



Minnesota Department of
Human Services

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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.

Report to the Legislature

Financial Management of Health Care Programs

Laws of Minnesota 2008
chapter 364, section 11

February 2009

History of DHS Health Care Services Study

The 2003 Legislature requested the Minnesota Department of Human Services (DHS) to complete a report which would identify potential cost savings for publicly funded health care programs. The impetus for the report was the significant increase in spending in Minnesota Health Care Programs (MHCP). DHS contracted with Bailit Health Purchasing, LCC to assist with the study.

In mandating this study, the legislature also requested that the report include a consideration of 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 program budget and enrollees' health status. The study took 14 months to complete. The findings from the study were compiled into a report, entitled the "Health Care Services Study."

Input for this report came from a number of sources: enrollees, stakeholders, health care providers, national health care experts, and state Medicaid directors from across the nation. Some of the ideas presented were contentious. In the final report, Bailit acknowledged that not all of the recommended strategies would be universally embraced. However, Bailit felt that each idea warranted serious consideration, so all were included in the final report.

In developing the report, Bailit divided the recommendations into three categories: (1) those for which savings have been developed; (2) those that require further development, but have the potential for significant savings; and (3) those that merit further exploration.

The first category was comprised of three strategies, all of which were included in the Governor's proposed budget for fiscal years 2006-2007. These three strategies included a move toward evidence-based decision making, changes in pharmacy reimbursement policies, and the provision of intensive medical care management services for chronically ill individuals who are enrolled in the Medical Assistance (MA) fee-for-service program.

The remaining recommendations were not adopted by the legislature or DHS. It should be noted that there was an acknowledgement in the report that more research, development, and consultation with stakeholders should be pursued over time. Furthermore, in the report summary, Bailit indicated that some of the suggested strategies would not yield any savings, but were included to set the stage for Minnesota to provide care more efficiently and effectively to MHCP enrollees in the future.

Legislative Report on Financial Management of Health Care Programs

Pursuant to Minnesota Laws of 2008, Chapter 364, Section 11, Report on Financial Management of Health Care Programs, the Department of Human Services is required to report to the Legislature information regarding the financial management of health care programs. Specifically DHS is required to report on:

(1) a status report on implementation of the cost containment strategies identified in the 2005 "Strategies for Savings" report:

The following information provides an update on the twelve high-level strategies in this report. The update includes subsequent action taken on each strategy.

1. Evidence-based Decision Making for Benefits Coverage Policy

- a. Hire a Medical Director*
- b. Create a Medical Policy Council*
- c. Support and Participate in a New Evidence-Based Research Collaborative*

Jeff Schiff, M.D., M.B.A. was hired as Medical Director for MHCP in the summer of 2006. In addition to providing clinical leadership and engaging with external stakeholders, Dr. Schiff has spearheaded DHS' efforts to develop evidence-based coverage policy by serving as a non-voting member of the DHS Health Services Advisory Council (HSAC), and providing oversight of DHS' existing pharmacy committees.

The DHS Health Services Advisory Council (HSAC) began meeting in July of 2006. HSAC meets nine times per year and is composed of ten physicians (including health plan medical directors), two allied health professionals, and one consumer representative. The Council advises the Department on evidence-based benefits and coverage policy, reviews the evidence, and recommends detailed policy for specific services. Guided by efficacy, safety, and value, HSAC evaluates new and established technologies and health care procedures (excluding pharmacy) to ensure that coverage policy in the MHCP reflects the best available evidence. Sources of evidence are evaluated according to their methodological rigor, and include information from peer-reviewed journals, a Medicaid-focused research collaborative (see below), health technology assessment organizations, and guideline developers. Approximately 25 health services have been evaluated by HSAC since its inception; examples include spinal fusion surgery, arthroscopic debridement of the knee, coronary CT angiography, and implantable spinal cord stimulation for chronic pain. System implementation of the clinical criteria continues and processes to streamline implementation are under development.

DHS has been a member of the Medicaid Evidence-based Decision (MED) Project at Oregon Health & Science University (OHSU) since its inception. The MED Project

pools the resources of 12 state Medicaid agencies to produce high-quality, policy-relevant evidence reviews. MED Project materials have formed the backbone of a number of the evidence summaries reviewed by HSAC and the coverage policies that resulted, including genetic testing for breast and ovarian cancer susceptibility, therapies for chronic low back pain, and high-tech diagnostic imaging topics. Membership in the collaborative affords Dr. Schiff and DHS staff the valuable opportunity to work collaboratively on evidence-based coverage policy issues with Medicaid colleagues from around the country, applying the evidence to the unique needs of Medicaid populations.

