Minnesota's Healthcare Imperative

DISCUSSION DOCUMENT

Allina Hospitals & Clinics
Blue Cross and Blue Shield of Minnesota
Fairview Health Services
HealthPartners
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UCare

Introduction

Several months ago, a group of health care plans and providers began a discussion about how Minnesota could maintain its position as a leader in providing health care to all its citizens. We challenged ourselves to find the best available data, to examine practices from around the country that successfully addressed total cost and delivery of care, and to consider all options regardless of their degree of difficulty.

We also agreed that our discussions would stay true to our guiding principle: to identify the opportunities that bend the cost trend *and* enable our state to improve access, affordability, and quality of care for all Minnesotans.

We pursued three primary goals:

- Promoting program expansion
- Making the program work better for the people it serves
- Fixing how we pay for care and rewarding better care

Many of the opportunities brought forward in this document are not new. They have been adopted in other states and they have been discussed in Minnesota. We believe that we now need to act upon them. Time is running out on our ability to reduce the deficit and remain true to our guiding principle of access, affordability, and quality care for all Minnesotans.

Payors and providers must work together to reduce costs and improve quality, with joint risk. The opportunity areas outlined in this document warrant further discussion and should be considered as a whole. We can no longer count on piecemeal remedies to deliver successful outcomes. Rather, we urge the examination of this document in total.

Thank you for your interest and attention. We will make our staff and resources available as the policy makers and key stakeholders embark on setting Minnesota's savings, spending, and revenue policies. Working together, we can apply our collective courage to transform publicly funded health care from a system in jeopardy to one that preserves Minnesota's position as a leader in high-quality, accessible, affordable health care for all.

Contents

Overall Guiding Principles

The overall guiding principles come from the "Triple Aim" philosophy articulated by the Institute for Healthcare Improvement. The Triple Aim describes an approach to transformational change in health care by optimizing performance in three dimensions: experience, cost, and health. Accordingly, our overarching principles are described as follows:

- Improved access to care for all Minnesotans, building on the principle that health care for all is a key value in our state;
- Improved affordability of heath care for the state and for individuals;
- Improved health and quality of care for Minnesotans.

We believe that any initiative proposed must support these guiding principles and that the approach to Medicaid[1] reform in Minnesota must be an integrated one which considers the **total cost and delivery of care.** At the same time, we understand that institutions serve Medicaid and Medicare members to different degrees. This difference in starting points cannot be allowed to condemn Medicaid- or Medicare-intensive providers to financial ruin.

The approach to reform must involve a bundle of initiatives that interrelate clinically and financially to deliver a holistic value proposition to all constituents. An à la carte selection of individual initiatives will deliver neither the full economic value of Medicaid reform nor on the principles we have stated.

The first step in realizing any improvements will be to reform the payment structure of the system so that it fosters innovation and provides equitable incentives promoting a collective approach to reforming Medicaid. We propose a consideration of a payment model that focuses on optimizing the three dimensions of care represented by the Triple Aim: total cost, health, and the patient experience. The details of the model would need to be worked out. In principle, those who create the improvements (e.g., providers, payors, patients) would be entitled to participate in the savings.

1 In this document "Medicaid" is used generically to refer to the federal program and to Minnesota state healthcare programs.

Brief Context and Case for Reform

PAYMENT REFORM AND HEALTHCARE MODEL REFORM

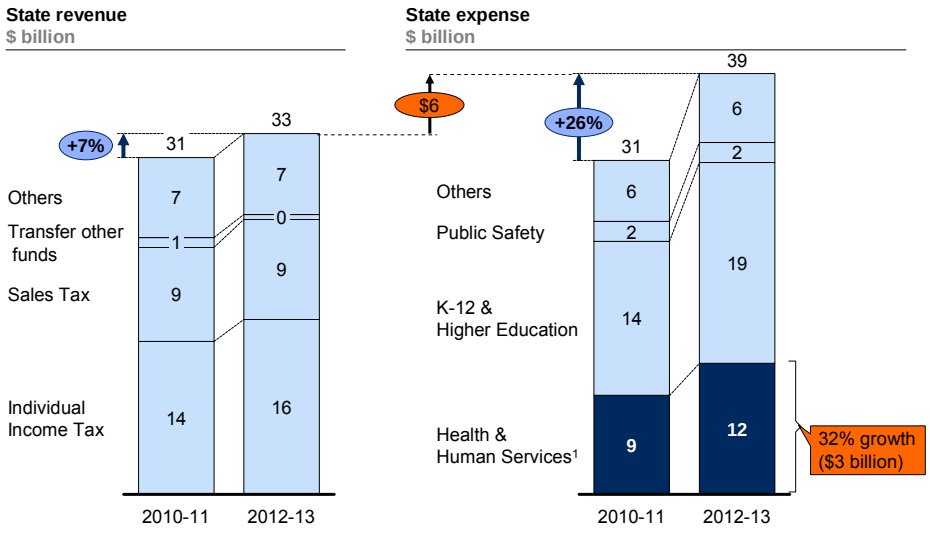
We believe that a fundamental reinvention of the payment system and new incentives for appropriate behaviors will prove critical to achieving meaningful change. Our recommendations – for the adoption of new payment models and the transitioning of state fee-for-service public programs into managed care – will not preclude providers and any organization that assumes the risk to contract directly with the state or seek other alternative payment models. As a state, Minnesota should remain open the broad variety of payment changes that obtain currently in the private sector.

