN economy is gross state product; overall inflation is consumer price index for the Twin Cities area; workers' wages is the average weekly wages for Minnesota workers.

A CRISIS OF AFFORDABILITY. The average Minnesota household pays about $11,000 per year in premiums, out-of-pocket costs and taxes for health care for themselves and others. A person working full-time at minimum wage does not make enough to pay the monthly premium for a typical family health insurance policy. If costs continue to grow at the current rate, the cost per household will reach $22,000 by the year 2010. Without a change, our health care system will be priced out of the reach of most Minnesotans. Businesses are also being hit hard by the increasing health care costs. As health care costs grow, employers have less money to spend on wage increases and other benefits for employees. Rising health care costs are also breaking the back of state and local governments. Based on a three percent growth rate each year for the

state's total health care spending and no reduction in the monthly cost of the average enrollee, by the year 2007, lawmakers will be faced with a decision of whether to cut another 104,000 low income Minnesotans from government health care programs.

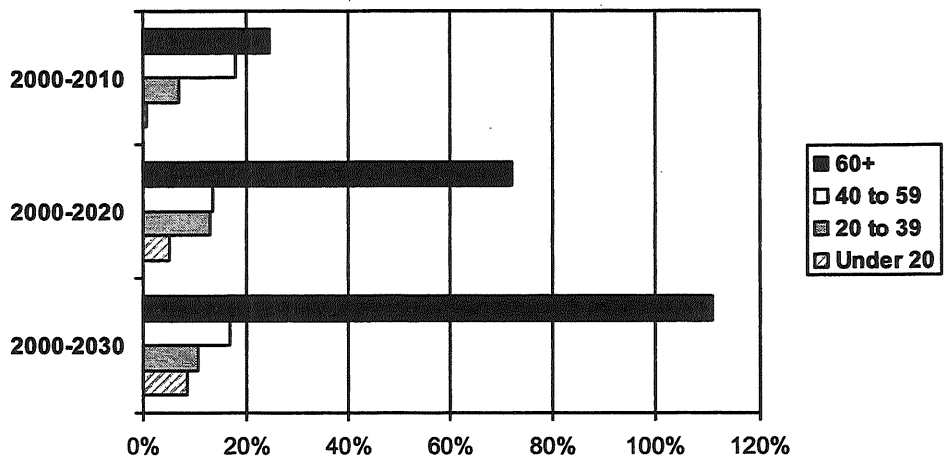
AN AGING POPULATION. The changing demographics of the state will further compound the problem. The age distribution in Minnesota is changing as the baby boomers age with a 70 percent projected growth of the sixty-plus age group by 2020. On average, as people age, their need and use of health care services increases. Because of this projected change in demographics, hospitalizations and use of physician services are likely to increase substantially. In 2001, Minnesota hospitals provided 2.5 million days of inpatient care (approximately 57 percent capacity); it is predicted that by 2030 this could rise as high as 3.9 million (approximately 91 percent of current capacity.) This growth will place strains on the health care system not only in terms of costs and services, but also in terms of workers.

Diagram 2: Variation in Health Care Spending by Age



SOURCE: Agency for Health Care Research and Quality, Medical Expenditure Panel Survey, data for per capita spending by age group in the Midwest, inflated from 1999 to 2000.

Diagram 3: Projected Minnesota Population Growth, by Age Group



SOURCE: Minnesota State Demographic Center

PEOPLE PAY FOR HEALTH CARE. The complexity of the health care system similarly compounds the health care costs crisis. People, not government or insurance companies, pay for health care. Even though everything comes out of their pockets, individuals are in the dark about health care costs and excluded from most decisions about coverage and financing. Most Minnesota households pay less than a third of the cost of health care directly out of their own pockets. The rest is paid by employers and government in ways that are hidden from view. Even this money is actually coming out of people's pockets, they just don't realize it. Government uses tax dollars for government programs and public employees' health insurance. Employers pay their share of health insurance premiums using employee benefit dollars that might otherwise be paid to workers in additional wages or other benefits. Businesses build the cost of their share of health care premiums into the price of goods and services purchased every day. For example, Ford Motor Company adds $700 to the price of every car to cover the cost of its employees' health care premiums. Because health care decisions are being made by people who do not pay for those services, there is no connection between those who pay for the services (the individual) and those who buy the services (the government or employer.) Leaving individuals out of decisions regarding health care results in higher costs for everyone because individuals have no idea how much things costs and therefore no incentive to choose cost-effective services.

WE MUST ACT NOW! Minnesota's health care system has to change. We have two options. We can either passively let the health care system change based on current pressures and take our chances that we will end up with a better health care system, or we can act now as a community to plan and control health care system changes so that our future health care system will meet our needs and be consistent with our community values. We believe Minnesotans are ready to learn from the past, define the problems and solutions, adopt a uniquely Minnesotan vision for the future and come together to make major changes to the health care system. With these steps, we believe our health care crisis will be averted.

How We Paid for Health Care in 2001 in Minnesota*

SOURCE: MDH Health Economics Program 12-15-03

Method of Payment	Average Per Household [2]	% of Household Income [3]	GSP $ [1]	GSP % [1]
Indirect				
Medicare Payroll Taxes [4]	$1,416	2.19%	$2,723,720,690	1.45%
Other Fed, State, Local Taxes [5]	$4,791	7.40%	$9,215,097,294	4.90%
Reduced Wages [6]	$1,311	2.02%	$2,521,054,293	1.34%
Other [7]	$236	0.36%	$454,506,112	0.24%
Direct				
Private Health Insurance Premiums [8]	$1,455	2.25%	$2,798,608,973	1.49%
OOP Payments [9]	$1,781	2.75%	$3,425,394,000	1.82%
Public Program Premiums [10]	$211	0.33%	$405,564,638	0.22%
Total	**$11,200**	**17.30%**	**$21,543,946,000**	**11.46%**

SOURCES AND NOTES:

1. GSP $ and % based on MDH HEP "2001 Minnesota Health Care Spending" Sept. 2003 and 2001 Minnesota Gross State Product from the Bureau of Economic Analysis (BEA).
2. Population and household estimates for 2001 are from the U.S. Census and MN State Demographer/MN Administration Department.
3. Average Minnesota Household Income is based on data from the 2002 American Community Survey plus employer provided health benefits.
4. Includes employee and employer paid. Data sources used in deriving estimate: CMS, BEA, LAUS and CEW data sets, and the 2001 MN Health Access Survey.
5. Taxes for government health care spending, plus general taxes to compensate for tax subsidies for health related income. Estimate is a residual. 2002 ACS used to break out by age.
6. Employer contributions for health insurance, less tax subsidies. Data used in deriving estimate: MN 2001 Health Plan Financial and Statistical Report, MDH HEP "2001 Minnesota Distribution of Insurance Coverage" Sept. 2003, 2001 MN Health Access Survey, KFF and HRET "Employer Health Benefits,2001", MN Dept. of Revenue "State of Minnesota Tax Expenditure Budget" Feb. 2002, Mark Pauly "Administering Social Problems Through the Tax System: Tax Implications of Health Benefits" Presented at June 2003 IRS Research Conference.
7. Non-patient revenue for the health care industry, including donations, interest income, hospital parking, gift shops, etc. Data Source: 2001 Audited Financial Statements of Health Facilities.
8. Includes employee contributions to private group plans, individual policy premiums, and Medigap and M+C premiums. Data used in deriving estimate: MN 2001 Health Plan Financial and Statistical Report, MDH HEP "2001 Minnesota Distribution of Insurance Coverage" Sept. 2003, 2001 MN Health Access Survey, KFF and HRET "Employer Health Benefits,2001", MN Dept. of Commerce Med. Supp. rates, MDH HEP "The Structure of Cost Sharing and Benefit Levels in Minnesota's Small Group and Individual Insurance Markets" Oct. 2003.
9. Data Sources: MDH HEP "2001 Minnesota Health Care Spending" Sept. 2003, Medical Expenditure Panel Survey (MEPS) used to break out OOP by age.

***These figures do <u>not</u> count that portion of the price of every product and service we buy that represents the cost of health benefits provided to workers who brought the product or service to us.**

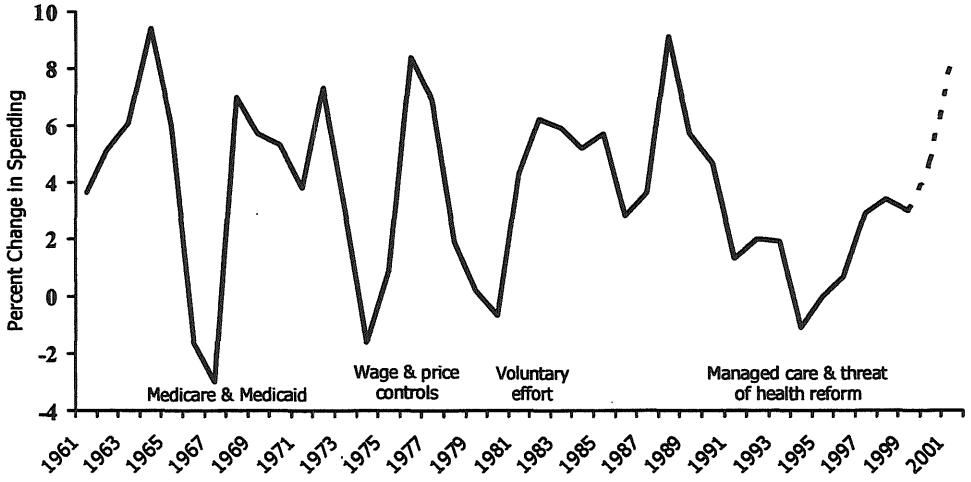
Chapter Two

LESSONS FROM THE PAST

These problems are not new. We have been struggling to find a solution to rising health care costs for a long time. As the diagram below shows, past efforts to reform the health care system provided temporary relief, but did not produce lasting results. Each time we thought we had solved the problem, the costs eventually started to rise again. Minnesota's comprehensive health care reform initiative of the early 1990's included a cost containment plan, but it was repealed in 1994, before it was implemented and costs began to rise soon afterwards. Lessons to be learned from these past experiences will increase our chances of having lasting success in our new efforts.

Diagram 4: The Sad History of Health Care Cost Containment as Told in One Chart

Annual Change in Private Health Spending Per Capita (Adjusted for Inflation), 1961-2001



SOURCE: "The Sad History of Health Care Cost Containment As Told in One Chart," *Health Affairs*, January 2002, Altman and Levitt.

Notes: Private health expenditures per capita 1960-99 are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita for 2000-2001 is estimated based on average premium increases for employer-sponsored coverage from Kaiser/HRET Survey of Employer-Sponsored Health Benefits (www.kff.org). Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961-2000 and July to July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than 15 years ago. See J.C. Merrill and R. J. Wassermann, "Growth in National Expenditures: Additional Analyses," Health Affairs (Winter 1985): 91-98.

THERE IS NO SILVER BULLET. Past efforts attempted to find a single solution that would solve all the problems, forever. But there is no silver bullet. We need a comprehensive effort and a way to continuously work together to make adjustments and changes as the health care environment changes. Health care "reform" must be a continuous activity and must utilize many different tools.

SERVING THE PEOPLE. From government price controls to managed care, past efforts to keep health care affordable have had at best only temporary success because they did not have sustained public support. Many people felt the changes were forced by outside forces in a health care system they did not trust. We have a health care system in which the customer is not necessarily the individual, but instead it is the employer, the physician or the health plan. The person who ultimately needs services is the individual. It is the individual, therefore, who has the greatest control over his or her health and the amount of money that he or she will ultimately spend in services. We need a health care system that listens to the individual and is patient-centered. To have lasting success, control of the health care system must be given back to the people who use and pay for it.

Chapter Three

COMMUNITY VALUES: A MINNESOTA DIALOGUE

Minnesota has earned a national reputation for public and private policy innovation, especially in health and human services. That success has always come from our ability to listen to our citizens and trust their collective judgment. The starting point must be the shared community values of Minnesotans and the goal must be the best interests of the people who use the health care system and who ultimately pay for it directly and indirectly.

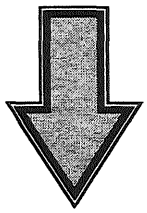
LISTENING TO PEOPLE. With this objective in mind, the Minnesota Citizens Forum spent November and December 2003, listening to Minnesotans. We asked Minnesotans what the problems are, how their lives are being affected and where they think changes should begin. Town hall meetings and informal listening sessions were held across the state. An online survey was developed to solicit information from those who were not able to attend the town hall meetings. Ideas sent by Minnesotans through the mail and the Internet were read. The Minnesota Citizens Forum worked with the Minnesota Board on Aging and the Minnesota Governor's Council on Developmental Disabilities to conduct a telephone survey of a representative sample of 800 Minnesotans. In the end, a surprising amount of agreement among Minnesotans was found about what they expect and what they think should be done about rising costs.

Throughout this process, people expressed many different views and their opinions on some topics varied widely. We found some recurring themes, however, in each community we visited. After listening and reviewing existing research about Minnesotans, we took these themes and identified a list of core values about the health care system that are shared by most Minnesotans. It is this list that we used to guide our recommendations and our vision of what Minnesota's health care system should look like in the future.

Detailed information on the "Minnesota Dialogue" is contained in our earlier report *"Listening to Minnesotans: the First Step towards Building a Better Health Care System."*

Themes from our Minnesota Dialogue

- Minnesotans are concerned about health.
- Most are concerned about rising costs and access.
- Some are dissatisfied with quality and access.
- The health care system is unnecessarily complex and masks hidden costs, profits and unfair pricing, especially in the area of drug pricing.
- Individual responsibility is important.
- Access should be assured for everyone.
- People want choices, control and personalized health care.
- People want a community-based health care system, which provides care at the right time and place.
- Prevention is important.
- Government has a role.
- Minnesotans want an inclusive, universal health care system.



Desired Characteristics of a Health Care System

- Accessible to all
- Fair
- Safe, high-quality care
- Personalized
- Promotes health
- Affordable
- Rewards personal responsibility
- Understandable

LISTENING TO THE EXPERTS. In addition to talking with the public, we sought the ideas and advice of experts and leaders from health care, business and government. We were impressed. Most major business and health care trade associations submitted detailed proposals for improving health care. They, like the general public, agree about more things than they disagree about. Key themes heard most frequently were:

1. Major change is needed to preserve excellence in health care services.
2. We need better information on cost and quality of health care.
3. Our system should focus more on prevention, restoring and maintaining health.
4. We should work together to assure patients receive the best and most effective treatment.
5. We have a responsibility to reduce the disparities that exist in health status, access, quality of care and coverage.
6. No one is to blame for the problems in our current system, but everyone has a responsibility to do their part to improve it.
7. We should continue Minnesota's tradition of seeking a universal system where everyone has access and coverage.

They know that major changes are needed and are ready and willing to work together.

DOES THE CURRENT SYSTEM MEASURE UP? Based on the values that we identified during our conversations with Minnesotans, we assessed whether the current health care system meets Minnesotans' needs. With respect to each value, Minnesotans told stories about how the current system did not live up to their needs and expectations. Whether it was because the system was difficult to navigate, unaffordable, did not provide the right incentives or provide useful information, the current health care system does not meet the needs of Minnesotans.

GOAL	REALITY	IN THEIR OWN WORDS
Accessible to All	Minnesota leads the nation in health coverage and access, but many Minnesotans are left out due to financial, geographic, cultural, linguistic or informational barriers. Those who do not have access or coverage often delay treatment and forego preventive care, costing everyone more in the long run.	*Every person is paying for health care either by paying taxes (public programs) or by paying for benefits (private coverage) or paying prices for goods and services . . . We are already paying for universal health care, we just aren't getting it.* *"We have what you don't have" needs to be replaced by "everyone does better when everyone does better."*
Fair	Minnesota does well on the averages, but below the surface there are serious disparities between different patients and groups.	*What is the American health care system? The only answer is "it depends." It depends on if you are a Veteran or an American Indian or a poor person or an employed person. The American health system is unfair.*

GOAL	REALITY	IN THEIR OWN WORDS
Safe, High-Quality Care	Minnesota does well compared to the nation, but we can do a lot better. There is wide variation in quality of care, and too much care is ineffective, unnecessary or unsafe.	*There is no connection between cost, value and what is received.*
Personalized	Consumers and patients are not given sufficient choices or empowered with information and control over decisions affecting their health.	*Health insurance is a medical model; we do not have a consumer driven model of health care. Consumers do not control their health care destiny.*
Promotes Health	Our health care system focuses on treatment rather than prevention and improvement of health.	*We pay for acute, episodic health care. We don't pay for education or prevention.*
Affordable	We enjoy the nation's highest rates of coverage and access to health care services, but rising costs are creating a crisis for individuals, businesses and government. Many more Minnesotans will lose coverage.	*I've worked all my life and I am now between jobs. I paid for insurance all those years and where did the money go? Now I need coverage and cannot get it.*
Rewards Personal Responsibility	The current system does not reward individuals for living healthy and for using the health care system appropriately.	*Car insurance gives us a break if we take safety classes. Why can't health insurance give us a break if we take classes for prevention of health problems?*
Understandable	The current system is too complicated and shrouded in mystery. Even the experts do not understand everything about how the health care system works.	*We don't have a health care system; we have a health care mess.* *We would have never created the system we have today.*

Chapter Four

FRAMING A SOLUTION

We found it useful to choose an "architecture" to help us organize our thinking as we tried to define the problem and the possible solutions. We used four **goals** to define the problem and identify new directions, and four **roles** to assign responsibility for getting us there.

GOALS

1. **Health**
2. **Access**
3. **Quality**
4. **Affordability**

ROLES

1. **Individuals**
2. **Communities (including government)**
3. **Providers: those who deliver health care services (including doctors, hospitals, medical technology companies, etc.)**
4. **Payers: those who finance health care (including government as a payer)**

HEALTH: PREVENTION AND IMPROVEMENT INSTEAD OF SIMPLY TREATMENT

> *Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.*
>
> - The World Health Organization's definition of "health."

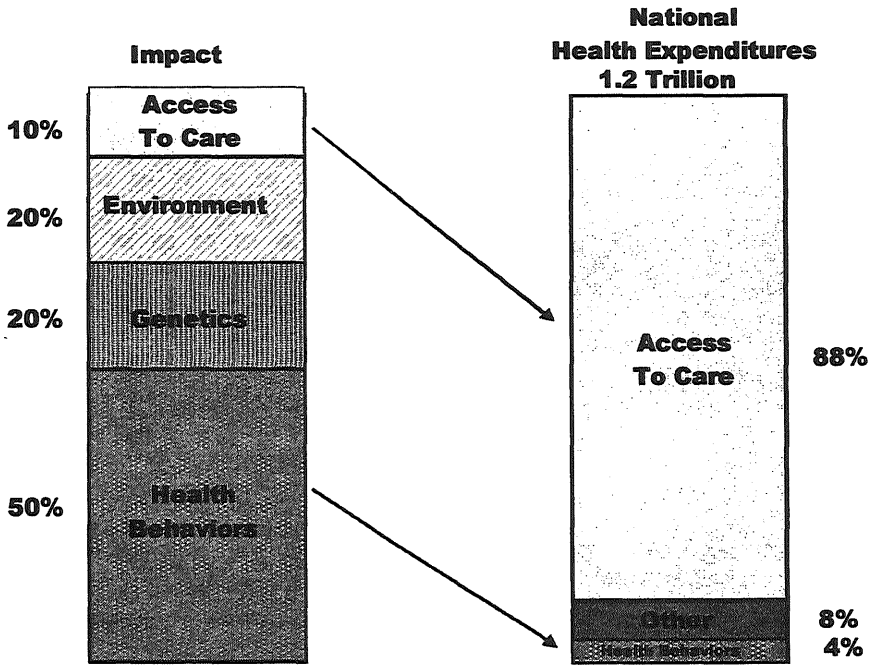
The current health care system does not promote better health, it promotes more treatment, especially of catastrophic conditions. It is like continuing to use band-aids on blisters when a pair of gloves would prevent the blisters from developing in the first place. The financing system does not support what needs to happen in order for people to be healthy. We need a shift in the thinking for everyone in the system. We should be "treating" people before they get sick when there is a chance to prevent the individual from having the illness at all.

Statistics show that if individuals are treated early or even before developing a chronic disease that the cost savings over the individual's life both in terms of quality of life as well as financial dollars are significant. For example, nearly 60 percent of adult Minnesotans are overweight and almost 17 percent of adult Minnesotans are obese. In 2000, an estimated $295 million – over 100 dollars per person – was spent treating diseases and conditions that

could have been avoided if all Minnesotans were physically active.[1] By merely encouraging people to walk 10 minutes three times a day, individuals would receive the recommended amount of physical activity to stay healthy.

The diagram below illustrates how our health care expenditures bear little relationship to the factors affecting our health.

Diagram 5: Health Status Impact versus Expenditures



SOURCES: Centers for Disease Control and Prevention, University of California at San Francisco, Institute for the Future

We need a system that gives **individuals** responsibility for maintaining a healthy lifestyle, while respecting each individual's right to pursue and maintain his or her own health. As a **community**, we need to create incentives and structures to encourage people to pursue healthier behaviors. We need to teach healthy behaviors early and reinforce the message throughout people's lives. **Providers** of health care should be rewarded for helping their patients adopt healthy behaviors. **Payers** have a role in creating incentives for providers and consumers that will encourage people to achieve their optimum health.

[1] Minnesota Department of Health Fact Sheet, *Health Care Costs of Physical Inactivity in Minnesota.* (May 15, 2002).

ACCESS: BARRIERS PREVENT ACCESS TO APPROPRIATE CARE

Access is not only about eliminating barriers; it is also about being able to get the services that you need easily.

Access means an ability to easily enter the health care system. Almost everyone in Minnesota has access to certain types of health care services, even the uninsured. When sick, any person may go to an emergency room for treatment. However, just because a person has access to these health care services does not mean that the services are provided efficiently, financed fairly or that the person is able to get all the care that they need. For a healthy life, people need some health care services even before they get sick and when sick, they need the right care, at the right time, in the right place. Our current health care system has many barriers which prevent people from getting the care that they need: informational, geographic, cultural, linguistic and financial. Each of these barriers raises the cost of health care for all of us because the barriers cause people to delay or not seek treatment until absolutely necessary. There is a need to ensure access to services in terms of coverage and financing as well as access to services in terms of eliminating geographic, social or cultural barriers.

There is not a one-size-fits-all solution to eliminating access barriers and each of us has an important responsibility. **Individuals** should use the system appropriately, including obtaining preventive care and seeking treatment early, and should purchase health coverage when they can afford it. **Communities** should provide information to help individuals use the system appropriately and provide assistance for those who need it. **Providers** should improve their ability to serve all communities and work within their communities to find ways to provide health care services to those that are left out. **Payers** have a role in making sure that the system as a whole is serving the needs of everyone the community.

QUALITY: UNACCEPTABLE VARIATION AND DUPLICATION

The purpose of the health care system is to reduce continually the consequences of illness, injury and disabling conditions, and to improve the health status and function of all people.

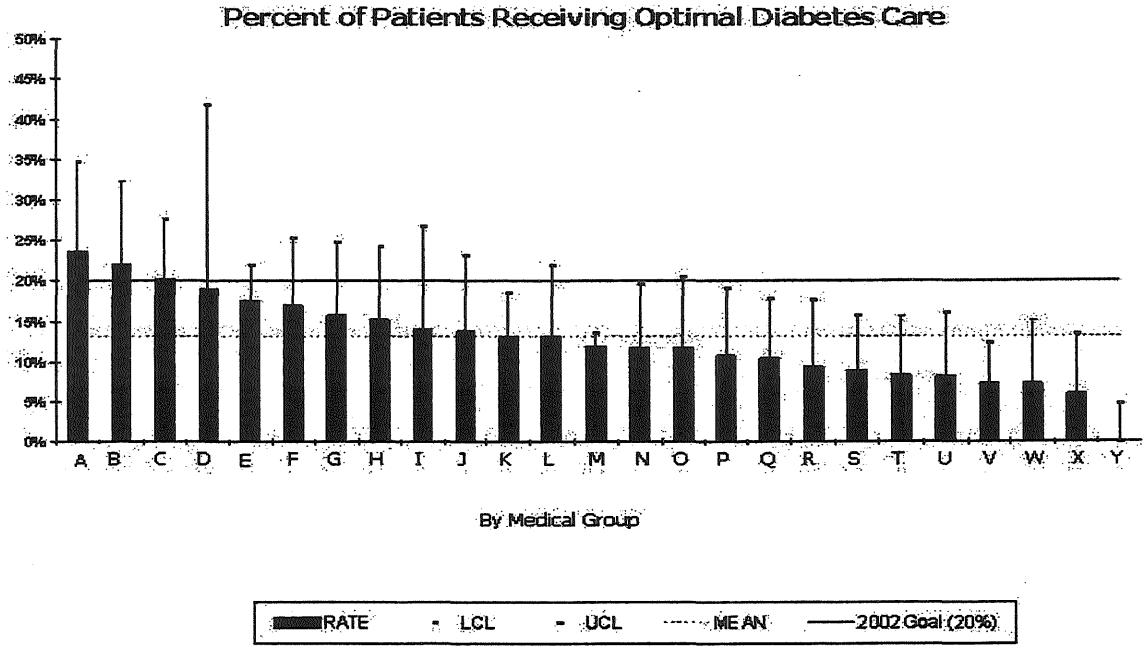
The current system focuses on volume rather than on value. The quality of treatment varies widely and many people do not receive the best quality of care, even though they generally feel satisfied with the care that they are receiving. Disparities in quality are especially acute for communities of color. On average, Americans receive the recommended medical treatment based on evidence-based guidelines only about one-half of the time.[2] Gaps in service delivery are found in all aspects of medical care: preventive, acute, as well as chronic. Mistakes in health care cause injuries, complications and death. Our quality improvement system is complicated at best, ineffective at worst. Minnesotan hospitals are subject to over 26 different quality measurement and patient safety projects for which they collect and disseminate information. There is no coordination between organizations or requests, which results in duplication and increased administrative costs. As a result, providers spend a lot of

[2] McGlynn EA, Asch SM, Adams J et al. *The quality of health care delivered to adults in the United States*, N Engl J Med 2003; 348:2635-45.

time and money producing quality reports that don't result in good quality information either for the payers or the public. Quality doesn't mean more expensive care. Providing the most effective care the first time can be less costly than continuing to provide ineffective care or waiting until a medical condition becomes more serious and more costly to treat.

The diagram below shows the wide variation that exists among Minnesota medical groups for one particular condition: diabetes. The chances a patient with diabetes will have his or her condition "optimally managed" varies six-fold depending on which medical group is chosen. In the best medical groups, which are national leaders in diabetes care, only one in four patients experience optimal disease management.

Diagram 6: Comparing Quality of Diabetes Care



SOURCE: Sample data from *Clinical Quality Report*, HealthPartners 1/1/2002-12/31/2002

We need quality information for both the individual and for the system as a whole. To achieve this goal, we need a plan that addresses both *service* quality and *technical* quality. Service quality aims to address things like satisfaction with providers, plans and insurance, while technical quality focuses on the structural measures for the health care system such as appropriateness, outcomes, process, freedom from error and elimination of waste. This plan must be based on national and Minnesota goals and incorporate medically-based criteria that health care providers measure, report and use for quality improvement programs. The Institute of Medicine's report *"Crossing the Quality Chasm"* contains six aims for the ideal health care system: safe, effective, patient-centered, efficient, equitable and timely. These six aims provide a useful framework for planning. The quality plan should be simple, straightforward and build on existing quality measurement projects already present here in Minnesota.

Ignorance is not bliss. Minnesotans have been left in the dark for too long. As **individuals**, they should be able to compare the quality of health care providers and health plans in order to make informed decisions. As a **community**, we should be able to demand high quality services, provide education and financial supports to achieve the quality we desire, and be able to hold providers accountable when services are not delivered with the quality we deserve. **Providers** need to work with each other to create a health care system that focuses on quality and rewards providers with the best quality. **Payers** should work with providers to develop financial incentives and payment structures that support quality care and better health.

AFFORDABILITY: PEOPLE PAY FOR HEALTH CARE

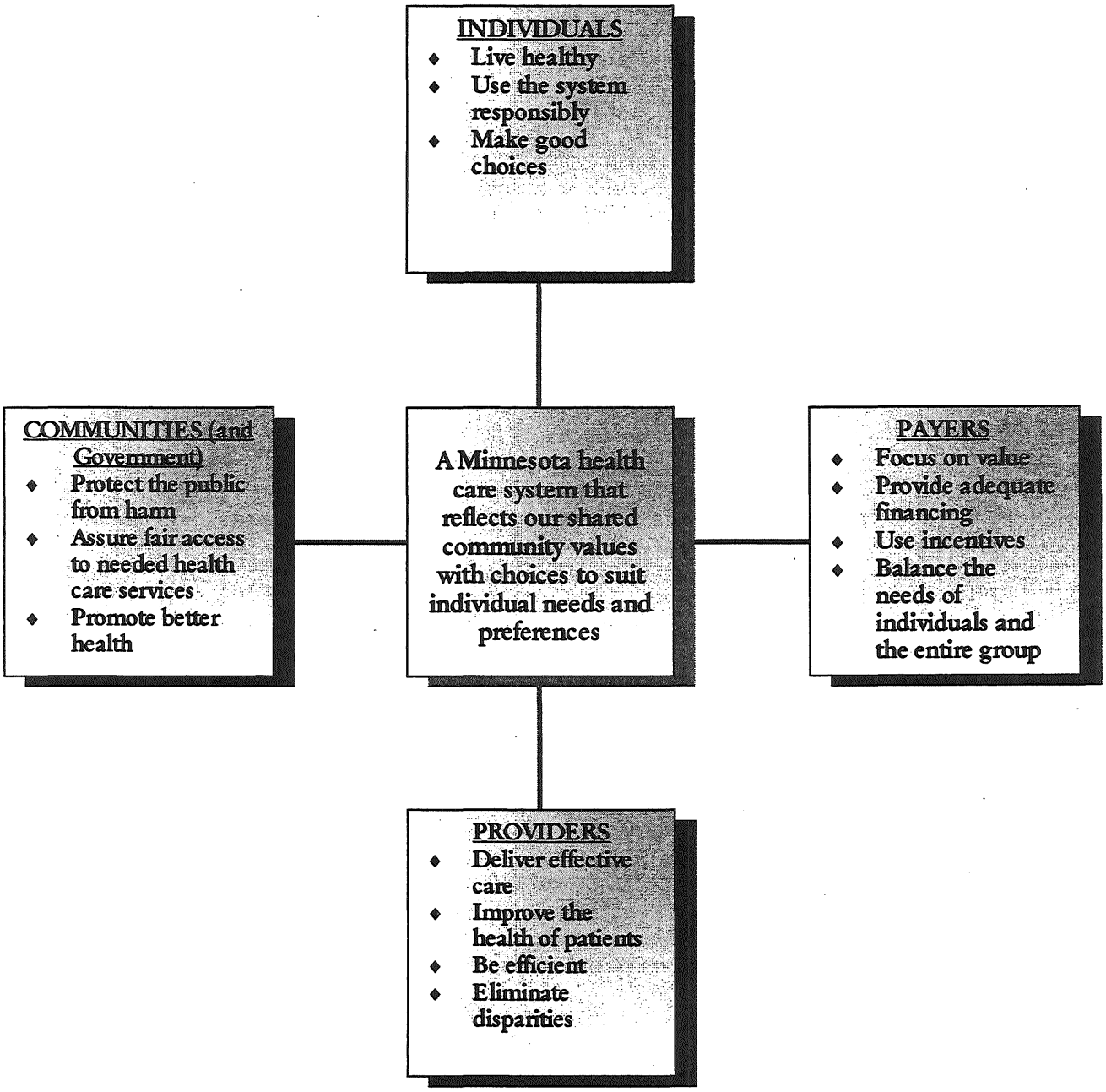
> *What constitutes "affordable" health care is relative, it is defined as what I can afford to pay and what I can purchase with that amount. However, we have no idea how much services and products actually cost or where the money paid into the system goes.*

Minnesota is not different from the rest of the nation in the issues confronting our health care system. We have a cost spiral that is currently unsustainable for many individuals and businesses, and will be unsustainable for all of us in the long-term. Too many Minnesotans are losing access to affordable health care. People are paying for health care through their premiums, co-payments and deductibles, as well as their taxes, the prices they pay for products and services and the dollars that their employers pay for their health coverage in lieu of paying higher wages or other benefits. Because of the complexity of the health care system, with hidden cost-shifting, multiple payment methods and variations in price for the same health care product or service, we don't know what anyone *really* pays for health care and we don't know where the money goes. Ultimately, people pay for everything and they should be fully informed and involved in decisions affecting their pocketbooks.

To implement changes in the health care system to make it affordable, we need to understand how the current system works and how it is financed. Different levels of coverage and access are inevitable and so we need to offer a full range of choices beginning with affordable basic care, then let people make their own decisions. At a minimum, we believe that we must have a health care system with universal participation in a basic benefit package that offers affordable first dollar coverage of preventive services and necessary services for chronic conditions with numerous options for the purchase of the remaining services. In order to do this, however, we need to know what services and products really cost, how prices are set and where the dollars flow. Once we understand the current system, we can decide how it should be changed. It is at that point that we can determine how health care dollars can be used to produce better health and better treatment.

In this process each of us has an important responsibility. **Payers,** in both the private and public sector, need to work together to provide comprehensive information on costs for both the individual and the system as a whole. **Providers** need to work with payers to define how much health care services and products really cost. **Communities** throughout Minnesota should have discussions about what costs are reasonable and what responsibility people and the community have in keeping health care affordable. Once the information is available, **individuals** have a responsibility to learn more about their health care, what services cost and whether their beliefs about what constitutes "affordable" health care are reasonable.

HEALTH SYSTEM ROLES AND RESPONSIBILITY



Case Study: Obesity and Diabetes

We cannot keep health care **affordable** without addressing the other three goals: **health**, **access** and **quality**. The factors underlying obesity and diabetes present a great example of this concept.