Additionally, DHS as a purchaser of health care services now works actively with other purchasers on common delivery initiatives. These include the ICSI High Tech Diagnostic Imaging program and the DIAMOND, depression assessment and treatment in primary care program. In these evidence based initiatives DHS staff serve to advance best practice in implementation of evidence based medicine.

2. Increase Pharmacy Savings

- a. *Require beneficiaries with hemophilia to obtain blood factor products through a 340B hemophilia treatment center*
- b. *Contract with specialty pharmacies to be exclusive providers of particular specialty pharmacy drug.*
- c. *Reduce the reimbursement rate for retail pharmacies to AWP -14% + \$3.65 dispensing fee*

In 2005, as requested by the Minnesota legislature, the Department of Human Services (DHS) developed the *2005 Strategies for Savings* report, which identified potential cost savings initiatives. The fee-for-service pharmacy division recommended three strategies, estimated to save an average of \$5 million annually. The complete implementation of the pharmacy strategies was not approved by the Minnesota legislature.

The first recommendation would have required recipients with hemophilia purchase their blood factor products through 340B providers. The 2005 legislature turned down this proposal, choosing to allow any-willing-provider to provide these products. The state legislature did approve a DHS request that the reimbursement rate for these products be reduced from Average Wholesale Price (AWP)-12% to AWP-30%. This cost saving measure is in place saving an estimated \$5 million dollars annually.

Second, DHS recommended that the state contract with a specialty pharmacy provider to obtain better pricing and services potentially available through these organizations. The 2005 legislature turned down this request, again favoring any-willing-provider access. The legislature approved a DHS request that decreased the reimbursement rate for specialty products from AWP-12% to AWP- (14% to 17%). This cost saving measure is in place saving an estimated \$500,000 annually.

Third, DHS recommended a reduction in the state's retail pharmacy reimbursement rate from AWP-11.5% to AWP-14%. The 2005 legislature allowed a decrease from

AWP-11.5% to AWP-12% and the 2008 legislature allowed a decrease to AWP -14%. The current rate has been in effect since July 1, 2008.

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

- a. *The state should competitively procure from and contract with an experienced vendor for these services*
- b. *Customize the program to meet enrollees' needs*
- c. *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*

There has been significant progress in this area since the report was written. The Department has initiated a number of programs, some using an outside vendor, and some which will be directly with the currently enrolled providers. These four approaches are detailed below:

Intensive Care Coordination

In July, 2007, DHS entered into a contract with AXIS Healthcare for the purpose of developing an Intensive Care Coordination (ICC) program. The goals of the contract are two-fold: 1) develop a predictive modeling capacity that will enable the state to identify fee-for-service recipients of the MA program who are at high risk of future medical costs, and 2) develop effective models of intensive care coordination services that assist recipients to obtain better health outcomes. Although the predictive model is not fully developed, a subset of recipients has been chosen for participation. Enrollment into the program has begun. The department is currently evaluating the efficacy of this program.

Primary Care Coordination

In 2007, the legislature enacted legislation authorizing the creation of "Provider-directed Care Coordination", now known as Primary Care Coordination (PCC). After considerable work, the department was granted approval in January of 2009 from Center for Medicare and Medicaid Services (CMS) to receive federal financial participation for the program. This CMS approval represents the first known federal approval for a care coordination payment for services occurring over a time interval and based on the actual cost of service provision. The department is planning to institute the program at the completion of the systems work in the summer of 2009.

PCC will be a pre-cursor to the Health Care Home services (see below). Initially, PCC will serve the department's fee-for-service clients with chronic and complex medical conditions. This program requires primary care clinics to meet criteria including the capacity to develop care plans, designate a dedicated care coordinator, have an adequate number of fee-for-service clients, and have evaluations and quality improvement mechanisms to qualify for reimbursement. The clinic also has to have 24/7 access and arrange for patients' comprehensive care needs as well as specialty care.