ECONOMIC IMPERATIVE

We believe Minnesota can and should consider exploiting a wide variety of commercial and governmental opportunities to achieve its healthcare aspirations. This document, however, focuses on governmental opportunities in light of the state's budget deficit. Minnesota will face a biennial shortfall of $6.2 billion (14 percent).[2]

Figure 1

Evolution of biennium general fund from break-even to $6 billion deficit



1 DHS programs include Medicaid, General Assistance Medical Care (GAMC), and Economic Assistance and Housing Programs

SOURCE: Minnesota Management & Budget

2 http://www.doer.state.mn.us/fin/budget

The status quo is unsustainable for the state and for healthcare delivery systems, since Medicaid payments do not cover costs. We do not imply that the system needs more money, but we want to stress that today's situation is not working for government, providers, employers, patients or communities. We are all motivated to achieve something better.

HEALTHCARE IMPACT

Health care accounts for roughly 30 percent of Minnesota's budget outlay[3]; by pro-rating the shortfall, healthcare spending accounts for $1.85 billion of the budget gap. This paper provides a road map to close this portion of the gap through actions that will also position the health care system of Minnesota for long-term success.

MEDICAID

One of the most significant contributors to public healthcare spending in Minnesota is the state's Medicaid program, requiring $7.0 billion per year of federal and state monies to maintain.[4] The program covers more than 780,000 low-income and disabled Minnesotans, including some of the sickest and most vulnerable state residents. The special needs of this population must be recognized, and the state must understand the impact that changes can have on diverse communities. We do not question the high value of keeping people with disabilities as healthy and independent as possible.

The state average cost per enrollee is the fourth-highest in the United States (behind NJ, NY and RI) and is 49 percent higher than the national average (Figure 2).[5] We believe that opportunities exist simultaneously to improve quality of life and address the state's affordability challenges.

The disproportional spending within the Medicaid program needs to be considered. Disabled and elderly patients consume the vast majority of resources, while children require the least support both nationally and within Minnesota. The disproportion is made the more striking when we realize that children account for roughly half of Medicaid enrollment. Per-enrollee spending on the elderly and disabled can be 6 to 9 times higher than on children. This is one of the reasons why long-term care is broken out separately from overall benefits in the design considerations in this document.

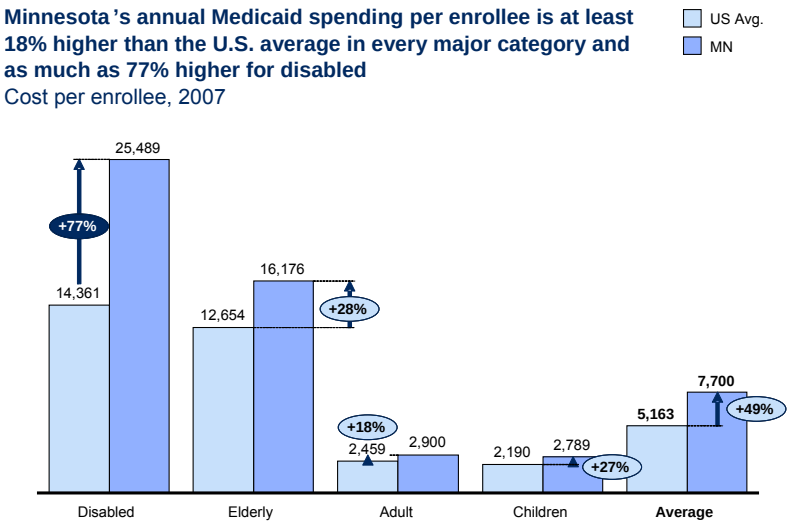
3 Ibid.