Health: Poor health habits of Minnesotans have resulted in a rapid rise in obesity, a major contributing factor to diabetes, which costs Minnesotans $2 billion per year. Improving the overall *health* of Minnesotans will reduce the need for costly treatment later on.

Access: Diabetes caused by obesity can be effectively managed only if patients have *access* to testing supplies, monitoring and other health care support that they need to manage their illness and prevent deterioration of their health and expensive complications.

Quality: The odds are **not** very good that diabetic patients in Minnesota will receive optimal care to keep the disease under control. In the best clinics in Minnesota, which are among the best in the nation, only one in four patients with diabetes is receiving optimal care. *Quality* of care is a responsibility of both the provider and the patient. If done well, patients will be healthier and costs will be greatly reduced.

Health, access, quality and affordability are the shared responsibility of individuals, communities, government, health care providers and employers and health plans that finance health care.

Chapter Five

PLANNING TO GET FROM HERE TO THERE

We cannot demolish our current system and build something new from scratch. We can't afford disrupting the current system while people are still receiving the care that they need. The "Harry and Louise" ad campaign of the Clinton health care reform era taught us that people are fearful of attempts to entirely replace the current health care system with an entirely new system. We need a vision for what the health care system should look like in the future, but we must carefully plan the steps that will get us from here to there.

MAJOR CHANGE IS NEEDED. There is a big gap between what people want and what the current system delivers. Many Minnesotans told us that we will not be able to fix the health care system without making major changes. Isolated, band-aid approaches will not have a lasting effect. They may even have the unintended effect of further increasing health care costs. We need more than incremental tweaks to the existing system. We need a sustained, long-term effort to transform the health care system and we need a transition plan to get us from here to there without disrupting care. Minnesotans are ready for change and willing to do their part.

We believe in creating a health care system based on community values through:

- Providing better health.
- Assuring access to safe, high quality treatment at a price we can afford.
- Offering a variety of choices to suit individuals needs and preferences.
- Being transparent and easy to understand.
- Making information on quality and cost readily available to the public.
- Having efficient health care organizations and minimal administrative costs.
- Flexibility and adaptability as the world changes.
- Accountability and responsibility for all of us - individuals, communities, government, payers and providers.

If we can achieve these goals, Minnesota will have the best health and best health care in the world.

In the short term, we need more information about the system, a place for individuals, government and the health care industry to work together and a process for planning and managing change. We also know that any plan must be based on the values of Minnesotans, so we firmly believe the dialogue with Minnesotans must continue. We know there are limited resources available in the government, so we need to all pitch in to make the changes happen. Our health is our goal, our responsibility, and our challenge. By working together we can get from here to a health care system that meets all of our needs.

WE ARE ALL IN THIS TOGETHER. Few of us can afford to pay the cost of a serious illness without insurance. We use a health insurance model to share the risk with others. In any given year, 20 percent of us will use no health care services while one percent will consume 27 percent of the health care dollars. By sharing the risk through

insurance, we can afford health care when we need it. We count on the system to balance our individual needs with the needs of others in the insurance system. The Minnesota Citizens Forum discovered that Minnesotans understand this concept and embrace it, but they have lost faith in the system's ability to do this fairly. They lack trust because they are left in the dark and do not have a say in important decisions. Past efforts to control costs have contributed to this distrust. Restoring trust in the system is the key to making sustainable improvements that Minnesotans can support.

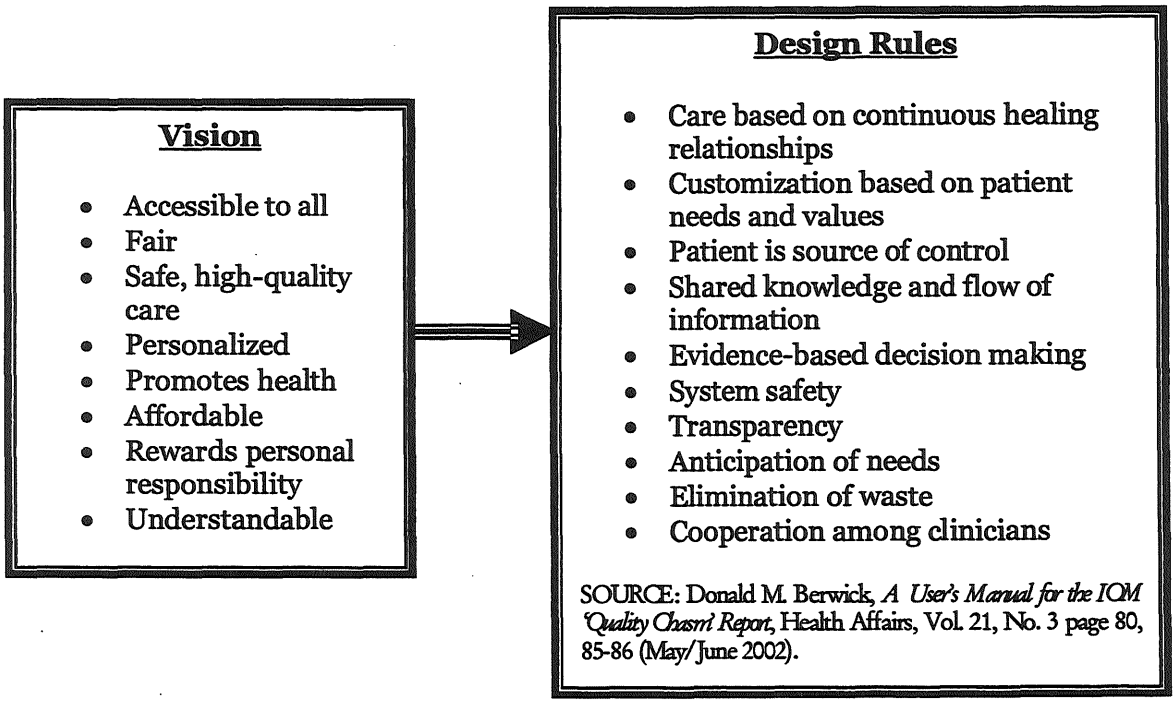
BUILDING ON EXISTING EFFORTS. Minnesota is a hotbed of nationally recognized leadership and innovation in health care. Our health care system has a strong climate of creativity, collaboration and commitment. Activities are already underway that take us halfway to our vision of how our health care system should work. Our goal is to build upon these existing efforts rather than creating new ones. We have learned from the past that we cannot afford or sustain an entirely new set of programs and requirements layered on top of old programs. Instead, we need to retool what we already have and redirect existing resources. We should create an environment that encourages collaboration among existing efforts to eliminate redundancies and capitalize on the ability to create successful new models for health care delivery.

MINNESOTA ACTING ALONE. Minnesota is bound by federal rules and programs that we cannot change on our own. While we understand that some of the changes to the health care system must take place at the national level, we feel many of the changes can happen locally. By creating a standard of health, access, quality and affordability that the rest of the nation will follow, we hope that we can lay the groundwork for national changes. We have done this before and we can do it again.

CHARGED WORDS. Because the health care reform discussion is so politically charged, some words have become associated with a particular political or philosophical agenda or mean different things to different people. We tried to avoid loaded terms such as "universal coverage," "free-market system, "consumer-driven health care," "evidence-based medicine," "personal responsibility" and "single-payer health care system." When we use these terms, we tried to explain what we meant. For example, when we use the term "health care" in this report, we are using it in its broadest sense – to include mental health, dental health and long term care – even though we have not developed specific recommendations in these areas.

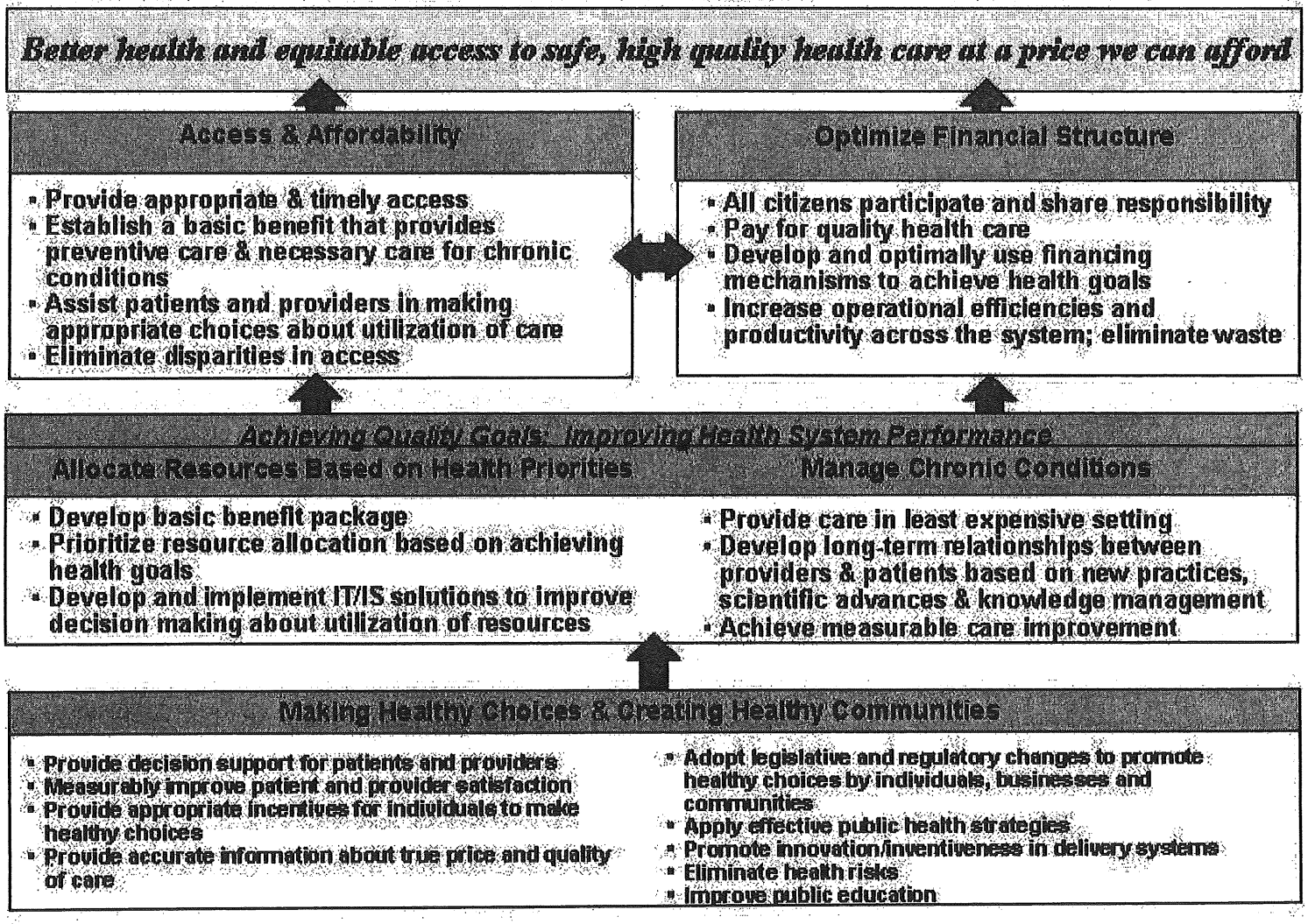
A VISION FOR THE FUTURE. We believe Minnesotans deserve a Minnesota health care system that delivers better health and equitable to safe, high quality treatment at an affordable price. Everyone must do their part to realize the vision, including individuals, communities, those who work in the system and those who finance it. We know that while some of these changes can be implemented immediately, many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals.

Much work has already been done to provide a roadmap for improving health care. We found the work of the federal Institutes of Medicine and the work of Don Berwick to be particularly helpful. The following is just one example of how Minnesota's vision can be translated to "design rules" for change.



Another way of thinking about how to transform our vision into implementable steps is the strategy map on the following page. This map highlights the interactions of several important elements of a comprehensive health care system. The foundation of a healthy Minnesota begins with individuals making healthy choices and living in communities that promote healthy lifestyles. Layered on this foundation is a health care system organized to deliver value in preventive services and effective treatment of chronic conditions in a system based on achieving quality goals and measurable improvements in performance. When the system achieves appropriate and timely access, eliminates waste and achieves consistent efficiency, the overall costs are more affordable. The result is better health and equitable to safe high quality health care at a price we can all afford.

A Strategy Map for Minnesota Health Care 2010



Chapter Six

RECOMMENDATIONS

Our recommendations are built on the large expanse of common ground existing among Minnesota citizens and leaders from health care, business and government. The current health system is very complex, but it is simple to describe what needs to change. We can drive a car without knowing exactly how the engine works. The following recommendations require major changes, but by working together and building on existing efforts already underway, the job will get done. For each recommendation, we have identified actions that should be taken to implement our recommendations.

1. PUT MINNESOTANS IN THE DRIVER'S SEAT

Minnesotans should make the decisions about health care, both individually and collectively. Minnesotans need to define what the health care system should do as opposed to the system defining itself. There also must be a collective discussion on how to fund the system and what affordability means. Employers, HMOs, and health insurance companies should play a supportive role, but not the lead role. This means we will have to rethink what the marketplace looks like.

a. **Personal choice and responsibility.** Encourage the general trend toward giving individuals more choices and control of their health care treatment, with incentives for choosing higher quality, lower cost providers. Minnesotans told us they do not feel they have any control over the health care system. They believe the important decisions are made by employers, health insurance companies and the government without their participation or input. The health care system should be transformed to one in which individuals have greater choice and control over decisions about their health coverage and their health care services. The general trend toward "consumer-centered health care" is heading in the right direction. It will increase awareness of costs and create incentives for responsible choices about personal health and use of the health care system. For example, the Minnesota Department of Employee Relations has implemented a health plan which asks state employees and their families to pay more out of pocket if they choose to use higher cost providers. This is the direction we all need to move. However, consumer-centered health care should not create financial barriers that prevent people from getting preventive care and cost-effective services they need to remain healthy. These kinds of services should be exempt from deductibles and cost-sharing requirements.

b. **Health plan options.** Consumers should have the opportunity to choose from a full array of health plan choices ranging from low-cost to high-cost while preserving the basic concept of insurance which uses money from the currently healthy to subsidize the currently sick. Affordability is in the eye of the beholder and depends on each person's assessment of value (cost and benefit). We found

in our Minnesota dialogue that most Minnesotans do not believe everyone must have the same level of health care coverage, even in a universal system. Some people will inevitably have less coverage by choice or necessity, but those who want to and can afford it should be able to buy more coverage or extra services by paying the extra cost. Care must be taken to preserve a broad risk pool, however, by preventing currently healthy people from refusing to pay into the system for the basic benefits that all people receive.

c. **Chronic diseases and disabilities.** Special considerations should be made to make sure that individuals with a chronic disease or disability can afford to receive the care they need to avoid preventable complications of disease. We know that 10 percent of the population drives 67% of the costs. We heard from many individuals with chronic diseases or disabilities and their family members that a lot of money is wasted by care that is delivered at the wrong time, place, or manner. They gave us examples of how recent increases in cost-sharing and cutbacks in benefits forced them to forego or delay care to the point where they eventually required more expensive treatment. For these consumers, modifications to general cost-sharing requirements under "consumer-centered" health care are needed. New models are emerging that can show the way to create a win-win situation where patients have the support they need to stay as healthy as they can, at a lower cost overall.

d. **Public dialogue.** A permanent process should be established for a continuing dialogue with the public and for conducting research on Minnesotans needs, values and preferences. We learned a great deal about what Minnesotans want in a health care system, but the work is not done. This should be an ongoing activity which will heighten public awareness and provide valuable public input on how the health care system is working. Much great work has been done in this area, including the Minnesota Decides project conducted by BlueCross BlueShield of Minnesota (BCBSM), the 2003 Healthcare Cost Drivers Dialogues facilitated by the National Institute of Health Policy and BCBSM, and the Medical Alley project to promote public discussion of health care priorities. There needs to be collaboration and sharing of information. People need to be encouraged to talk on their own and to make decisions as a community about what is important to them in health care.

2. FULLY DISCLOSE COSTS AND QUALITY

Ignorance is not bliss. Minnesotans have been left in the dark for too long. They should be fully informed about health care costs and quality. Individuals should be able to compare the price and quality of health care providers and health plans in order to make informed decisions. This will be eye-opening for the public. Most people have no idea how much variation exists in quality and price. As members of a community, they should know where the money goes, how it is used, who profits from it and what quality and outcomes they get for their money. They should also know the cost to the community when people receive no care or low quality care. Better information on health care costs, quality and financing systems are needed to support both public policy decisions and consumer decisions in a competitive marketplace. Buyers and government should work together to provide comprehensive information on costs and quality at both the individual level and the overall

system level. This information needs to be disseminated in a way that helps people understand and manage their health care needs.

a. **Full disclosure of prices and costs.** The public should have access to detailed information on costs and financing in the current system including prices, underlying costs, cross subsidies, cost-shifting, profits and administrative expenses. Many Minnesotans told us that they do not understand how health care is financed, why costs are so high and where the money goes. They said if they had better information about the current financing system, they would be able to give us more suggestions on how to reduce costs. We recommend that the Minnesota Department of Health conduct a health care cost study in 2004 to describe the current financing and payment system. The MDH study should describe where the money comes from and where it goes in the current health care financing system including administrative costs, taxes and profits. The study should also identify and compare inequities in pricing, payments and quantify any cost shifting. This study would lay the groundwork for financing reforms in 2005.

b. **Health care information web site.** A health care information web site should be created to gather in one place comprehensive information about health care costs and quality in Minnesota, including comparisons between health care providers and between health plan companies (see recommendation 3 below). People have been left in the dark about health care costs and quality for too long. Minnesotans want more information to help them make *individual* decisions about coverage and treatment and *collective* decisions about how the entire system should work. The web site could also offer information and advice to help people improve their health and manage their health conditions. This website could consolidate national and state links provided through federal agencies, national accreditation organizations, Leapfrog, Minnesota Department of Health and other sources. It could contain provider and system links, provide health risk assessment tools and health improvement planning tools for every Minnesotan.

c. **Public awareness campaign on costs.** Implement a public awareness campaign to increase the public's knowledge of the costs of health care. This would include information on how much people *really* pay, the cost drivers, cost trends and consequences of rising costs. It should also describe how insurance works and how we are all affected by the access, treatment and quality received by any one of us. The Minnesota Citizens Forum meetings were the beginning of the process, but more information must be made available to the public. Knowledge is power. The more people know and understand, the more empowered they are to make decisions about the health care that is right for them.

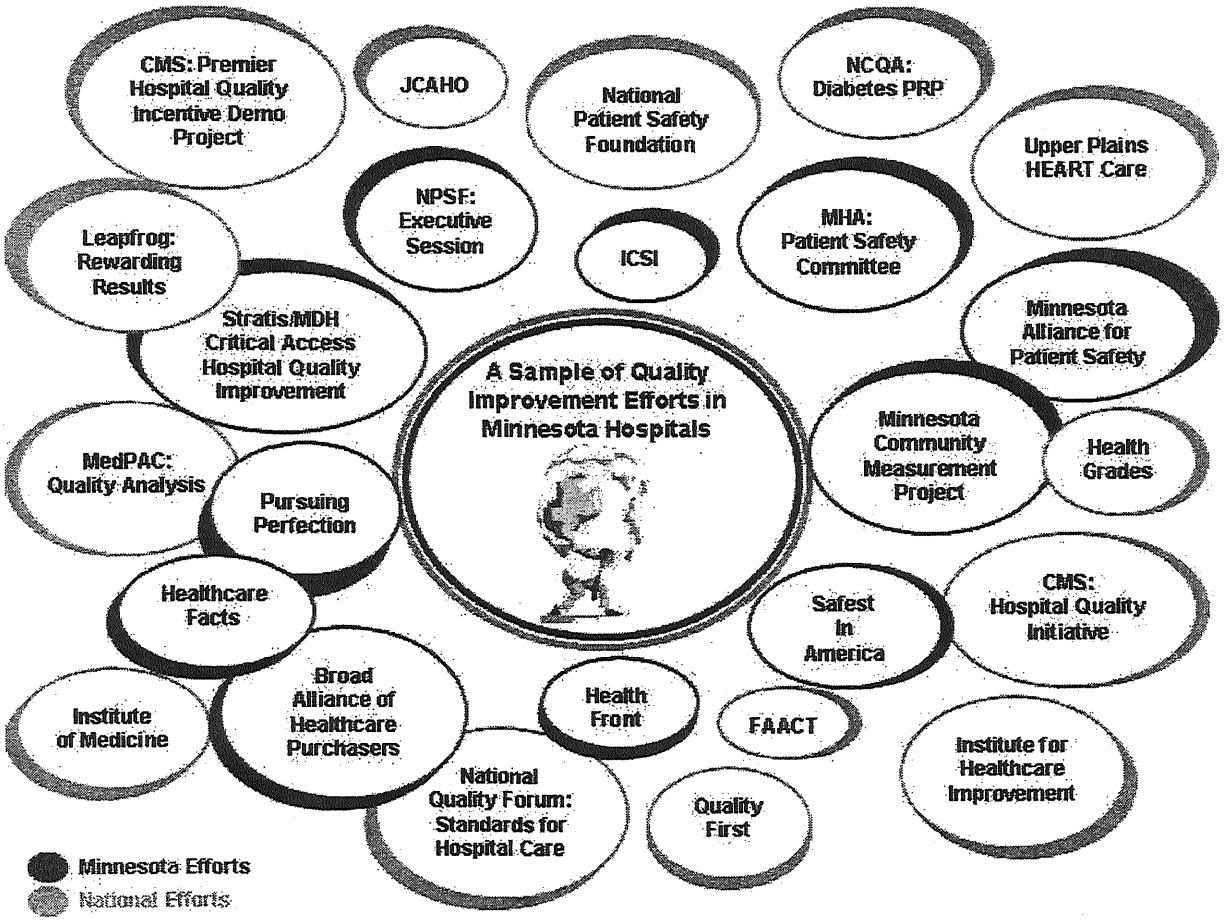
3. REDUCE COSTS THROUGH BETTER QUALITY

Many examples were given of how health care dollars are often wasted on ineffective treatments, mistakes and poor quality care. By some estimates, 30 to 40 percent of our health care dollars are spent on ineffective and unnecessary care. Health care costs can be reduced by improving quality of care and eliminating health disparities. Recent improvements in the Veterans Administration health care plan are examples of how to improve quality and efficiency.

a. **Pay for results.** Payment systems should be changed to reward better quality, safety and efficiency. In a later recommendation, we suggest changing the payment system to reward better health outcomes. This is a key to our success in reducing costs without reducing quality because it will reduce the waste that results from poor quality of care, ineffective treatments and harmful mistakes. By standardizing quality measures and reporting, we will have good comparative information to use for rewarding quality. Through collaboration on quality, doctors, hospitals and other health care providers will have the tools and training they need to improve quality.

b. **Standardization.** Methods of measuring and reporting quality should be more standardized. A barrier to improving quality is the lack of industry standards on how quality is measured and reported. Different approaches are taken by different employers, health plans, regulators, government health care programs and accreditation agencies. The diagram on the following page illustrates the many different quality expectations and reporting requirements Minnesota hospitals must cope with. This is an inefficient and ineffective approach that is very expensive, yet does not produce good, apples-to-apples comparisons of quality. By standardizing quality measures and reporting, we can reduce administrative costs and provide better information on quality. Excellent efforts to coordinate and consolidate are already underway in Minnesota, including the Institute for Clinical Systems Improvement (ICSI) and the Joint Community Measurement Project being pilot tested by Minnesota's health plans and medical groups. These efforts should be supported and expanded.

Diagram 7: A Sample of Quality Improvement Efforts in Minnesota Hospitals



SOURCE: Sheila Moroney, National Institute of Health Policy, January 2004

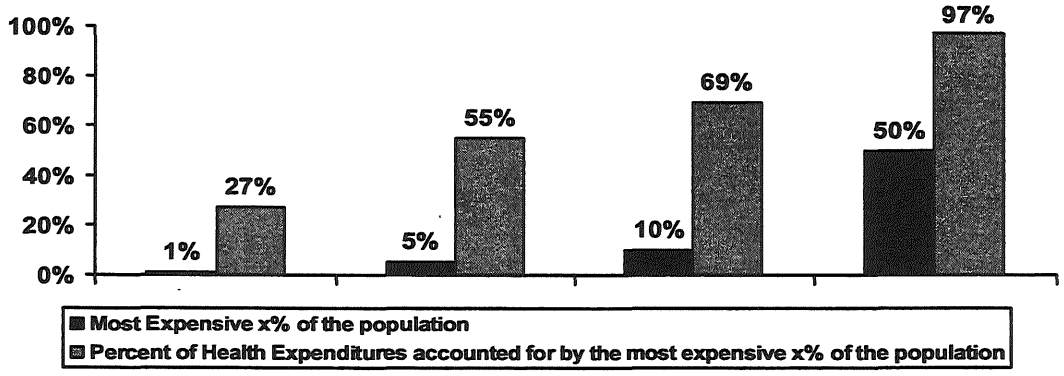
c. **Public reporting.** Quality information about health plans and health care providers should be made available to the public on the health care information web site and in other formats. Minnesotans want more information on quality of care. Researchers have documented a wide variation in quality of care and outcomes from one patient to the next and between different health care providers, yet this information is not available to the public. By making this information publicly available, people will be able to make informed choices and poor quality providers will be motivated to improve. The information will also be useful in designing payment systems that reward those who provide high quality care.

d. **Collaboration on quality.** Existing quality initiatives should be brought together in a state forum to develop a statewide quality plan and coordinate efforts that will achieve specific quality improvement goals. Minnesota is the home of several projects that are on the cutting edge of efforts to measure quality and to improve it. We have a community of nationally respected leaders and researchers who are working on quality. Between the various initiatives, millions

of dollars are spent each year. Improved collaboration and coordination will allow these dollars to be leveraged to produce the greatest possible gains. The quality forum should set priorities based on what is important to the state's consumers and buyers of health care. There are opportunities to utilize the work of organizations like StratisHealth (QIO), ICSI, and insurers to achieve better quality reporting and improvement at a lower cost. We should not have to create any new initiatives if we coordinate the activities already occurring throughout the state.

e. **New approaches for chronic disease and disability.** Encourage and support new community-based models for maintaining better health and quality treatment for patients with chronic diseases or disabilities. In Minnesota, it is estimated that one percent of the population incurs 27% of the health care costs and that five percent of the population incurs over half of all health care expenses. Most of these people have chronic illnesses. For those of us with chronic diseases, our ability to obtain the right services, at the right time and right place is essential to a healthy life. When barriers exist, whether financial, geographic, cultural, linguistic or informational, needed care is often delayed until our conditions further deteriorate and, as a result, the cost of treatment ends up being greater. With such a high percentage of health care costs being consumed by a small number of us, we have a special interest in assuring access and cost-effective care for individuals with a chronic disease or disability. There is an opportunity to simultaneously save money and improve quality through better care and coordination of services for people with a chronic disease or disability.

Diagram 8: Concentration of Health Care Spending: A Small Share of the Population Accounts for Most Health Care Spending

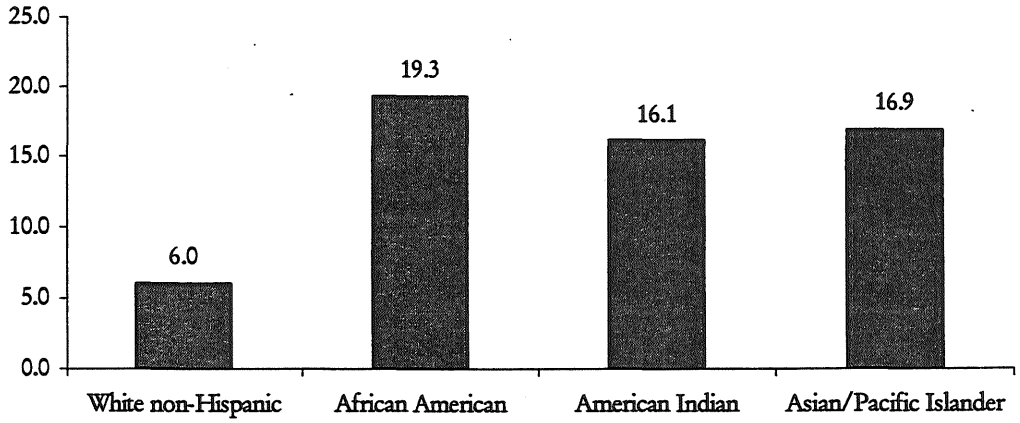


SOURCE: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, March/April 2001. Expenditure estimates for civilian non-institutionalized population.

f. **Quality disparities.** Our definitions of quality should include cultural competence and no disparities in health status, access and quality. We heard from communities of color that our health care system fails to meet their needs for high quality, culturally competent care. Research has shown that a wide gap

exists between the health status and quality of care for communities of color compared to other communities. For example, virtually all occurrences of invasive cervical cancer and death are preventable through regular preventive screenings and treatment of precancerous abnormalities. As the diagram below shows, the incidence rates of cervical cancer for African American, American Indian and Asian/Pacific Islander women are significantly higher than those for white women.

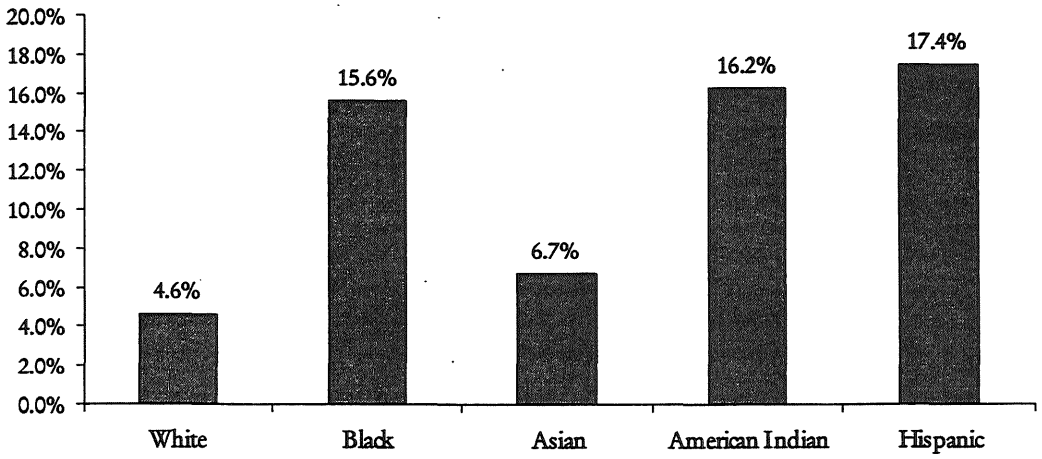
Diagram 9: Cervical Cancer Incidence, Minnesota 1995-1998



SOURCE: Population of Color in Minnesota, Minnesota Department of Health, Center for Health Statistics (2001); Minnesota Cancer Surveillance System.

Similar disparities exist when looking at the uninsured. As the diagram below illustrates, uninsurance rates for non-whites, with the exception of Asian/Pacific Islanders, are two to three times higher than uninsurance rates for whites.

Diagram 10: Percent of Uninsured by Race



SOURCE: 2001 MN Health Access Survey, MDH Health Economics Program

As our workforce becomes increasingly more diverse, the health care system must develop ways to better serve this growing market. The State of Minnesota has made eliminating health disparities a priority and should continue to do so in collaboration with others in the health care system.

4. CHANGE INCENTIVES TO ENCOURAGE HEALTH

The decisions we make as individuals can negatively affect our health in ways that cannot be repaired by the health care system. Super-sized, caloric, high-fat fast food has replaced healthy home-cooked meals. Poor diet, lack of exercise, high stress lifestyles and smoking result in higher rates of obesity, heart disease, cancer and mental illness. The current system does not reward individuals for living healthy, nor does it reward health care providers for improving their patients' health. The broader environment, too, does not encourage good health. Incentives in the health care system should be changed to produce better health and outcomes. Buyers, communities and government should work together to promote better health habits through additional incentives and assistance. And everyone should be working together to use public health strategies to achieve healthier communities.

a. **Payment system changes.** Payment systems should be changed across the entire health care system so that financial incentives produce better outcomes and better health. The current payment system fuels rapid growth in health care because it rewards providers for providing more and more services, drugs and equipment with little accountability for outcomes and efficiency. The current system actually penalizes providers who help their patients be healthy or who find ways to reduce utilization while improving outcomes.

b. **Individual incentives.** People who maintain good health should be rewarded with discounts on health care, lower premiums or other benefits. It is important to provide education and support to help people improve their health, but financial incentives are an effective way to motivate people.

c. **Community health.** Employers, government and communities should expand efforts to provide programs and other incentives to encourage individuals to adopt healthier behaviors. A large percentage of our health care spending goes for preventable illness and injury. For example, the obesity epidemic will lead to higher rates of diabetes, heart disease and other costly health problems. While individuals know that changes need to be made, we all - individuals, communities, health care providers, employers, health plan companies and others - share responsibility for improving our health. We encourage the Governor to give public recognition to businesses and communities who adopt programs to encourage better health. We believe the initial priorities for statewide community health efforts should be obesity and smoking.

d. **Obesity.** Minnesota should launch an aggressive campaign to reduce obesity, especially among children. We recommend that obesity be made a top priority for a statewide health improvement campaign to be undertaken jointly by state, local public health agencies, employers, schools, health care providers, health plan companies and other partners. Among other things, communities should discourage the marketing and sale of pop and junk food in schools, reinstate

mandatory physical education and work with schools to provide education to students on how to be healthy and a responsible health care consumer. Adults should take the Minnesota Citizens Forum's challenge to walk 10,000 steps a day. If we all do something to become physically active, as a community, we can challenge obesity head-on.

e. **Tobacco.** Minnesota should strengthen efforts to reduce tobacco use, with a special focus on youth smoking. Tobacco has a devastating effect on the health of Minnesotans. After several years of declining smoking rates, recent cutbacks in tobacco prevention funding have resulted in a resurgence of smoking, especially among young people. Research has shown that higher cigarette prices reduce smoking rates, especially among children. We recommend the addition of a $1.00 per pack "user fee" on cigarettes to reduce smoking rates and raise revenue for state efforts to reduce smoking, improve health and provide access to uninsured Minnesotans.

f. **Public health.** The public health system should be adequately funded and should play the lead role in convening community partnerships to improve the health of all Minnesotans, whether insured or uninsured. Public health has a critical role not only in reducing avoidable behavioral or environmental hazards, but also in detecting and containing widespread risks like the West Nile virus or SARS to the whole community. An inadequate public health infrastructure ultimately means slower detection, containment, increased health care costs, economic loss and avoidable illness and death. Ironically, these core public health protection functions are being greatly reduced by the high costs of medical treatment for individuals. The Minnesota Citizens Forum discussed for a long time the Healthy Minnesotans Public Health Improvement Goals 2004 issued by the Minnesota Department of Health. Rather than trying to isolate specific goals, the Leadership Panel felt that we, as a community, should be working to achieve all of these goals by 2010. In order to do this, the public health system must be adequately funded and businesses, government, communities, health care providers, and individuals all must work together to make the Public Health Improvement Goals a priority.