Care Coordination Grants

2007 legislation also provided funding for four care coordination pilot projects. The grantees include a primary care clinic for clients with physical disabilities (Courage Center), a primary care clinic-based system for children with autism (University of MN/Fairview), a project that will identify, recruit and assist clinic sites that will service as Primary Care Clinics to clients with complex needs (Minnesota Academy of Pediatrics/Minnesota Academy of Family Physicians), and a project that will build medical home infrastructure in 12 clinic sites (Neighborhood Health Care Network).

DHS has not had the staffing available in order to collaborate with MCO's to learn about their experience with similar programs. DHS staff did meet with one health plan to learn about their phone-based care coordination program. Phone based programs are being used in a number of MCO's. The effectiveness of using this method may be questionable considering the population served by public programs.

Health Care Reform Act

Along with the Minnesota Department of Health, DHS is very involved in the development and implementation of health care home certification standards that include using personal clinicians, focusing on delivering high quality and efficient health care, encouraging patient-centered care, providing patients with consistent and ongoing access, developing comprehensive care plans, incorporating quality improvement measure, and using information technology. Certified health care homes must offer health care home services to interested patients with chronic and complex health conditions, must participate in a health care home learning collaborative and must meet all reporting requirements. Certification must be renewed annually. This process has involved the department in a number of important collaborations with Minnesota health plans, who will be responsible for paying for these certified services.

4. Expand Managed Care for People with Disabilities

- a. *Beginning in January 2007, the state should start transitioning enrollees with disabilities from FFS into managed care*
- b. *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.*
- c. *The state should expand MnDHO to serve people with other kinds of disabilities (other than those with physical disabilities).*
- d. *MnDHO should be expanded geographically to the extent that interested providers can be identified.*

Implementation of the Medicare Part D prescription drug benefit had a significant impact on Minnesotans who were dually eligible for Medicare and Medicaid (Medical Assistance). In Minnesota, dual eligibles are primarily seniors and disabled adults. These individuals had previously been able to access their prescription drugs through the state's MA program. Implementation of Part D required that they enroll in a Medicare Prescription drug program. For many people, this resulted in difficulty accessing their

normal drug regime, fragmentation of care and conflicting requirements for service authorization and appeals.

Dually eligible seniors enrolled in managed care had the option of enrolling in Minnesota Senior Health Option (MSHO), which allowed them to access their Medicare, MA, and Part D prescription coverage through a single plan. Although there were some difficulties in the implementation phase, MSHO seniors experienced fewer disruptions than individuals on fee-for-service. One result of this implementation was to increase interest in managed care arrangements for dually eligible persons with disabilities that would offer similar integration of benefits. During 2006 and 2007, DHS worked with consumers, advocates and other stakeholders to develop an appropriate managed care arrangement. The new program covers basic health care services with the exception of personal care attendants (PCA) and private duty nursing (PDN).

In January 2008, DHS implemented an innovative new integrated Medicare and Medicaid managed care program for people with disabilities, Special Needs BasicCare (SNBC), offered by seven Medicare Advantage Special Needs Plans (MA-SNPs) in 83 counties. SNBC is one of only a handful of integrated Medicare and Medicaid managed care programs in the nation designed especially for people with disabilities on MA. Enrollment in SNBC is voluntary. Individuals ages 18-64 that are dually eligible for both Medicare and Medicaid can enroll as well as those only eligible for MA. Enrollment reached 2,800 in December 2008.

Contracting with MA-SNPs simplifies access to all Medicaid and Medicare drugs through one health plan instead of through three separate sources (Medicaid, Medicare fee-for-service and Medicare Part D plans) as is typical for people served through fee-for-service. Medicare and Medicaid enrollment and member materials are also integrated to make it simpler for members. SNBC provides initial risk screening and assessment and facilitation of annual physician visits to improve access to primary and preventive care. All of the participating plans also provide individualized navigation or care coordination assistance to members as well as some additional Medicare benefits such as access to fitness programs. SNBC plans have also elected to cover MA co-pays for all members at their own cost. Rates are risk adjusted using the Chronic Disability Payment System (CDPS) which is designed to reflect variations in diagnoses and costs of care among various groups of people with disabilities.

5. Improve Training, Oversight, and Investigation Processes in the PCA Program

- a. Increase training opportunities for public health nurses*
- b. Increase the training opportunities for PCAs*
- c. Increase the training opportunities for enrollees using PCA services*
- d. Develop a new enrollment contracting process and establish performance requirements for PCA agencies*
- e. Provide better information to physicians who prescribe PCA services*
- f. Institute a registry of individual PCAs*

- g. Develop new credentialing requirements for PCAs and Agencies*
- h. Increase and strengthen the department's capacity to investigate PCA fraud and abuse*

The recommendations for improving training, oversight and investigation processes in the PCA program were not adopted or funded by the legislature. A significant investment of resources would be necessary to fully implement as recommended.