4 Kaiser estimate from www.statehealthfacts.org

5 Ibid.

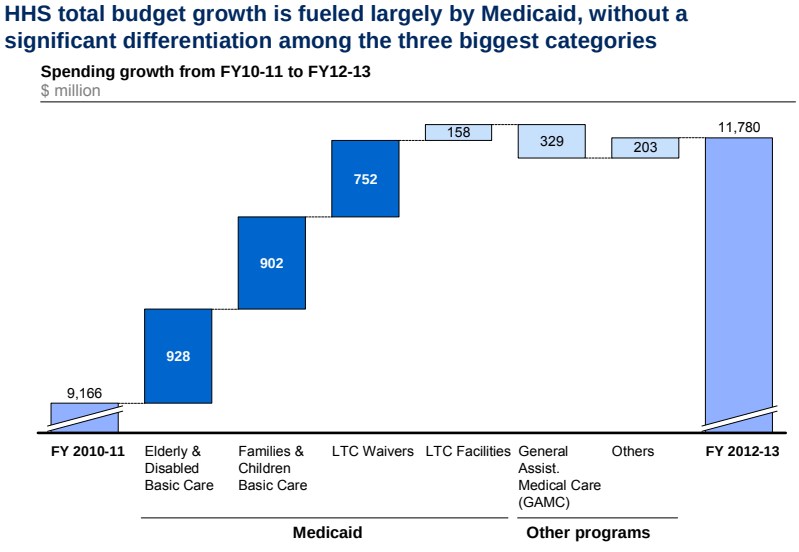
There is also variation in Medicaid dependence across providers. Some facilities (e.g., pediatric hospitals) are highly dependent on Medicaid with a very significant amount of their revenue coming from Medicaid, while some others may have very little exposure. Changes made to Medicaid can affect those with highly Medicaid-dependent revenues many times more significantly than those with little exposure. Such variations across facilities must be taken into account in any changes to the program. Similarly, one must consider the disparate impact across populations.

Figure 2



SOURCE: Kaiser Foundation

Figure 3



SOURCE: Minnesota Management & Budget

Given Medicaid's large size, measured in both people and dollars, it is not surprising that it is governed by a highly complex system of federal, state, and local laws and regulations. In this document we will attempt to highlight where this complexity is not working in favor of Minnesotans and will suggest opportunities for program improvement and cost savings.

PROPOSED MINNESOTA MEDICAID INSTITUTE

The full value from the opportunities outlined in this document will come only from careful development and execution of a detailed implementation plan.

We have only hinted at the complexities inherent in capturing the opportunities, and have estimated cost savings based in some cases on limited available data. To articulate the full potential quantitative and qualitative impact of the opportunity, additional and ongoing work will be needed. To this end, we ask the new administration to establish the "Minnesota Medicaid Institute" to act as the government's policy committee in considering these and other opportunities to reform Medicaid in Minnesota.

The Minnesota Medicaid Institute should be charged with ensuring that all opportunities are fiscally sound and meet acceptable standards for quality and efficacy, particularly when it comes to making any adjustments to current benefits or initiatives that might introduce new benefits. The Minnesota Medicaid Institute should serve as the primary source for analyzing and informing all Medicaid related topics and decisions that require public discourse and attention.

Other states have established such groups to focus on state Medicaid issues. In New York, for example, the Medicaid Institute™ was established in 2005 to provide information and analysis explaining the Medicaid program of the state. According to its website,

> The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, health plans, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the state program.

A similar approach may serve the Medicaid stakeholders of Minnesota well. We could foresee assembling resources from among our group to develop a similar program, either as constituents or expert advisors. We believe such a program would provide a strong foundation for a sustainable Minnesota Medicaid program. For it to be most effective, participants must commit to real, ongoing work.