5. ACHIEVE UNIVERSAL PARTICIPATION

Minnesotans are strongly in support of a universal health care system where everyone has access to the health care they need. Over 90 percent of Minnesotans support a "universal health care system"—it is a shared community value. We must work together to eliminate barriers to the system whether they are financial, geographic, linguistic or cultural. Coverage is an important part of financial access. Lack of coverage results in poor health, less preventive care and delays in needed treatment that eventually add costs to the system. However, a universal system is not just about access and coverage, it is also about meaningful *participation* so that we have a health care system in which everyone obtains appropriate health care, including preventive care, at a cost they can afford, and everyone contributes to better health through their behavior and their financial contribution. We share the financial risk of medical expenses through insurance so that we can afford health care when we need it. If everyone is not contributing financially, especially when healthy, we run the risk that others will not receive care when they need it.

The polarized, political debate between a "single-payer" government health insurance plan and a private, market-based health care system continues, and in the mean time nothing changes and we slip deeper into the health care crisis. We looked to Minnesotans for the answer. We found that almost all Minnesotans agree on two fundamental principles: (1) we want a responsive system where everyone gets the health care they need, and (2) we want a privately based health care system that offers as much choice as possible. Our recommendations will lead us to an integrated and uniquely Minnesotan universal health care system that promotes healthy private sector competition while assuring that the overall system serves the best interests of all Minnesotans.

a. **Universal health care system.** Minnesota should set a goal of "universal participation" in the health care system. We struggled to find the appropriate term to use when talking about Minnesotans' support for a universal system in which everyone gets the services they need at the right time and in the right place. The same term may be viewed by some as positive and others as negative. For example, to many people the term "*universal coverage*" is equated with a "single-payer" system of government-financed health care, which has a strong positive connotation for some and a strong negative connotation for others. Yet, universal coverage can be achieved through several different ways, some of which do not involve a government-financed or government-administered system. As another example, "*universal access*" has a positive ring to some people, but to others it is negative because it means that while everyone can get medical treatment, some people will still face financial barriers to getting preventive services and may be financially devastated by the costs of their treatment because they do not have health coverage.

   For Minnesota, we recommend a universal system that combines both private and public financing and uses predominately privately based health care services. We recommend a system of "*universal participation*" in which (1) everyone receives needed health care, including preventive care, at a cost they can afford, in a system financed by both public and private dollars, and (2) everyone participates in improving the health of individuals and communities.

b. **Health coverage for the uninsured.** The state of Minnesota should continue its commitment to the goal of health **coverage** for all Minnesotans, with a priority for covering all children. While *universal access* can be achieved without everyone being enrolled in a health insurance plan, through the development of alternative models for providing uninsured persons with appropriate health care, including preventive care, while ensuring that they pay into the system according to their ability, we recommend *universal health coverage* continue to be the ultimate goal.

   Minnesota enjoys a relatively low percentage of persons who do not have health insurance. Research has shown that people without health insurance experience poorer health and inferior access to needed services, even if free health care is available to them through emergency rooms and free clinics. When we are uninsured, we are likely to delay preventive care and early treatment of illness and injury until our health problems become more serious and expensive to treat. When we need health care desperately, we are not turned away, but most of us

cannot pay for extensive care and, as a result, our care will be subsidized by higher fees charged by health care providers to paying customers and insurance companies and by tax dollars from state and local governments. This method of financing is inefficient and results in poorer health and lower quality care for the uninsured.

We do not believe that expanding government programs is the only way to make progress toward universal coverage. The most important thing we can do is to improve affordability of health care through system reform, so that more people can buy their own health coverage and the State of Minnesota can do more with its limited resources. In the foreseeable future, economic realities preclude major expansion of government programs to serve more uninsured people. However, the state should set priorities and use limited resources to expand coverage for those uninsured persons who have the greatest need. A basic benefit package must be defined and the risk pool clearly identified in a way that insurers can provide coverage at a reasonable cost for working families. The following chart, prepared by the National Institute of Medicine, lists five principles for insuring the uninsured. We think that any basic health care package must be able to answer the questions it contains.

Assessing Proposals for Major Health Insurance Reform
Principals for Eliminating Uninsurance

The Institute of Medicine's Committee on the Consequences of Uninsurance recommends five principles[1] to guide reforms to extend health insurance to all Americans. The following list of questions can be used to measure how close proposals and strategies for extending coverage come to fulfilling these principles.

1. **Health care coverage should be universal.**
   - Are individuals required to obtain coverage or are employers required to offer it?
   - Who is eligible for which types of coverage?
   - Who is not eligible for coverage?
   - How easy or difficult is it for eligible people to enroll?
   - What kinds of subsidies are available for lower-income individuals and families?
2. **Health care coverage should be continuous.**
   - Is re-enrollment required? If so, how frequently?
   - How streamlined is that process?
   - What happens to people who lose or change jobs?
   - What happens to people who have a change in income or family circumstances?
   - What happens to children upon reaching the cut-off age for coverage under a parent's policy?
   - What happens to early retirees?
3. **Health care coverage should be affordable to individuals and families.**
   - How much are families and individuals expected to contribute toward the premium?
   - What kinds of premiums, co-payments, and deductibles are included? Do these cost-sharing amounts vary with family size, health status, family income, or other criteria?
   - What subsidies are available to individuals and families, and what are the criteria for qualifying for them?
4. **The health insurance strategy should be affordable and sustainable for society.**
   - Do the assumptions and estimates about the number of people to gain coverage and the cost per person seem realistic?
   - Does everyone contribute to the new system? If not, who is excluded and why?
   - Who bears the main burden to support the extended coverage?
   - Are the sources of revenue/financial support for the extended coverage, such as taxes, likely to be relatively stable even in tough economic times?
   - How will funding currently in the system for service to the uninsured, such as the Disproportionate Share (DSH) Adjustment, be treated? How much of the current funding will be shifted to the new system?
   - Are utilization controls and cost-control mechanisms built into the program?
   - Is the benefit package designed to encourage the use of cost-effective services?
   - Does the new strategy emphasize simplicity and administrative efficiency?
5. **Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient centered, and equitable.**
   - Does the benefit package include preventive and screening services, mental health services, and outpatient prescription drugs as well as hospital and outpatient medical care?
   - Are there incentives for enrollees to fully use essential services, such as screening and preventive services?
   - Are there incentives for the enrollees to avoid overuse and inappropriate use of services?
   - Are there incentives for providers to offer high-quality care consistent with medical guidelines and scientific evidence?

---

[1] The five principles are presented in the committee's final report, *Insuring America's Health.* They are based on the findings of the committee's earlier reports: *Coverage Matters, Care Without Coverage, Health Insurance Is a Family Matter, A Shared Destiny,* and *Hidden Costs, Value Lost.* These reports and more information about uninsurance is available at www.iom.edu/uninsured.

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES
500 FIFTH STREET, NW, WASHINGTON, DC 20001
Phone: 202-334-2352 Internet: www.iom.edu/uninsured

c. **Cost-effective health care services for the uninsured.** Uninsured Minnesotans should be given access to affordable basic preventive care and other cost-effective services that will improve their health and reduce the need for more costly treatment. In the short-term we believe incremental steps can be taken to improve access to *services for the uninsured.* Easier access to certain services will reduce overall costs to the health care system. It is especially important to make these services available to uninsured Minnesotans with existing health conditions, especially those who are likely to enroll in government programs in the future if their health deteriorates. Sooner or later, people with unmanaged health problems will need expensive health care services that will be provided at the expense of taxpayers or shifted onto the private sector. Children should be a priority since health care problems left untreated during development often result in decreased productivity and lower life quality during adulthood. Assistance could also be targeted to those who have the greatest need and represent the greatest opportunity for reducing future costs by improving access to early intervention and effective management of chronic health conditions.

d. **Participation of people who can afford health coverage.** Explore ways to ensure participation in the health care system by uninsured who can afford to buy health coverage, but choose not to. A universal system is not just about access, but also about making sure everyone is paying into the system according to their ability. A small, but growing number of uninsured persons, can afford to buy health coverage but choose not to. Often these are young, healthy people who do not think they will need health care and have other priorities on which to spend their money. When they have a serious health problem, they receive treatment they can't pay for and the costs are shifted to everyone else. It is important to have everyone paying into the system according to their ability.

e. **Financing for the uninsured.** Change the current system of financing uncompensated care for the uninsured. The costs of serving many of the uninsured are already in the health care system and fall disproportionately on some hospitals and clinics or are shifted onto the private sector. The Minnesota Department of Health should develop several options for improving the financing system, for consideration by the Governor and the Minnesota Legislature.

f. **Non-economic barriers to access.** Eliminate non-economic barriers to access of needed health care services. Some people have health coverage and still are not able to get the health care they need because of geographic, linguistic, or cultural barriers. Communities of color, in particular, told us many people forego or delay treatment because they do not feel comfortable that they will be treated fairly and appropriately in the health care system, and often do not receive care that is appropriate to their individual needs and preferences. Research has shown that their fears are justified. Communities, government, payers and providers should come together to eliminate non-economic barriers. There is not one magic solution that will immediately eliminate these disparities, but rather each community needs to work with government, payers and providers to develop solutions to conquer their own unique barriers.

g. **Insurance market reform and purchasing pools.** Reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses to purchase affordable health coverage or obtain needed health care through models other than insurance. We discussed, on several occasions, various options for transforming the insurance market, including purchasing pools, eliminating the employer-based system and others. The current market creates affordability and access problems for individuals who buy their own health insurance policies and for small employers who have fewer options and less control over their health coverage than larger, self-insured employers. The current employer-based insurance system can sometimes limit Minnesotans' choices and disrupt continuity of care when an employer changes its employee health coverage plan. We are aware that other individuals and groups such as Senator Sheila Kiscaden, the Minnesota Chamber of Commerce and the Children's Defense Fund have invested time in developing new models for consideration by policy makers (see the Cover All Kids Coalition's conference publication from November 2003). Because others are working on this issue, and due to time constraints, we did not develop specific recommendations on this issue, but we believe this is an extremely important topic and attempts should be made in other settings to develop a proposal to be integrated into a larger health care reform package for the 2005 legislative session.

6. SUPPORT NEW MODELS FOR HEALTH CARE EDUCATION

Minnesota is facing a growing shortage of health care workers, even in urban areas typically not affected by worker issues. Fewer children are growing up wanting to become doctors, nurses, dentists or other health care providers. Those that do become health care workers are not enough to meet the geographic, linguistic and cultural needs of our ever-changing Minnesota population. Systems must be put in place to allow for adequate funding and planning of Minnesota's health care workforce requirements and the subsequent needs for students in the health care programs. Given the impact of aging on the state's demographics, more geriatricians and geriatric nurse practitioners will be needed. The same is true with respect to the recruitment of faculty and students of color as a result of Minnesota's growing immigrant populations and ever-increasing health disparity gap. For each category of health professional, plans need to be developed to ensure that adequate numbers and types of health care professionals are educated and available in the state. New models for educating health professionals need to be developed, which include greater use of technology and more interdisciplinary coursework. These models should be the result of public-private partnerships, academic and service partnerships and partnership between businesses, communities, and educational institutions.

7. REDUCE THE COST OF OVERHEAD AND ADMINISTRATION

The complexity, duplication and lack of accountability in the current system results in unnecessary costs for overhead and administration. Significant savings can be achieved by streamlining and standardizing administrative procedures and government regulations. At town hall meetings and through the Minnesota Citizens Forum website, many Minnesotans

offered suggestions for reducing administrative costs. New technologies are emerging that could greatly reduce the amount of paperwork required for recordkeeping, reporting, billing and other administrative activities. There are also major opportunities to reduce administrative costs and burdens by standardizing forms and procedures throughout the health care system.

a. **Industry standards.** The health care industry should establish uniform standards for electronic billing, electronic medical records, reports and other administrative procedures. Millions of dollars are wasted on inefficient administrative procedures and transaction costs. We cannot afford to let this money be diverted from direct patient care.

b. **Electronic technology.** The health care industry should work together to facilitate the rapid adoption of new electronic technologies that will improve efficiency, service and reduce administrative costs. The "smart card," electronic billing and electronic medical record are good examples.

c. **Regulatory reform.** The State of Minnesota should adopt a new approach to health care regulation. Existing state regulations add unnecessary costs and paperwork for health care providers and health plans. They focus on process rather than outcomes. They prevent innovation in the health care marketplace. Extensive reporting requirements cost money but produce data that is seldom if ever used. We suggest that the Governor create an interagency task force with an advisory panel of stakeholders to develop legislation to reform the regulatory system. National policies also affect health care in Minnesota. Federal policy changes should be sought to support state level reforms.

d. **Health care taxes.** The Minnesota Department of Revenue should complete a study of health care taxes and recommend a tax reform plan to the Governor and the Legislature. Minnesota's current health care system is unfair and imposes heavier financial burdens on small employers and individual policyholders compared to large, self-insured employers and group purchasers. It is also very complex and expensive to administer. The original purpose of most health care taxes, to finance health coverage for the uninsured, has been eroded as more and more health care tax revenues have been diverted to the general fund or earmarked for other uses. The tax reform plan should generate the same level of revenue as existing health care taxes, but be designed to reduce administrative costs and burdens and eliminate the inequities and tax disparities in the current tax system. The tax reform plan should also enhance the ability of the health care tax system to capture savings and benefits that accrue to the health care industry when the government uses tax revenues to provide coverage to the uninsured and improve health, access and quality. This will ensure that savings to the health care system are used to repay the initial investment. All revenues from health care taxes should be dedicated to the purpose of financing health care for those who cannot afford to pay the entire cost themselves.

RECOMMENDATIONS ON HOW TO GET THERE

A major effort is needed to make the transformational changes recommended above. The good news is that much agreement exists about the direction we need to go, everyone seems ready to do their part and leaders are stepping forward to spearhead the effort. These three ingredients – vision, commitment and leadership – will get us to our goal. We suggest the following specific steps to get started, but all should be done in a way that is open to the public and maximizes participation of Minnesotans to assure that the changes truly serve the needs of Minnesotans.

8. LEADERSHIP OF THE STATE

The State of Minnesota will lead the way by changing the way the state carries out its role as purchaser, regulator and provider of health care services. On Friday, February 6, 2004, Governor Tim Pawlenty announced that the State of Minnesota will develop a **united health care purchasing and regulatory strategy** that will set the example for the entire state. Without major change, health care costs will continue to drain state resources and force the difficult choice of either increasing the number of uninsured Minnesotans or reducing funding for other state priorities such as education, roads and the environment. There is support among most Minnesotans, including many influential leaders in health care and business, to make the changes we recommend. As the purchaser of health care for a large number of Minnesotans who are public employees or enrolled in government programs, the state will join with private purchasers to create a powerful force for change. The state can also serve as an incubator to support the development and testing of new purchasing models that will lead to better quality and lower costs for public employees and government programs.

9. BUYERS ALLIANCE

With state leadership, consumers, employers and other buyers will be brought together to form a **united buyers alliance** to get the leverage needed to drive major changes in the health care delivery system. Governor Pawlenty and some of the state's largest employers and business organizations have agreed to provide leadership. Purchasers and payers will strengthen and expand existing partnerships and set specific statewide goals and expectations for the health care industry in Minnesota. A universal health care system does not need to be government run, but it does need to have a method of addressing system-wide problems and facilitating beneficial competition in the marketplace. This can be accomplished by bringing together all those currently involved in financing health care (employers, health plan companies, government agencies and representatives of individual market consumers) to work together to assure that the overall health system meets the needs of Minnesotans and provides the choices and information that is needed for competition to work. By working together, purchasers can send a stronger message to the health care industry about what needs to change, and back up their expectations with financial incentives in their payment systems. A buyers alliance can also improve choices and competition in the marketplace, by using their purchasing power differently. Potential problems that could be tackled include the medical arms race for expensive equipment and specialty facilities, costly excess capacity, worker shortages and geographical, ethnic or cultural barriers. There is an important role for government, but there is a lot buyers can do without government mandates or regulation.

10. PUBLIC/PRIVATE PARTNERSHIP

Once consumers and buyers make it clear what they expect from their health care system, the health care industry will respond. An action-oriented, **public/private partnership** will be formed to help the health care industry retool and work together to manage a seamless transition from the old way to the new way of doing things. Private leaders from health care and business will work with Governor Pawlenty to organize this activity. All activities will be undertaken with participation and input from consumers and the public. The State of Minnesota will be a partner in its roles as a regulator and purchaser of health care. The new group will have the responsibility to work with affected persons and organizations to implement the changes recommended in this report.

11. BIPARTISAN LEGISLATIVE WORK GROUP

While much can be accomplished through public and private collaboration, without the need for legislation, the Minnesota Legislature will play an important role in changing the state's public policy to support improvements in health care policy. Health care leaders in the House and Senate from both parties have agreed to work together and with the Governor, in a bipartisan way, to agree on public policies and draft legislation for the 2005 legislative session.

TIMING

Quick action is also needed to put the ball in motion because it will take several years for many of our recommendations to bear fruit. Most of our recommendations do not require legislation during the 2004 session to get underway. However, work should begin now to draft comprehensive legislation for the 2005 session.

Of the recommendations above, several general categories create opportunities for action to be taken within the next six months to generate short-term reductions in health care costs. These include:

- Standardization of administrative procedures and transactions.
- Adoption of electronic technology for recordkeeping and transactions.
- Collaboration on quality measurement and reporting.
- Improvements in care for patients with chronic disease and disability.
- Cost-effective services to high-risk uninsured persons to reduce overall costs.

OTHER TOPICS

Several important topics came up frequently in our dialogue with Minnesotans and were discussed at the Leadership Panel meetings, but were not addressed in this report either because others were already working on solutions or we were unable to develop specific recommendations due to time constraints. These include:

1. Long-term care;
2. Mental health;
3. Dental health;
4. Prescription drugs; and,
5. Transportation issues in rural Minnesota.

Conclusion

This report offers a road map to take us to the kind of health care system Minnesotans want. It also suggests vehicles that can be used to get us there. Our work is only the beginning. A strong commitment and sustained effort by individuals, communities, health care providers and third-party payers is needed. By working together, we can achieve the goal of better health and equitable access to safe, high-quality, affordable health care for all Minnesotans.

LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

EXECUTIVE SUMMARY

FEBRUARY 23, 2004

Minnesota Citizens Forum on Health Care Costs

www.mncitizensforum.org

LEADERSHIP PANEL MEMBERS

David Durenberger, Chair

Chair
National Institute of Health Policy

Peter Benner

Executive Director
Minnesota State Employees Union, AFSCME Council 6

Duane Benson

Former Executive Director
Minnesota Business Partnership

Jesse Bethke Gomez

President
Chicano-Latinos Unidos En Servicios (CLUES)

Ray Christensen, MD

Assistant Dean for Rural Health
School of Medicine, University of Minnesota-Duluth

Joanne Disch, PhD, RN, FAAN

Professor and Director of the
Katharine J. Densford International Center for Nursing Leadership
School of Nursing, University of Minnesota

Al Fallenstein*

Executive Vice President
Taylor Corporation

Frances Gardeski

Former CEO
University Medical Center-Mesabi

Jeanne Lally

Former President
Fairview Northland Regional Health Care
Fairview Health Services

Roger Moe

Business and Policy Consultant

Glen Nelson, MD

Chairman
GDN Holdings

Karl Self, DDS

Executive Director
Community-University Health Center

Bob Senkler

Chairman, President and
Chief Executive Officer
Minnesota Life Insurance Company

Tom Swain

Former Executive Vice President
St. Paul Companies

Chris Twomey

President and Chairman of the Board
Arctic Cat

Pamela Wheelock

Senior Vice President and
Chief Financial Officer
Minnesota Sports and Entertainment Group

Colleen Wieck

Executive Director
Governor's Council on Developmental Disabilities

Douglas Wood, MD, FACP, FACC

Vice Chair
Department of Medicine
Mayo Clinic and Mayo Foundation

*Al Fallenstein was tragically taken from us in an automobile accident in December. He remains with us in spirit.

Executive Summary

A CRISIS OF AFFORDABILITY. The average Minnesota household pays $11,000 per year for health care in taxes, premiums, and out-of-pocket costs for themselves and others. If health care costs continue to grow at the current rate, the cost per household will reach $22,000 by the year 2010. Without a change, our health care system will be priced out of reach of most Minnesotans. Businesses are also being hit hard by the increasing health care costs. In the past four years, insurance premiums have grown 3½ times faster than the state's economy and workers' wages. As health care costs continue to grow, employers have less money to spend on wage increases and other benefits for employees. Rising health care costs are also breaking the back of state and local governments. The relentless rise in health care costs has forced the Minnesota Legislature to divert millions of dollars away from education, roads, and the environment. Based on a three percent growth rate each year in the state's total health care spending and no reduction in the monthly cost of the average enrollee, by the year 2007, lawmakers will be faced with a decision of whether to cut another 104,000 low income Minnesotans from government health care programs.

PEOPLE PAY FOR HEALTH CARE. In our current financing system, people are in the dark about health care costs and excluded from most decisions about coverage and financing. Most Minnesota households pay less than a third of the cost of health care directly out of their own pockets. The rest is paid by employers and government in ways that are hidden from view. Even this money is actually coming out of people's pockets, they just don't realize it. Government uses our tax dollars for government programs and for health insurance for public employees. Employers pay their share of the health insurance premium using employee benefit dollars that might otherwise be paid to workers in additional wages or other benefits. Businesses build the cost of their share of health care premiums into the price of goods and services we purchase every day. Ultimately, people, not government or insurance companies, pay for everything and they should be fully informed and involved in decisions affecting their pocketbooks.

SERVING THE PEOPLE. Past efforts to keep health care affordable – from government price controls to managed care – have had at best only temporary success because they did not have public support. People felt the changes were forced on them by outside forces in a health care system they did not trust. To have lasting success, control of the health care system must be given back to the people who use and pay for it. Minnesota has earned a national reputation for leadership and innovation in health care. That success has always come from the ability to listen to citizens and to trust their collective judgment. The starting point must be the shared community values of Minnesotans and the goal must be a health care system where the individual is in control of his or her own care and coverage.

LISTENING TO PEOPLE. At the request of Governor Tim Pawlenty, the Minnesota Citizens Forum on Health Care Costs (Minnesota Citizens Forum) spent November and December, 2003 listening to Minnesotans. Town hall meetings and informal listening sessions were held across the state. An online survey was developed to solicit information from those who were not able to attend the town hall meetings. Ideas sent by Minnesotans through the mail and the Internet were read. Surveys and other research on public opinion

in Minnesota were studied. The Minnesota Citizens Forum worked with the Minnesota Board on Aging and the Minnesota Governor's Council on Developmental Disabilities to conduct a survey of a representative sample of 800 Minnesotans. In the end, a surprising amount of agreement was found about what Minnesotans expect from the health care system and what they think should be done about rising costs. Our first report, "*Listening to Minnesotans: the First Step towards Building a Better Health Care System*," describes the results of the dialogue with Minnesotans in detail.

In addition to talking with the public, we also sought the ideas and advice of experts and leaders from health care, business and government. We were impressed. Most major business and health care trade associations submitted detailed proposals for improving health care. We found that they, like the general public, agree about more things than they disagree about. They know major changes are needed and are ready and willing to work together. Our recommendations are built on the large expanse of common ground that exists among Minnesota citizens and leaders from health care, business and government.

MAJOR CHANGE IS NEEDED. There is a big gap between what people want and what the current system delivers. Many Minnesotans said we will not be able to fix the health care system without making major changes. Isolated, band-aid approaches will not have a lasting effect. They may even have the unintended effect of increasing health care costs further. Minnesotans are ready for change and are willing to do their part.

WE ARE ALL IN THIS TOGETHER. Few of us can afford to pay the costs of a serious illness without insurance. We use a health insurance model to share the risk with others. In any given year, 20 percent of us will use no health care services while one percent will consume 27 percent of all health care dollars. By sharing the risk through insurance, we can afford health care when we need it. We count on the system to balance individual needs with the needs of others. The Minnesota Citizens Forum discovered Minnesotans understand this concept and embrace it, but they have lost faith in the system's ability to do this fairly. They lack trust because they are left in the dark and do not have a say in important decisions. Restoring trust in the system is the key to making sustainable improvements Minnesotans can support.

BUILDING ON EXISTING EFFORTS. We were very impressed with the commitment and leadership shown by Minnesota's health care community, business community and public officials. Minnesota is a hotbed of nationally recognized leadership and innovation in health care. Our health care system has a strong climate of creativity, collaboration and commitment. Activities are already underway that take us halfway to our vision of how Minnesota's health care system should work. Our goal is to build on these existing efforts rather than create new ones. We want to foster an environment that encourages collaboration among existing efforts, eliminates redundancies and capitalizes on the ability to create successful new models for health care delivery.

CHARGED WORDS. Because the health care reform discussion is so politically charged, some words have become associated with a particular political or philosophical agenda or mean different things to different people. We tried to avoid loaded terms such as "universal coverage," "free market system," "consumer-driven health care," "evidence-based medicine," "personal responsibility" and "single-payer health care system." When we used these terms, we tried to explain what we meant. For example, when we use the term "health

care" in this report, we are using it in its broadest sense – to include mental health, dental health, and long-term care – even though we have not developed specific recommendations in these areas.

COMPETITION IN A WELL-FUNCTIONING HEALTH CARE SYSTEM. The polarized, political debate between a "single-payer" system (a universal, government-financed health insurance plan that covers everyone) and a "free market" health care system (where government plays a minimal role in regulating or managing health care) continues. In the mean time, nothing changes and we slip deeper into the health care cost crisis. The Minnesota Citizens Forum looked to Minnesotans for the answer. We found that almost all Minnesotans agree on two fundamental principles: (1) they want a responsive system where everyone gets the health care they need, and (2) they want a privately-based health care system that offers as much choice as possible. Our recommendations will lead to a uniquely Minnesotan universal health care system that promotes healthy private sector competition while assuring the overall system serves the best interests of all Minnesotans.

A VISION FOR THE FUTURE. We believe Minnesotans deserve a health care system that delivers better health and equitable to safe, high quality treatment at an affordable price. Everyone must do their part to realize the vision, including individuals, communities, those who work in the system and those who finance it. Some of these changes can be implemented immediately; many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals.

GENERAL RECOMMENDATIONS

The current health system is very complex, but it is simple to describe what needs to change. We can drive a car without knowing exactly how the engine works. The following recommendations require major changes, but by working together and building on existing efforts already underway, the job will get done. For each recommendation, we have identified actions that should be taken to implement the recommendation. Time is essential, we must act now.

1. **PUT MINNESOTANS IN THE DRIVER'S SEAT.** Minnesotans should make the decisions about health care, both individually and collectively. This is a paradigm shift from the current system where many of the most important decisions are made by employers, health plans, health care professionals and government. Minnesotans need to define what the health care system should do as opposed to the system defining itself. There also needs to be a collective discussion on how to fund the system and what affordability means. Employers, HMOs, and health insurance companies should play a supportive role, but not the lead role. This means we will have to rethink what the marketplace should look like.

    a. **Give individuals more choices and control of their health care treatment, with incentives for choosing higher quality, lower cost providers; however, consumer-centered health care should not create financial barriers that prevent people from getting preventive care and cost-effective services.**

b. **Give individuals the opportunity to choose from a full array of health plan choices ranging from low-cost to high-cost, while preserving the basic concept of insurance which uses money from the currently healthy to subsidize the currently sick.**

c. **Make sure individuals with a chronic disease or disability can afford to receive the care they need to avoid preventable complications of disease.**

d. **Establish a permanent process for a continuing dialogue with the public and for conducting research on Minnesotans needs, values and preferences.**

2. **FULLY DISCLOSE COSTS AND QUALITY.** Minnesotans should be fully informed about health care costs and quality and able to compare the price and quality of health care providers and health plans in order to make informed decisions. This will be eye-opening for the public. Most people have no idea how much variation exists in quality and price. As members of a community, they should know where the money goes, how it is used, who profits from it, and what quality and outcomes they are getting for their money.

a. **Give Minnesotans detailed information on prices costs and financing in the current system.**

b. **Create a health care information web site with comprehensive information about health care costs and quality in Minnesota (see recommendation 3 on quality).**

c. **Implement a public awareness campaign to increase the public's knowledge of the costs of health care.**

3. **REDUCE COSTS THROUGH BETTER QUALITY.** During the dialogue with Minnesotans, many examples were given of how health care dollars are often wasted on ineffective treatments, mistakes and poor quality care. By some estimates, 30 to 40 percent of health care dollars are spent on ineffective and unnecessary care. Health care costs can be reduced by improving quality of care and eliminating health disparities.

a. **Change payment systems to reward better quality and effectiveness.**

b. **Standardize methods of measuring and reporting quality.**

c. **Give Minnesotans quality information about health plans and health care providers.**

d. **Bring together existing quality initiatives in a state forum to coordinate existing quality improvement efforts and develop a statewide quality plan that will achieve specific quality improvement goals.**

e. **Test new improvements in care for persons with chronic disease and disability.**

f. **Define "quality" to include cultural competence and no disparities in health status, access and quality.**

4. **CHANGE INCENTIVES TO ENCOURAGE HEALTH.** The current system does not reward individuals for healthy lifestyles, nor does it reward health care providers for improving a patient's health. The broader environment, too, does not encourage good health. Super-sized, caloric, high-fat fast food has replaced home-cooked meals. Poor diet, lack of exercise, high stress lifestyles, and smoking result in higher rates of obesity, heart disease, cancer and mental illness. Incentives in the health care system should be changed to produce better health and outcomes, and together we should seek to create healthier communities.

a. **Change payment systems across the entire health care system so that incentives produce better health.**

b. **Reward people who maintain good health with discounts on health care, lower premiums, or other benefits.**

c. **Encourage employers and communities to provide programs and incentives to influence individuals to adopt healthier behaviors.**

d. **Strengthen the state's efforts to reduce tobacco use, with a special focus on youth smoking.**

e. **Add a $1.00 per pack user fee on cigarettes to reduce smoking rates and raise revenue for state efforts to reduce smoking, improve health and provide access to uninsured Minnesotans.**

f. **Launch an aggressive campaign to reduce obesity, especially among children.**

g. **Strengthen the public health system through community partnerships and adequate funding.**

5. **ASSURE UNIVERSAL PARTICIPATION IN THE HEALTH CARE SYSTEM.** Minnesotans are strongly in support of a health care system where everyone has access to needed health care. Access to health care may be limited by financial, geographic, linguistic or cultural barriers. These barriers result in poorer health, lack of preventive care and delays in needed treatment, all of which add cost to the system. We must work together to eliminate barriers so that everyone has health care coverage and is able to get the services they need. However, a universal system is not <u>just</u> about access and coverage, it is also about meaningful participation by individuals so we have a health care system in which everyone receives needed health care, including preventive care, at a cost they can afford and everyone contributes to better health. We share the financial risk of medical expenses through insurance so that we can afford health care when we need it. If

everyone is not paying in, especially when healthy, we run the risk that others will not receive care when they need it.

a. **Set a goal of "universal participation" in the health care system, which is broader than just universal access or coverage.**

b. **Continue the state's commitment to the goal of health coverage for all Minnesotans, with a priority for covering children.**

c. **Give uninsured Minnesotans access to affordable basic preventive care and other cost-effective services that will improve their health and reduce the need for more costly treatment.**

d. **Require participation in the health care system by uninsured Minnesotans who can afford to buy health coverage but choose not to.**

e. **Change the current system of financing uncompensated care for the uninsured to eliminate cost-shifting and spread the burden more equitably.**

f. **Eliminate non-economic barriers to access for needed health care services.**

g. **Reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses.**

6. **SUPPORT NEW MODELS FOR HEALTH CARE EDUCATION.** Minnesota is facing a growing shortage of health care workers even in areas typically not affected by worker shortages. The existing workforce cannot keep up with current demand, nor is it adequately prepared for the rapid changes that are taking place in our state's demographic makeup and the revolution of medical technology treatment. **Support new models for health care education to meet Minnesota's changing health care needs.**

7. **REDUCE THE COST OF OVERHEAD AND ADMINISTRATION.** The complexity, duplication, and lack of accountability in the current system results in unnecessary costs for overhead and administration. Significant savings can be achieved by streamlining and standardizing administrative procedures and government regulations. New electronic technology offers an opportunity for further savings.

a. **Establish uniform health care industry standards for electronic billing, electronic medical records, reports and other administrative procedures.**

b. **Use health care industry partnerships to facilitate the rapid adoption of new electronic technologies that will improve efficiency and service and reduce administrative costs.**

c. **Adopt a new approach to state health care regulation.**

d. **Reform health care taxes.**

HOW TO GET THERE

A major effort is needed to make the transformational changes recommended above. The good news is that much agreement exists about the direction we need to go; everyone seems ready to do their part, and leaders are stepping forward to spearhead the effort. These three ingredients – vision, commitment and leadership – will get us to our goal. We suggest the following specific steps to get started, but all should be done in a way that is open to the public and maximizes participation of Minnesotans to assure that the changes truly serve the needs of Minnesotans.