A number of actions have been taken to address training related to the PCA program, such as:

- Regular training and additional technical assistance sessions with public health nurses who assess for PCA services are available statewide;
- Three day training, Steps for Success, was initiated for PCA provider agencies that cover program outcomes, policies, and administrative procedures. Included in the training are video clips demonstrating the role of the PCA in assisting someone in their home. It is offered monthly to providers, and has been deemed by those attending to be an informative and a valuable training;
- A manual for enrollees using PCA services was developed; and
- Physician training was provided around the state to provide better information about the PCA program.

The Minnesota Department of Health (MDH) is taking the lead, with participation from DHS, to develop recommendations for licensure, or other strategies, to assure that PCA agencies and individual PCAs are qualified to provide these services.

On April 28, 2006 MHCP sent Provider Update PCA-06-02 announcing the requirement of the Physician Statement of Need (PSON) (DHS-4690) to PCA provider agencies, counties, managed care organizations and Physicians. The update included the purpose of the form and the responsibilities for both the PCA Provider Agency and the Physicians. The form was revised and announced in Provider Update PCA-07-02 which provided further direction. MHCP continues to offer information and education about the purpose, responsibilities and completion of the PSON through the ongoing Steps for Success for PCA Provider Agencies, training workshops. Both PCA provider agencies and Physicians or Nurse Practitioners have and are welcome to attend the workshops, in efforts to better understand the PCA program and each of their responsibilities as providers and through the evaluation process have been able to gain better understanding for the need of the form as well as offer suggestions for continued improvement in providing even greater clarifications. Feedback from these workshops has resulted in MHCP being aware of and acknowledging the issues identified by the agencies and Physicians regarding the PSON. MHCP continues its work in collaboration with DSD, to standardize communications with Physicians when the PSON is received by DHS; and also in the development of more proficient navigation from the Physician's section of the MHCP provider manual to the clarified information specific to the purpose and completion of the PSON.

DHS Provider Enrollment began enrolling Individual PCAs in June, 2005. DHS implemented the requirement of identifying the individual PCA identification number on the claim form in March, 2006. As of May, 2006, DHS denies payment on PCA claims without a PCA identified as the treating provider. As of April, 2008, claims are denied when the treating PCA on the claim is not affiliated with the PCA organization on the pay-to line of the claim. (Affiliation is established when a PCA organization submits an application for enrollment for a PCA who may or may not already be enrolled.)

DHS has strengthened the Department's oversight of PCAs by adding key edits such as all billing must identify individual services by date and by the end of 2008 an edit will be installed that prohibits billing more than 24 hours/day by individual PCAs. DHS has not received any additional resources or staff to expand oversight or investigations of PCAs.

The Department established a home care advisory committee, which provided recommendations to the Department for home care reform, especially PCA program integrity. The report will be available by January 15, 2008.

6. Help County Health and Human Services Programs Collaborate

- a. Facilitate collaboration among counties regarding administration of health and human service functions on a phased basis over five years*
- b. Work with counties to develop core performance standards and performance indicators*
- c. Improve management of, and support to, regional county entities*
- d. Address liability concerns that individual counties may consider*

The Department and Legislature did not approve specific measures or requirements based on this report. However, there are activities underway that relate to the underlying issues in this recommendation.

Performance measures have been established for home and community based services, and the Department is conducting in-depth reviews of county administration of these programs. The results of the reviews include corrective actions needed, identification of best practices and recommendations for county consideration. Follow up to the corrective actions demonstrate that counties have been making improvements in response to the reviews, and the evaluation by participating counties of the review process has been positive.

There are collaborations between counties in areas such as contract management and rate setting. Counties have worked with the Department to address liability issues they have with waiver service contracting to help the Department adapt the model contract elements that counties are required to use. County social service directors initiated a workgroup to recommend changes in MA home and community based services waiver administration to the Department in early 2009. Technical assistance is provided by Department staff to this effort. This effort is leading to identification of activities that should be done by county collaborations, rather than individual counties. There will be

significant changes in county responsibilities for waiver administration as a result CMS requirements, including the elimination of county contracts for waiver services, enhancing provider standards and the MA provider enrollment process, and establishing statewide rate setting methodologies. The changes in federal requirements are increasing the level of oversight and documentation required by the state, and will result in a need for investments to manage these activities through technology, and more directly reimburse counties, especially regional efforts, for their role in these assurances as administrative functions that are separate from case management.