FEDERAL MATCHING

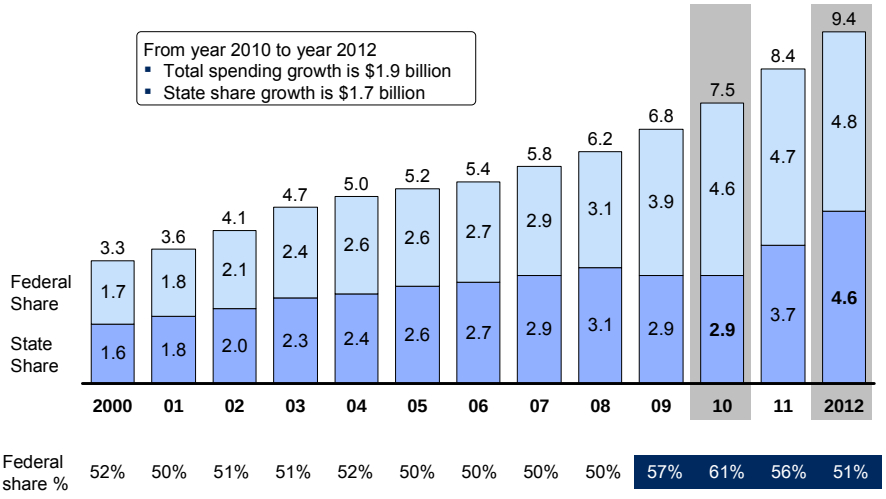
In light of the high cost of Medicaid, the state has made efforts to improve its federal matching fund level, and has achieved some success. Nonetheless, we must continue to be vigilant to capture further opportunities.

The federal share of Medicaid costs for each state is determined by a formula based on the state's per capita income and results in a Federal Medical Assistance percentage (FMAP) of total Medicaid costs that the federal government will reimburse. Usually, Minnesota's federal match is 50 percent, but from October 1, 2008, through December 31, 2010, the American Recovery and Reinvestment Act increased the percentage to 61.59 percent.[6] In August 2010, the federal government extended the FMAP for another 6 months into 2011, however, at a lower rate. The $263 million for 2011 will not affect the 2012-13 budget cycle, which starts in July.

Figure 4

Future Medicaid State spending growth is driven by a reduction in federal support

$ billion



SOURCE: DHS, team analysis

The 50 percent rate places Minnesota toward the lower end of U.S. state matching; some states receive up to 76 percent. While the formula used to estimate the federal match cannot be changed (it is a population-based algorithm applied consistently across the nation), Minnesota must continue to do all it can to maximize federal reimbursement to ensure proper care of Minnesotan's state healthcare needs. Minnesota's share of future Medicaid

6 http://www.house.leg.state.mn.us/hrd/pubs/famasst.pdf

spending will increase over time as the increase in FMAP is phased out over time and the federal match returns to the historical level of 50 percent.

UTILIZATION

Minnesotans utilize health care at a rate significantly above benchmarks. In many areas of the state, Medicaid is significantly more "generous" than in other states, particularly for certain populations such as the disabled who have more options in Minnesota than elsewhere. While Minnesota's Medicaid-covered population rate is somewhat lower than average, our spend per covered enrollee, according to available data, is significantly higher. Though it can be difficult to compare utilization of services against benchmarks that may be based on different overall benefit packages, Minnesota appears to offer a richer package than most other states, and we do tend toward higher utilization of the services offered.

Our Medicaid program must contemplate and articulate the true needs of the population and be robust and flexible enough to serve them well while remaining economically viable. Our approach to the program must reflect, at least, an awareness of proven best practice utilization models and policies in both public and private markets.

AFFORDABILITY

Given the extraordinary size of the healthcare budget gap, the aspiration must be to improve overall affordability, not just to move money from pocket to pocket. Cost-shifting to the commercial market – to plans that can least afford the increased burden, such as fully insured small group employers – plays no role in our recommendations. Sensible risk sharing, however, is part of the solution. Total cost of care must be considered as the system looks to avoid "squeezing the balloon," saving one dollar through an initiative only to incur two dollars of cost somewhere else.

Opportunity Areas

To address these issues, we have identified and developed a set of opportunities to provide high-quality health care in new ways that both improve outcomes and reduce costs. In particular, we support redesign of the healthcare delivery system so that services can be offered at lower cost to the state. To achieve this aspiration, these opportunities must be viewed as an integrated whole. Opportunities fall within five broad themes.

1. **Utilization and cost:** fundamentally redesigning the way care is delivered to create more value ($100 million opportunity)
2. **Benefits design:** optimizing Medicaid benefits packages to align with practices used in other states while continuing to support our principles of more affordable health care and improved health ($985 million-1,105 million opportunity)
3. **Long-term care:** similar to benefit design optimization but with a specific focus on meeting the needs of the elderly and disabled ($105 million-300 million opportunity)
4. **Plan administration:** streamlining Medicaid program administration through technology and process improvements ($36 million opportunity)
5. **Alternative revenue opportunities:** implementing alternate sources of revenue to offset Medicaid costs and fund future innovation ($280 million-680 million opportunity).

