



MINNESOTA
HEALTH CARE
FINANCING
TASK FORCE

Health Care Financing Task Force Final Report—At-a-Glance Summary of Recommendations

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Health Care Financing Task Force Vision: Sustainable, quality health care for all Minnesotans

Health Care Financing Task Force

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At-a-Glance Summary Chart of Recommendations

RECOMMENDATION AREA

Removing Barriers to Access to Coverage and Care and Addressing Disparities

Recommendation 1: Improve and enhance community based consumer assistance resources, including Navigators, consumer assisters and agents/brokers:

- Develop expanded community based, consumer assistance capacity to support consumers in accessing health coverage, understanding how to use their health coverage, and addressing social determinants of health (e.g., food and nutrition, housing);
- Provide adequate and timely payment to, and appropriate training for, community based consumer assisters;
- Utilize currently available race/ethnicity/data to identify type and level of consumer needs and target deployment of consumer assistance resources; and
- Ensure that the State's selection of Navigators prioritizes entities able to provide linguistically and culturally appropriate assistance and that new state-developed consumer assistance tools are culturally and linguistically appropriate.

Recommendation 2: Create benefit alignment across the coverage continuum and provide access to high value benefits:

Transportation

- Provide non-emergency medical transportation (NEMT) as a covered benefit in MinnesotaCare.
- Build volunteer transportation provider capacity through a grant program.
- Assess the impact of enacted NEMT legislation on improving access to care and provider capacity.

Dental

- Require that QHP issuers make available dental benefits on par with coverage in Medical Assistance and MinnesotaCare.
- Seek 1332 waiver to allow QHP enrollees to apply Advance Premium Tax Credits/ Cost Sharing Reductions to available dental coverage.
- Raise Medical Assistance dental reimbursement rates.

Recommendation 3: Evaluate the impact of 2015 telemedicine (health) legislation on payment for and access to broad based telehealth/telemedicine (including mobile applications) services and effectiveness in addressing geographic barriers and health disparities.

Recommendation 4: Improve demographic data collection and reporting to inform development of solutions to address disparities in health access and care:

- Ensure that all Minnesota health data collection and reporting systems including state agencies, providers, payers, and systems that collect health data comply with the State Quality Reporting and Measurement System's (SQRMS') standardized best practices (i.e., allowing patients to identify themselves, allowing a multi-racial category) for collection and reporting of race, ethnicity, language and country of origin data and data elements.
- Charge MDH with development of a standardized set of additional socio-economic measures affecting health and health disparities.
- Develop mechanism for continuous improvement of health data collection and reporting in partnership with racial and ethnic communities disproportionately affected by disparities.

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Recommendation 5: Provide access to coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status by using State funding to provide MinnesotaCare benefits to children and adults with incomes up to 200% FPL.

Provide coverage for services included in the elderly waiver package and nursing facility benefits to individuals under 138% FPL who are eligible for these benefits.

In all instances, maintain confidentiality of applicants to ensure information collected is only used for health coverage and maximize available federal funding (i.e., federal funding for EMA and coverage of lawfully present MinnesotaCare individuals 0 – 200% FPL).

Recommendation 6: Rationalize affordability definition for families with access to employer sponsored insurance (ESI) (i.e., fix the “family glitch”), provided, however, that there is no impact on employer tax penalty related to affordability of coverage for dependents.

Recommendation 7: Adopt 12 month continuous eligibility for Medical Assistance & MinnesotaCare enrollees. (This only applies to Medical Assistance enrollees eligible under a MAGI-income basis.)

RECOMMENDATION AREA

Improving Affordability of Coverage and Care for Consumers

Recommendation 8: Require standard Qualified Health Plan offerings in the Marketplace to improve consumer choice and experience and ensure availability of no- or low-deductible options. Look to federal standardized designs as a potential model.

- Require carriers to offer low and no deductible plan options, in addition to other products they choose to offer.
- Require carriers to offer standard plan designs that exempt certain services from deductibles to incentivize utilization of primary care and other high value preventive services.
- Study option of 1332 waiver to allow for 60 to 100% actuarial value and how this will improve consumer choice.

Recommendation 9: Improve affordability and reduce the cliff in premiums, cost-sharing and deductibles for health coverage at 200% FPL in Minnesota’s coverage continuum by establishing a Minnesota-tailored health coverage affordability scale and provide enhanced subsidies to consumers with incomes 200 to 275% FPL (pre-ACA MinnesotaCare eligibility levels).

Recommendation 10: Expand MinnesotaCare up to 275% FPL, using the recommended affordability scale under Recommendation 9 for those between 200 and 275% FPL, and maintain Marketplace coverage for consumers >275% FPL.

RECOMMENDATION AREA

Sustainably Financing the Coverage Continuum

Recommendation 11: Seek Medicaid match to provide additional federal funding for enhanced subsidies to the MinnesotaCare population with incomes from 138 to 275% FPL.

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Recommendation 12: Repeal the sunset of provider tax to continue a dedicated state funding stream to support health care for low-income Minnesotans. With continuation of the provider tax, establish more stringent parameters for: (a) uses of Health Care Access Fund (HCAF) revenue and (b) the mechanism for contingent tax reduction based on program funding needs.