The Department established six priorities that will guide planning efforts for the next two years. These are at risk adults, at risk children, reducing disparities, health care, chemical and mental health and home and community based services. The recommendations resulting from these focused efforts will require different solutions and approaches than traditionally found in our system. Recommendations for collaborations, establishing expectations and performance measures, and monitoring results will come from the priorities.

The Department received a three year CMS grant to develop a profile of the long term care system, and indicators to measure changes in the state rebalancing efforts to reduce reliance on institutional models of care. An HCBS Expert Panel of leaders in aging and disability services from across the state was developed to assist in the development of the profile, develop provider performance measures, and improve long term care services.

7. Improve MCO Contract Management

- a. *The state should implement a strategically focused, senior manager-led, contract management approach to working with its MCO vendors.*
 - i. *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.*

DHS annually reviews purchasing goals and priorities, maintaining core priorities including: Network Adequacy, Improving access to benefits, Strong Grievance process, Standards of Quality of Care, and Improving care utilization. DHS focuses on what we incent and what we monitor (G & A, Licensing deficiencies, performance measures).

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*

DHS has established a number of ongoing collaboration workgroups and meetings; including external stakeholders as appropriate, to align purchasing priorities across the broader health care delivery system. We focus our limited resources towards common, system goals through HMO Council meetings, Measurement Alignment sessions, Purchasing Quarterly meetings, and other meetings as needed. System-wide shared projects include: Diamond, Medical Home, pay-for-performance (P4P), and Q-Care.

5. Annual review of plan performance across a set of leading statistical performance indicators

The Annual Technical Report is an extensive audit covering access, quality, and timeliness encompassing the federal 2007 balanced budget act (BBA) requirements, MDH licensing audit, and certified performance measures.

6. Annual application of financial and non-financial incentive strategies that are aligned to MCO achievement of agency priorities.

We have employed financial incentives to expand preventive services since 2001, and we have joined with commercial purchasers in Minnesota, employing financial incentives to improve care for chronic diseases since 2006.

8. Improve County Partnership and Performance Management

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

The Department established six priorities that will guide department planning efforts for the next two years. These priorities include: at risk adults, at risk children, reducing disparities, health care, chemical and mental health and home, and community based services. The recommendations resulting from these focused efforts will require different solutions and approaches than traditionally found in our system. Recommendations for collaborations, establishing expectations and performance measures, and monitoring results will come from the priorities.

There have been collaborations between counties in areas such as waiver service contract management and rate setting. The Department worked with stakeholders to develop rate setting strategies and a contract template for use across the state. Additionally, county social service directors initiated a workgroup to recommend changes in MA home and community based services waiver administration to the

Department in early 2009. Technical assistance is provided by Department staff to this effort.

There will be significant changes in county responsibilities for waiver administration as a result of recent waiver plan agreements with CMS in response to federal requirements. This will include the elimination of county contracts for waiver services, enhancing provider standards and the MA provider enrollment process, and establishing statewide rate setting methodologies. In designing the future administrative roles for counties, health plans, and DHS, there will be opportunities for collaborations and consolidations of administrative functions across counties in order to manage functions within available administrative resources.

DHS has encouraged MCOs to develop collaborative relationships with counties in order to utilize and build on current infrastructures for case management and care coordination. MCOs contract extensively with counties for care coordination and care management activities under the State's managed long term care programs for seniors, Minnesota Senior Health Options (MSHO) and Minnesota Senior CarePlus (MSC+), and to some extent for people with disabilities under Special Needs BasicCare (SNBC) for non long-term care related care coordination. MCOs are responsible for overseeing functions delegated to counties under these agreements according to MDH rules and DHS contract requirements. Contract requirements also include review criteria for home and community based services delivery designed to meet federal oversight requirements. DHS, MCOs and counties have established several workgroups that continue to address issues such as streamlining oversight requirements, changes in responsibilities and requirements for network development and maintenance, refinement of performance measures, and standardized rate setting tools for key services.