8. **STATE LEADERSHIP.** The State of Minnesota will lead the way by changing the way the state carries out its role as purchaser, regulator and provider of health care services. On Friday, February 6, 2004, Governor Pawlenty announced that the State of Minnesota will develop a **united state health care purchasing and regulatory strategy** that will set an example for the entire state.

9. **BUYERS ALLIANCE.** With state leadership, consumers, employers and other buyers can be brought together to form a **united buyers alliance** to get the leverage needed to drive major changes in the health care delivery system. Governor Pawlenty and some of the state's largest employers and business organizations have agreed to provide leadership.

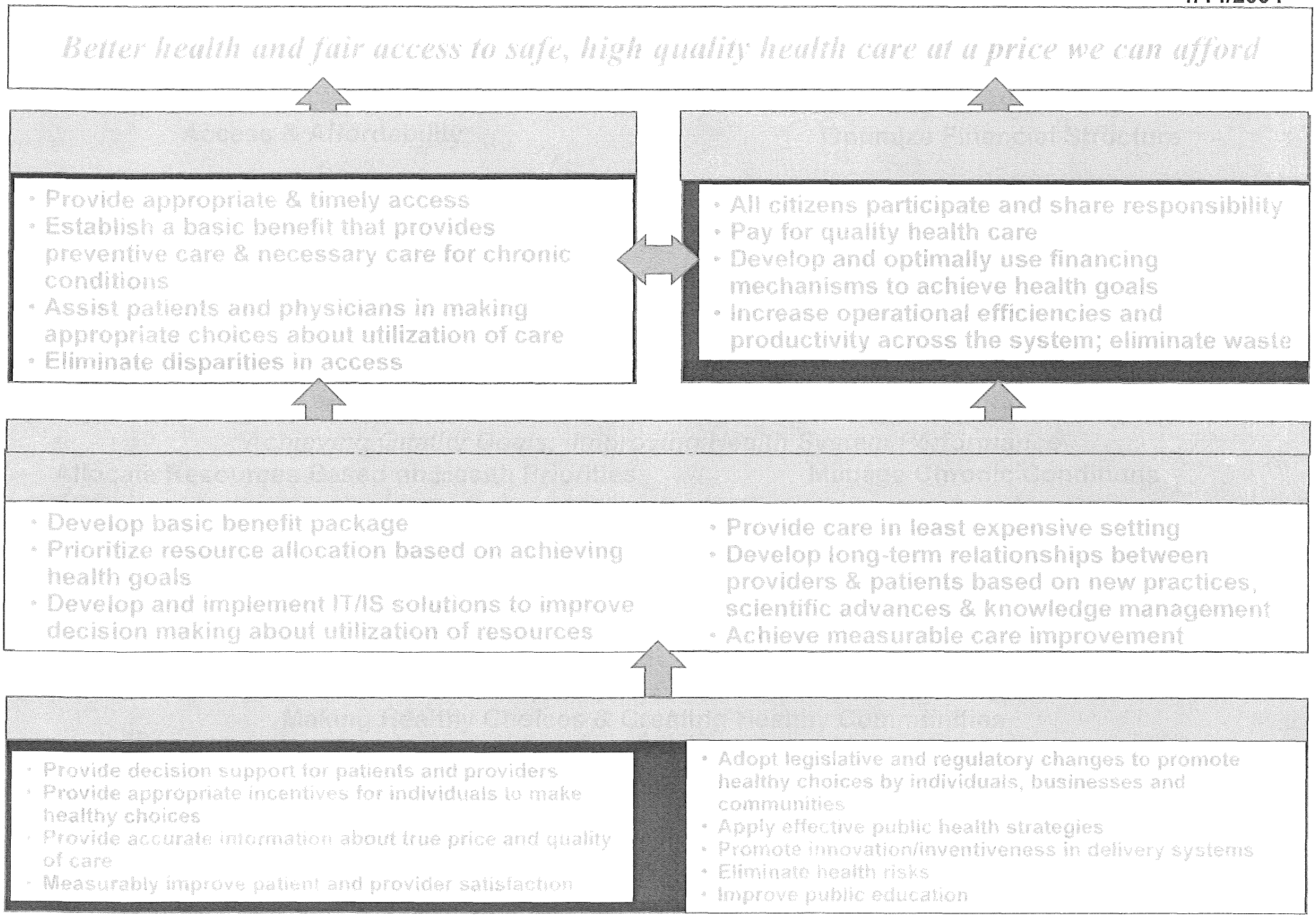
10. **PUBLIC/PRIVATE PARTNERSHIP.** Once consumers and buyers make it clear what is expected from their health care system, the health care industry will respond. An action-oriented, **public/private partnership** is needed to help the health care industry retool and work together to manage a seamless transition from the old way to the new way of doing things. Private leaders from health care and business will work with Governor Pawlenty to organize this activity.

11. **BIPARTISAN LEGISLATIVE WORK GROUP.** While much can be accomplished through public and private collaboration without the need for legislation, the Minnesota Legislature will play an important role in changing the state's public policy to support improvements in health care. Health care leaders in the House and Senate from both parties have agreed to work together and with the Governor, in a bipartisan way, to agree on public policies and draft legislation for the 2005 legislative session.

A Strategy Map for Minnesota Health Care 2010

L. Wood, M.D.

1/14/2004



Health Care Services Study: Findings and Strategies for Savings

Report to the Minnesota Legislature

Minnesota Department of Human Services
January 2005

Table of Contents

Executive Summary

Nationwide, Medicaid budgets are rapidly eating up a larger portion of state spending. The National Association of State Budget Officers predicted that state Medicaid spending would for the first time surpass spending on elementary and secondary education in FY 2004. While this has not occurred in Minnesota, increases in health care spending in recent years suggest the state is headed in that direction.

A collision of numerous factors has produced unsustainable cost growth in publicly funded health care programs. Spending in Minnesota Health Care Programs (Medical Assistance, General Assistance Medical Care and MinnesotaCare) is projected to increase $1.4 billion from the 2004-05 biennium to $6.567 billion in the 2006-07 biennium.

Like many other states, Minnesota's short-term solutions have included limiting enrollment, increasing cost sharing, reducing coverage and reducing provider payment rates.

The 2003 Minnesota Legislature sought a longer term solution through a rigorous review of Minnesota Health Care Programs' (MHCP) comprehensive benefit package. Lawmakers directed the Minnesota Department of Human Services (DHS) to recommend covered services that could be eliminated from the state's public programs.

Upon further consideration, legislative leaders agreed to expand the scope of the exercise to consider what services should be covered, under what conditions, and how they should be provided. This approach offered greater opportunity to identify strategies that could produce long-term positive impacts on both the budget and program enrollees' health status.

DHS hired Bailit Health Purchasing, LLC (Bailit) to assist with the study, titled the Health Care Services Study. The 14-month process included research on multiple fronts as well as numerous meetings with stakeholders.

Input was solicited locally from consumers and providers as well as state Medicaid directors and health cost experts across the nation. Some ideas gave rise to contentious discussions.

The strategies resulting from the Health Care Services Study will not be universally embraced. Yet each warrants serious consideration. Many hold significant potential for lowering the trajectory of long-term cost growth. And equally important, these same strategies offer new means for improving program integrity and quality.

The strategies are presented in the report in three categories:

- Three strategies for which DHS has developed implementation plans and savings estimates

- Nine strategies for which DHS has not developed implementation plans or savings estimates, but which hold significant promise for savings
- Additional strategies that could not be fully researched, but which warrant serious consideration for future exploration (see full report for these strategies.)

In some cases, relatively modest initial savings are projected to grow considerably over time.

For the savings determined by DHS, the standard legislative fiscal note process was used. In other instances, the strategy has not been converted to a detailed implementation plan and proposal, including any necessary changes to state law. In these instances, Bailit estimated potential savings based on his research of the issues from a national perspective.

Strategies for which DHS has Developed Implementation Plans and Savings Estimates

1. Evidence-based Decision Making for Benefits Coverage Policy

The question of what services to cover and when is one of increasing interest nationally as greater attention is given to using research to support coverage policy. This approach is commonly referred to as "evidence-based medicine," defined in recent literature as:

> ... a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.

Research literature is replete with examples of inappropriate service delivery. Certain services that research finds to be effective in specified circumstances are being delivered in situations when the services are *not* effective.

Minnesota likely spends a significant amount of money, perhaps in the tens of millions of dollars, providing services that are not effective, or are not the most cost-effective option.

The state should implement an integrated approach to evidence-based decision making for benefits coverage policy to reduce these unnecessary expenditures. This approach should include three components: hiring a medical director for benefits policy, creating a Medical Policy Council, and participating in a multi-state Medicaid Evidence-based Practice Center.

Implementing an evidence-based benefits coverage process would require careful deliberation, sufficient resources, and persistence.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	$832,000	$1.9 million	$2.816 million	$3.793 million

2. Increase Pharmacy Savings

Minnesota's fee-for-service Medicaid program experienced double-digit increases in pharmacy costs (net of rebates) during calendar years 2001 through 2003. Minnesota, like other states, has been increasingly aggressive in implementing pharmacy management programs to control costs while continuing to provide clinically appropriate pharmacy coverage.

While important steps have been taken by the state, additional initiatives are possible. Specifically, the state should:

- reduce the reimbursement rate for retail pharmacies
- require beneficiaries with hemophilia to obtain blood factor products through a 340B hemophilia treatment center, and
- contract with specialty pharmacies to be exclusive providers of particular specialty pharmacy drugs.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	$5.3 million	$4.3 million	$4.7 million	$5.1 million

The cost savings for the specialty pharmacy initiative would continue to grow as the use of specialty pharmacy drugs increases.

3. Implement Intensive Medical Care Management for the Chronically Ill in Fee-for-Service Medical Assistance

There is a distinct "highest-risk" segment within the population of high-cost Medicaid enrollees. These are typically characterized as individuals at risk of hospitalization within a year's time. Highest-risk individuals often comprise 1 to 3 percent or less of the total population, but account for up to 25 percent of all acute care costs. Typically, people in this group suffer from more than one chronic medical condition and have confusing psychosocial issues.

Highest-risk enrollees are often not identified through traditional high-cost case management, county case management, or disease management programs because they

are often isolated from the community and disconnected from primary care within the health care system.

The state should contract with an experienced vendor to administer a program that identifies highest-risk individuals and provides intensive outreach and support to them. Research with similar programs for people who have private insurance reveals a savings of three dollars for each dollar invested. Managed care organizations (MCOs) serving Medicaid enrollees in other states also report positive results.

The state should collaborate with contracted MCOs to learn from their experience with similar programs, both to inform the fee-for-service program, and to promote performance improvement across MCOs.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	*Cost* of $337,500	$225,000	$225,000	$225,000

Strategies for which DHS has Not Developed Implementation Plans or Savings Estimates, but which Hold Significant Promise for Savings

1. Expand Managed Care for People with Disabilities

An increase in both enrollment and costs attributable to people with disabilities demands that the state rethink how well this population is being served. Between 2000 and 2004, the number of enrollees with disabilities increased 27.6 percent. During the same time period, the relative per capita cost increased 34.2 percent for this population. It is worth noting that these rates of enrollment and cost increases are double that of the elderly population in public programs.

People with disabilities are the only large group that Minnesota exempts from managed care enrollment. Limited research indicates that people with disabilities, including those with physical disabilities, mental illness, or developmental disabilities, can be better and more efficiently served through appropriately designed managed care programs.

The state should begin a multi-year process to transition enrollees with disabilities into managed care. Specifically, beginning January 1, 2007, the state should start providing basic health care (i.e., non-continuing care) to enrollees with disabilities in the metro

counties through a managed care approach. Continuing care services should be phased in at a future date, with possible geographic expansion as well. The program could be delivered through contracted managed care organizations, a state-operated managed care plan, or both. It could be either voluntary or mandatory for enrollees. The state should not require MCO involvement, but focus instead on those MCOs willing to develop the specialty skills and provider networks necessary for serving people with disabilities.

In addition, the state should expand its Minnesota Disability Health Options (MnDHO) program, which currently serves only metro area residents with physical disabilities. The program should be expanded to serve people with other kinds of disabilities and additional geographic areas.

DHS estimates that initial year savings from this strategy would be more than offset by the cost of moving from fee-for-service to capitation, due to the timing of payments. Any savings in future years would be dependent on the ability of the MCOs to manage medical expenses. The Department's estimates are based on the state's experience with health care purchasing in Minnesota, as well as the federal requirement that Medicaid capitated payments be actuarially sound.

Bailit estimates that the state could save from 1 to 4 percent after the initial year. His estimates are based on reported rates of saving achieved by other states' managed care programs for people with disabilities.

2. Improve Training, Oversight and Investigation of the PCA Program

Cost growth in the Personal Care Assistance (PCA) services, both in fee-for-service and managed care, has attracted significant attention. Some stakeholders allege that services are being used inappropriately. In addition, there have been findings of fraud. Overall, concerns pertain to both how people qualify for PCA services and how the benefit is administered.

The state can obtain significant savings from the PCA program through closer oversight and better training.

Specifically, training and program information should be improved for provider agencies and direct care workers, for nurses who perform PCA needs assessments, for physicians who prescribe PCA, and for the enrollees who receive it. The state should improve oversight of the program by enhancing the Department's capacity to investigate potential fraud and abuse by hiring additional investigative staff, by completing work on the provider registry and developing an improved PCA provider enrollment process that assures better tracking of individuals and agencies providing this service, and developing new provider credentialing requirements.

These cost-savings strategies are designed to preserve the program's benefits for the thousands of enrollees who depend on PCA as an integral part of their care plan.

3. Help County Health and Human Services Programs Collaborate

The state currently delegates management of service delivery for a large portion of its health care budget to the counties. The need to work with 87 separate counties represents one of the greatest challenges to improved accountability and performance. It also creates considerable demands for counties, and problems of equity for enrollees.

Currently, DHS is able to exercise only limited oversight and control over services and administrative functions that significantly impact enrollee outcomes and state expenditures. The problem is a result of poor structural design that makes it difficult for DHS or the counties to excel.

Increased county collaboration on the delivery of health and human services would be an important first step to improve performance and achieve efficiencies. The state should pursue efforts to help counties collaborate. Ultimately, this may result in regionalization of these functions. The state should work cooperatively with counties and the Association of Minnesota Counties to explore and pursue collaboration opportunities.

4. Improve MCO Contract Management

The state should implement a strategically focused, senior manager-led, contract management approach to working with its MCO vendors. In so doing, the state would create sufficient management systems to ensure accountability for performance that both meets state expectations and continuously improves. In addition, DHS should improve its existing relationship with contracted MCOs that is marked too much by confrontation and conflict, and too little by collaboration and joint problem solving.

DHS has begun implementing a strategically focused contract management approach to work with its MCO vendors, described in the full report. This approach has worked elsewhere in the United States and would support state efforts to maximize the performance of contracted MCO programs.

5. Improve County Partnership and Performance Management

Minnesota counties, to a large degree, manage the $2.465 billion (FY04) continuing care system (with the exception of nursing facility rate setting). Included in this responsibility is the allocation of much of those funds.

While the state and counties have a special partnership relationship, the state should apply some of the same contract management techniques with county entities as suggested above for its relationship with contracted MCOs. The collaboration and possible consolidation of county health and human service functions across counties would make this management process more effective for the state.

6. Pilot and Evaluate Disease Management

The state should pursue a two-pronged approach to evaluate the potential for disease management (DM) to improve quality of care and reduce health care costs associated with chronic illness.

First, the state should implement a DM pilot for the fee-for-service Medical Assistance population, and include a rigorous process for independent program evaluation by a party other than the DM contractor or its affiliates.

Second, the state should work cooperatively with its contracted MCOs to:

- review the varied approaches that vendors have taken to implement DM
- compare those approaches to best practice standards and accreditation standards for DM programs
- review MCO self-evaluations of DM program clinical and cost effectiveness for Medical Assistance enrollees, and
- meet with MCOs to learn first hand their experiences with DM and the Medical Assistance enrollee.

7. Divert and Reduce the Length of Nursing Facility Stays

Building on past work supporting long-term care alternatives for Minnesotans, the state should pilot two strategies designed to further reduce avoidable nursing facility utilization.

The first strategy places county-based Long Term Care Consultants (LTCCs) in hospitals and geriatric clinics to inform consumers and their family members of long-term care alternatives at the point when they are contemplating a nursing facility admission.

The second strategy funds assessment workers and independent care planning for consumers choosing to leave a nursing facility within a set timeframe, e.g., 120 days.

8. Improve County Case Management for the Home and Community-Based Waivers

Stakeholders often cited case management for home and community based waiver services for elderly and people with disabilities as a problematic area with potential for both service improvement and cost savings. The most pressing case management problems stakeholders and DHS staff identified are:

- unclear definitions and standards
- redundancy
- fragmented administration.

To address these issues, a first step towards program improvement should be to pursue the recommendation made in a 2003 DHS report to the Legislature on case management

and promptly define program parameters in clear operational terms that are well understood by state, county, and provider staff, as well as by consumers, their families, and advocacy organizations.

In addition, the state should eliminate duplication of case management services so that the structure of case management is dictated by the consumer's needs and not by case management financing streams.

Finally, the state should establish and provide training on statewide standards for all case managers, and enforce compliance.

9. Support Efforts to Expand Use and Connectivity of EMRs

There is national consensus that electronic medical records (EMRs) hold great promise for reducing redundancy of testing, eliminating medication errors, preventing adverse medical events, and increasing the efficiency of medical practice in both office and institutional settings.

Minnesota has begun to address this opportunity through the creation of the Minnesota e-Health Initiative. DHS is currently a participant in this Minnesota Department of Health-led effort.

The two agencies should continue to work together, accessing available federal grant funds to support the initiative. In addition, the state should target increasing EMR accessibility for rural practices and clinics and for continuing care providers, and should actively improve and promote connectivity and interoperability with Minnesota providers and among Minnesota providers.

Conclusion

This report identifies a range of strategies to yield additional savings and improve health care program services for program enrollees. The most viable of these strategies have helped form the basis for policy and budget proposals that will be presented to Legislature. Other strategies require more research, development and consultation with stakeholders and can be pursued over time.

Introduction

In 2003, the Minnesota Legislature directed the Department of Human Services (DHS) to conduct a Payment Code Study. Minnesota Laws 2003, First Special Session, chapter 14, article 13C, section 2, subdivision 7, specifically directed DHS to:

> "determine the appropriateness of eliminating reimbursement for certain payment codes under medical assistance, general assistance medical care, or MinnesotaCare" and to "examine covered services under the Minnesota health care programs and make suggestions on possible modification of the services covered under the program."

A report to the Legislature was to identify payment codes, "if any, to be eliminated from the payment system, and estimates of savings to be obtained from this approach." DHS was concerned that identifying individual payment codes without first exploring underlying issues and processes would result in inappropriate decisions about which covered services should be eliminated.

With legislative leadership's consent, DHS expanded the scope to address:

- **What** services should the state cover?
- **When** (i.e., under what circumstances) should the state cover specific services?
- **How** should the state provide the services?

To assess these questions, DHS hired Bailit Health Purchasing, LLC (Bailit) to assist with a study, retitled the Health Care Services Study. Bailit had previously assisted with the work of the state's Long-Term Care Task Force (2000-2002).

To obtain input from many constituents, DHS created a Stakeholder Work Group to make suggestions and to react to draft strategies. Participants included consumers, family members, consumer advocates, providers, health plans, counties, and state agency staff. This group met seven times. In addition, DHS convened an Expert Panel which met four times to provide advice (see Appendix A for a list of Expert Panel members). Finally, DHS sponsored the following:

- three additional meetings to obtain input from consumers and other stakeholders interested in services for people with disabilities
- an additional meeting for further discussion on case management and personal care attendant services, specifically scheduled to obtain input from stakeholders unable to attend regular Stakeholder Work Group meetings
- a meeting with health plan executives to review potential strategies pertaining to medical policy

- with support from The Commonwealth Fund, a meeting of non-Minnesotan health care experts in Boston.

Bailit worked extensively with many DHS staff members to learn about existing problems. (See Appendix F for an example of a working document from a brainstorming meeting with DHS Disability Services Division staff.)

Bailit also conducted extensive research with other states and examined research literature and media reports. From this, he developed a number of white papers, some, but not all, of which led to strategies in this report. (See Appendix G for a sample white paper on selective contracting.)

This report presents strategies derived from the study. The most viable of these strategies have helped form the basis for policy and budget proposals that will be presented to Legislature. Others will be considered for future pursuit. Each of the issues raised in this report, however, is important for Minnesotans to grapple with as they contemplate the future direction of the Minnesota Health Care Programs.

Background

Medicaid costs nationally increased faster than any other area of state spending in fiscal year 2003, according to the National Association of State Budget Officers and the National Governors Association. Medicaid costs were expected to consume a greater portion of total state spending than elementary and secondary education for the first time in FY 2004.[1]

While Minnesota's Medicaid spending hasn't yet become the largest piece of the state budget, projected costs suggest it is heading in that direction. Spending in Minnesota Health Care Programs (MHCP) is projected to increase $1.4 billion from the 2004-05 biennium to $6.567 billion in 2006-07. MHCP includes Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare.

The 2003 Legislature's directive to conduct the Health Care Services Study came amidst severe budget pressures resulting in decisions to drop coverage for certain populations and specified services, add new cost-sharing requirements for program enrollees, and reduce payment rates to providers.

With health care costs forecast to rise at a rate at least three to five times the Consumer Price Index (CPI), Minnesota can expect to confront increasingly difficult decisions regarding how to provide health services to low-income, needy populations.

---

[1] 2003 State Expenditure Report, National Association of State Budget Officers, 2004, www.nasbo.org.

With awareness that there are no easy answers, the strategies presented in this report attempt to reconsider basic assumptions regarding how the state covers services and delivers covered services.

The strategies presented in this report represent only a subset of those that were identified and considered during the course of the study. Most are anticipated to yield savings within the next two fiscal years, while a few are not. Nonetheless, the latter group is included to set the stage for Minnesota to be able to provide care more efficiently and effectively to MHCP enrollees in the future.

There are no strategies that stakeholders will find universally acceptable. However, each of the strategies warrants serious consideration. Some address long-standing issues that the state has been unable to address. Discussions with stakeholders will be necessary to make changes that will improve financial accountability and system performance.

Examining *What* to Cover

The question of what services to cover in publicly funded programs is one of increasing interest nationally as greater attention is given to using research to support coverage policy. This approach is commonly referred to as "evidence-based medicine," defined in recent literature as:

> ... a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.[2]

In an era when Minnesota has been compelled to drop effective services from coverage and to drop some population groups, it is appropriate to ask, "Couldn't we be certain that we are only paying for necessary and effective services?"

A roundtable convened by the California HealthCare Foundation and the health policy journal *Health Affairs* recently concluded:

> ...in the absence of evidence-based, cost-effective priority setting, the health care system likely will be driven to control inflation through heavy-handed reductions in provider payments and higher consumer cost sharing.[3]

In public programs for the poor, where cost sharing is a tool of limited use, most states have placed more emphasis on dropping services and coverage. Using evidence-based principles to make coverage decisions can offer the state one alternative to cost sharing.

There are limitations, however, to using scientific evidence to define necessary covered services based on a criterion of effectiveness:

---

[2] Eddy DM. "Evidence-Based Medicine: A Unified Approach," *Health Affairs*, January/February 2005.

[3] Yegian JM. "Conference Summary: Setting Priorities in Medical Care Through Benefit Design and Medical Management," *Health Affairs* Web Exclusive, May 19, 2004.

- Existing research indicates that most services are effective with some people on some occasions. Research occasionally, but not often, finds a service to *never* be effective.
- Many services have never been subject to rigorous scientific review of effectiveness, or even to the level of scrutiny applied to drugs. This is especially true of continuing care services, e.g., personal care assistance, home care, supportive living services.
- Where research has been conducted, it has seldom been performed using subjects like those of the populations served by publicly funded health care programs (e.g., people with physical or developmental disabilities, children,).
- Research findings can change over time as additional evidence accumulates.

Based on the first two points above, research evidence can occasionally be used to identify services that do not warrant coverage based on effectiveness (e.g., bone marrow transplants for treatment of breast cancer[4]), but it tends to be more useful in identifying the circumstances under which a service could or could not be covered. The third point instructs policymakers to be mindful when applying research evidence that no one will ever be able to know with certainty whether the findings would be replicated with any given subpopulation of public program enrollees. Nonetheless, decisions must be made carefully with the best available information.

Research evidence can be more useful for developing coverage decisions when effectiveness of treatment is considered in conjunction with a cost assessment. This type of analysis is applied regularly to drugs. Drug formularies typically cover the least expensive drug when competing drugs are of equal effectiveness. This approach has not been extended as aggressively to other health services, in part because there is less research evidence available about other services. Like others,[5] the state believes evidence-based medicine as an approach to coverage policy merits consideration as a method to responsibly reduce health costs.

Examining *When* to Cover

Research literature is replete with examples of inappropriate service delivery. Certain services that research finds to be effective in specified circumstances are being delivered in circumstances when the services are *not* effective.

A common example of this is in the use of antibiotics. Antibiotics can be extremely effective with bacterial infections. They have no effectiveness with viral infections, however. Nonetheless, antibiotics are widely prescribed for viral infections.

Evidence-based medicine offers the potential for savings by creating rules that guide when a service can and cannot be delivered. Some of these rules were removed by

---

[4] Mello M and Brennan T. "The Controversy Over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer," *Health Affairs* 20, no. 5 (2001): 101-117.

[5] "Medicine Tests," *Washington Post* editorial, Nov. 8, 2004, p. A24.

managed care organizations in the late 1990s in reaction to the "managed care backlash." Consumers don't like these service coverage rules, perceiving them to impede access to desired care. In a strong labor-tight economy, consumer dissatisfaction was enough to have these rules removed. Now, higher health costs and a less robust economy have led to the reintroduction of these techniques with greater focus and precision than before.[6,7]

Systems that require prior authorization of certain services before they can be delivered are believed by some to be effective deterrents of cost growth due to unnecessary service use. They also have some widely accepted shortcomings, including:

- consumers viewing such systems as a barrier to care, even when limited access is warranted.
- providers view such systems as a "hassle factor" that slows care delivery and adds to provider administrative cost.
- insurers must incur additional administrative cost.
- insurers' failure to conduct periodic reviews of the procedures for which they are requiring prior authorization. Consequently, some procedures continue to be restricted when new evidence shows they no longer need be.

Despite these limitations, evidenced-based systems that control when services prone to overuse are delivered should play an important role in ensuring appropriate state spending. Furthermore, there is a possible role for strategies that direct access to more appropriate service alternatives (e.g., primary care offices instead of hospital emergency departments).

Examining *How* to Cover

The question of how the state should deliver covered services requires a broad consideration of how DHS purchases and manages service delivery.

DHS' purchasing strategy has two primary components:

- Varying use of managed care and traditional fee-for-service (FFS) systems

  Minnesota currently employs a managed care purchasing strategy for non-disabled adults, children and elderly. The state is transitioning to a managed care strategy for the elderly, combining non-institutional services and limited institutional services. With the exception of a small, voluntary program serving people with physical disabilities, the state maintains a traditional FFS system for the diverse range of people who are eligible for Medicaid due to a disability.

---

[6] Mays G, Claxton G, White J. "MarketWatch: Managed Care Rebound? Recent Changes In Health Plans' Cost Containment Strategies," *Health Affairs* Web Exclusive, Aug. 11, 2004; "MCOs' Strategies to Slow Imaging Costs Are Starting to Take Effect, Radiology Firms Say," *Managed Care Week*, June 7, 2004; and Fuhrmans V. "Overuse of Medical Scans Is Under Fire," *Wall Street Journal*, Jan. 12, 2005.

[7] Kazel R. "Tightening the leash," *American Medical News*, Oct. 18, 2004.

- Delegation of select responsibilities to counties

  Minnesota's purchase of most[8] continuing care services for the elderly and for people with disabilities is largely managed in a delegated fashion through the state's 87 counties. Counties not only assume management responsibilities for some functions, but they fund a portion of expenditures as well.

The state should reconsider these basic strategic approaches to purchasing and evaluate whether and how modifications could improve value, in terms of the cost and quality of services.

The strategies resulting from this study address what, when, and how services might best be purchased and delivered. They were designed to not only provide cost savings to the state, but also to maintain or improve the overall value attained by its purchasing efforts, including the accessibility and quality of services.

[8] DHS is beginning to transition Elderly Waiver (EW) services and coverage of 180 days of institutional services into its managed care contracts in SFY05.

Strategies

Many issues, and a lesser but still large number of potential strategies, were considered in the course of this study. Stakeholders, DHS staff, and members of the study's Expert Panel offered strategy suggestions.

The strategies in this report are organized as follows:

- strategies for which DHS has developed implementation plans and savings estimates
- strategies for which DHS has not developed implementation plans or savings estimates, but which hold significant promise for savings
- additional strategies that could not be fully researched, but which warrant serious consideration for future exploration.

For proposals with savings estimated by DHS, the standard legislative fiscal note processed was used. For the remainder of the proposals, the savings were estimated by Bailit.

Some suggestions were not included in this report because the problems they targeted were not sufficiently pervasive, and/or the strategies were unlikely to produce significant savings (Appendix B).

It should be noted that DHS is currently pursuing a wide range of policy initiatives to achieve savings and improve program performance. Only a few of these initiatives are reflected in some of the strategies in this report. Others are not included here, not because they do not hold promise, but merely that they were not selected as the highest priorities to achieve savings and improve value.

DHS should pursue federal authority, if necessary, to implement any of the resulting strategies.

Strategies for which DHS has Developed Implementation Plans and Savings Estimates

1. Evidence-based Decision Making for Benefits Coverage Policy

Problem Statement

Research shows that many health care services are delivered when not needed and produce no benefit to the patient.[9] Spending on ineffective, inappropriate, or unproven services for Minnesota Health Care Programs (MHCP) enrollees is a poor use of taxpayer resources. They also carry a large opportunity cost – those dollars instead could have been used to cover additional people or to prevent cutting people from existing programs, or to cover other services that *have* been proven effective.

Using calendar year 2003 MA FFS claims data and managed care organization (MCO) encounter data, Bailit analyzed expenditures for a sample of services identified as overused by some research literature. (See Appendix C for a summary of selective findings.) Bailit then calculated the estimated spending attributed to overuse of these specific services. The research was not specific to Minnesota or to Medicaid populations and Minnesota may have less overuse. Furthermore, the approach did not include actual review of enrollees' medical charts to assess appropriateness. Nonetheless, the analysis is effective in placing a dollar amount on the range of possible savings by reducing delivery of inappropriate care.

Estimated payments (FFS and managed care) associated with overuse of selected services, CY 03 (includes state and federal funds)	
Emergency Room Visits	$ 26,205,148
Coronary Angiography	2,735,419
Cardiac Catherization	2,249,300
Upper Gastrointestinal Endoscopy	1,486,384
Knee Surgery for Osteoarthritis	1,149,424
MRI for Back Pain	1,014,606
Hysterectomy	824,417

[9] Chassin MR, Galvin RW. "The Urgent Need to Improve Health Care Quality: IOM Roundtable on Health Care Quality," *JAMA*, Sept. 16, 1998, Vol. 280 - No. 11; also see Appendix C of this report for a summary of selective findings.

Cardiac Pacemaker Insertion	469,291
Tympanostomy Tubes	381,790
Pneumonia (Pediatric)	168,202
Bronchitis (Pediatric)	138,025
Carotid Endarterectomy	137,016
TOTAL	**$ 36,993,907**

The few services in the chart above produced no benefit to the enrollee. While they represent a minute percentage of total services paid for by MA, they account for approximately $37 million in spending. Given the large savings associated with a small sampling of services, the potential for considerable savings across all services is great. It is important to note, however, that private payers that have attempted to reduce payment for overused services have met resistance.

Bailit also surveyed the state's contracted MCOs and outside experts, asking them to identify covered services that they believe are either overused or never appropriate. They generated an additional list of services. (See Appendix D for a list of some of these services, and associated CY03 spending (as opposed to estimates of spending on *overuse*).)

Payments for unnecessary services can be avoided by making informed coverage decisions based on research evidence. Further, some unproven services can actually be harmful, as the recent recall of Vioxx[10] demonstrates.

The federal Center for Medicare and Medicaid Services (CMS) appears to have reached the same conclusion. CMS Administrator Mark McClellan recently said he supports "examining the cost-effectiveness of various treatments to get more value for each Medicare dollar." [11] This is all part of a national trend occurring with private insurers and government - both demanding more proof that treatments are effective as a prerequisite for coverage.[12]

There is one other compelling reason for DHS to establish policy leadership here. Contracted MCOs need to make coverage decisions every day within a broad state framework that often leaves the MCOs with responsibility to operationally define medical necessity. This structure inevitably results in inequitable variation in coverage policy administration. A recent national study found a lack of consistency between how medical directors and regulators define and apply the terms 'medical necessity' and 'coverage.'[13] It is reasonable to conclude that the same variation exists among the state's

[10] "Merck Announces Voluntary Worldwide Withdrawal of VIOXX®," Sept. 30, 2004. Accessed at www.vioxx.com/rofecoxib/vioxx/consumer/index.jsp, Nov. 22, 2004.
[11] Lueck S. "Dr. McClellan's Medicare Rx," *Wall Street Journal*, Sept. 28, 2004, p.A4.
[12] Rowland C. "Payers want proof for medical treatments," *Boston Globe*, Nov. 26, 2004.
[13] Bergthold L. et. al. "Using Evidence and Cost in Managed Care Decision-Making," accessed Oct. 21, 2004 at www.hcfo.net.

contractors and will persist, absent any efforts to facilitate consistency. Some states are beginning to address this problem,[14] but most have not.