In arriving at these opportunities, we identified and evaluated dozens of potential economic improvement ideas. Some of the ideas are new, several have been implemented successfully in other states, while others have been long discussed but insufficiently implemented.

To maintain the leadership position of Minnesota's health care system nationally, we must reform the payment structure of the system to one that fosters innovation and provides incentives to promote the health and care coordination of Medicaid participants. An equitable payment structure (details TBD) can lead to decreases in overall utilization and more cost-effective patient care. In tandem, we must redesign the care model. Improvements in utilization and cost alone could be worth over $100 million in the next biennium.

Several ideas stand out among the opportunities considered in this document, either because of their high impact in the next budget cycle or because of the importance to our state:

- Legally authorizing early Medicaid expansion ($1.3 billion of new money, approximately $800 million net of new programs). *Completed*.
- Reducing hospital admissions to achieve median HEDIS rates (national rates of admissions) in 3 years ($55 million)
- Advancing the transition of Minnesota's FFS disability program into managed care ($105 million-300 million)
- Levying or increasing "sin taxes" on products and services that negatively affect health ($280 million)
- Reforming government programs through reduction in administrative duplication and waste ($25 million)

The details of these and all other opportunities will be explored in turn. It is first important to understand the context in which they must progress: **a fundamental reform in the healthcare payment structure.** Changing the way that health care is paid for is critically important to moving the overall system towards sustainable equitable access, affordability, and health. Meaningful payment reform must be viewed as essential to achieving any of the utilization savings in state public programs. Providers must be accountable and commensurately compensated for patient care, in a manner that is consistent with the guiding principles of this work. Fee-for-service payment is a significant barrier to proper incentives.

Medicaid is currently in transition from a fee-for-service (FFS) model for some populations; in the existing FFS models, either (a) health plans pay a pre-negotiated rate for each service under capitated arrangements with the state, or (b) the state sets a fee to be paid to providers for each service. The destination "Triple-Aim" model begins to pay according to the overall value of the services delivered at a fixed rate per enrolled individual. This transition can be very costly if payment reform is not implemented correctly and concurrently with other initiatives for savings.

Achieving a balance of government regulations and market-based freedom to innovate will be critical as opportunities are pursued. Fortunately, a spirit of collaboration and market-based innovation is already in place in Minnesota. For example, the medical home concept currently under way in Minnesota and in other parts of the country can meet the guiding principles we outlined above. A medical home provides coordinated, planned care to a patient and facilitates partnerships between individual patients, their personal providers and, when appropriate, the patient's family. Providing a medical home to an individual and using a clinical team's expertise to refer patients to the appropriate part of the system (as opposed to relying on the patient to self-

refer appropriately) can result in fewer emergency room visits and hospitalizations, according to a study published in the journal *Health Affairs*.[7]

There are nearly 30 medical home demonstration projects nationwide.[8] One of these programs designed to improve the quality of health care and control costs is under way at the Seattle-based Group Health Cooperative. Compared to other Group Health clinics, patients in the medical home program made 29 percent fewer emergency visits and had 6 percent fewer hospitalizations, yielding an estimated total savings of $10.30 per patient per month. Minnesota has begun development of medical homes and although Group Health Cooperative is an integrated delivery system, meaning that it may be easier for them to coordinate care and realize the full potential of the medical home model, we expect to achieve some savings by transitioning Minnesota patients in prepaid medical assistance programs (PMAP) into medical homes and keeping them there.

The gains from medical homes cannot be realized without payment reform, however. Implementing a medical homes program entails costs that are currently not reimbursed or are subject to regulations that may be unduly burdensome, such as certification requirements. The current payment structure discourages providers and plans from exploring a program that could be very beneficial to all Medicaid constituents. Payment should be flexible enough to allow innovation in quality improvement and efficiency, incorporating experiential lessons as the system makes the transition to more accountable payment models.

The principles of these gains are not limited to medical homes; similar benefits are foreseen from "total cost of care" concepts and the rise of "Accountable Care Organizations." Besides market-based strategies, legislation should also continue to be a source of support in meeting the health care needs of the population. For payment reform to be palatable and sustainable, it should be allowed to develop in the market with the collective guidance of experts.

Several payment reform models are based on the specific population served, the nature of the provider entity providing service, and the entity that creates the plans to support the services and population financially. As providers begin to contemplate and pursue new relationships to coordinate care, the payment system must continue to be flexible to accommodate those providers.

7 "Structuring Payment For Medical Homes," *Health Affairs* 29 (May 2010): 852-858; available at http://www.healthaffairs.org

8 "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs* 29 (May 2010): 835-43.