Over the past several years, the Department has worked collaboratively with the counties on Minnesota Health Care Connect, an effort to improve the processes related to Minnesota Health Care Programs eligibility and enrollment. A steering committee with MACSSA-appointed representatives as well as representatives from all DHS administrations oversees this effort, which includes initiatives related to electronic document management services, specialized support of long-term care eligibility, enrollment into health plans, and client choice of venue.

9. Pilot and Evaluate Disease Management

- a. *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.*
- b. *The state should establish a rigorous process for independent evaluation of program effectiveness by a party other than the DM contractor or its affiliates.*
- c. *The state should cooperatively work with its contracted MCOs to:*
 - i. *review the varied approaches that vendors have taken to implement DM*
 - ii. *compare those approaches to best practice standards and accreditation standards for DM programs*

- iii. review MCO self-evaluations of DM program clinical and cost effectiveness for MA enrollees*
- iv. learn first hand of the MCOs' experience with DM and the MA enrollee*

Primary Care Coordination (PCC) was authorized by the Minnesota Legislature in 2007. PCC provides payment to primary care providers for the delivery of care coordination services to fee-for-service MA recipients who have complex and chronic medical conditions. PCC closely resembles the Health Care Home legislation enacted in the 2008 legislative session. Participating individual providers or clinics may be certified to provide this service. Clinics seeking certification must meet certain criteria in order to receive reimbursement. Risk adjusted rates have been developed and will pay providers based on the patient's number of chronic conditions. The initial State Plan Amendment to the CMS was not approved. A revised State Plan Amendment has been sent to the Centers for Medicare and Medicaid Services (CMS) seeking authority to begin this program in the spring of 2009.

DHS has not had the staffing available in order to collaborate with MCO's to learn about their experience with similar programs and analyze outcomes. DHS staff is aware of reports regarding care coordination and have worked with experts in the field in the development of PCC.

10. Divert and Reduce the Length of Nursing Facility Stays

- a. The state should place county-based long term care consultants 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.*
- b. The state should fund assessment workers and independent care planning for consumers choosing to leave a nursing facility within a set timeframe, e.g., 120 days.*

Minnesota pursued these strategies:

- Purchasing strategy: By next year 90% of persons on Elderly Waiver (EW) will be in managed care, either a Medicare/Medical Assistance integrated product called MSHO, or MSC+, a non integrated product. The strategy provides financial incentives for health plans to use case managers to divert and convert Medical Assistance eligible persons from expensive nursing home services to more efficient home and community-based settings.
- Accompanying the purchasing strategy is a rebalancing initiative that supports the downsizing of nursing home beds while developing reliable home and community-based services, including consumer-directed support services that many families prefer.

- Providing meaningful information to persons while they are private pay and considering long-term care supports is vital for good decisions. Minnesota has adopted additional strategies to Long-Term Care Consultation (LTCC):
 - Expanding and enhancing information through Minnesota Help Network (Senior LinkAge Line®, Disability Linkage Line and www.MinnesotaHelp.info®) for better access to home and community-based services, regardless of income. Minnesota Help Network has expanded its presence in primary care clinics in order to provide information about home and community-based services to keep someone in their home.
 - Minnesota currently has an initiative on consumer use of housing with services settings, frequently called as assisted living. This initiative includes a study about how people make decisions about long-term care services, a requirement that persons seeking placement in assisted living be offered an Transitional Consultation, and a mandate to place information about assisted living settings on www.MinnesotaHelp.info for public reference. The study will better inform us about how to best present information about community alternatives.
- Relocation case managements: Minnesota requires that consumers under 65 years of age be assessed for relocation and provide all consumers information about the availability of those relocation upon entry to nursing facility. Data shows that there have been significant increases in the use of relocation services..
- MDH data shows the outcome of reducing nursing home beds and increasing the supply of home and community-based services has decreased stays in nursing homes a mean of 502 days to 298 days in 2006 and a median of 41 days in 2002 to 30 days in 2006. Nursing home stays trend toward post acute care and for rehabilitation.