Strategy

The state should implement an integrated approach to evidence-based decision making for benefits coverage policy that is much more rigorous than the existing coverage policy function. This approach should include three components: hiring a medical director for benefits policy; creating a Medical Policy Council; and participating in a multi-state effort to establish and direct a Medicaid Evidence-based Practice Center.

The components of the recommended approach are as follows:

1. **Hire a Medical Director**. DHS has been without a physician medical director to provide policy leadership for several years. At present, lay staff at DHS, without the expertise possessed by a physician, make coverage policy decisions. Other coverage decisions are simply legislated, without the benefit of scientific opinion. (Contracted health professionals are available to the department to review case-by-case requests for prior authorization of services.)

   Physician leadership would provide greater clinical rigor to coverage policy development, and would improve the credibility of the function with external stakeholders.
   DHS should hire a physician with expertise in both acute and continuing care to direct the medical policy function for Minnesota Health Care Programs.

   This position is common in other state Medicaid agencies. For example, the medical director of Washington's Medicaid program has spearheaded efforts to bring evidence-based coverage policy to his state. He has estimated that his medical policy on bariatric surgery for obesity alone has resulted in a savings of $9 million, as well as five fewer deaths related to surgery and 48 fewer severe morbidities.[15]

   The MHCP medical director would be charged with the following responsibilities:

   - Establish and chair an internal DHS committee to review coverage policy and ensure consistent application across the agency and its contractors. The committee's purview should include all health services and procedures, including new and existing technology, but excluding pharmacy services. The committee's role would be to establish coverage criteria for specific services, drawing upon evidence-based resources such

[14] The Governor of Tennessee has recommended defining medical necessity as items and services "required to diagnose and treat an enrollee's medical condition, be safe and effective and be the least costly course of treatment adequate to address the medical condition." (*Memphis Commercial Appeal,* Aug. 20, 2004)

[15] Personal communication with Jeff Thompson, MD, Director of Medical Management, Washington State Department of Health and Social Services, July 12, 2004.

as the Institute for Clinical Systems Improvement (ICSI) guidelines, the Community Measurement Project, and other available resources. Representation from DHS' FFS prior authorization contractor on this committee would ensure clear communications, as medical policy is developed and implemented.

- The medical director also should serve as an ex-officio member of DHS' existing pharmacy committees (the drug utilization review board and the drug formulary committee) and the Medical Policy Council described below.

To be successful, the medical director would need a clear legislative mandate to perform the assigned role.

2. **Create a Medical Policy Council.** It is important that coverage policy be consistently applied across delivery systems, both managed care and FFS. Executives of some of the MCOs currently serving MHCP enrollees expressed interest in the state asserting more leadership on coverage policy.

   The state should establish a Medical Policy Council to discuss medical policy issues with the chief medical officers of contracted MCOs, representatives of the FFS provider community, and the contracted health professionals reviewing prior authorization requests. The MHCP medical director should hold at least eight meetings annually with the Council. The Council should be charged with:

   - advising the medical director on coverage policy
   - determining how best to ensure consistent application of coverage policy across MHCP programs and contractors.

   Subcommittees of the Council, comprised of non-physician health care providers and particular physician specialties, should be convened on an ad hoc basis to assist the Council's review of policies pertaining to specific services.

   Through this forum, the state would show leadership in promoting uniform coverage policies across all programs and delivery systems.

3. **Support and Participate in a New Medicaid Evidence-based Research Collaborative.** Historically, states have not had expert resources to assess the extent to which health services research supports or does not support coverage of specific services. As a result, states have tended to be generous and inclusive regarding medical coverage, and managed care contractors have often followed the state's lead, particularly for non-acute services.

   When Minnesota previously attempted to scrutinize coverage and prior authorization policies, it often met provider and consumer advocate resistance. Powerful and emotional arguments are raised, yet too often these arguments are

ill-supported by fact and research. If decisions made in the public sector are to be fair, maximize value, and maximize health, there is a compelling need for these decisions to be informed by the latest and highest quality research evidence available.

Research is expensive, however. Depending on its scope, a systematic review of the care for a given condition might run more than six figures. Few states have the resources to conduct or commission the amount of research needed to advise all of the difficult decisions they make in their assistance programs.

One solution is collaboration among states willing to pool resources. By sharing the cost, states can increase the amount of research each can obtain while lessening the financial commitment each makes. States also can ensure that research is focused on areas specific to the Medicaid population.

DHS explored the feasibility of obtaining information needed for coverage decisions through an evidence-based policy center in 2004, informally surveying the nation's Medicaid directors about their interest in doing likewise. Forty-seven states responded positively to the idea. The Center for Evidence-based Policy at the Oregon Health and Science University is now facilitating the creation of a multi-state collaborative. The collaborative should become operational in SFY 2006, with an initial multi-state organizing meeting planned for early 2005.

The collaborative will be modeled on an existing collaborative for drug effectiveness research.[16] At present, 11 states (including Minnesota) and two non-profit organizations are cooperatively financing systematic reviews of the relative effectiveness of drugs within 25 different classes of medications. The collaboration is also organized and staffed by the Center for Evidence-based Policy at the Oregon Health and Science University. DHS estimates that Minnesota already has saved more than $20 million as a result of coverage decisions based on drug effectiveness research obtained through this collaborative, or from DHS' contractor, First Health Services.

After the initial planning activities for the new collaborative, which will be covered with foundation funding, states will participate on a subscription basis. Minnesota should participate to provide the new medical director function needed evidence to inform coverage policy.

Improved access to and consideration of research could be useful in many areas, including:

- **Decisions to not cover.** The state could elect to not cover new services, or new applications of existing covered services (e.g., using MRI for preventive care full body scans), unless there is adequate research supporting efficacy and benefit.

[16] Pear R and Dao J. "State Tactics Aim to Reduce Drug Spending" *New York Times*, Nov. 21, 2004.

- **Decisions to prior authorize.** The state could choose to introduce prior authorization requirements for services that research indicates are frequently delivered inappropriately.
- **Decisions to influence enrollee behavior.** The state could introduce initiatives to modify enrollee care-seeking behavior so as to diminish rates of inappropriate or unnecessary use (e.g., outreach to and education of consumers who repeatedly use hospital emergency rooms for primary care).

Evidence-based decision making for benefits coverage policy addresses what many national experts feel is the most pressing problem in our health care system today – how to limit the delivery of services of unproven value. *Washington Post* columnist Robert Samuelson summarized the issue recently:

> Our medical advances save lives and improve the quality of life. But some spending -- perhaps a lot -- is unneeded. The practical problem, says Drew Altman of the Kaiser Family Foundation, is to find ways of imposing limits on individual patients. This is hard at best, but it requires a political will that's missing.[17]

Minnesota will need to be persistent and steadfast if it is to confront growing health care costs in its public programs.

DHS has estimated the following cost and savings in the FFS system:

State fiscal year	2006	2007	2008	2009
Estimated state savings (excluding federal funds)	$1.034 million	$2.083 million	$2.995 million	$3.972 million
Estimated state administrative costs	$202,000	$183,000	$179,000	$179,000
Estimated net savings	$832,000	$1.9 million	$2.816 million	$3.793 million

The state is paying for services that research has identified as overused. Based on a sample of such expenditures, Bailit concludes that as much as $10 million in state funds annually may be spent in FFS for services that are not appropriate. The DHS estimates above are based on the assumption that if this strategy were implemented, the state would

[17] Samuelson, R.J. "Prognosis: Stalemate," *Washington Post*, Sept. 22, 2004, p. A31.

save about 10 percent of Bailit's estimate initially, with the savings growing each year as more services are limited.

Costs include the salaries of the medical director and staff, and the subscription with the evidence-based policy center.

Savings figures do not include any savings that contracted MCOs might realize.

2. Increase Pharmacy Savings

Problem Statement
Pharmacy expenses have been one of the fastest growing costs in Medicaid programs for several years. Minnesota's FFS Medicaid program experienced double-digit increases in pharmacy costs (net of rebates) during calendar years 2001 through 2003. Minnesota, like other states, has become increasingly aggressive in implementing pharmacy management programs to control costs while continuing to provide clinically appropriate pharmacy coverage.[18] While important steps have been taken, additional initiatives are possible.

What steps have been taken to date to control pharmacy expenses?

The state began implementing aggressive pharmacy cost savings initiatives in 2003 in response to a serious budget shortfall. The following measures were implemented in March 2003:

- Reimbursement to pharmacies was reduced, from Average Wholesale Price (AWP) – 9% + $3.65 dispensing fee, to AWP – 14% + $3.65 dispensing fee. The discount was in place for three months, but then decreased to 11.5% percent on July 1, 2003, where it currently stands.
- Several hundred drugs were added to the "maximum allowable cost" list, which establishes very competitive prices for generic drugs that are available from multiple sources.

[18] "Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003," The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation; "Clinical Pharmacy Management Initiative: Integrating Quality into Medicaid Cost Containment," Center for Health Care Strategies, Inc., April 2003; "Medicaid Short List," *American Medical News* May 3, 2004, p. 5.

The state has continued to implement cost-saving programs, most notably:

- Co-payments were implemented Oct. 1, 2003, in the amounts of $1.00 for generic drugs and $3.00 for brand name drugs. There are a few, very specific exceptions to the co-pay requirements.
- Beginning January 2004, prior authorization was required for brand name medications for which generics were available.
- To reduce potential waste, in January 2004, retail pharmacists were no longer allowed to override a "refill too soon" edit, thus requiring enrollees to complete a substantial portion of an existing prescription before having another one refilled.
- Day supply was reduced from 90 days to 34 days, also to reduce potential waste.
- The preferred drug list (PDL) was expanded to 12 categories, and supplemental rebate agreements were signed with several manufacturers.
- Prior authorizations were instituted for drugs subject to over or inappropriate use.

These cost containment activities are in line with actions of other states.[19] Moreover, the state is pursuing, or plans to pursue, the following additional cost saving programs:

- Participate in a multi-state purchasing group to develop consistent Preferred Drug Lists (PDLs) and maximize supplemental reimbursements. CMS granted DHS permission to join this program. Savings are estimated to be $11 million each year or approximately 5 percent of annual state pharmacy expenditures. These savings, however, are likely to be less in the future following implementation of the new Medicare Part D benefit that reduces the scope of Medicaid pharmacy services.
- Within the next few months, increase the number of drug classes controlled by the PDL to 34. This would not only increase supplemental rebates, but could also reduce unit costs by encouraging use of the most cost-effective drug.
- Adopt the new Medicare reimbursement rates for drugs administered in outpatient facilities. This change would eventually reduce reimbursement from AWP – 5% to AWP – 15%.
- Bundle payments of home IV infusion drugs and related services, resulting in a reasonable payment for related services and drugs.
- Develop quantity and trial limits for smoking cessation drugs.
- Implement an aggressive physician education initiative based on best practices and peer-to-peer discussions with regard to behavioral health drug administration and consolidation. This initiative will focus on one of the most frequently prescribed classes of drugs. Based on the experience of another state's implementation of this strategy, DHS expects to realize a noticeable decline in the cost trend for specified classes of behavioral health drugs as a result of this program.

[19] *Ibid.* Kaiser, pp. 28-60.

Strategies

Within this context, there are a number of new pharmacy management programs to pursue.

1. **Require beneficiaries with hemophilia to obtain blood factor products through a 340B hemophilia treatment center.** Under this strategy, Minnesota would benefit from the lowest factor rates available. The newest factor products, which are biotech drugs, are substantially more costly than traditional factor products, and are fast becoming the first line of treatment. Federally recognized 340B hemophilia treatment centers are able to obtain factor products at substantially discounted, legislatively authorized rates.

   DHS estimates the costs of this strategy to be limited to the cost of staff time, and the state savings to be $340,000 in SFY 2006 and $510,000 in SFY 2007.

   This strategy focuses on obtaining these drugs at the lowest per unit cost. DHS is continuing to implement management programs directed at assuring that the appropriate enrollees receive these treatments.

2. **Contract with specialty pharmacies to be exclusive providers of particular specialty pharmacy drugs.** Under this strategy, Minnesota would take advantage of the increased competition that is developing as the number of specialty pharmacies increases.

   Biotech drugs provide highly effective treatments for diseases, such as rheumatoid arthritis, that previously could only be minimally managed, and new treatment for conditions previously untreatable, such as certain types of cancer. Biotech drugs often cost in excess of ten thousand dollars annually (one drug costs $10,000 *per dose*), and often must be taken for the duration of the patient's life. Because of the treatment benefits associated with these drugs, there is interest in the medical profession to expand the range of people receiving these drugs (e.g., using a new asthma drug for patients with mild to moderate asthma, rather than limiting use to patients with severe asthma). The introduction of these drugs and the expanding patient population receiving them or potentially receiving them will mean exponential growth in costs associated with these specialty drugs. Moreover, because these drugs are relatively new, most are single source drugs and few have either competing biotech drug alternatives or "generic" equivalents. This strategy focuses on obtaining these drugs at the lowest per unit cost. DHS is continuing to implement management programs that are directed at assuring that the appropriate beneficiaries receive these treatments.

   DHS estimates the state savings of this strategy to be $133,000 in SFY 2006 and $202,000 in SFY 2007. The cost savings for this initiative would continue to grow as the use of specialty pharmacy drugs increases.

3. **Reduce the reimbursement rate for retail pharmacies to AWP -14% + $3.65 dispensing fee.** With this strategy, DHS would realize significant savings while allowing retail pharmacies to retain a sizable spread between acquisition costs and reimbursement levels.

   Minnesota's discount rate at 11.5% is comparable to neighboring states, but noticeably lower than other Midwestern states. For example, Kansas pays AWP – 13% and a $3.40 dispensing fee for brands. Colorado pays AWP -13.5% for brands and a $4.00 dispensing fee. Illinois pays AWP -12% plus a $3.40 dispensing fee for brands.[20] Furthermore, an August 2001 study by the Office of the Inspector General in the U.S. Department of Health and Human Services found the average discount paid by state Medicaid programs (AWP -10.3%) to be too low. The study recommended states increase their discount to more closely match the actual average pharmacy acquisition cost of AWP –17.2%.[21,22]

   DHS estimates the costs of this strategy to be limited to the cost of staff time, and the savings to be $5 million in SFY 2006 and $3.6 million in SFY 2007.

DHS estimates the combined pharmacy initiatives would produce net state savings of:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	$5.3 million	$4.3 million	$4.7 million	$5.1 million

3. Implement Intensive Medical Care Management for the Chronically Ill in Fee-for-Service Medical Assistance

Problem Statement

There is a growing recognition of a distinct highest-risk segment within the population of high-cost enrollees. These highest risk individuals often comprise 1-3 percent or less of the total population, but can generate 25 percent of all acute care health costs.[23] In state fiscal year 2002, 3,631 fee-for-service MA enrollees utilized more than $100,000 in

[20] op. cit., Kaiser Commission on Medicaid and the Uninsured, pp. 43-45.

[21] "Medicaid Pharmacy - Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products," Office of the Inspector General, U.S. Department of Health and Human Services, Sept. 16, 2002.

[22] Arguments that this comparative analysis is flawed because it does not consider the Minnesota 2 percent wholesale drug distributor tax have their own flaws, since the 2 percent tax is not calculated off of AWP, but off of the pharmacy's actual acquisition cost (AAC) of purchasing the drug. On average, the AAC is about 17.1 percent less than AWP for brand name drugs, and for generics 40-70 percent less than AWP. So even factoring in the wholesale drug distributor tax, the state still pays more for drugs and a dispensing fee than the Pharmacy Benefit Management Institute reported as the average PBM reimbursement in 2003.

[23] Forman S. and Kelliher M. Status One: Breakthroughs in High Risk Population Health Management. Jossey-Bass, San Francisco, CA, 1999 and personal communication with Sam Forman, 2004.

health care services. Typically, people in this sub-population suffer from more than one chronic condition.

These highest risk enrollees are often not identified through traditional high-cost case management, county case management, or disease management programs because they are often isolated from the community and disconnected from the primary care health care system. They frequently have complex co-morbidities and confounding psychosocial issues.

Strategy

Opportunities exist to avoid near-term hospitalizations by providing proper medical care management services to these enrollees. These services attend to the interaction between medical and social issues and have been proven to reengage enrollees. This reengagement can result in behavioral changes that can reverse a decline in health status.

The program works as follows: A contracted vendor analyzes claim data, including health and pharmacy claims, to identify through predictive modeling enrollees deemed to be at high risk of hospitalization within 12 months. Enrollees are ranked based on level of risk, and only those at highest risk are targeted for intervention.

Intervention consists of intensive telephonic and in-person outreach and support by skilled clinical staff. Attempts are sometimes made to contact enrollees who lack a telephone. There is typically a high voluntary engagement rate when individuals are contacted. The outreach focuses on both medical self-management issues and on social issues such as isolation, depression, or substance abuse, which may directly impact the enrollee's ability to manage their chronic medical condition(s).

An independent assessment by Milliman and Robertson of predictive modeling, coupled with intensive medical care management targeted at the highest risk subpopulation, has documented a return on investment of 3 to 1 in a large commercial health plan.[24]

Other research has reported reductions in costs of this highest risk subpopulation by 10-20 percent, with coinciding improvements in functional health status by 10-20 percent.[25] While the cost of this intervention can be considerable, so too can be the savings.

It should be emphasized that not all high-cost populations would be appropriate for this intervention. In addition, the introduction of Medicare Part D may impede efforts to conduct predictive modeling of dual eligibles for whom the state will lack pharmacy data.

- **The state should competitively procure from and contract with an experienced vendor for these services.** The most effective approach may be

[24] Laursen RA, "Re: Outcomes Study for Health Plan X StatusOne Intervention Program" Milliman USA, Nov. 21, 2003.

[25] Forman S, Kelliher M, and Wood G. "Clinical Improvement with Bottom-Line Impact: Custom care Planning for Patients with Acute and Chronic Illnesses in a Managed Care Setting," *American Journal of Managed Care*, 1997, 3(7), 1039-1048.

initially targeting MA FFS enrollees who have been in MA for at least eight months and are not also eligible for Medicare.

- **Customize the program to meet enrollees' needs.** The state should work with the contracted vendor to develop specific approaches to working with immigrants with limited basic knowledge of the health care system and with people with mental illness who find self-management of chronic conditions especially challenging.

- **The state should collaborate with contracted MCOs to learn from their experience with similar programs, both to inform DHS' FFS program, and to promote performance improvement across MCOs.** The state should also make available the option for health plans to participate in its contract at the health plan's cost, if so desired.

DHS estimates the following cost and savings for this strategy:

State fiscal year	2006	2007	2008	2009
Estimated state savings (excluding federal funds)	$562,500	$1.125 million	$1.125 million	$1.125 million
Estimated state administrative costs	$900,000	$900,000	$900,000	$900,000
Estimated net savings	*Cost* of $337,500	$225,000	$225,000	$225,000

Costs are for the contract with a predictive modeling/intensive medical care management vendor. Costs and savings assume a contract for 500 MA enrollees with complex chronic conditions that put them at risk for emergency room and inpatient services use. Savings assume a 1.5:1 return on investment with a phase-in of the savings in the first year.

Bailit believes that savings would equal more than $4 million per year with implementation across all FFS enrollees with at least three months of eligibility, assuming a return on investment of 2:1.

Strategies for which DHS has Not Developed Implementation Plans or Savings Estimates, but which Hold Significant Promise for Savings

1. Expand Managed Care for People with Disabilities

Problem Statement

An increase in both enrollment and costs attributable to people with disabilities demands that the state rethink how well this population is being served. Between 2000 and 2004, the number of enrollees with disabilities increased 27.6 percent. [26] During the same time period, the relative per capita cost increased 34.2 percent for this population. It is worth noting that the enrollment and cost rates of increase are double that of the elderly population in public programs.

People with disabilities are the only large group that Minnesota exempts from managed care enrollment. They are served through the state's FFS system.

Enrollees describe the FFS system as bureaucratic and non-responsive. It does not provide care coordination to help enrollees manage their way through a fragmented "system." It lacks a focus on enrollees' needs.

Many enrollees with disabilities may have unmet needs. Many also don't receive preventive care or care coordination, both of which can help to prevent emergency room visits, hospitalization, and nursing facility admission.

Minnesota has a small managed care option for adults with physical disabilities. Less than 1/2 percent of MHCP's estimated 90,000 enrollees with disabilities participate in the demonstration project, Minnesota Disability Health Options (MnDHO). The two-year-old project has been limited to the metro area. While enrollment has grown steadily since its inception, it was serving fewer than 400 people as of December 2004.

Background

Evaluations of other states' programs indicate that people with disabilities, including physical disabilities, mental illness, or developmental disabilities, can be better and more efficiently served through managed care programs. For example:

- An evaluation of the Arizona Medicaid managed care system examined total program experience between 1983 and 1991 and found costs for the SSI disabled

[26] George Hoffman, DHS, obtained Oct. 13, 2004. 2004 figures are based on projections as of 10-04.

grew at an annual rate of 6.7 percent compared to 12.3 percent for a traditional Medicaid FFS program. [27]

- An evaluation of Oklahoma's managed care programs for special-needs populations examined individuals covered under Heartland Health Plan (2002) and found savings of more than 4 percent in total medical and administrative costs (17 percent when removing the 10 highest-cost individuals), and 61 percent of enrollees said that care was better than under traditional Medicaid FFS. [28]
- An evaluation of Colorado's managed care program (2002) found dramatically higher rates of preventive care for people with disabilities in the state's MCO and state-operated primary care case management programs than in FFS Medicaid for the following measures: cervical cancer screening, breast cancer screening, prostate cancer screening, and preventive visits. [29]
- An evaluation of MnDHO (2003) found that enrollees were more satisfied with the services they received, felt they received more coordinated and self-directed care, and were more likely to access needed primary care and medical equipment services after enrolling.[30]

See Appendix E for a summary of additional state evaluations regarding managed care and people with disabilities.

States have taken five primary approaches toward serving people with disabilities in managed care plans:

- enrollment in "general purpose" acute care Medicaid managed care plans without specialized capacity to serve people with disabilities (e.g., Colorado, Maryland)
- enrollment in specialty Medicaid acute care managed care plans with specialized capacity to serve people with disabilities (e.g., Community Medical Alliance in Massachusetts, Special Needs Plans in New York, behavioral health "carve-outs" in Massachusetts , Iowa, Nebraska)
- enrollment in state-operated acute care managed care programs with varying degrees of specialized capacity to serve people with disabilities (e.g., Massachusetts , Oklahoma, Vermont)
- enrollment in Medicaid managed care plans responsible separately or together for acute and long-term care services (e.g., Arizona, Texas)

---

[27] McCall N. et. al. "Managed Medicaid Cost Savings: The Arizona Experience," *Health Affairs* Spring (II) 1994, p.234-245.
[28] Schaller Anderson Inc. "Serving the Special Program/Aged, Blind, and Disabled Population Through Medicaid Managed Care," Center for Health Care Strategies, April 2002.
[29] Health Services Advisory Group, Inc. "Colorado Medicaid Access to Preventive Care for the Disabled Focused Study," Colorado Department of Health Care Policy and Financing, June 2003.
[30] Ho P. "The Impact of the Minnesota Disability Health Options (MnDHO) Program on the Healthcare Experience of People with Physical Disabilities in Minneapolis/St. Paul: Preliminary Longitudinal Findings," MedStar Research Institute, June 2004.

- enrollment in Medicaid managed care plans responsible for acute and long-term care services with integrated Medicare and Medicaid financing (e.g., Minnesota, Wisconsin)

There is no sufficient body of knowledge to distinguish the comparative effectiveness of these different approaches, although the presence of some degree of specialized capacity to serve people with disabilities is intuitively sensible.

The trend toward expanding managed care for people with disabilities continues. The California legislature is currently considering this step. [31]

Strategies

Beginning in January 2007, the state should start transitioning enrollees with disabilities from FFS into managed care. This is consistent with the multi-year direction that DHS has been taking with Minnesota's Health Care Programs and promises improvements in both quality of care and cost management.

Savings resulting from this strategy is dependent on multiple variables. A key factor will be whether the state decides to:

- eliminate its existing FFS system and rely solely on contracted MCOs to serve this population
- establish a state-operated managed care plan by introducing managed care features into the current FFS program
- contract with MCOs to provide managed care for these enrollees or
- implement some combination of the options above.

In addition, the state must decide whether managed care enrollment would be required or voluntary for this population. A voluntary approach might be more attractive to enrollees. It might also make it more difficult to attract managed care vendors due to the uncertain enrollment volume. Bailit estimates that a voluntary approach may not yield significant savings.

A fundamental change in delivery of services to people with disabilities should be approached in phases, as noted below.

Enrollment: The program should start with metropolitan area enrollees, expanding geographically at a later date as appropriate.[32]

---

[31] Benson C. "Plan targets social services," *Sacramento Bee*, Jan. 11, 2005

[32] There are a few reasons for beginning with metro counties. There are more providers and more referral resources in the metro area. Analysis in other states suggest that managed care programs in metropolitan areas can be more cost-effective than in rural areas.Finally, more than half of the state's population lives in this region. This regional rollout approach was successfully used with the state's Prepaid Medical Assistance Program.

Enrollees should have an incentive to sign up with a contracted MCO, such as the waiver of some or all co-payments.[33] In addition, enrollees should be allowed to opt out of their chosen managed care plan within the first three months.

Covered Services: Initially only basic health care should be provided through managed care. Most personal care attendant and private duty nursing services (those provided as a waivered service rather than a state plan service) should be excluded from managed care for at least the first three years.

Stakeholders noted that elderly MA enrollees who receive basic care through MCOs and continuing care from the FFS system face difficulties due to the lack of care coordination inherent in this arrangement. At the same time, stakeholders expressed valid concerns about whether MCOs have demonstrated an ability to meet the continuing care needs of people with disabilities.

Lessons from the current MA experience integrating continuing care services for the elderly into managed care should inform the future transition of continuing care into managed care for people with disabilities.

Integration with Medicare: In later years, consideration should be given to integrating Medicare benefits and payments into managed care options. Meanwhile, the state should continue efforts to expand MnDHO. Early research indicates that MnDHO is well received by enrollees,[34] and the contractor reports a significant drop in avoidable hospitalizations among enrollees.[35] While there is still much to be learned, the ability to integrate Medicare and Medicaid funding and to create new care models should be supported in parallel with the introduction of a new, expanded managed care program for people with disabilities. MnDHO is currently expanding from four to seven counties. The program should expand geographically to the extent that interested providers can be identified, and should also be tested with other populations of people with disabilities (e.g., people with developmental disabilities, people with mental illness).

The state's efforts would dovetail with the new Medicare Advantage program, which makes special provision for special needs plans under Medicare that will focus on serving the dually eligible population only. A recent report concluded that the provision offers a good opportunity to provide an integrated plan that coordinates Medicare and Medicaid services.[36] Many MCOs nationally are pursuing Medicare special needs plan status.[37]

---

[33] DHS can not require managed care plans to waive co-payments under the state's federal waiver, but it can successfully encourage them to voluntarily do so, as it has with Minnesota Senior Health Options program.

[34] op. cit., Ho.

[35] Personal communication with Chris Duff of AXIS Healthcare, July 12, 2004.

[36] Bryant J. et. al. "Business Opportunities in the Medicare Modernization Act for Community Affiliated Health Plans," The Lewin Group, April 15, 2004.

[37] "CareOregon May Enter MA Program, Starting With SNP for Dual Eligibles," *Medicare Advantage News*, October 2004.

Contracting with vendors: The state should selectively contract with vendors, including non-MCO organizations if appropriate, that demonstrate the greatest commitment and capability for serving people with disabilities. Selective contracting should accomplish two aims. First, it should ensure that only the most qualified contractors would serve enrollees. Second, it should allow selected contractors to enroll enough people to achieve necessary economies of scale and develop sufficient resources to provide efficient and effective services.

Before soliciting bids, the state should issue a request for information (RFI) to help inform the development process of managed care for people with disabilities.

Some vendors may have interest in serving people with specific characteristics (e.g., adults with mental illness), as was done with the initial MnDHO program for adults with physical disabilities. The state should consider making this option available for potential bidders with specialty expertise.

The state should consider a vendor's provider network when selecting contractors. Enrollees want to maintain access to providers with whom they hold existing relationships. Special attention should be given to access to dentists and psychologists to which access is reportedly problematic in the current FFS system.

To give MCOs and other organizations an incentive to participate, the state should case-mix adjust payments to reflect the varying needs of the population. Some enrollees with disabilities can require more frequent or expensive care, while others use few, if any, services on an ongoing basis. DHS currently uses Ambulatory Care Groups (ACGs) to risk-adjust payment to MA managed care contractors. The state should consider using the Chronic Illness and Disability Payment System (CDPS) to risk-adjust capitation payments to MCOs serving enrollees with disabilities, as the CDPS is better suited to accurately adjust payment for this population.

The state also should share risk with contractors during the first three years through the use of risk corridors, in which contractors assume almost no risk in the first year, and progressively more risk in following years. This approach has proven effective in multiple states as the states and the contractors gained experience and confidence in serving a new population in managed care and in setting appropriate capitation rates.

Establishing a state-operated managed care alternative: The state should opt to offer enrollees an alternative to contracted managed care vendors by integrating managed care features into its existing FFS system. This state-operated managed care alternative would include new clinical strategies such as intensive medical care management for selected enrollees, as well as the use of evidence-based decision making to determine coverage for selected services. It would also utilize alternative purchasing strategies such as a restricted provider network, selective provider contracting, and the use of centers of excellence for particular services.

Contracted MCOs reported spending growth of 47 percent between 2001 and 2002, and 65 percent between 2002 and 2003. This growth was due more to an increase in number of PCA hours provided to their enrollees than to an increase in the number of enrollees utilizing PCA services.

Some DHS staff and an array of external stakeholders, including the Inspector General of the federal Department of Health and Human Services, Minnesota's legislative auditor and attorney general, and county public health nurses and health plans, allege that PCA services are being used inappropriately with some frequency. Appendix I identifies the recent experience of the DHS Surveillance and Integrity Review unit with PCA investigations. Finally, there have been findings of fraud.

These problems do not call into question the value of the PCA benefit, but only the need to improve its delivery. PCA services play an essential role in supporting MHCP enrollees' efforts to live and work in their communities. A state plan service since 1977 that currently serves approximately 6000 Minnesotans, PCA improves the quality of life for enrollees, despite problems with reported high PCA turnover rates.[38]

The state has a tradition of meeting the health care needs of enrollees within their homes or communities, whenever possible. More and more care is being provided in the homes and apartments of enrollees rather than in centralized or institutional type settings. Personal care assistance is one of the benefits that have made this possible. This worthwhile program has saved the state money by keeping individuals out of institutions. However, PCA service options continuously evolve and there has recently been a tremendous increase in MHCP expenditures for personal care services. This the high rate of PCA use means that the presence of even a small amount of inappropriate use represents a significant savings opportunity. That is the focus of this strategy.

Background

Qualifying for the state plan PCA benefit

Throughout this section the term "state plan benefit" is used. A state plan benefit is one which is available to all MA enrollees, whether or not they are on a waiver program. An MA enrollee who also participates in a waiver program may receive waiver services and state plan services simultaneously.

To qualify for Minnesota's state plan (non-waiver) PCA benefit, a person must have a medical need for the services. Medical need is determined both through a public health nurse assessment and a doctor's order. People at any age with any type of disability, including a cognitive disability, may qualify.

PCA services are available through several different mechanisms:

- Any enrollee may request, be assessed, and be authorized to receive PCA services as a state plan service.

[38] "Minnesota's 2003 PCA Consumer Survey," Wilder Research Center, September 2004.

- Enrollees may receive personal care services as part of the MA home care benefit package.
- Enrollees who are eligible for the home and community-based waiver programs may receive PCA services as part of their waivered service plan, either separately or simultaneously with state plan PCA services. The waiver PCA benefit is intended to extend the state plan benefit, i.e., provide additional PCA hours.

Assessing the need for state plan PCA services

The first step to receiving services is for the enrollee to receive a needs assessment by a nurse. Assessments are conducted either by county public health nurses or an MCO nurse[39] for managed care enrollees.

The nurse determines how many units should be authorized on a per-day or per-week basis.[40] The determination is based on an assessment of the complexity of need, number of activities of daily living (ADLs)[41] and instrumental activities of daily living (IADLs)[42] with which the person needs assistance, and an assessment of behavior. The maximum number of PCA units (15 minute increments) per day allowed is usually 14.5. On average, $2\text{-}2^{1/2}$ hours/day are authorized. On an exceptional basis, a person can be granted 24 hours/day.

If the public health nurse's assessment determines that PCA services are needed, the nurse explains to the enrollee that a doctor's order must be obtained for the amount of services recommended. The doctor's order is required at the outset and then again every 365 days when need must be re-determined. There is currently no standard order form for doctor's orders for PCA services and doctors frequently use a prescription pad. DHS accepts the amount authorized without confirming that the doctor's order was obtained, and without DHS clinical review, unless something looks peculiar. DHS sends a letter describing the approved units, or the denial if no units have been approved, to the enrollee. The enrollee has appeal rights if he or she disagrees with the decision.

PCA agencies

The state currently contracts with 619 PCA agencies. Enrollees obtain PCA services in one of three ways.

The first is through a Personal Care Provider Organization (PCPO). The PCPO employs the personal care assistants. Under this option, the enrollee has a limited ability to choose an assistant and set up a schedule. An enrollee can encourage a friend or relative to become a PCPO's employee and can then request that person to be the enrollee's PCA.

---

[39] Most MCOs contract with private organizations to perform this function in the Metro area. In the outstate areas, the MCOs generally contract with county public health nurses to perform this function.
[40] Some consumers make use of a flexible option in which an annual total dollar amount for PCA is authorized rather than units or days
[41] ADLs include dressing, grooming, bathing, eating, toileting, transferring, positioning and mobility.
[42] IADLs include meal planning and preparation, managing finances, shopping for food, clothing and other essential items, completing necessary homemaking tasks, communicating by telephone and/or other media, getting around in the community and participating in community activities.