OPPORTUNITY AREA ONE: UTILIZATION AND COST

Description

Payment reform leads to savings through changes in cost and utilization patterns. Medicaid benchmarking (of HEDIS, per-enrollee costs) with other states indicates several areas where Minnesota is an outlier with respect to utilization. No evidence supports the notion that higher utilization results in higher quality or better outcomes.[9] For the most part, hospital and clinic systems do not cover their costs serving public program populations and the gap in cost ends up being shifted to the private sector. Since 2002 hospital payments have been cut by more than 14 percent below 2002 costs. Similarly, physicians have seen reductions in their payments under government programs.

Guiding principles

1. Enable the private sector to redesign care and reduce costs independent of legislative measures
2. Create value and provide incentives through payment reform for appropriate healthcare redesign
3. Integrate public programs into efforts to redesign the current system of care
4. Redesign system using evidence-based principles
5. Fund public programs to set the foundation for care redesign.

Opportunities

We acknowledge that any meaningful reduction in utilization and cost will not be easy and will require the concerted effort of all constituents to realize any significant value, but we strongly assert that all of the opportunities identified here are possible.

1. Reduce hospital admissions by 5 percent per year to achieve median HEDIS rates in 3 years ($55 million)

There is an opportunity to reduce preventable hospital admissions; like the following propsal relating to emergency departments (EDs), this opportunity is largely created by a reduction in ED use.

A reduction in aggregate hospital admission rates of 5 percent across all Medicaid facilities annually for 3 years would generate a total cost savings in

9 Dartmouth Atlas of Healthcare, http://www.dartmouthatlas.org

the metro area of $85 million. Total 2009 spend for the metro area alone is approximately $600 million for MA, GAMC, and MA FFS. The rate of mean inpatient discharges per 1,000 in Minnesota is at the 75th percentile of the national rates (2009 HEDIS). Based on 2009 data, if we were successful in cutting utilization by 5 percent annually for 3 years the Minnesota rate would be at approximately the 50th percentile nationally.

2. Reduce emergency department (ED) use by 5 percent annually in line with HEDIS rates ($15 million).

Minnesotans are increasingly using hospital EDs for non-emergencies and even for routine health care problems. For some, the ED is the default center for all health concerns for a variety of reasons, including cultural norms and lack of health care infrastructure in rural areas (e.g., the ER may be the only real place to get care after hours). This increased use has been linked to growth in the number of uninsured residents, which has accelerated in the recent recession. It is also closely tied to reduced access to a regular source of care, especially primary care providers. According to data collected from Minnesota's largest health plans, as many as 90 percent of all Medicaid ED visits are treated and discharged. Only 20 percent of ED visits are true emergencies, and at least one-third of all visits are for non-urgent health problems.

Studies have shown that when a regular source of health care is available to patients – such as the "medical homes" mentioned earlier – ED use goes down significantly, not only for healthy patients but also for those who are sicker and have greater health care needs. Several states have focused on providing primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

As an example of the benefits of a medical home to EDs, a Medicaid-managed care plan in Ohio implemented a multi-faceted medical homes initiative in 2003. It includes a 24-hour, 7-day nurse triage line to engage in symptom-based triage and direct enrollees to the appropriate care setting for their condition. In the first 18 months of operation, the nurse triage line was able to divert 58 percent of 13,000 callers from the ED to a more appropriate level of care, resulting in a net savings of over $1.7 million for only one plan. Similar experience is emerging in Minnesota.

Mounting evidence supports the need to reform payment in a way that provides incentives to individuals to seek care in a coordinated fashion such as a medical home, and that this type of care can have a dramatic effect on ED utilization and overall Medicaid costs. This opportunity and the medical homes and payment reform opportunities are closely linked, since they all seek to optimize utilization and structure the payment systems that will enable this.

To achieve this and related goals, the state should consider a series of incentives and restrictions to motivate enrollees to select the *appropriate* source of care. Modest copays for ED use, much like those in private plans, could help to steer patients towards urgent care or primary care. Even if many of these copays turn out to be uncollectible, they would still help guide behavior in the right direction.

Reducing emergency department utilization rates by 5 percent annually for 3 years would generate a total cost savings of $25 million. Total 2009 spend for the metro area is approximately $160 million for MA, GAMC, and MA FFS. The mean rate of ED visits per 1,000 in Minnesota is at the 50th percentile of the national rate (2009 HEDIS). Using 2009 data, if we were successful in cutting utilization by 5 percent annually for 3 years the MN rate would be at approximately the 25th percentile of the national rate.