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

- a. *Establish a common agreement among all case managers, county agencies and consumers:*
 - i. *define HCB waiver case management*
 - ii. *establish HCB waiver case management's goals*
 - iii. *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*
- b. *Based on the definition and goals, establish statewide standards for all case managers to follow in its provision:*
 - i. *assure consistency of provision through training of case managers*
 - ii. *enforce the standards among all providers*
 - iii. *conduct audits of the provision of HCB waiver case management*

The federal government proposed rule changes for case management, which prompted a subsequent moratorium by Congress to prevent implementation. This has

delayed our ability to act on waiver case management changes. The Department commissioned a case management report in 2007 to provide recommendations for the future role, standards and payment for case management services in the disability waivers. Options provided in the report include those that are consistent with federal direction, including identification of functions that are administrative and separate those from those that are clearly case management service functions. Elderly waiver case management will predominately be provided through MCOs. Practices and standards for coordinated care management of health care and waiver services have been managed through MCO contracts, and their subsequent contracts with counties and other providers. There will be an initial cost to establish training and technical assistance to assure best practices, regardless of purchasing model, to support a transition that streamlines and effectively assures that appropriate case management services are delivered and provide desired results.

The Department conducts lead agency waiver reviews that evaluate county administrative and case management functions with waiver services on the basis of established criteria. The report of each review includes corrective actions needed, best practices noted, and recommendations. Subsequent follow up has found that counties have taken corrective action and improved their case management and administrative practices.

12. Support Efforts to Expand Use and Connectivity of Electronic Medical Records (EMRs)

- a. Increase EMR accessibility for rural practices and clinics*
- b. Promote connectivity and interoperability among MN providers*
- c. Ensure 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*

In addition to active participation with the MDH in the MN e-Health Initiative, the Department undertook two initiatives which supported the expanded use and connectivity of EMRs. The first did so in a very direct manner, and the second did so in a more indirect fashion. The Department did not seek additional funding from the legislature for either initiative.

Expanding the Department's technological capability as outlined below allows rural areas with basic internet capacity to take advantage of the same low cost communications, new forms of patient care, and novel reimbursements available to larger urban providers.

First, the DHS was one of the earliest and proponents and activists in the conception and formation of the successful Minnesota Health Information Exchange (MN HIE), a public/private secure electronic network which allows the information contained in EMRs to flow safely between various health-related entities. It was launched the first week of November 2008, in the Regions Hospital Emergency

Department giving providers access to consenting patients' medication history. Future services will include e-prescribing, access to lab results, communicable disease reporting and more.

MN HIE will improve patient safety and health care quality, increase provider efficiency and reduce administrative costs for participating health care organizations, including DHS. It is one of the largest e-health initiatives in the nation. In addition to DHS, other partners include health care plans and providers.

Led by the Health Care Operations (HCO) division, DHS staff have been involved in the collaborative, public-private effort since the fall of 2007 participating on work groups ranging from privacy and security to provider communications and training, and completing an extensive business requirements development process.

And second, the Department sought and was granted nearly \$3 million in federal technology funding to create the Care, Authorization and Performance System (CAPS) in early 2007. In spring of 2009 the CAPS project will deliver an automated authorization process for health care providers and also supply them with electronic medication, inpatient stay and emergency room visit claims information. It will also facilitate sharing of children's mental health data between DHS and providers. The system will be built into MN-ITS, the existing provider portal. CAPS technology will be adaptable for future uses such as exchanging information with EMRs for programs like pay for performance (P4P), care coordination, and medical home programs.

(2) DHS shall provide to the Legislature a description of and an explanation of recent differences between the health plan net revenue targets established by the commissioner for health plans participating in public health programs and the actual net revenue realized by the plans from public programs.

For most populations covered under managed care contracts, DHS no longer has sufficient comparable enrollment in fee-for-service programs to use as a base for managed care rate setting. Therefore, DHS sets rates based on the managed care organizations' aggregate experience. We use a three-year period as a base to provide a more stable base for our rate setting. When we used a single year, the rates were more volatile and often out of sync with cost and utilization trends for the time period in which the rates were paid. The three-year rate base period gives the most weight to the most recent time period. The most recent year use in rate setting is the last complete calendar year prior to the year in which the contract is being negotiated. Thus, the base years for negotiation of rates for the 2009 contract were 2005 through 2007. We also ask plans to submit re-stated claims for the final year of the base period so that we have information about claims run-out that was not available when their annual financial reports were filed in April. In addition, as a check of reasonability we ask MCOs to submit information on claims for the first 6 months of the current contract period so that we can assess any significant upward or downward changes in cost or utilization trends not reflected in the base period. The base rate is then adjusted for increases or decreases in benefits and changes in eligibility and trended forward to reflect the anticipated trends in cost and utilization.