The second way is through PCA Choice, the self-directed option. In this case, an enrollee who has been approved for PCA services identifies a PCA he or she would like to hire. The selected PCA then registers with a PCA Choice organization. The PCA becomes the co-employee of the enrollee and the PCA Choice organization. The PCA provider, the enrollee and the PCA Choice organization sign a joint agreement regarding what will be provided, when, and the rate of pay. The enrollee trains and evaluates their PCA. The PCA Choice organization primarily serves in a fiscal intermediary-payroll capacity. The PCA Choice organization holds the MA provider agreement, collects the PCA's timesheets and pays them, and bills DHS for the PCA time.

Another option, the Shared Care Option, is available if two or three enrollees choose to share services in the same setting at the same time from the same PCA. This option is not available when the PCA provides services to more than one enrollee in more than one location.

Who are the PCAs?

Virtually anyone can be a PCA. PCAs must be 18 years of age, with limited exceptions for those at least 16, and cannot be a consumer of PCA services. Once an applicant completes the initial paperwork and the criminal background check run by the PCA organization (when required) checks out, the person can be employed. There is no formal training required. It is assumed that the enrollee will train the PCA.

What the PCA state plan benefit covers

PCA services are divided into four broad categories:

- assistance with ADLs,
- assistance with IADLs,
- assistance with health-related functions and redirection, and
- intervention for behavior, which includes observation and monitoring.

Evidence of Fraud in the PCA Program

The tremendous flexibility regarding how the current PCA benefit may be used is one of the reasons that the program has been a success in Minnesota. The state's current effort to roll out of the Consumer Directed Community Supports option across the waiver programs provides even greater flexibility. While the flexibility offered by the less structured option will be beneficial for many enrollees and their families, it does provide an opportunity for additional abuse by a minority who will take advantage of the flexibility within Minnesota's PCA programs.

An audit of 100 MA PCA claims conducted in 1998-1999 by the Office of the Inspector General at the U.S. Department of Health and Human Services[43] revealed many cases of

[43] "Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services: October 1, 1998 through September 20, 1999," Office of the Inspector General, U.S. Department of Health and Human Services, April 2002.

improper reimbursement, and modest levels of fraud. The PCA program has grown significantly since this time period.

According to the Fraud Unit of the state Attorney General's Office, the PCA program is the most problematic of all of the state's health care programs in terms of fraud and abuse.[44] Concerns about fraud and abuse have been focused on:

- instances in which PCAs are not providing authorized services to enrollees but are billing for these services, and
- instances in which people may be hiring family members to provide many PCA hours as a way to provide family members with a source of income rather than fulfill a true need.

In the past three years, the Attorney General's Office has opened 43 docketed cases of PCA fraud. Charges have been filed for 19 of them, and convictions were made for 15. The court ordered restitution paid to the MA program in the amount of $272,060.58. The restitution paid underestimates the total fraudulent paid benefits because the court frequently orders restitution at an amount which is lower than the total amount of fraud for which the person has been convicted.

A recent review by DHS' Surveillance and Integrity Review Section (SIRS) found that:

- PCA providers accounted for 7 percent of SIRS total case load.
- PCA providers accounted for 22 percent of the cases referred by SIRS to the Attorney General (AG) for civil or administrative action.
- PCA providers accounted for 62 percent of the cases referred by SIRS to the AG's Medicaid Fraud Control Unit (MFCU) for further criminal investigation and prosecution.
- MFCU's 2002 annual report indicated that PCA providers accounted for 17 percent of its total case load. It is significant to note that during that year 60 percent of MFCU's case load related to patient abuse, neglect, and financial exploitation. Cases related to provider billing fraud and theft from public programs accounted for 43 percent of PCA cases.

Examples of Fraud and Abuse in the PCA Program

SIRS identified several examples to illustrate their concerns regarding fraud and abuse in the PCA program.

- SIRS frequently visits agencies asking for physicians' orders. Some PCPO agencies claim they did not know that this was a requirement and consequently have been providing and billing for PCA service without a physician order.

[44] Personal communication with Deb Peterson, Office of the Attorney General, Fraud Unit, Dec. 1, 2004.

- Other PCA agencies have claimed no knowledge of the requirement that they their PCA employees must have background criminal checks. Again, several agencies did not have the required documentation.
- Agencies are billing from the hours they have been authorized rather than the number of hours actually worked. An example is a PCPO whose payroll service reported 94 RN hours in one quarter, but who billed DHS for 900 RN hours. The PCPO stated they billed DHS that many hours because the service authorization allowed that many hours. They believed that if that many hours were authorized they could bill that many, whether or not the hours were worked.
- SIRS has identified persons who are working at other jobs while at the same time claiming to be providing (billing and being paid for) PCA service.
- Overstating PCA hours worked and not documenting hours are frequent complaints.
- Flexible use hours are being abused. An example: a provider informed SIRS that when he needed more money to pay bills, he billed DHS for more hours under flexible use. He did so not because the client needed more hours but because the provider needed more cash.
- Both PCAs and enrollees have been involved in collusion and/or coercion which resulting in billing the state for hours not actually worked. The extra money was shared between the enrollee and the PCA.
- As an employer, a PCPO should be reporting income and wages to Economic Security, the IRS, and Workers Compensation. SIRS has identified several instances where this is not occurring.
- In some cases, the provider's documentation is incomplete or missing, preventing an audit trail. Some agencies have no recordkeeping or timekeeping procedures in place. Some have no patient charts indicating treatments given. Others just do not keep any records at all. The number of sites where PCA services are provided and records kept has multiplied exponentially, and these locations are private and more difficult for monitors to access. In addition, most PCA services are provided by unlicensed individuals, including family members of the enrollee, many of whom either choose not to or do not know how to keep accurate records.
- Record review of PCA services delivered is a challenge. Traditionally, monitoring entities rely on the professionalism of licensed entities and their ability to keep good records and to properly bill for services provided. Consumer Directed Community Supports is proving to be especially difficult to monitor. The option provides increased flexibility, and therefore oversight and investigation is more difficult. Often there is not adequate documentation of the care provided through this option.

Additional Factors Identified Which May Contribute to Fraud and Abuse

- There are an increasing number of enrollees whose principal disability is cognitive in nature, such as dementia, psychiatric illness, behavioral diagnoses, brain injury and developmental disability. Some public health nurses reported that they feel "out of their territory," when doing assessments for enrollees with some cognitive disabilities. As a result, they reported discomfort disagreeing with the requests for service from enrollees or their caregivers.
- Some public health nurses reported experiencing pressure from the enrollee, PCA or PCA agency to increase the number of hours of PCA service authorized for an enrollee. A small number of enrollees believe, or have been led to believe that PCA services are an entitlement. They may feel, for example, that they "deserve" the same amount of PCA services that a neighbor or relative is receiving, regardless of their actual need as determined by the needs assessment process. Since the prohibition on non-responsible family members providing PCA was lifted, more and more family members are providing PCA services. In other situations, the PCA is a friend or roommate of the enrollee. It was clear from the testimony at stakeholder meetings that most PCAs and enrollees would never do anything to increase the chance for approval of services beyond actual need. But concern continues to exist regarding a small minority of cases.
- Once PCA hours are authorized, which is often for a one year period, the request for additional hours can be handled over the phone. As a result, these requests receive less scrutiny than if another face-to-face assessment was conducted.

Strategies for Reducing Incidences of Fraud or Inappropriate Use of the PCA Benefit

1. *Increase training opportunities for public health nurses*

   A new training program should be created to ensure that the public health nurses understand how to consistently make level of need determinations for PCA services. The state should hire nurses to participate in the oversight and training process, as part of the activities described under the county partnership and performance management strategy below.

2. *Increase the training opportunities for PCAs*

   DHS is concerned that PCA agencies may not properly train their registered PCAs regarding which services are appropriate for a PCA to provide to an enrollee. The DHS provider enrollment unit provides assistance to PCA providers when it is sought, but frequently the problem is related the actual provision of care, and they are not equipped to help with these questions. The state should focus on training opportunities for non-agency employed PCAs, in particular.

3. *Increase the training opportunities for enrollees using PCA services*

   Under this strategy, the state should require that anyone interested in hiring a PCA under the self-directed option, or the person acting as the responsible party on his or

her behalf, agree to receive instruction about how to employ a PCA. The state should hire nurses to provide this training.

4. *Develop a new enrollment contracting process and establish performance requirements for PCA Agencies*

   The state should create a new, formal contract process with PCA that includes performance requirements. PCA agencies should be required to demonstrate through a readiness review or certification process that it is ready to effectively provide and administer the PCA benefit. As part of this process, agencies should be informed that they may be audited randomly to ensure that they were adhering to the PCA program policies and procedures. The state should hire qualified staff to develop and implement readiness reviews with new PCA agencies, and conduct random audits.

5. *Provide better information to physicians who prescribe PCA services*

   The state should provide information to primary care physicians and certain specialty providers which clarifies the PCA benefit and the requirements for participation. Training should be made available to physicians on the use of the DHS physician authorization form for PCA services. The state should work with the Minnesota Medical Association to develop an effective education approach. The approach could include targeting physician practice managers through existing forums and meetings.

6. *Institute a registry of individual PCAs*

   As the Office of the Legislative Auditor reported in August 2003, "the claims that the personal care provider organizations submit record the recipient that received the services but not the individual PCA that provided them. Claims for most other MA services include identifying information about the service provider. Thus, the state cannot track and identify aberrant billing patterns of individual PCAs—for example a PCA may bill DHS for more hours than there are in a day or for multiple clients being served during the same time period."[45]

   The department should complete planned work on a PCA registry, and assign unique identification numbers to all individual PCAs. This would allow DHS to monitor the activities of all PCAs, across all provider agencies. This system would be consistent with the way DHS treats all other provider types. The individual PCA identification number would be akin to the "treating provider" number DHS uses to track individual physicians and other providers across clinic, hospital, and office settings. The registry would also support criminal background checks for consumer-directed PCAs. Completion of registration development would be consistent with the response DHS provided to the 2002 federal audit of DHS PCA program.[46]

---

[45] "Controlling Improper Payments in the Medical Assistance Program," Office of the Legislative Auditor, State of Minnesota, Evaluation Report, August 2003, http://www.auditor.leg.state.mn.us/ped/pedrep/0307all.pdf, p. 24.

[46] Ibid. Office of the Inspector General, U.S. Department of Health and Human Services

7. *Develop new credentialing requirements for PCAs and Agencies*

   In 1995, the Legislature mandated that DHS create a task force to make recommendations on home care services (Laws of Minnesota 1995, Chapter 207, Article 6, Section 121). The task force was composed of a broad range of stakeholders, including legislators; consumers with mental illness, physical disabilities and developmental disabilities; advocates; county public health and human services; the Office of the Attorney General; and, the Minnesota Department of Finance. The task force's report, "Recommendations of the Home Care Services Task Force," delivered to the 1996 Legislature recommended:

   - Require PCPOs to hold a modified class A home care license from the Minnesota Department of Health in order to provide PCA services.
   - All PCAs should be required to be registered in a central data base maintained by DHS.

   SIRS strongly supports these two recommendations, which have not been implemented to date.

8. *Increase and strengthen the department's capacity to investigate PCA fraud and abuse*

   The current staffing level does not permit DHS to adequately investigate PCA fraud and abuse. Following personnel cuts in 1994, DHS has had only one staff member assigned to PCA fraud. This remains the case despite the rapid growth of the MA and PCA programs during the same period. On a recent day, the sole PCA fraud investigator received 14 calls reporting suspected fraud. Not all leads can be investigated at the current staffing level, reducing the chance that some of the fraud that is occurring will be investigated or prosecuted. Three additional employees should be dedicated to this function.

Savings

Regarding strategy #8, DHS estimates that the additional financial recoveries from providers due to an increase in fraud and abuse investigation work would offset additional staff costs. Regarding strategies 1 through 7, potential savings figures have not been completed because the necessary details required for program restructuring have not been developed.

It is important to note that any efforts to improve the integrity of the PCA program should not compromise access to necessary and appropriate PCA services. Current problems with program accountability should not obscure the important benefit that this program delivers to many Minnesota citizens.

3. Help County Health and Human Services Programs Collaborate

Problem Statement
DHS currently delegates MHCP functions regarding most eligibility determination, case management, licensing, contract management, rate negotiation, transportation, service oversight and other functions to the state's 87 counties. DHS also delegates many functions that are not related to health care programs. Most of the delegated county functions relate to the delivery of continuing care services (i.e., services beyond basic health care such as nursing facility and community-based waivered services) for the elderly and people with disabilities. Continuing care services constitute 49 percent of MA expenditures. They are provided to many of MHCP's most vulnerable enrollees.

This arrangement does not work well for the state, the counties, or consumers. New and improved models of service delivery should be considered.

Why the current model works poorly for the state

The state, through DHS, is responsible for ensuring that counties effectively, efficiently, and consistently perform the full range of their delegated functions. Unfortunately, it is unable to do so because:

- It lacks sufficient staff to perform ongoing monitoring and management of 87 counties across the scope of delegated functions. Despite honest and sincere efforts by committed agency staff, oversight is inconsistent at best. There are simply too many counties and too few staff dedicated to assess performance and pursue improvement goals.
- It often lacks the leverage, financial or otherwise, to influence changes and improvement in county performance where it fails to comply with state and federal requirements.
- Counties sometimes have interests that compete with those of the state (e.g., economic development) and can make it difficult for the state to have its aims met through its delegated county partners.

As a result, the state is currently able to exercise only limited oversight and control over services and administrative functions that significantly impact consumer outcomes and agency expenditures. The problem is a result of poor structural design that makes it difficult for the state or the counties to excel.

Why the current model works poorly for counties

Research conducted among the general public by the Association of Minnesota Counties (AMC) reveals that the role of counties is little understood. The public does not view county services as priorities, and there is little interest in either tax increases or service

cuts. In the face of fiscal challenges and foreboding forecasts[47], counties also struggle with the sometimes ill-defined division of responsibilities between state and county government and the desire of state and federal government for consistent program administration. These challenges are daunting for Minnesota counties, most of which are quite small and which nonetheless are required to meet a long list of state and federal requirements.

The AMC states:

> The second role of county government is to serve as an administrative arm of the state and federal governments. This role is equally challenging as it is often hard to distinguish where the state or federal mandate begins and where local administrative authority and discretion ends. In addition, a third twist centers on the fact that county government was not made with a cookie cutter and each county has developed unique structures, policies and practices to carry out their mission.[48]

A simplified approach to operating services and administrative functions on behalf of the state, while garnering efficiencies, would benefit both counties and the state.

Why the current model works poorly for enrollees and providers

The current system provides services in a manner that does not treat consumers or providers equitably. Providers have testified at study stakeholder meetings as well as in other meetings conducted by DHS regarding current intra-county variation in coverage policy decisions, contracting processes, and rates. This variation is "resulting in significant differences in services available across counties."[49] The state is unable to confidently assure enrollees and providers that MA waiver services are reviewed and approved in a consistent manner across counties, nor that service payments are equivalent for the same service across counties. This is not the result of malfeasance on anyone's part; it is a result of a system whose complexity makes it untenable.

Background

It is difficult to find anyone who would design a system of delegated authority to 87 separate entities if designing "from scratch." Collaboration among counties would facilitate state oversight and ultimately support accountability. This approach would also provide important economies of scale, especially given the small size of many counties.

Only a minority of the 50 states delegates administration of health and human service programs to counties. At least one state, Mississippi, decided not to delegate to its 82 counties, but elected to regionalize administration of certain state health and human services functions, including waiver outreach, assessment screening, and case management services. Ten regional districts are essentially associations of member

---

[47] Neu C. "Five Mega-trends Redefining the Future of County Government," *County News*, National Association of Counties, Feb. 2, 2004.

[48] www.mncounties.org, accessed Oct. 13, 2004.

[49] "Summary of Roundtables on Aging and Long-Term Care: A Series of Regional Discussions with Stakeholders in Minnesota, August 20 – September 8, 200," Minnesota Department of Human Services

counties and operate as non-profit corporations.[50] They support area-wide governmental planning and management.

Within Minnesota, DHS has supported efforts among counties to work cooperatively for the purpose of service administration for certain program areas. Some current examples include:

- Lincoln, Lyon and Murray counties function as one health and human services administrative unit, having entered into shared services agreements with one another. Martin and Faribault counties have done the same. These efforts were initiated by the participating counties under the direction of a joint human services board comprised of commissioners from the participating counties.
- Other counties, such as Scott and Dakota, have begun to share services.
- County-Based Purchasing Groups currently work together collaboratively under joint powers agreements. Prime West and South Country Health Alliance currently include 10 and nine participating counties, respectively.
- Delegates from the Minnesota Association of County Social Service Administrators (MCSSA) have been working with DHS for two years to design a new model of county/state business processes that improve efficiency, accuracy and customer service across state and county governments. Their proposal includes centralized management of documents and telephone contacts, functions that could be performed outside of the metro area, regionalized or outsourced.
- The AMC is currently considering new models for counties through its *Minnesota County Futures Project.* Multi-county collaborations are being considered, among other potential future directions, as counties struggle with how to deliver quality services in an efficient manner while facing constrained resources.[51]

Strategies

Bailit believes that the requirement that the state work with 87 delegated counties represents one of the agency's largest impediments to improved accountability and performance. Collaboration among counties may be a necessary first step to improve performance and achieve efficiencies. The specific strategy options are as follows:

1. **Facilitate collaboration among counties regarding administration of health and human service functions on a phased basis over five years.** Under this approach, DHS would work with the AMC and from the thinking produced through the *Minnesota County Futures Project* to design collaborative approaches to service delivery and administration. Collaboration might enable counties to combine functions.

[50] Personal communication with F. Clarke Holmes, Central Mississippi Planning and Development District, Dec. 3, 2004.

[51] Himle J. and Penny T. "Minnesota Counties Futures Task Force," presentation made to the AMC-Minnesota Counties Futures Task Force, June 2004.

Bailit recommends serious consideration of regionalized delivery of services by collaborating counties in order to reduce the number of entities with which the state must work and to promote economies of scale, equity and consistency of practice. Bailit suggests that administrative services for which efficiencies might be achieved using technology and economies of scale would be regionalized first. Examples of these services include data entry and document management, information and referral services, and maintenance of help desks. Personal face-to-face services would continue to be delivered at the county level, keeping decision making close to the consumer. There would be a plan, however, to transition oversight of local service delivery to the regional offices over time.

More active promotion of collaboration among counties would be beneficial for the following reasons:

- Less active, encouragement and support are unlikely to produce the needed results.
- Only collaboration of counties for all county health and human service functions adequately addresses the profound challenges facing both the state and the counties.
- Most of the county-employed staff involved in direct service provision would be able to retain their jobs, but would work under the direction of regional instead of county authority.

2. **Work with counties to develop core performance standards and performance indicators.** A set of core performance standards and associated statistical indicators would assist state efforts to work with county partners and monitor performance on delegated functions. Some of the building blocks for a performance indicator system are already in place or in development, and include:

    - DHS has developed a proposal to include a statewide electronic document management system (described above) with the new automated eligibility system. This provides the tools necessary to assess accuracy and timeliness of eligibility determinations and allows both DHS and county agencies to identify and address best practices and performance issues.
    - The state previously adopted benchmarks to measure the "rebalancing" of long-term care within counties as part of the Long-Term Care Task Force's work.[52] These measures include:
        - the percentage of public long-term care money that goes to nursing homes vs. home and community-based services by county
        - the percentage of low-risk people in nursing homes by county
        - the percentage of higher case mix people who are supported in their own homes/apartments by county
        - the percentage higher case mix in assisted living by county
        - nursing home bed rate/1000 age 65+ by county.

[52] "Reshaping Long-Term Care in Minnesota," State of Minnesota Long-Term Care Task Force, January 2001.

- Other potential measures should be drawn from existing statute and could, as an example, include the following:
  - the percentage of people with mental retardation or a related condition who receive an evaluation within 60 days of a request for service
  - the percentage of people applying to a county board for case management services who receive a diagnostic assessment within 35 working days of application.

The final body of measures should assess both the quality and the cost/efficiency of the full range of services.

3. **Improve management of, and support to, regional county entities.** The state would need to work with the regional county entities in a manner that promotes accountability, collaboration, and improved performance. Specific staff should be assigned to managing the relationships with the regional county entities. These staff should use the aforementioned core performance standards and performance indicators to identify best practices and opportunities for improvement. The regional entities should be held accountable for effecting improvements, with specific predefined rewards and consequences for performance outcomes. In addition, the state should continue its current practice of providing technical support whenever appropriate and feasible.

4. **Address liability concerns that individual counties may consider.** Counties and their legal counsel reportedly hold concerns about liability that may arise relative to multi-county collaboration. The state should take any necessary and responsible steps to allay such concerns, while maintaining essential consumer protections.

   For example, the state could foster cooperative development by forming a liability pool, similar to what the state has developed for family foster care, which would insure any claims against a county cooperative. In addition, the state could work with counties to identify other barriers and/or incentives that might be addressed so as to encourage the development of additional cooperatives.

4. Improve MCO Contract Management

Problem Statement

Minnesota has made a clear commitment to date to provide most Medicaid services via contracted MCOs. DHS currently contracts with nine MCOs that collectively serve 305,000 PMAP enrollees and another 140,000 MinnesotaCare enrollees for a total of 445,000 people served.[53] The MCOs are a mix of large insurers primarily serving the commercially insured population and smaller plans that are Medicaid-focused and, in some cases, county-based.

[53] As of October 2004. Personal communication with Karen Peed of DHS on Oct. 21, 2004.

Bailit believes that Minnesota's prepaid MCO program has maintained a level of stability that would be the envy of many other states. The program may, nonetheless, be performing at a sub-optimal level:

- Bailit finds that DHS does not engage in sufficiently active *strategic* management of its contractors. As a result, Bailit believes that DHS lacks sufficient management systems to ensure accountability for performance that meets purchaser expectations and continuously improves. For example, DHS senior managers should be working with MCO executives on a regular basis as is common in some other states.
- Bailit finds the state-MCO relationship is marked too much by confrontation and conflict, and too little by collaboration and joint problem solving.
- Contracted MCOs are fearful and resentful of state efforts to dictate how the plans should operate.

The tenor of the current relationship between DHS and the MCOs serves neither DHS nor enrollees well. DHS can achieve higher levels of performance on behalf of enrollees and taxpayers by altering its approach to working with MCOs.

Strategy

DHS should implement a strategically focused, senior manager-led, contract management approach to working with its MCO vendors. This approach creates a stronger and more effective partnership. It has the following core components:

1. Annual identification of agency purchasing priorities
2. Annual negotiation of approximately six contractual performance improvement goals (and measures) that are aligned with purchasing priorities and reflect clear opportunities for improvement
3. Semi-annual review of contractor performance on the aforementioned goals through half-day meetings involving senior DHS and MCO management
4. Ongoing collaboration throughout the year between DHS and individual MCOs, as well as groups of MCOs, to help advance efforts to address agreed-upon opportunities for improvement
5. Annual review of plan performance across a set of leading statistical performance indicators
6. Annual application of financial and non-financial incentive strategies that are aligned to MCO achievement of agency priorities

This approach has achieved measurable results in other states.[54] Bailit believes that the state will not be able to maximize the value of its purchasing activities if it does not recast its current approach.

---

[54] Friedman MD, Bailit MH, Michel JO. "Vendor Management: A Model for Collaboration and Quality Improvement," *Joint Commission Journal of Quality Improvement* 21:635-645, 1995.

5. Improve County Partnership and Performance Management

Problem Statement

Approximately half of MA expenditures in state fiscal year 2004 -- $2.465 billion -- were for continuing care services for people with disabilities and the elderly.[55] Minnesota counties to a large degree manage the continuing care system (with the exception of nursing facility rate setting), and the allocation of those funds.

The 87 counties contract for these services, determine eligibility, authorize care plans and monitor how care plans are provided.

As discussed earlier in this report, greater collaboration regarding administration of county functions would improve the consistency of service delivery across the state and allow the state to work more effectively with counties to maximize performance.

Yet county collaboration will not ensure closer collaboration between *state* and county agencies, nor will it ensure greater accountability for county performance. While the state and the counties have a special partnership relationship, the state needs to apply some of the same contract management techniques with county partners that are recommended above for contracted MCOs. In both cases, the state has delegated responsibility for significant agency functions to external organizations. DHS can better manage these relationships to ensure maximum performance that achieves the state's aims for access to effective services that are provided in the most efficient manner possible.

Strategy

The state should implement a strategically focused contract management approach to working with its county partners. Successful implementation statewide would require some measure of consolidation of functions by counties; otherwise there are simply too many counties and too few agency staff. Absent any move towards consolidation or regionalization, DHS would have to implement this approach selectively, focusing on the most populous counties.

An appropriate contract management approach with a parallel set of components to that described for MCO contract management is defined as follows:

- Annual identification of agency purchasing priorities
- Annual negotiation of approximately six contractual performance improvement goals (and measures) with each regional county entity that are aligned with purchasing priorities and reflect clear opportunities for improvement

[55] "November 2004 Forecast Report" Minnesota Department of Human Services.

- Semi-annual review of regional county entity performance on the aforementioned goals through half-day meetings involving senior DHS and regional county management
- Ongoing collaboration throughout the year between DHS and the regional county entities, as well as with all of the regional county entities, to help advance efforts to address agreed-upon opportunities for improvement
- Annual review of regional county entity performance across a set of leading statistical performance indicators
- Annual application of financial and non-financial incentive strategies that are aligned with regional county entity achievement of agency priorities.

Improved performance management of both MCO and county relationships warrants state prioritization.

6. Pilot and Evaluate Disease Management

Problem Statement

In the U.S. health care system, most expenditures (70 percent) are associated with a small percentage of the population (10 percent), typically those with chronic or complex medical conditions.[56] This same general phenomenon exists in Medicaid populations. For example, in one state, 10.3 percent of recipients had asthma, diabetes, and/or CHF/heart failure. These recipients accounted for 25 percent of paid claims. In addition, significant research shows that individuals with chronic conditions only sometimes receive care that follows evidence-based treatment guidelines.[57]

Disease management (DM) programs typically identify a population of consumers with one or more of a set of specified chronic conditions for which well-established evidence-based treatment guidelines exist. These programs then attempt to work with consumers to educate them and improve their self-care and compliance with these guidelines. They also may work with physicians to help educate and remind them of best practices for the DM population.

The managed care industry has aggressively pursued DM as a strategy to improve quality and decrease costs. State Medicaid agencies have followed suit, and increasing numbers are contracting with DM firms (e.g., Florida, Washington, Colorado, New Hampshire, Indiana) or requiring that their health plans offer DM programs, as is the case in Minnesota.[58]

---

[56] Berk ML and Monheit AC. "The Concentration of Health Expenditures Revisited" *Health Affairs* Vol 20, No. 2 (March/April 2001).

[57] Crossing the Quality Chasm: A New Health System for the 21st Century, Institute of Medicine, National Academy Press, Washington, DC, 2001.

[58] "Disease Management in Medicaid: 2004," California HealthCare Foundation, December 2004.

While individual DM firms are able to present self-reported savings figures, and many employers and states find DM intuitively appealing, independent research does not yet support its cost effectiveness. A recent report by the Congressional Budget Office found "there is insufficient evidence to conclude that disease management programs can generally reduce overall health spending."[59] This conclusion was primarily based on the paucity of available research, especially for non-commercial populations such as Medicare and Medicaid.

The growing prevalence of chronic illness, the high costs associated with chronic illness, and the well-documented low rates of treatment guideline compliance by physicians and patients alike still suggest cost savings potential for DM, potential that could be confirmed when additional research is available.

Strategy

The state should pursue a two-pronged strategy to evaluate the potential for DM to improve quality of care and reduce health care costs associated with chronic illness.

First, the state should pursue its current plans to implement a DM pilot for the fee-for-service MA population that is tailored to a Medicaid population. When so doing, the state should establish a rigorous process for independent evaluation of program effectiveness by a party other than the DM contractor or its affiliates.

Second, the state should cooperatively work with its contracted MCOs to:

- review the varied approaches that vendors have taken to implement DM
- compare those approaches to best practice standards and accreditation standards for DM programs
- review MCO self-evaluations of DM program clinical and cost effectiveness for MA enrollees
- learn first hand of the MCOs' experience with DM and the MA enrollee.

While contracted MCOs have expressed concern about DHS evaluating their DM programs, doing so in a cooperative fashion is necessary if the state is to learn about the actual efficacy of such programs. Other states, such as Texas, have gone further by requiring formal external evaluations of their MCO's DM programs.

These assessment efforts, coupled with ongoing monitoring of the research literature, could inform future state strategy with respect to DM.

[59] "An Analysis of the Literature on Disease Management Programs," Congressional Budget Office, Oct. 13, 2004.

7. Divert and Reduce the Length of Nursing Facility Stays

Problem Statement

Despite significant policy efforts in past years, Minnesota remains near the top in the country in terms of filled nursing home beds per capita. The percentage of Minnesota residents age 65 or older residing in a nursing facility exceeds the national average by 39 percent.[60] This is a result of Minnesota having more beds per capita, as well as having a higher occupancy rate than the national average.

With annual MA nursing home costs averaging $49,000 in Minnesota,[61] it is prudent to consider additional strategies that might help reduce avoidable nursing home utilization.

Minnesota, like other states, has struggled with how to divert people from selecting a nursing facility when they might have another community-based option available to them. In addition, the state has struggled to find effective mechanisms for helping individuals return to the community after a need for post-acute nursing facility services has passed.

Nursing facility stays for most existing community-based MA enrollees are now authorized by the MCOs under 90-day or 180-day liability provisions under Minnesota Senior Care. However, private pay consumers entering nursing facilities and subsequently converting to Medicaid remain a significant challenge to the state. Moreover, this latter group represents the majority of MA nursing facility residents.

Strategies

The state should pilot two strategies designed to reduce avoidable nursing facility use, and consider changes in the current relocation services case management program.

The first strategy is to place county-based Long-Term Care Consultants (LTCCs) in hospitals and geriatric clinics to inform consumers and their family members of long-term care alternatives at the point when they are contemplating a nursing facility admission.

Bailit reports that a few other states (e.g., Indiana, Maryland, Washington, Wisconsin) have attempted to place personnel at hospitals (or dedicate staff who outreach to hospitals), while none, to their knowledge, have targeted geriatric clinics. With the exception of Indiana, states that have targeted hospitals have not reported good success. Some of the barriers included the medical need for discharge to a nursing facility in many cases, and the inability of the consumer or family to emotionally confront a rational review of options at the point of decision-making. Others barriers resulted from failed

---

[60] Harrington C. et. al. "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 1996 Through 2002," Department of Social and Behavioral Sciences, University of California, San Francisco, August 2003.

[61] Personal communication with Hal Freshley and Gary C. Johnson of DHS, on Nov. 9, 2004.

execution of the function. States often lacked strong relationships with hospital and medical staff to allow for timely identification and referral.

Indiana's effectiveness appears to result from the fact that it has staff with sole responsibility to outreach to individuals who are Medicaid-eligible and considered in immediate need of nursing facility admission. Indiana state staff have invested considerable energy to ensure that hospitals alert outreach staff, and outreach staff visit qualifying individuals, immediately upon identification. State outreach staff continues to work with those consumers who choose to be admitted to a nursing facility, but express interest in enrollment in the home and community-based waiver program. The state staff will expedite the consumer's transition into the waiver program.

Minnesota can draw from the experiences of these four states in operationalizing an effective outreach and diversion initiative. This strategy appears worthy of exploration, with a structured evaluation component.

The second strategy is to fund assessment workers and independent care planning for those consumers choosing to leave a nursing facility or subacute hospital unit within a set timeframe, e.g., 120 days. Bailit reports that other states (e.g., Georgia, Indiana, Washington, Wisconsin) have found some success when providing immediate outreach to people who are new admissions to skilled nursing facilities or rehabilitation beds. These other state efforts involved workers meeting and collaborating with the consumer and the nursing facility staff soon after the consumer had been admitted to hasten the discharge process. The state of Washington found that Medicaid-covered nursing facility stays (i.e., the Medicaid nursing facility caseload) decreased from 17,000 to 12,000 between 1995 and 2004 and believes that part of this decrease is attributable to the program. Washington has implemented it statewide.

The third strategy would improve relocation services case management. First, the state should consider whether people eligible for this service could be better served if they were offered a choice of providers. And second, they should be offered information about how to obtain a relocation case manager when admitted to a nursing facility.

8. Improve County Case Management for the Home and Community-Based Waivers

Problem Statement

At the study's public input meetings, stakeholders cited case management as a problematic area with potential for both service improvement and cost savings. Case management is perceived and defined with confusion and inconsistency both within and outside of DHS. A lack of basic agreement on program objectives and parameters made it difficult to assess the size, significance and scope of the expressed problems.

There are many types of case management provided to publicly funded clients. However, most stakeholder discussion centered on a) case management to targeted populations, and

b) case management for the Home and Community-Based (HCB) waivers (DD, TBI, CADI, CAC,[62] and Elderly). Because opportunities for state savings may be greater with HCB waiver program case management, this report's discussion and suggestions focus on this segment of case management.

The following summarizes identified problems within HCB waiver case management, and the cost implications:

- *Unclear definitions and standards:* This results in unclear expectations for both state staff and consumers, compromised data, uncertain standards for quality assurance and accountability, and diminished capability for enforcement by the state.

- *Redundancy:* Some waiver participants, in addition to the case management they receive under the waiver, receive case management in conjunction with other programs in which they are enrolled. This duplication is costly and wasteful.

- *Large caseload sizes:* Because case managers' caseloads are high in some counties, case managers cannot manage cases in a proactive manner. As a result, they are unable to help clients anticipate and plan for sometimes costly but avoidable problems.

- *Fragmented administration:* Because the state administers case management by program, standards for quality, data collection, monitoring, reporting and enforcement vary, adding costs and complexity for county staff.