The legislation to advance this opportunity is in place, but no cost savings have been booked to the State for the ED metric in DHS/health plan contracts. The objectives of this opportunity are to realize the 5 percent cost savings to the state and bring the providers into the collaborative effort to reduce ED utilization. It would be next to impossible for the health plans alone to accomplish the 5 percent ED reduction.

3. Reduce hospital readmissions by 5 percent per year to achieve median rates in 3 years ($10 million)

A recent study of an administrative database at the University of California San Francisco observed that Medicaid patients have a 15 percent higher readmission rate than non-Medicaid patients. A number of contributing factors were cited including acuity at admission and current medications. But even when controlling for all variables, the study concluded that a disproportionate number of hospital readmissions are in the Medicaid community.

Besides the cost-saving opportunity stemming from curbing unnecessary hospitalizations under new health reform legislation, the Secretary of Health and Human Services has the power to identify “excess hospital readmissions” and then impose financial penalties on hospitals that surpass that rate. The need to address hospital readmissions in the Medicaid community and indeed overall is great.

Reducing Medicaid hospital readmit rates in Minnesota by 5 percent annually for 3 years would save nearly $10 million. Total 2009 spend in the metro area alone is approximately $85 million for Medical Assistance, GAMC, and FFS patients.

4. Optimize supplies and preference-sensitive care spending ($20 million).

Providers allocate roughly 40 percent of their cost base to purchasing non-capital equipment and supplies. Hospital supply chain management and preference item management constructs are notoriously inefficient and costly. Care providers are further subject to unchecked inflationary growth in the prices of necessary supplies and equipment. A study by the Efficient Healthcare Consumer Response Report identified $11.6 billion of cost-saving opportunities in the American healthcare system directly due to inefficient product movement and ineffective inventory control and materials management. Nearly 10 years later, this situation has only grown worse. In addition to procedural inefficiencies, large discrepancies are observed in the prices of supplies, particularly for expensive preference items. There are opportunities to reduce spend beyond purchasing consortia.

By using a major U.S. healthcare organization as a proxy for all Minnesota providers, we can estimate that $2.2 billion is spent on supplies. It is not uncommon for aggressive programs in individual hospitals or systems that address the total cost of ownership of supplies to achieve savings of 20-30 percent in preference items and 8-12 percent in non-preference supplies. *By conservatively shaving 6 percent off the total Medicaid spend on supplies in Minnesota ($460 million) near-term savings of $20 million would result.*

This opportunity could be expanded to include consideration for preference-sensitive care. In this area additional savings would come from care which, according to the Dartmouth Atlas, is comprised of treatments for conditions where legitimate treatment options exist with significant trade-offs (e.g., some people will prefer to accept a small risk of complication to improve their function; others won't).[10] Decisions about these interventions can have costly implications, especially when the trade-off may involve incurring significant cost with little clinical return (e.g., spinal surgery with small chance for improvement of condition, inductions prior to 39 weeks gestation as the Health Services Advisory Council at DHS is currently discussing). Further analysis would be required to understand and articulate a methodology to approach the opportunity and quantify its economic value more fully; the analysis would include claims data across health plans, but we believe that the effort would have a significant payoff.

[10] The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2938

OPPORTUNITY AREA TWO: BENEFITS DESIGN

Description

Benefits design is one of the most difficult and contentious topics within the movement to reduce healthcare cost trends. The role of the consumer is important in making healthy decisions and using health care resources wisely. That process can be challenging within public programs, which serve complex medical and social needs of so many individuals. Benefits are often viewed as entitlements, making it difficult to change levels of coverage. Before the financial crisis, many states attempted to change benefits with little success, though some states (in particular Tennessee) were able to reduce costs when the government had strong support from legislators and the population (Tennessee expects to reduce Medicaid costs by $2.5 billion).

Current budget crises have forced many states to reevaluate their benefits. In FY 2010, 20 states implemented benefit restrictions and 14 have planned benefit restrictions in FY 2011. These benefit restrictions include the elimination of covered benefits and the application of utilization controls or limits for existing benefits. Several states, including Arizona, California, Hawaii and Massachusetts, eliminated all or some adult dental services for example. A number of states, including Minnesota, also imposed limits on benefits such as imaging services, medical supplies or durable medical equipment, therapies or personal care services.[11] We believe that a comprehensive evaluation of current Minnesota benefits according to national and peer-state benchmarks and optimal plan design will show significant savings opportunities in healthcare cost.