Each year, DHS projects an amount that the MCOs could be expected to set aside for reserves from the capitation rates. In addition, we expect that they will also benefit from any investments that the MCO is able to make. DHS began setting targets for contributions to reserves in 2003. In years past, some MCOs made significant “profits” on their MHCP business. DHS has made a strong effort in recent years to apply increasing weight to data to assure that changes in rates reflect actual trends and changes. In addition, DHS has been successful in recent years in reducing the disparity between expected and actual returns. If anything, DHS has been excessively zealous in rate reductions in recent time.

In general, the population that has been most difficult to rate has been the MinnesotaCare population. This is due to a number of factors including changes in eligibility and benefits. In 2007, there was a significant loss for health plans in both MinnesotaCare and General Assistance Medical Care (GAMC). We believe that we underrated the illness burden of both the population that transferred into MinnesotaCare (Transitional MinnesotaCare enrollees) and the illness burden of the population remaining in GAMC. This resulted in an overall loss to MCOs across all MHCP lines of business in that year.

Another area where DHS has had difficulty in assessing plan profitability is in contracts serving individuals who are dually eligible for Medical Assistance and Medicare. Because of the way costs and revenues are reported, we have been unable to clearly separate Medicare and Medical Assistance returns.

The table below reflects price and utilization increases, benefit and eligibility changes and rate reductions (2003). It shows annual rate changes, projected and actual returns.

	2003	2004	2005	2006*	2007
Medical Assistance					
% Rate Increase	7.32%	4.89%	4.75%	-7.96%	10.02%
Projected Return	1.0%	1.94%	0.50%	0%	0.5%
Actual Return	3.0 %	4.08 %	0.18%	-7.41%	0.050%
GAMC					
% Rate Increase	23.5%	5.71%	-1.78%	7.96%	8.33%
Projected Return	1.0%	0%	0%	0%	0%
Actual Return	-10.5%	-11.35%	-9.96%	-9.97%	-20.40%
MinnesotaCare					
% Rate Increase	7.5%	3.46%	3.64%	6.95%	9.64%
Projected Return	1.0%	1.94%	0.50%	0%	0.50%
Actual Return	2.40%	10.60%	6.20%	2.36%	-4.50%
Overall Program					

% Rate Increase	8.70%	3.4%	5.40%	-2.50%	10.00%
Actual Return	4.0%	4.9%	0.73%	-0.97%	-3.00%

* Includes the effect of the carve-out of Medicare Part D Pharmacy for dual eligible seniors.

As noted above, it is difficult to assess returns for products that include Medicare and Medicaid. Therefore, the overall program results do not include MnDHO or MSHO.

(3) DHS shall report to the Legislature on the adequacy of public health care program fee-for-service provider rates including an identification of service areas or geographic regions where enrollees have difficulty accessing providers.

The 2008 Legislature appropriated \$96,000 to study MHCP fee-for-service rates. Burns and Associates, an independent health care consulting firm that focuses on state Medicaid programs, was hired to conduct the study. The deliverables are on schedule and the final report is due in mid May. Based on their work to date, the research is demonstrating that many of the primary care rates (pediatric preventive, office outpatient, emergency and critical care, for example) are much lower than other states, while Minnesota's medication management rate is higher than any of the other comparison states. A preliminary report will be available in March. Preliminary recommendations include providing an interim rate increase for physician services that have been identified as being significantly below the comparison states, via a methodology that would increase rates to a percentage of Medicare rates.

Currently, most MHCP professional services rates are paid at the 50th percentile of 1989 less a discount. The most recent increase assigned to physician services was 3%. This increase was implemented on January 1, 2000. Since the January 1, 2000 increase, there have been no further increases to payment rates of professional providers such as physicians. DHS continues to be concerned about fairness in payment rates across all professional services.

Alternative strategies will be addressed in the report to the legislature.

(4) DHS shall provide a progress report on the implementation of [current Minnesota law] requiring payments for physician and professional services to be based on Medicare relative value units.

As of February 2009, the resource-based relative value scale (RBRVS) has not been implemented due to the department's difficulty hiring a staff person with the knowledge and experience necessary for this project at the pay level and classification level assigned. These staffing issues have prevented development and implementation of this project. Conversion from the current fee-for-service rate methodology to RBRVS is

budget neutral. RBRVS is not expected to contain program costs but is expected to shift payments.