- *Lack of integration of medical and continuing care concerns*: Current county case management programs generally do not integrate prevention and management of chronic care conditions. This responsibility is left to MCOs or FFS acute care providers. Maintaining two types of case management systems, one medical in orientation and the other non-medical in orientation, is inefficient and does not treat the individual as a whole person.

- *Perverse financial incentives*: Some believe there are built-in, perverse incentives that yield inefficiency and ineffectiveness. Counties are paid standard rates that may suffice for what some counties bill as a unit of service, but may be more than sufficient for what others bill for in the same size unit. As one stakeholder noted, case management has become a "cash cow" for these counties.

- *Lack of competition:* Some consumer stakeholders reported their belief that they could get better, more personalized case management and the state could get better value for its case management dollar if counties competed on the open market. Though contracting for case management is not prohibited by law, virtually all case management is provided by county agencies.

[62] DD = Developmental Disability, TBI = Traumatic Brain Injury, CADI = Community Alternatives for Disabled Individuals, and CA = Community Alternative Care.

- *Consumer-directed case management*: Some state staff expressed concern that the lack of a clear, consistent definition, consistent standards, and well defined outcome expectations will make it more difficult for consumers to direct their own case management and for the state to monitor and assess the value of the case management provided.

Background

When delivered in its most comprehensive fashion, case management can provide benefits to both consumers and purchasers. These benefits include the accessing and coordination of appropriate, individualized services that improve or maintain a consumer's functioning. Such services address a multiplicity of needs, including medical, long-term care, residential, social service, and educational.

Delivered appropriately, case management is proactive and pre-emptive. As such, case management can be an important tool facilitating prudent acquisition of services. It facilitates the delivery of lower cost services when they are more appropriate than higher cost alternatives. It also helps the purchaser avoid expensive future service costs through the delivery and coordination of preventive services.

The state's expenditures on case management are large, and in recent years have been growing at a rapid pace. HCB waiver case management has been the focus of concern for both the Legislature and the state for the past few years. In 2002, the Legislature directed DHS to "study case management ..." and report "on strategies that: streamline administration; ... improve accountability and the use of performance measures; ... and ...improve the financing of case management services."[63]

While the full directive of the legislation had a broader focus than just cost, many of the mandated report's findings and recommendations have implications for cost savings, beginning with its succinct description of the challenges and opportunities in identifying and recouping cost savings from case management services: "(DHS) currently do(es) not have "one system" of case management for targeted populations and recipients of home and community-based waivers. We have multiple forms of case management authorized under different programs serving more than 100,000 people for whom we are spending hundreds of millions of dollars with little documentation of the value of this particular intervention."[64]

The report stated that the "key components" of case management are "ongoing assessment, planning, referral, service coordination, monitoring, consultation and advocacy assistance through which multiple service needs of clients are addressed."[65]

---

[63] Laws of Minnesota 2002, Chapter 375, Article 2, Section 48

[64] Minnesota Department of Human Services Continuing Care Administration, *Case Management in Minnesota: A Report to the Minnesota Legislature,February 2003*, p. 2.

[65] Ibid.

It noted that the components are "implemented with considerable variation" across the state.[66]

The report outlined a goal and vision for the case management system that, if pursued, might address many of the inefficiencies identified by the Health Care Services Study stakeholders: "The goal of a case management system for ... recipients of home and community-based waivers is to improve the accountability and quality of case management services that assist public clients to navigate across the continuum of health and social services and programs and achieve desired outcomes."[67]

Many aspects of the report's vision have a direct bearing on cost. The vision included "clearly articulated expectations of case management and case managers ... standardized reporting mechanisms to track and monitor performance and outcomes for all populations ... and the ability to enforce ...." The system would "use administrative resources more efficiently, remove barriers between funding streams, and eliminate "silos" in program administration ... and build on elements of best practice across all populations."[68]

Many of the report's strategies also offered a sound basis for improving the cost effectiveness of HCB waiver case management. These included:

- Establish a clear definition of case management
- Establish common understanding that guides professional responsibilities for case management
- Collect and report appropriate data for tracking and monitoring performance and outcome measures
- Streamline administration
- Establish enforcement mechanisms.[69]

Strategies

The high level of disagreement about the basic definition of HCB waiver case management suggests that as a first step towards program improvement, the state should pursue the recommendations outlined in DHS' 2003 report: Define program parameters in clear operational terms that are well understood by state, county, and provider staff, as well as by consumers, their families, and advocacy organizations.

1. Establish a common agreement among all case managers, county agencies and consumers:
    - define HCB waiver case management
    - establish HCB waiver case management's goals
    - eliminate duplication of case management services so that the structure of case management is dictated by the consumer's needs and not by case management financing streams.

[66] Ibid.
[67] Ibid.
[68] Ibid.
[69] Ibid.

2. Based on the definition and goals, establish statewide standards for all case managers to follow in its provision:
    - assure consistency of provision through training of case managers
    - enforce the standards among all providers
    - conduct audits of the provision of HCB waiver case management.

Enacting these strategies would create a sounder, more consistent system on which to build a cost-effective case management system across all HCB waivers, positioning the state to obtain the best value for its case management dollars.

These strategy options do not address all of the problems noted above. The other problems should be addressed once these initial strategy options are pursued and the requisite tasks completed.

9. Support Efforts to Expand Use and Connectivity of EMRs

Problem Statement

There is national consensus that electronic medical records (EMRs) hold great promise for reducing redundancy of testing, eliminating medication errors, preventing adverse medical events, and for increasing the efficiency of medical practice in both office and institutional settings.[70] A recent study by the California Health Care Foundation reported that EMR system costs can be recouped through savings within one to two years.[71]

Despite the promise of EMRs, there remain two significant hurdles to optimizing their use. First, the systems are expensive ($15,000 to $50,000 per physician) and are seldom found in small and rural practice settings, or in clinics and centers serving the poor. Second, the existing EMR systems are not interoperable, thus preventing providers from sharing information with one another.

The federal government has recently assumed a leadership position in these issues. Dr. David Brailer is the federal Department of Health and Human Services' lead on the initiative, and has called for the development of regional health information networks of linked electronic medical record systems that might some day be connected into a national network. Dr. Brailer calls on health plans and businesses to partner with public agencies to front some of the money that doctors need to purchase such systems.[72]

In addition, the federal government has begun to address the second issue by pursuing the development of standards for electronic medical records.

---

[70] Hawryluk M. "President launches push for electronic medical records," *American Medical News*, July 26, 2004.
[71] Ibid.
[72] Finkelstein JB. "Health IT chief: Public-private partnership needed for EMRs," *American Medical News*, May 17, 2004, p. 5-6.

Strategies

Minnesota has begun to address this opportunity through the creation of the Minnesota e-Health Initiative. DHS is currently participating in this Minnesota Department of Health-led effort.

The two agencies should continue to work together, accessing available federal grant funds to support the initiative. In addition, the state should target:

- increasing EMR accessibility for rural practices and clinics
- promoting connectivity and interoperability among Minnesota providers
- ensuring that providers of continuing care services are included in efforts to expand use of EMRs so that current problems with care coordination across the acute care and continuing care systems are addressed.

All efforts would need to address confidentiality concerns and be HIPAA compliant.

While this initiative would not yield short-term savings, there is strong national agreement that it would improve both the quality and efficiency of care delivery for all.

Strategies that Could Not Be Fully Researched, but which Warrant Serious Consideration for Future Exploration

A few promising strategies were identified in the course of the study, but could not be researched due to limited availability of pressed agency staff or other factors. Some of them warrant serious consideration and further exploration by the state should staff resources become available in the future.

1. Set Rates for Community Continuing Care Services

The state, through DHS, currently delegates rate setting responsibility for the wide range of community-based continuing care services for people with disabilities to the 87 counties. This approach is problematic for at least the following reasons:

- Counties set rates inconsistently such that the same provider routinely gets paid different amounts for the same service in two different counties. This inequity is unfair to both providers and enrollees.
- Small counties seldom have the expertise or the leverage to negotiate rates that are advantageous to the state or the county, and may end up paying more than might be necessary or appropriate. Reportedly some county staff do not even determine required staffing levels, but leave that decision to the provider. The proliferation of for-profit supported living services (SLS) providers suggests that payments may sometimes exceed what is warranted.

While regionalization of county health and human service functions would help to address this problem, there may be benefit in nonetheless creating a central state rate setting function as is common for most other MA services in Minnesota and in other states. Creating a common rate system for the whole state, while still permitting necessary flexibility to respond to varying enrollee needs, is achievable.

The DHS Disability Services Division is currently undertaking a review of the cost and cost structures associated with SLS under home and community-based waivers. This information could be used to inform a new rate system.

2. Encourage Retention of Private Commercial Insurance Coverage

Anecdotally, DHS staff report incidences in which children with disabilities who possess parental health insurance coverage graduate from high school and then drop the commercial coverage, in favor of state coverage. Existing Minnesota state law permits

children with disabilities to continue on parental health insurance policies after graduation from high school under state-regulated insurance plans.

For families with self-insured ERISA plans, the federal COBRA regulations permit continuation of private plans for 36 months when a child is no longer eligible for a parent's plan. At that point, a child who can't get coverage on the private market can buy into the Minnesota Comprehensive Health Agency program.

DHS should investigate the frequency with which children with disabilities drop commercial coverage in favor of state coverage, and pursue potential strategies for providing education and/or incentives that will result in increased rates of retention of private commercial insurance coverage. This strategy must take into account the fact that some families would need assistance meeting the high cost of extending their private policies via the COBRA option.

Conclusion

This report identifies a range of strategies to yield additional savings and improve health care program services for program enrollees. The strategies are projected to produce savings that would sustain and grow over time. They are not quick fixes, but rather fundamental changes in how the state covers and purchases services.

The most viable of these strategies have helped form the basis for policy and budget proposals that will be presented to Legislature. Other strategies require more research, development and consultation with stakeholders and can be pursued over time.

Appendix A

Members of DHS' Health Care Expert Panel

Name	Organizational Affiliation, if any
Kathleen Cota	Minnesota Dept. of Human Services
Steve Eisenberg, MD	independent consultant
Nancy Feldman	UCare Minnesota
Karen Gervais	Minnesota Center for Health Care Ethics
Pat Irvine, MD	independent consultant
Paul Johnson, MD	AXIS Healthcare
Brian Osberg	Minnesota Dept. of Human Services
John Selstad	Minnesota Dept. of Human Services
Judy Soderberg	Fairview MS Achievement Center
Read Sulik, MD	St. Cloud Hospital
Tom Van Sternberg, MD	Health Partners

Appendix B

A Sample of Additional Strategies Suggested by Stakeholders but not Incorporated into this Report

- Develop a mobile crisis team to support assessment and care planning when a consumer is identified as being at the precipice of institutionalization.
- Vary provider payment based on performance.
- Provide consumers with financial incentives to adhere to preventive care guidelines, e.g., influenza vaccine, regular well-care visits, and blood sugar control.
- Consider a "centers of excellence" model for certain procedures or conditions.
- Educate families regarding choices and care planning resources for end-of-life care.
- Modify DHS policy so that immigrants enrolled in Emergency MA do not continue to receive costly institutional care rather than community-based care.
- Maximize use of Medicare for home health services.
- Support expanded housing access to address a barrier to consumers moving out of nursing facilities.
- Privatize county case management.
- Eliminate duplication of case managers for individual enrollees.
- Address inappropriate financial incentives and practice when a provider of day training and rehab also provides transportation and chooses to transport the consumer a longer distance than would otherwise be necessary.
- Create restrictions on how far DHS will cover transportation service to a consumer's choice of provider in situations in which services deemed comparable by DHS are available in nearer proximity to the consumer's residence.
- Put counties at partial risk for state expenditures that exceed growth targets.
- Cover falls assessment or more general home safety assessments for senior consumers dwelling within the community.
- Provide presumptive eligibility to seniors who are held up in hospitals awaiting an SSI eligibility evaluation by the State Medical Review Team, and allow them to be discharged to nursing facilities where they can be provided services at a lower cost to DHS.
- Limit the amount of case management provided when homemaker services are the only other service provided.
- Develop clear policy direction regarding when to cover Assisted Living services.
- Enroll remaining seniors into managed care by finding a way to enroll "spend downs."
- Collaborate more closely with the Medicare Quality Improvement Organization (QIO) to encourage it to address risk factors that impact DHS cost (e.g., fall prevention).
- Remove the requirement that counties contract with every provider and tighten some DHS provider enrollment requirements.

Appendix C

Selected Health Services Research Findings Regarding Inappropriate Use of Health Care Services

Sample of Overused Health Services	Finding and Source
Coronary angiography	4% of coronary angiographies were performed for clearly inappropriate reasons, and 20% were equivocal (Bernstein et. al., 1993, in *Crossing the Quality Chasm*, Table A-2) 17% of coronary angiographies were performed for clearly inappropriate reasons in a nationally represented sample of Medicare beneficiaries in 1981 (RAND Health Services Utilization Study)
MI: Treatment with Lidocaine	The median percentage of patients ineligible for lidocaine who received it in the first 48 hours of hospitalization was 12% (Soumerai et. al., 1998, in *Crossing the Quality Chasm*, Table A-2)
Unstable angina	62% of those for whom calcium blockers were contraindicated received them (Simpson et. al., 1997, in *Crossing the Quality Chasm*, Table A-2)
Antibiotic use	In 60% of Kentucky Medicaid encounters for the common cold, patients filled prescriptions for antibiotics (Mainous et. al., 1996, in *Crossing the Quality Chasm*, Table A-2) 51% of patients diagnosed with a cold were treated with antibiotics (Gonzales et. al., 1997, in *Crossing the Quality Chasm*, Table A-2) 52% of patients diagnosed with a URI were treated with antibiotics (Gonzales et. al., 1997, in *Crossing the Quality Chasm*, Table A-2) Over 70% of patients received antibiotics for pharyngitis (excluding streptococcal), over 50% received them for rhinitis, and over 30% received them for a nonspecific URI, cough, or cold (Dowell and Schwartz, 1997, in *Crossing the Quality Chasm*, Table A-2) 80% of antibiotics prescribed for acute respiratory tract infections are unnecessary (Journal of Family Practice, Oct. 2001, Vol. 50, No. 10, pg. 853-858)

Sample of Overused Health Services	Finding and Source
Pneumonia	9.4% of pediatric admissions were inappropriate (Payne et. al., 1995 in *Crossing the Quality Chasm*, Table A-2)
Bronchitis and Asthma	4.4% of pediatric admissions were inappropriate (Payne et. al., 1995 in *Crossing the Quality Chasm*, Table A-2)
Hysterectomy	Between 16-30% of hysterectomies performed each year are believed to be unnecessary and complication rates are between 25-50%. (MWBG – footnote 134: Lepine, LA et al, "Hysterectomy Surveillance – US 1980-1993" in CDC Surveillance Summaries; Chassin MR, 1987 *JAMA*; Chassin MR, Galvin RW. 1998. "The Urgent Need to Improve Health Care Quality, *JAMA*.)
Carotid endarterectomy	Approximately 10% of carotid endarterectomies are inappropriate and another 5% are of questionable benefit. (Halm EA, Chassin MR, et al. "Revisiting the appropriateness of carotid endarterectomy." Stroke 2003 June.) 32% of carotid endarterectomies were performed for clearly inappropriate reasons in a nationally represented sample of Medicare beneficiaries in 1981 (RAND) ("Reducing the Cost of Poor Quality Health Care" Midwest Business Group on Health, 2003, footnote 135: Chassin MR, et. al. 1987. "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures." *JAMA*; Bernstein et. al. 1993. "The Appropriateness of Use of Coronary Angiography in New York State," *JAMA*.)
Cardiac pacemakers	20% of cardiac pacemakers were inserted for clearly inappropriate reasons (Footnote in Chassin MR, Galvin RW, "The Urgent Need to Improve Health Care Quality: IOM Roundtable on Health Care Quality" *JAMA* September 16, 1998 – Vol 280 – No. 11 – original source – Greenspan AM et al, Incidence of unwarranted implementation of permanent cardiac pacemakers in a large medical population," *NEJM* 1988.)
Upper GI endoscopy	17% of upper GI endoscopies were performed for clearly inappropriate reasons in a nationally represented sample of Medicare beneficiaries in 1981 (Chassin et. al., 1987, RAND Health Services Utilization Study)

Sample of Overused Health Services	Finding and Source
Tympanostomy tubes	Nearly 25% of the children who undergo tympanostomy do not need the procedure and another 33% of these procedures provide questionable benefit. ("Reducing the Cost of Poor Quality Health Care" Midwest Business Group on Health, 2003, footnote 136: Kleinman, LC et al 1994. "The Medical Appropriateness Tympanostomy Tubes Proposed for Children Younger than 16 years in the US," *JAMA*, see also Chassin *JAMA* 1998.)
Arthroscopic surgery for treating osteoarthritis	Arthroscopic surgery (arthroscopic lavage or debridement) for treating osteoarthritis of the knee is no better than a placebo for relieving knee pain and improving overall physical function (Moseley JB, O"Malley K, Petersen NJ, et al "A Controlled trial of arthroscopic surgery for osteoarthritis of the knee." *NEJM* Jul 11, 2002.)
Cardiac catheterizations	25% of 1,000,000 cardiac catheterizations per year are either inappropriate or of questionable benefit. (Chassin MR 1993 *JAMA*)
Spinal manipulative therapy for low back pain	There is no evidence that spinal manipulative therapy is superior to other standard treatments for patients with acute or chronic low back pain. For patients with acute low-back pain, spinal manipulative therapy was superior only to sham therapy or therapies judged to be ineffective or even harmful. Spinal manipulation had no statistically or clinically significant advantage over general practitioner care, physical therapy, exercises, or back school (Assendelft W, et al. "Spinal manipulative therapy for low back pain" Department of Guideline Development and Research Policy, Dutch College of General Practitioners. Netherlands. (Meta analysis of 39 randomized controlled trials.))
MRIs for back pain	Patients with back pain referred for an MRI, instead of an X-ray, ended up with more intensive treatment – more doctor visits, more physical therapy, acupuncture and chiropractic manipulations, as well as more surgery. Yet these patients were no better than the X-ray patients (Jarvik JK et al, "Rapid Magnetic Resonance Imaging Versus Radiographs for Patients with Low Back Pain." *JAMA* 2003.)
Surgical explorations for suspected appendicitis	40% of surgical explorations for suspected appendicitis are unnecessary (World Journal of Surgery, Feb. 1999, Vol. 23, No 2)

Sample of Overused Health Services	Finding and Source
Emergency department use	20% of patients coming to the ED did not have conditions requiring emergency care, and another 20% had urgent conditions that could have been treated in a primary care setting" (Regenstein M et al, "Walking a Tightrope: The State of the Safety Net in 10 U.S. Communities." The George Washington University Medical Center, May 2004.)

Appendix D

Sample of Services Identified by Minnesota MCOs and Other Advisors to DHS as Subject to Inappropriate Use

	Total MA Payments (FFS and managed care) CY 2003
Acupuncture	$171,493
Sleep Testing	$1,867,822
Fetal Ultrasounds	$845,146
Obstetrical Ultrasounds	$6,550,741
IVIG[73]	$1,982,443
Hyperhydrosis Report	$244
Panniculectomy	$121,467
Mammoplasty	$1,146,106
Rhinoplasty	$5,260
Bariatric Surgery for Obesity	$4,754,350
Vision Therapy	$13,842
Duplicate Glasses	$2,964,000
Manual Wheelchair in LTC Facility	$257,469
Seasonal Affective Disorder Lights	$20,404
Ultrasonic Bone Growth Stimulations	$458,882
Laser Treatment for Acne Scarring	$173
Spinal Fusion	$12,477,351
Varicose Vein Treatment	$173,517
Single Vessel Coronary Artery Bypass Graft	$513,666
Swanz-Ganz Catheter	$141,165
Home Uterine Monitoring	$25,212
Percutaneous Transluminal Coronary Angioplasty	$9,480,925
Dental Implants	$116,175

[73] Intravenous immunoglobulin therapy

Orthodontia	$9,940,906
Occupational Therapy/Physical Therapy for LTC Residents	$3,606,386
Speech Therapy for LTC Residents	$354,084
Audiology for LTC Residents	$189,238
Total	**$58,178,466**

NOTE: These are <u>not</u> savings estimates, but rather total expenditures for services that are alleged to be prone to overuse.

Appendix E

Additional Evidence of the Effectiveness of Medicaid Managed Care for People with Disabilities

- An evaluation of Texas' STAR+PLUS program (2003)[74] which includes both acute and continuing care services in the HMO capitation rate found that
  - adult SSI disabled recipients, when compared to those recipients enrolled in HMOs without continuing care services in the capitation:
    - used ERs 38% less often and were admitted to hospitals 22% less often, and
    - cost 74% less, with the most significant savings among those with the worst health status.

- A qualitative evaluation of Medicaid managed care for adults with disabilities in California (2002)[75] found:
  - the assessed experience of those plans serving the 158,000 adults with disabilities (as of 7-02) in managed care "underscore[s] the value of managed care for this population, and
  - "the existence of a coordinated care system with delineated points of contact, primary care relationships, and accountability for the integrity of that system would offer great promise to those individuals whose special needs require frequent and/or unique access to care."

- California's five County Organized Health Systems serve all 550,000 Medicaid recipients within a county, including people with disabilities, and are responsible for all Medicaid-covered services in those counties.[76] The California Legislative Analyst's Office (LAO) reported to the Legislature in February 2004 that the possible loss of COHS plans would cost the state $150M in savings to the state's General Fund. The same LAO found that California counties with mandatory managed care enrollment for people with disabilities experienced annual costs that were 13% lower than those counties with a FFS program for recipients with disabilities in 2002-03.[77]

---

[74] Aydede SK. "The Impact of Care Coordination on the Provision of Health care Services to Disabled and Chronically Ill Medicaid Enrollees," Institute for Child Health Policy, November 2003.
[75] Nolen JR. "Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives," Medi-Cal Policy Institute, September 2003.
[76] Hurley et. al. "An S.O.S. for the COHS: Preserving County Organized Health Systems," Pacific Health Consulting Group, May 2004.
[77] "Better Care Reduces Health Care Costs for Aged and Disabled Persons," Legislative Analyst's Office, March 4, 2004.

- An evaluation of Maryland's managed care program (2001)[78] revealed that overall access to care for SSI children, as well as preventive care specifically, improved following the implementation of managed care in 1997.

- A detailed analysis by The Lewin Group on behalf of the state of Texas found that "substantial savings are possible by extending Medicaid managed care to the SSI blind and disabled population." Lewin's report projected savings in larger metropolitan counties that ranged between 3.1 and 5.1 percent for non-dually eligible recipients with disabilities, with 60 percent of the savings achieved the first year, and an additional 10 percent reached each following year until reaching steady state in the fifth year post-implementation.[79]

- An evaluation of the Wisconsin Partnership Program (WPP)[80], which integrates Medicare and Medicaid funding using a PACE-like model based in a center for independent living for people with disabilities, examined the period 1998-2000 and found:
    - enrollees with disabilities had fewer preventable hospital admissions compared to a same county non-enrolled cohort;
    - enrollees with disabilities had fewer emergency room visits than either of two control groups;
    - enrollees with disabilities had fewer preventable emergency room visits than a different county non-enrolled cohort in the 18 months after enrollment after adjustment;
    - the rate of nursing home admission was lower for WPP enrollees with disabilities than a different county non-enrolled cohort for stays greater than 30 days, and
    - the combined WPP capitation payments for enrollees with disabilities were lower than fee-for-service Medicare and Medicaid payments for the comparison group.

[78] "HealthChoice Evaluation: Final Report and Recommendations," Maryland Department of Health and Mental Hygiene, January 2002.
[79] Ibid, The Lewin Group.
[80] Kane RL and Homyak P. "Multi State Evaluation of Dual Eligibles Demonstration: Final Report," University of Minnesota School of Public Health, July 2004.

Evidence of the Effectiveness of Medicaid Managed Care for People with Disabilities: Behavioral Health

- An evaluation of the Massachusetts Medicaid managed behavioral health care program examined total program experience between 1990 and 1993[81] and found:
  - expenditures for enrollees with disabilities (child and adult combined) fell 37%, and
  - inpatient readmissions for people with disabilities fell from 25.8 to 22.7 percent, providers' reports regarding clinical quality were favorable, with the exception of for child mental health.

- Evaluations of Iowa's Medicaid managed behavioral health care programs found the following:
  - access and utilization of substance abuse treatment increased while treatment cost per client decreased for Medicaid enrollees in the Iowa Managed Substance Abuse Care Plan (1996-1998) while cost per client dropped from $3500 to $1200. There were no apparent declines in quality[82], and
  - the Iowa Plan for Behavioral Health produced savings of 1.8%, maintaining and/or improving access and quality, and was evaluated as "a national leader and model program."[83]

- An evaluation of Nebraska's Medicaid managed behavioral health care program examined performance from FY96 to FY98 and compared it to pre-carve-out implementation[84], finding:
  - the cost of care declined significantly for mental health service recipients with no appreciable impact on access or quality.

- An evaluation of Utah's Prepaid Mental Health Plan[85] found:
  - the quality of care declined for recipients with schizophrenia after the introduction of the program.

- Evaluations of Tennessee's managed behavioral health care programs have had mixed findings regarding quality of care.[86]

---

[81] Callahan JJ et. al. "Mental Health/Substance Abuse Treatment in Managed Care: The Massachusetts Medicaid Experience" *Health Affairs*, Vol. 14, No. 3, Fall 1995, p. 173-184.
[82] Argeriou et. al. "Evaluation of the Impact of the Iowa Managed Substance Abuse Care Plan on Substance Abuse Treatment Services," Brandeis University.
[83] "Independent Assessment of the Iowa Plan for Behavioral Health," William M. Mercer, August 2000.
[84] Argeriou et. al. "State Substance Abuse/Mental Health Managed Care Evaluation" Brandeis University, Aug. 1, 2001.
[85] Popkin MK et. al. "Changes in the Process of Care for Medicaid Patients with Schizophrenia in Utah's Prepaid Mental Health Plan," *Psychiatric Services* 49:518-523, April 1998.
[86] Saunders RC and Heflinger CA. "Access to and Patterns of Use of Behavioral Health Services Among Children and Adolescents in TennCare," *Psychiatric Services* 54:1364-1371, October 2003, and Chang CF et. al. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services," *JAMA* 279:864-869, March 18, 1998.

Appendix F

Example of a Working Document from an Internal DHS Meeting with Disability Services Division Staff

Continuing Care for People with Disabilities
Summary of 3-19-04 Brainstorming Meeting

What to Cover
No strategies identified for this category.

When to Cover
Strategy #1: Reduce prescription drug waste by restricting availability of long-term prescriptions.

- *Restrict 30-day and 90-day prescriptions when they are likely to result in waste, e.g., new medication trials that could result in allergic reaction, end of life care.*

Strategy #2: Eliminate duplicative case management services.

- *Eliminate duplicate provision of case management services.*

Strategy #3: Eliminate inappropriate use of transportation services.

- *Create restrictions on how far DHS will cover transportation service to a consumer's choice of provider in situations in which services deemed comparable by DHS are available in nearer proximity to the consumer's residence.*
- *Address inappropriate financial incentives and practice when a provider of day training and rehab also provides transportation and chooses to transport the consumer a longer distance than would otherwise be necessary.*

Strategy #4: Eliminate duplicate payments between the waiver and the state plan.

- *Eliminate duplicate payment of foster care and ILS between the waiver and the state plan.*

How to Cover
Strategy #1: Improve delivery of preventive care services

- *Get case managers to do a better job of addressing preventive care needs.*

Other Suggestions

- *Review rate setting practices for SLS to examine issues of potential inequity and overpayment.*

Appendix G

Example of a White Paper Prepared for the Study by Bailit, March 5, 2004

Briefing Paper
Selective Contracting for Inpatient Acute Care Services

As part of its efforts to reduce Medicaid costs without narrowing eligibility or cutting benefits, DHS has expressed interest in selective contracting as one potential strategy to pursue. This briefing paper presents background information to assist the Department in its decision-making process. This briefing paper will address selective contracting for inpatient acute care services.

Market Conditions

Underlying the strategy of selective contracting is the potentiality that not all providers able to provide desired services will receive a provider contract. It is a strategy that uses competition, bargaining power and market forces to obtain the most cost efficient price without sacrificing quality and access. Because this strategy relies on market forces, certain market conditions must be present and implications to providers considered for the strategy to be successful.[87]

- Current Medicaid Rates: Current Medicaid rates must be sufficiently above provider actual costs to encourage aggressive competitive bidding, resulting in lower rates. However, if Medicaid rates are close to the providers' current costs, for selective contracting to be successful providers must have sufficient opportunity to lower costs through increased efficiencies. If Medicaid rates are below provider costs without many opportunities to increase efficiencies, selective contracting may exacerbate quality and access issues. In this last case, providers may either cut quality as they cut costs to continue participating in Medicaid, or they may decline to participate. Contracts awarded must provide sufficient rate payments to be attractive to providers.
- Market Capacity: The market area must have some excess capacity and a sufficient number of providers to promote competitive bidding. The threat of exclusion from the Medicaid program promotes competitive bidding and allows Medicaid to drive volume to the successful bidders.
- Access: Sufficient contracts need to be awarded to meet capacity demands for the anticipated volume and type of services needed, as well as geographic access. An insufficient number of providers may result in lower overall costs, but an access bottleneck.

---

[87] Barber, Janet P. "Selective Contracting for Medicaid Nursing Home Beds," Florida Health Care Journal, January 2000. Available at www.floridahealthstat.com/publications/fhcj/barber.htm.

- Patient Volume: Contracts awarded must provide patient volume at levels to be attractive to providers. Without sufficient volume at stake, providers will not find it worth their while to participate in a selective contracting process. The potential volume "in play" must make a difference to the providers in each geographic or service market.
- Other Payers: If providers are likely to abandon Medicaid or shift cost to others under a competitive contacting process, obtaining the participation of all other payers (including private insurers) will reduce that possibility. By including all payers in the selective contracting process, the state has increased the volume in play for each provider, and increased the likelihood of competitive bidding to occur. It is important to note that viability of any hospital not selected would be seriously threatened.

Political Climate

In addition to market factors, the political climate must also be considered. Because selective contracting may result in eliminating specific providers from the Medicaid program, it is potentially a politically explosive initiative. The extent of the political impact will depend on which services are being targeted for selective contracting. For example, no states have adopted selective contracting for nursing home services, although, several have considered it.[88] Texas reported that its selective contracting initiative for inpatient acute care services has been limited by political realities.[89]

Selective Contracting Approaches

Selective contracting requires potential service providers to bid on state business. States generally use two types of selective contracting:[90]

- contracts are awarded to the lowest fixed-price bid, or
- states establish price ranges plus technical requirements, such as quality measures, and award bids to either all bidders who meet price and technical requirements or to bidders with the lowest prices within the price ranges.

Rates for selective contracting may cover a broad range of services, such as primary care services, or a very focused service, such as oxygen and related respiratory services. Selective contracting may also be limited to specific geographic service areas or cover the entire state. The geographic and service scope of a selective contracting initiative would depend on the market conditions, the goals of the initiative, the level of political support and the level of resources available to implement and manage a selective contracting program.

States' Experiences with Selective Contracting for Inpatient Acute Care Services

---

[88] *Ibid.*
[89] Based on discussions with Scott Reasonover, Texas Medicaid program, on 3/2/04.
[90] *Op. Cit.*

Selective contracting for inpatient acute care services is relatively rare. Only three states (California, Washington, and Texas) currently have selective contracting programs for inpatient acute care services. We were able to talk with Texas Medicaid staff extensively about their experiences with selective contracting. We believe that the Texas experience highlights both the upside and downside potential of selective contracting.

Texas[91] implemented selective contracting for inpatient acute care services and inpatient behavioral health care services in 1993 and 1994 for its FFS beneficiaries. The Texas Medicaid agency contracts with hospitals in the 27 largest Metropolitan Statistical Areas. The program is implemented through negotiated discounts off of standard Medicaid rates. Texas reaped $65 million in savings (both state and federal cost savings) during the first year. The savings have declined substantially in subsequent years and is approximately $12 million for the current fiscal year. The state agency has been unable to be truly selective, limiting its ability to garner savings through this program. Selectivity has been limited by four key factors:

- CMS waiver requirements concerning access. CMS identified specific zip codes that must have hospital coverage with no travel burdens for beneficiaries. The hospitals in these areas with large Medicaid members are the large safety-net hospitals where most of the state's Medicaid members receive care. With no likelihood of loss of Medicaid business, these hospitals have negotiated minimal to no discounts.
- Disenfranchisement of Medicaid physicians. Physicians with large Medicaid patient populations do not always have admitting privileges at the hospitals willing to give the Medicaid program negotiated discounts. Selecting these hospitals would result in significant disruption to the provider network and Medicaid members.
- Political issues. Political pressure has limited the ability of the state to decline to contract with hospitals. For example, rural hospitals, as well as having little competition, are also job centers and well protected by the state legislature.
- Recent budget cuts. With cuts to hospital reimbursement rates from other sources, including disproportionate care funds and other Medicaid program payments, Texas hospitals are unwilling to continue participating in the selective contracting program.

Within these constraints, Texas has been relatively successful in gaining significant discounts only with smaller hospitals. Even within that industry segment, it has been difficult to be selective because of the potential impact on the hospital. Not only would a non-contracted hospital lose Medicaid payments, but the hospital's disproportionate share funds would also be dramatically reduced under the Texas formula. Not having a Medicaid contract could lead to the failure of the hospital. The Texas Medicaid agency was understandably reluctant to start that process.

[91] Based on discussions with Scott Reasonover, Texas Medicaid program, on 3/2/04.

Today, Texas' selective contracting program for inpatient acute care services is effectively "defunct," according to the state.[92] The state agency will distribute solicitation packages to all hospitals for the upcoming fiscal year, but does not expect to be very successful in negotiating discounts.