Recommendation 13: Expand the MNsure user fee to on- and off-Marketplace products, provided that the Legislature statutorily reduces the user fee/premium withhold level.

RECOMMENDATION AREA

Assessing the Future of MNsure

Recommendation 14: The Task Force does not recommend transitioning to either the Federally Facilitated Marketplace (FFM) or Supported State-Based Marketplace (SSBM) at this time. A partially-privatized State-Based Marketplace (SBM) model could be considered following the evaluation of MNsure's 2016 open enrollment period. Therefore, the Task Force recommends continuing a SBM at this time.

Recommendation 15: Develop framework to evaluate MNsure's 2016 open enrollment period performance, including the criteria listed in this report and in Appendix N.

Recommendation 16: Codify the current IT executive steering committee structure for overseeing the IT modernization plan, including MNsure's IT system.

RECOMMENDATION AREA

Ensuring Stability of the Insurance Market

Recommendation 17: The Department of Commerce should explore options to stabilize Marketplace premiums by:

- Studying and modeling potential Minnesota-tailored rate-stability mechanisms for the individual market, such as a reinsurance program
- Studying and modeling merging Minnesota's individual and small group markets
- Considering the impact of establishing maximum limits on health plan carriers' excess capital reserves or surplus
- Studying options for making Minnesota's rate review process more transparent with public information and hearings.

RECOMMENDATION AREA

Expanding Innovative Health Care Purchasing and Delivery Systems Strategies and Advancing the Triple Aim

Enhancements to Data Sharing

Recommendation 18: Modify the Minnesota Health Records Act to conform with HIPAA and make technical updates and clarifications to the Minnesota Health Records Act to leave a patient's ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.

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Recommendation 19: Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.

Recommendation 20: Conduct a broad study that will make recommendations on the appropriate future structure, legal/regulatory framework, financing, and governance for health information exchange (HIE) in Minnesota, building on lessons learned in Minnesota and from other states and countries.

LONGER-TERM RECOMMENDATIONS AND CONSIDERATIONS RELATED TO DATA SHARING:

- Dependent on results of health information exchange study (see recommendation 20), consider other modifications to Minnesota's Health Records Act, to further align with federal HIPAA standards or to update opt-in or opt-out requirements.
- Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to enable smaller and specialty providers to participate in HIE.
- Consider developing a funding mechanism for core HIE transactions, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide.
- Support the establishment of robust, sustainable HIE "shared services," such as consent management, which would be available statewide through a central vendor.

Enhancements that Support Integrated Care Delivery

Recommendation 21: Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted. At a minimum, the evaluation should address the following domains:

- Health disparities - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers?
- Financial stability and cost of health care system – What is the impact of the model on costs across the system, including all payers? What costs are associated with the model at the provider level? What is the return on investment (ROI) of the program?
- Patient choice and provider attachment - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider?
- Multi-payer alignment – What are the areas of alignment across payers under the model? What additional areas could be aligned?
- Quality of patient care – How has the model impacted the quality of patient care?
- Population health – How does the model address population health?
- Social determinants of health – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)?
- Impact on provider work force - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact?

Recommendation 22: To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.

Recommendation 23: Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches:

- Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels;

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- Expansion of value-based purchasing within current system;
- Publicly-financed, privately-delivered universal health care system.

The study would additionally examine the stability and sustainability of health care system under the approach and identify any data or information needed to design and implement the system.

Recommendation 24: Incorporate enhancements, as described in recommendations 25 through 33 below, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with expansion only following robust evaluation (as described in Recommendation 21 above).

Immediate Enhancements to Pilots, Demonstrations and Existing Programs

Recommendation 25: Enhance community partnerships by:

- Encouraging or incentivizing partnerships and care coordination activities with broad range of community organizations within care coordination models, and
- Funding innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.

Recommendation 26: Encourage or incentivize participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.

Recommendation 27: Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider's previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.

Recommendation 28: Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions; appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.

Recommendation 29: For participants not attributed to an ACO (such as certified Health Care Homes), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.

Recommendation 30: For participants attributed to an ACO (including risk-taking IHP program), provide a prospective "pre-payment" of a portion of their anticipated total cost of care (TCOC) savings.

Recommendation 31: Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include: (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.

Recommendation 32: Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social and non-medical complexity, and enhance payment rates to incorporate costs associated with

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care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.

Recommendation 33: Strengthen the patient attribution and provider selection process by:

- Allowing patients to choose a provider during the enrollment process and change their primary provider outside of enrollment;
- Giving providers data about who enrolled with them so they have the opportunity to proactively engage with those enrollees;
- Using consistent methods for attaching patients to providers across payers;
- Attributing or assigning patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery) under an ACO or similar model, with back-end reconciliation.

LONGER TERM RECOMMENDATIONS RELATED TO SUPPORTING INTEGRATED CARE DELIVERY:

- Identify ways of enhancing existing payment models to more comprehensively include the dual eligible population.
- Identify methods to report on the costs and savings associated with non-medical services, with potential integration into TCOC calculations.
- Address increasing costs of prescription drug costs in excess medical inflation.
- Develop an approach to managing the growth of long-term care costs, especially in light of the aging population.
- Address workforce shortages, particularly in the areas of primary care and mental health practitioners.
- Identify ways to capture the savings from care delivery and payment modifications back into the health care system.