Texas realized some program savings through selective contracting. However, the Medicaid agency was not able to maintain the level of initial savings because of regulatory constraints, physician disenfranchisement, political pressure and provider resistance. Selective contracting occurs within a dynamic environment. The Texas market and political conditions required for success could not be sustained.

California's selective contracting program for inpatient acute care services was established 21 years ago. It covers inpatient acute care services for 3 million Medi-Cal members and reimburses hospitals for services totaling $4 billion annually. When it was first established, California was extensively overbedding in most metropolitan areas according to Karin Johnson, division director for the selective contracting program.[93] Therefore, the state had considerable leverage in forcing a competitive bidding process for Medi-Cal business. The Executive Director of the California Medical Assistance Commission (the Commission overseeing the program and responsible for negotiating hospital contracts), Keith Berger, believes that today it would be impossible for the state to establish a similar program.[94] The hospitals are more sophisticated in their negotiating strategies and the overbedding that created a competitive marketplace no longer exists. In fact, the Commission has no hospital contracts north of Sacramento because of the lack of competition in these largely rural areas.

Over the years, the California program has evolved from one with leverage based on over bedding and selective contracting to one offering steady revenues and unique benefits to participating hospitals. The Commission has developed incentives around construction costs, ER services and special programs for county hospitals, which the hospitals consider very desirable. Also, the Commission has more flexibility than other sectors of the state government to respond to unexpected hospital financial needs. As a result, the Commission has been able to step in to provide emergency, short-term relief to hospitals. Finally, most of the participating hospitals receive a significant percentage of their revenue from Medi-Cal billings, so these hospitals cannot afford to leave the program, according to the state.[95]

The Texas and California experiences demonstrate the realities involved in implementing and managing selective contracting for a highly visible, albeit high cost, service.

Conclusions and Recommendation

---

[92] *Ibid.*

[93] Based on discussions with Karin Johnson, California Medi-Cal program, on 3/4/04.

[94] Based on discussions with Keith Berger on, Executive Director of the California Medical Assistance Commission, on 3/4/04.

[95] *Ibid.*

Successfully initiating a selective contracting program for inpatient acute services requires certain market conditions relating to patient volume, provider costs and capacity, Medicaid reimbursement levels and a strong political will. Even if all variable are aligned at the inception of the program, it is a difficult program to sustain over a long period of time. Several selective contracting programs appear to have evolved into a process of individually negotiated discounted hospital rates or to have been abandoned.[96]

With respect to Minnesota, we do not recommend that this initiative be pursued. First, 80,000 Medicaid members located throughout the state is a relatively small amount of inpatient volume on which to build a selective contracting program. Second, approximately half of the 80,000 fee-for-service membership is dually eligible. Any selective contracting savings for inpatient services would accrue to the Medicare program.

Third, we also estimate that over half of the Minnesota fee-for-service members are disabled. This population has a higher likelihood of requiring highly specialized services, which could limit hospital de-selection options. Fourth, the benefits from selective contracting seem to diminish over time. This means that a great deal of effort and political good will are expended for a relatively short-term gain. This option to reduce inpatient costs must, therefore, be weighed against other programs. We believe that some of the other options bring considered will provide more sustained savings and member benefits.

Additional Information

Texas' Experience with Selective Contracting for Inpatient Behavioral Health Services

The behavioral health selective program contracting was initially successful because it resulting in a weeding out of inappropriate hospitalizations, moving care to outpatient settings. Since its inception in the mid-1990s, the Lone Star II program has gone from 200 participating hospitals to 40 hospitals. Most of the 160 hospitals not currently under contract went out of business or were part of an industry consolidation. Texas officials believe that the market changes were more influenced by factors other than the selective contracting initiative. Between the mid-1990s and today, the focus of care moved to the outpatient setting, reducing the need for large number of mental hospitals. These hospitals also experienced reductions in reimbursement from Medicare, Medicaid and managed care programs. During this time the industry underwent major changes nationally.

---

[96] "HHS 36: Use Selective Contracting for Some Medicaid Services." Texas Performance Review: Disturbing the Peace, Chapter 2. Available at www.window.state.tx.us/tpr/tpr4/c2.hhs/c236.html.

Washington

In 1988 Washington implemented a selective contracting program for primary care and inpatient acute care services in eight targeted areas.[97] The key goals of the program are to shift all routine inpatient care from higher cost to lower cost settings, and contain overall expenditures for inpatient services. The Medicaid agency contracts with sufficient hospitals in each geographic area to provide the full range of hospital services, including specialty services. Payment is based on a pre-determined contracted rate. Excluded services include:

- emergency services
- state hospitals
- children's hospitals
- remote hospitals, alcoholism and detoxification treatment services,
- long term acute care hospital services
- cancer research center services

Washington expected to save $10 million in 2001 and 2002. We were unsuccessful in speaking with Washington State Medicaid agency staff, so we do not know whether Washington has reached its targeted savings.

[97] "The State of Washington 19159b) program." Available at www.cms.hhs.gov/medicaid/1915b/wa05fs.asp

Appendix H

List of Participants in the Commonwealth Fund Sponsored Discussion Exploring Evidence-Based Coverage as a Purchasing Strategy for Minnesota's Medicaid Program

Institute for Health Policy
Massachusetts General Hospital
50 Staniford Street, Room 901
Boston, MA 02114

Participants: March 24, 2004

Anne-Marie Audet, MD
The Commonwealth Fund
One East 75th Street
New York, NY 10021
212-606-3856
ama@cmwf.org

Michael Bailit
Bailit Health Purchasing, LLC
120 Cedar Street
Wellesley, MA 02481-3501
781-237-5111
mbailit@bailit-health.com

Karen Bell, MD
324 Winter Street
Weston, MA 02493
781-431-1721
kmbellmd@netscape.net

David Blumenthal, MD, MPP
Institute for Health Policy
Massachusetts General Hospital
50 Staniford Street, Room 901
Boston, MA 02114
617-726-5212
dblumenthal@partners.org

Kathleen Cota
Health Care Management, Benefits
Policy and Provider Relations
Minnesota Department of Human
Services
444 Lafayette Road, North
St. Paul, MN 55155-3854
651-297-3200
kathleen.cota@state.mn.us

Tom Fields
Health Care Management, Benefits
Policy and Provider Relations
Minnesota Department of Human
Services
444 Lafayette Road, North
St. Paul, MN 55155-3854
651-297-7303
tom.fields@state.mn.us

Roberta Herman, MD
Harvard Pilgrim Health Care
93 Worcester Street
Wellesley, MA 02481
617-509-6025
roberta_herman@hphc.org

Appendix I

Joint PCA Initiatives of the Performance Measurement and Quality Initiatives Division SIRS Section and the Disability Services Division

SIRS and DSD have met several times and discussed the above listed problems. The following initiatives were agreed upon as a way to help reduce abusive practices:

1. **Registry:** SIRS and Provider Enrollment will be requiring all PCAs to enroll and be given an individual provider number. The PCPO will be required to report on the claim to DHS who the actual PCA is that provided the service. SIRS will then be able to identify the individual PCA that reportedly provided the service, which agencies they work for, and how many hours they reportedly worked. This will further allow SIRS to better monitor hours billed to DHS.

2. **Certification of Medical Necessity for PCA Services:** DHS will require that before PCA services can be performed and billed to the department the PCPO must be in possession of a signed certificate authorizing such service. The certificate must be completed and signed by the client's treating medical professional. The medical professional must attest to the fact under MN Rules 9505.0174, subpart 25, and 9505.0355 that the PCA service is medically necessary. The certification must be kept in the client's file and renewed annually. Failure to have a current certification on file may lead to the recovery by DHS of funds paid to the organization for the PCA services.

3. **Background Checks:** The PCPO must have submitted a background check for each person employed by them as a PCA prior to performing any services. Provider Enrollment will not issue an individual PCA provider number until they know a background check has been completed.

4. **Correct Billing and Charting Procedures:** DSD is exploring PCA training in the area of patient care. SIRS and Provider Relations will be exploring PCA and PCPO training in the areas of required documentation and billing procedures.

Appendix I

Joint PCA Initiatives of the Performance Measurement and Quality Initiatives Division SIRS Section and the Disability Services Division

SIRS and DSD have met several times and discussed the above listed problems. The following initiatives were agreed upon as a way to help reduce abusive practices:

1. **Registry:** SIRS and Provider Enrollment will be requiring all PCAs to enroll and be given an individual provider number. The PCPO will be required to report on the claim to DHS who the actual PCA is that provided the service. SIRS will then be able to identify the individual PCA that reportedly provided the service, which agencies they work for, and how many hours they reportedly worked. This will further allow SIRS to better monitor hours billed to DHS.

2. **Certification of Medical Necessity for PCA Services:** DHS will require that before PCA services can be performed and billed to the department the PCPO must be in possession of a signed certificate authorizing such service. The certificate must be completed and signed by the client's treating medical professional. The medical professional must attest to the fact under MN Rules 9505.0174, subpart 25, and 9505.0355 that the PCA service is medically necessary. The certification must be kept in the client's file and renewed annually. Failure to have a current certification on file may lead to the recovery by DHS of funds paid to the organization for the PCA services.

3. **Background Checks:** The PCPO must have submitted a background check for each person employed by them as a PCA prior to performing any services. Provider Enrollment will not issue an individual PCA provider number until they know a background check has been completed.

4. **Correct Billing and Charting Procedures:** DSD is exploring PCA training in the area of patient care. SIRS and Provider Relations will be exploring PCA and PCPO training in the areas of required documentation and billing procedures.

Appendix J

Example of a Working Document from a Health Care Expert Panel Meeting February 24, 2004

DHS Health Services Expert Panel Meeting, 2-24-04
Summary of Panel Input on Strategies for the Non-disabled

What to Cover
Strategy #1: Avoid coverage of treatment that is always ineffective.

- *Yes, this does happen. For example: single vessel CABGs, Swanz-Ganz catheters*
- *Plans don't ask this question – they only ask whether new technology should be covered*
- *Plans use a pretty low bar when deciding what treatments to discover*
- *The FDA relies on very limited research when deciding to approve new medical devices*
- *Plans need help from DHS to make politically difficult decisions to not cover services*

Strategy #2: Cover new services that will reduce overall costs.

- *Covering phone calls and e-mail makes sense only in a capitated environment*
- *Coverage of non-physician education is intuitively attractive and consistent with disease management approaches*
- *Would make sense for smoking cessation, obesity, exercise; could work well for group visits*
- *Partner with volunteer health organizations*

Strategy #3: Better define covered services so as to improve third party liability (TPL) collection

- *Not discussed by expert panel*

Strategy #4: Support infrastructure development that will result in improved care statewide.

- *Create a commonly accessed, web-based, electronic medical record (long-term)*
- *Support use of a smart card (short-term)*

Strategy #5: Apply cost/benefit testing to decide which services to cover for which conditions.

- *There are significant cost savings for DHS in pharmacy if it adopts the practices that have been pursued by the insurers.*

When to Cover
Strategy #1: Avoid coverage of services when medical evidence does not support their appropriateness.

- *A viable strategy, but plans will need DHS to help back them up ("we'd like to have support to put structure back in") to re-institute prior approval procedures*
- *Need a joint DHS-HMO medical policy committee*

- *Plans are currently influenced by DHS' general practice of covering everything)*
- *An easy strategy with pharmacy*
- *There is a risk of providers rebelling*
- *Examples of overused services: PCAs, UPPP instead of CPAP for sleep apnea, ER visits*
- *Alternative to re-instituting prior approval: reimburse providers less for inappropriate/overused services*

How to Cover

Strategy #1: Better support the needs of the chronically ill through special care management programs.

- *If pursuing disease management (DM), be careful and prudent and have modest expectations*
- *Needs to be tailored for DHS' populations: "it's not about doing it, it's about doing it right"*
- *Already being done for PMAP*
- *Prefer building DM capacity through provider organizations rather than contracting with external vendors*
- *Believe CHF is an excellent candidate for DM*

Strategy #2: Anticipate and then intercede with those who will be at high risk.

- *Some limited expression of interest*

Strategy #3: Guide consumers to higher value care using information and incentives.

- *Believe that the economics of this strategy don't work since DHS is a poor payer and additional patient volume would not be viewed as desirable by providers*

Other Stakeholder Suggestions

- *Address problems with continuity of eligibility*
- *Coordinate statewide immunization registries*
- *Support providers and plans to address cultural, language, and ethnic issues in treatment*

Recommendations

- *Identify cost drivers in DHS' populations*
- *Develop a medical management plan and a medical policy committee*
- *Work with health plans to develop criteria to address overuse and waste*
- *Disease management and "StatusOne" approach*
- *Cover non-physician patient education, ER triage*

Appendix K

The following pages are an example of a

Working Document from a
Stakeholder Meeting on
Potential Coverage Strategies for the Elderly
July 13, 2004

DHS Health Care Services Study: *Potential Coverage Strategies for the Elderly*

Michael Bailit
Bailit Health Purchasing, LLC
July 13, 2004

Recap: Goals of the Study

- Identify where cost savings can be realized in MA, GAMC, and MNCare. We are considering:
  - What to cover (e.g., perhaps eliminate services that add little value to members' health)?
  - When to cover (e.g., perhaps require trial of less expensive alternatives before approving a more expensive service)?
  - How to cover (e.g., perhaps use new care models to maximize effectiveness of services)?

2

Study Efforts to Date

- Concluded series of meetings held January to March on strategies when considering the *non-disabled population*.
- Concluded series of meetings held May to June on strategies when considering the *disabled population*.
  - One more meeting focused on gathering consumer input to be scheduled for August.
- Began meetings in June on strategies when considering the *elderly population*. Process concludes in August.

3

Profile of DHS' Programs for the Elderly

4

What to Cover

1. Cover falls assessment or more general home safety assessments for senior consumers dwelling within the community.
2. Support greater use of telemedicine in rural areas and reduce unnecessary medical transportation costs.
3. Provide MSHO and MNDO coverage for pre-duals to avert nursing home admissions.

5

When to Cover

1. Limit the amount of case management provided when homemaker services are the only other service provided.
2. Develop clear policy direction regarding when to cover PCA, Assisted Living, and Assisted Living Plus services.
3. Move to a more objectively scored screening tool.

6

When to Cover

4. Create a formula that counties must use to build the budget amount for an individual consumer based on the consumer's specific needs.

   The budget will apply when developing a monthly payment rate for a group of services provided by one provider in a licensed setting.

   The formula should use DHS-defined unit rates.

7

When to Cover

5. Implement scheduled screenings for persons over age 65 closely following nursing facility admission (e.g., at one month and at two months) to reassess the need for nursing facility level of care and create criteria for expected discharge.
6. Create a state review team to review all nursing home admissions.

8

When to Cover

7. Create an audit process to catch consumer fraud whereby consumer homes would be visited unannounced.
8. Maximize Medicare and other party coverage for home health.
   - current strategy not effective

9

How to Cover

1. DHS assumes responsibility for county service contracting through either direct purchasing (e.g., current provider enrollment process) or brokered purchasing.
2. Regionalize certain county functions, e.g., licensing, contract management, transportation, information systems (this could be at state level), service oversight.

10

How to Cover

3. Adjust financial incentives by assigning some financial risk to counties for both nursing facilities and community-based services.
4. Enroll remaining seniors into managed care by finding a way to enroll "spend downs."

11

How to Cover

5. Explore daily payment limits for services delivered in one hour or 15 minutes increments.
6. Tie case management payment rates to intensity of consumer need. *(Tie to larger issue of When to Cover)*
7. Examine the net financial impact of pharmacy co-payments to the elderly, and the possible reduction in Rx compliance as a result of the co-payments.

12

How to Cover

8. Collaborate more closely with the Medicare QIO to encourage it to address risk factors that impact DHS cost (e.g., fall prevention).
9. Support efforts to improve palliative, or end-of-life, care in hospitals, consistent with the work of the MN Partnership for End-of-Life Care (e.g., modify the state guardianship law to support greater flexibility in end-of-life care).

13

How to Cover

10. Create incentives to use the consumer-directed community supports and reduce the per-person cap in exchange for increased flexibility.
11. Address problems related to polypharmacy for elders residing in the community or in non-licensed facilities (e.g., board and lodging, assisted living).

14

How to Cover

12. Make better use of community services to prevent or delay the need for nursing facility admission.
13. Require counties to compete for case management contracts.
14. Disallow counties from providing case management *and* home and community-based services.

15

How to Cover

15. Remove the requirement that counties contract with every provider and tighten some DHS provider enrollment requirements to balance the removal of the contracting requirement.

16

How to Cover

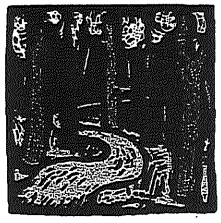
16. Create reportable performance standards for counties re: eligibility determination and case management (e.g., maximum case management workload limits) and create a report card to assess county performance.

    Also – create incentives for counties re: use of low-cost HCBS and county-wide availability of such services.

17

Next Steps

- Staff to work on strategies with the most promise.
- Specificity will be added as necessary, and cost savings estimated.
- Expert Panel to reconvene in the fall to review final draft strategies.



18

Key Contacts

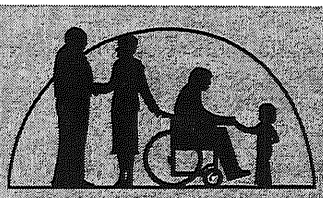
- Michael Bailit
  mbailit@bailit-health.com
  781-237-5111
- Tom Fields
  tom.fields@state.mn.us
  651-297-7303

19

Appendix L

Cost of Preparation of this Report

Contract, Bailit Health Purchasing, LLP	$127,401
Staff salaries, DHS	$ 34,358
	$161,759



Minnesota Department of
Human Services

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

EXECUTIVE SUMMARY

of the
Health Care Services Study: Findings and Strategies for Savings

Report to the Legislature
January 2005

Copies of the full report can be printed from the DHS Web site, www.dhs.state.mn.us/healthcare/studies.

DHS-4357-ENG (1/05)

Executive Summary

Nationwide, Medicaid budgets are rapidly eating up a larger portion of state spending. The National Association of State Budget Officers predicted that state Medicaid spending would for the first time surpass spending on elementary and secondary education in FY 2004. While this has not occurred in Minnesota, increases in health care spending in recent years suggest the state is headed in that direction.

A collision of numerous factors has produced unsustainable cost growth in publicly funded health care programs. Spending in Minnesota Health Care Programs (Medical Assistance, General Assistance Medical Care and MinnesotaCare) is projected to increase $1.4 billion from the 2004-05 biennium to $6.567 billion in the 2006-07 biennium.

Like many other states, Minnesota's short-term solutions have included limiting enrollment, increasing cost sharing, reducing coverage and reducing provider payment rates.

The 2003 Minnesota Legislature sought a longer term solution through a rigorous review of Minnesota Health Care Programs' (MHCP) comprehensive benefit package. Lawmakers directed the Minnesota Department of Human Services (DHS) to recommend covered services that could be eliminated from the state's public programs.

Upon further consideration, legislative leaders agreed to expand the scope of the exercise to consider what services should be covered, under what conditions, and how they should be provided. This approach offered greater opportunity to identify strategies that could produce long-term positive impacts on both the budget and program enrollees' health status.

DHS hired Bailit Health Purchasing, LLC (Bailit) to assist with the study, titled the Health Care Services Study. The 14-month process included research on multiple fronts as well as numerous meetings with stakeholders.

Input was solicited locally from consumers and providers as well as state Medicaid directors and health cost experts across the nation. Some ideas gave rise to contentious discussions.

The strategies resulting from the Health Care Services Study will not be universally embraced. Yet each warrants serious consideration. Many hold significant potential for lowering the trajectory of long-term cost growth. And equally important, these same strategies offer new means for improving program integrity and quality.

The strategies are presented in the report in three categories:

- Three strategies for which DHS has developed implementation plans and savings estimates

- Nine strategies for which DHS has not developed implementation plans or savings estimates, but which hold significant promise for savings
- Additional strategies that could not be fully researched, but which warrant serious consideration for future exploration (see full report for these strategies.)

In some cases, relatively modest initial savings are projected to grow considerably over time.

For the savings determined by DHS, the standard legislative fiscal note process was used. In other instances, the strategy has not been converted to a detailed implementation plan and proposal, including any necessary changes to state law. In these instances, Bailit estimated potential savings based on his research of the issues from a national perspective.

Strategies for which DHS has Developed Implementation Plans and Savings Estimates

1. Evidence-based Decision Making for Benefits Coverage Policy

The question of what services to cover and when is one of increasing interest nationally as greater attention is given to using research to support coverage policy. This approach is commonly referred to as "evidence-based medicine," defined in recent literature as:

> ... a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.

Research literature is replete with examples of inappropriate service delivery. Certain services that research finds to be effective in specified circumstances are being delivered in situations when the services are *not* effective.

Minnesota likely spends a significant amount of money, perhaps in the tens of millions of dollars, providing services that are not effective, or are not the most cost-effective option.

The state should implement an integrated approach to evidence-based decision making for benefits coverage policy to reduce these unnecessary expenditures. This approach should include three components: hiring a medical director for benefits policy, creating a Medical Policy Council, and participating in a multi-state Medicaid Evidence-based Practice Center.

Implementing an evidence-based benefits coverage process would require careful deliberation, sufficient resources, and persistence.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	$832,000	$1.9 million	$2.816 million	$3.793 million

2. Increase Pharmacy Savings

Minnesota's fee-for-service Medicaid program experienced double-digit increases in pharmacy costs (net of rebates) during calendar years 2001 through 2003. Minnesota, like other states, has been increasingly aggressive in implementing pharmacy management programs to control costs while continuing to provide clinically appropriate pharmacy coverage.

While important steps have been taken by the state, additional initiatives are possible. Specifically, the state should:

- reduce the reimbursement rate for retail pharmacies
- require beneficiaries with hemophilia to obtain blood factor products through a 340B hemophilia treatment center, and
- contract with specialty pharmacies to be exclusive providers of particular specialty pharmacy drugs.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	$5.3 million	$4.3 million	$4.7 million	$5.1 million

The cost savings for the specialty pharmacy initiative would continue to grow as the use of specialty pharmacy drugs increases.

3. Implement Intensive Medical Care Management for the Chronically Ill in Fee-for-Service Medical Assistance

There is a distinct "highest-risk" segment within the population of high-cost Medicaid enrollees. These are typically characterized as individuals at risk of hospitalization within a year's time. Highest-risk individuals often comprise 1 to 3 percent or less of the total population, but account for up to 25 percent of all acute care costs. Typically, people in this group suffer from more than one chronic medical condition and have confusing psychosocial issues.

Highest-risk enrollees are often not identified through traditional high-cost case management, county case management, or disease management programs because they

are often isolated from the community and disconnected from primary care within the health care system.

The state should contract with an experienced vendor to administer a program that identifies highest-risk individuals and provides intensive outreach and support to them. Research with similar programs for people who have private insurance reveals a savings of three dollars for each dollar invested. Managed care organizations (MCOs) serving Medicaid enrollees in other states also report positive results.

The state should collaborate with contracted MCOs to learn from their experience with similar programs, both to inform the fee-for-service program, and to promote performance improvement across MCOs.

DHS estimates net state savings from this approach to be:

State fiscal year	2006	2007	2008	2009
Estimated net state savings (excluding federal funds)	*Cost* of $337,500	$225,000	$225,000	$225,000

Strategies for which DHS has Not Developed Implementation Plans or Savings Estimates, but which Hold Significant Promise for Savings

1. Expand Managed Care for People with Disabilities

An increase in both enrollment and costs attributable to people with disabilities demands that the state rethink how well this population is being served. Between 2000 and 2004, the number of enrollees with disabilities increased 27.6 percent. During the same time period, the relative per capita cost increased 34.2 percent for this population. It is worth noting that these rates of enrollment and cost increases are double that of the elderly population in public programs.

People with disabilities are the only large group that Minnesota exempts from managed care enrollment. Limited research indicates that people with disabilities, including those with physical disabilities, mental illness, or developmental disabilities, can be better and more efficiently served through appropriately designed managed care programs.

The state should begin a multi-year process to transition enrollees with disabilities into managed care. Specifically, beginning January 1, 2007, the state should start providing basic health care (i.e., non-continuing care) to enrollees with disabilities in the metro

counties through a managed care approach. Continuing care services should be phased in at a future date, with possible geographic expansion as well. The program could be delivered through contracted managed care organizations, a state-operated managed care plan, or both. It could be either voluntary or mandatory for enrollees. The state should not require MCO involvement, but focus instead on those MCOs willing to develop the specialty skills and provider networks necessary for serving people with disabilities.

In addition, the state should expand its Minnesota Disability Health Options (MnDHO) program, which currently serves only metro area residents with physical disabilities. The program should be expanded to serve people with other kinds of disabilities and additional geographic areas.

DHS estimates that initial year savings from this strategy would be more than offset by the cost of moving from fee-for-service to capitation, due to the timing of payments. Any savings in future years would be dependent on the ability of the MCOs to manage medical expenses. The Department's estimates are based on the state's experience with health care purchasing in Minnesota, as well as the federal requirement that Medicaid capitated payments be actuarially sound.

Bailit estimates that the state could save from 1 to 4 percent after the initial year. His estimates are based on reported rates of saving achieved by other states' managed care programs for people with disabilities.

2. Improve Training, Oversight and Investigation of the PCA Program

Cost growth in the Personal Care Assistance (PCA) services, both in fee-for-service and managed care, has attracted significant attention. Some stakeholders allege that services are being used inappropriately. In addition, there have been findings of fraud. Overall, concerns pertain to both how people qualify for PCA services and how the benefit is administered.

The state can obtain significant savings from the PCA program through closer oversight and better training.

Specifically, training and program information should be improved for provider agencies and direct care workers, for nurses who perform PCA needs assessments, for physicians who prescribe PCA, and for the enrollees who receive it. The state should improve oversight of the program by enhancing the Department's capacity to investigate potential fraud and abuse by hiring additional investigative staff, by completing work on the provider registry and developing an improved PCA provider enrollment process that assures better tracking of individuals and agencies providing this service, and developing new provider credentialing requirements.

These cost-savings strategies are designed to preserve the program's benefits for the thousands of enrollees who depend on PCA as an integral part of their care plan.

3. Help County Health and Human Services Programs Collaborate

The state currently delegates management of service delivery for a large portion of its health care budget to the counties. The need to work with 87 separate counties represents one of the greatest challenges to improved accountability and performance. It also creates considerable demands for counties, and problems of equity for enrollees.

Currently, DHS is able to exercise only limited oversight and control over services and administrative functions that significantly impact enrollee outcomes and state expenditures. The problem is a result of poor structural design that makes it difficult for DHS or the counties to excel.

Increased county collaboration on the delivery of health and human services would be an important first step to improve performance and achieve efficiencies. The state should pursue efforts to help counties collaborate. Ultimately, this may result in regionalization of these functions. The state should work cooperatively with counties and the Association of Minnesota Counties to explore and pursue collaboration opportunities.

4. Improve MCO Contract Management

The state should implement a strategically focused, senior manager-led, contract management approach to working with its MCO vendors. In so doing, the state would create sufficient management systems to ensure accountability for performance that both meets state expectations and continuously improves. In addition, DHS should improve its existing relationship with contracted MCOs that is marked too much by confrontation and conflict, and too little by collaboration and joint problem solving.

DHS has begun implementing a strategically focused contract management approach to work with its MCO vendors, described in the full report. This approach has worked elsewhere in the United States and would support state efforts to maximize the performance of contracted MCO programs.

5. Improve County Partnership and Performance Management

Minnesota counties, to a large degree, manage the $2.465 billion (FY04) continuing care system (with the exception of nursing facility rate setting). Included in this responsibility is the allocation of much of those funds.

While the state and counties have a special partnership relationship, the state should apply some of the same contract management techniques with county entities as suggested above for its relationship with contracted MCOs. The collaboration and possible consolidation of county health and human service functions across counties would make this management process more effective for the state.

6. Pilot and Evaluate Disease Management

The state should pursue a two-pronged approach to evaluate the potential for disease management (DM) to improve quality of care and reduce health care costs associated with chronic illness.

First, the state should implement a DM pilot for the fee-for-service Medical Assistance population, and include a rigorous process for independent program evaluation by a party other than the DM contractor or its affiliates.

Second, the state should work cooperatively with its contracted MCOs to:

- review the varied approaches that vendors have taken to implement DM
- compare those approaches to best practice standards and accreditation standards for DM programs
- review MCO self-evaluations of DM program clinical and cost effectiveness for Medical Assistance enrollees, and
- meet with MCOs to learn first hand their experiences with DM and the Medical Assistance enrollee.

7. Divert and Reduce the Length of Nursing Facility Stays

Building on past work supporting long-term care alternatives for Minnesotans, the state should pilot two strategies designed to further reduce avoidable nursing facility utilization.

The first strategy places county-based Long Term Care Consultants (LTCCs) in hospitals and geriatric clinics to inform consumers and their family members of long-term care alternatives at the point when they are contemplating a nursing facility admission.

The second strategy funds assessment workers and independent care planning for consumers choosing to leave a nursing facility within a set timeframe, e.g., 120 days.

8. Improve County Case Management for the Home and Community-Based Waivers

Stakeholders often cited case management for home and community based waiver services for elderly and people with disabilities as a problematic area with potential for both service improvement and cost savings. The most pressing case management problems stakeholders and DHS staff identified are:

- unclear definitions and standards
- redundancy
- fragmented administration.

To address these issues, a first step towards program improvement should be to pursue the recommendation made in a 2003 DHS report to the Legislature on case management

and promptly define program parameters in clear operational terms that are well understood by state, county, and provider staff, as well as by consumers, their families, and advocacy organizations.

In addition, the state should eliminate duplication of case management services so that the structure of case management is dictated by the consumer's needs and not by case management financing streams.

Finally, the state should establish and provide training on statewide standards for all case managers, and enforce compliance.

9. Support Efforts to Expand Use and Connectivity of EMRs

There is national consensus that electronic medical records (EMRs) hold great promise for reducing redundancy of testing, eliminating medication errors, preventing adverse medical events, and increasing the efficiency of medical practice in both office and institutional settings.

Minnesota has begun to address this opportunity through the creation of the Minnesota e-Health Initiative. DHS is currently a participant in this Minnesota Department of Health-led effort.

The two agencies should continue to work together, accessing available federal grant funds to support the initiative. In addition, the state should target increasing EMR accessibility for rural practices and clinics and for continuing care providers, and should actively improve and promote connectivity and interoperability with Minnesota providers and among Minnesota providers.

Conclusion

This report identifies a range of strategies to yield additional savings and improve health care program services for program enrollees. The most viable of these strategies have helped form the basis for policy and budget proposals that will be presented to Legislature. Other strategies require more research, development and consultation with stakeholders and can be pursued over time.

Minnesota Department of **Human Services**

Minnesota Health Care Services Study

The Health Care Services Study was requested by the 2003 Legislature to identify potential cost savings for Minnesota Health Care Programs, for which spending is increasing at a significant rate. It identifies a number of strategies to improve the value of the Minnesota Health Care Programs. The study was conducted over 14 months and included input from enrollees, stakeholders, health care providers and national health care experts, and an independent review (by Bailit Health Purchasing) of the practice of covering health care services in Minnesota and other states.

The strategies are grouped into three categories – those for which savings estimates have been developed, those that need further development but have the potential for significant savings, and those that merit further exploration.

Copies of the Health Care Services Study report can be printed from the Department of Human Services (DHS) Web site at www.dhs.state.mn.us/healthcare/studies.

Strategies with implementation plans and savings estimates

Funding for the three strategies listed here is included in Governor Pawlenty's proposed FY 2006-2007 budget.

- **Evidence-based decision making.** This would apply research on clinical effectiveness in shaping coverage policy and reducing state spending for ineffective services. Implementation involves a state medical director, medical policy council and participation in a multi-state Medicaid evidence-based practice center.

- **Pharmacy savings.** Three initiatives would save pharmacy costs in the fee-for-service Medical Assistance (MA) program. They include contracting for specialty drugs, providing blood factor products for hemophiliacs through 340 treatment centers and reducing pharmacy reimbursement rates.

- **Intensive medical care management for the chronically ill.** People enrolled in the MA fee-for-program who are at high risk of hospitalization would be provided with intensive medical care management services. This is expected to reduce the medical expenses for this group, while improving access to quality health care and their health status.

Strategies that hold promise for savings

- **Expand managed care for people with disabilities.** People with physical disabilities, mental illness or developmental disabilities could be better and more efficiently served by appropriately designed managed care programs. DHS has put forth a legislative proposal to develop a planning process to

implement a managed care arrangement for providing MA covered services (excluding continuing care services) to these fee-for-service enrollees.

- **Improve training, oversight and investigation of the Personal Care Assistance (PCA) program.** Closer state oversight, better training and enhanced program integrity efforts could produce additional state savings for this program.

- **Help county health and human services programs collaborate.** Increased collaboration among counties could improve performance and efficiencies in the delivery of health and human services.

- **Improve managed care organization (MCO) contract management.** A strategically focused approach to working with MCOs would ensure and improve performance accountability with these providers.

- **Improve county partnership and performance management.** Strategic contract management efforts would also help counties, which are responsible for providing continuing care services.

- **Pilot disease management.** A pilot for MA fee-for-service could evaluate the potential for disease management to improve the quality of care and reduce costs for people with chronic illnesses.

- **Divert and reduce nursing home stays.** Two pilot efforts could test strategies to reduce avoidable nursing home stays. They include placing long term care consultants in hospitals and geriatric clinics and funding assessment worker and independent care planning for people leaving nursing homes within a set timeframe.

- **Improve case management for home and community based waivers.** Pursuing recommendations in a 2003 DHS legislative report could improve these services for people with disabilities and elderly.

- **Support electronic medical records (EMR).** EMR hold great promise to reduce redundant testing, eliminate medical errors and increase efficiency. Minnesota has begun to address this through a Department of Health-led effort.