In Minnesota we have prioritized a more expansive Medicaid benefit package than many other states. Minnesotans generally enjoy higher-quality health care than can be obtained elsewhere and higher percentages of Minnesotans have health coverage. Currently, Minnesota spends on average $7,700 per enrollee in Medicaid, while the U.S. average is $5,600 per enrollee (Figure 2). Were Minnesota to move to be more in line with the U.S. average spending per enrollee, the total addressable opportunity would be $2.3 billion. We believe that certain of Minnesota's benefit offerings may be richer than the state can afford.

We are not suggesting a specific package of benefit reductions. We merely observe the significant amount, in total, of Minnesota's gap to other states in light of an unsustainable budget deficit. Though reductions may be necessary, they must be evidence-based and made equitably, with exceptions where necessary to certain vulnerable populations. It would be an oversight to make

[11] Kaiser Foundation

blanket or arbitrary changes to benefits without careful consideration of the impact the changes would have on diverse communities. We must also recognize the relationship between short-term and long-term spending. The Minnesota Medicaid Institute proposed earlier in this document would be, in our estimation, an appropriate venue for such evaluation.

Guiding principles

1. Provide coverage for those who are in most need at a lower overall cost, recognizing that Minnesota's higher than average benefit levels indicate a potential opportunity for reductions in some areas
2. Maintain access to high-quality services for a population with varying needs
3. Maximize the capture of available federal funding and investing in projects where waivers may be available
4. Implement a deliberate planning process to evaluate and develop Minnesota benefit packages that best serve the needs of the populations covered under Minnesota state public programs. The benefits must work within the available resources and the above principles should guide the decision making.

Opportunities

1. Legally authorize early Medicaid expansion (completed – $800 million).

By January 15, 2011, the governor-in-office had the discretion to direct DHS to implement early enrollment in Medical Assistance for adults without children at or below 75 percent of federal poverty guidelines (FPG), where $188 million is already allocated. This opportunity increased the benefits provided to this population utilizing a large share of federal funds ($1.4 billion) and a much smaller share of the State General Fund ($188 million).[12] Our $800 million figure estimates the new federal money less the cost of new programs.

2. Make targeted reductions to home and community-based waiver services (HCBS) ($170 million)

In FY 2010, more than $1.8 billion (Total Fund) was spent on waivered services for around 65,000 for the elderly and people with disabilities under the age of 65 (individuals with developmental disabilities, traumatic brain injuries and physical disabilities). Waivered services include case

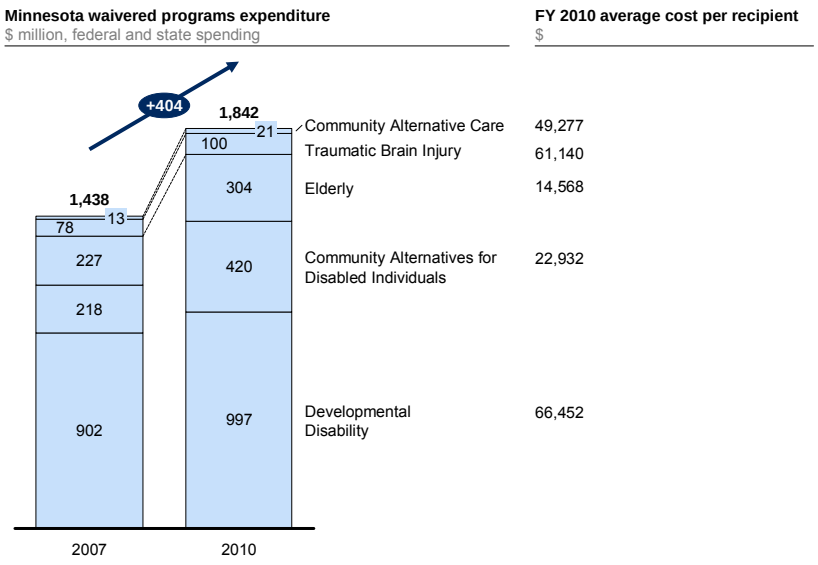
12 http://minnesotabudgetbites.org/2010/06/09/medicaid-expansion-a-good-deal-for-uninsured-state-budgets/

management, adult day care, residential services, homemaking and chore services. The rationale for HCBS is that it is a cost-effective solution; however, Minnesota spent $400 million more for HCBS in 2010 than in 2007. HCBS costs might exceed the savings from a slower nursing home cost growth.[13] Adding to the discussion, Minnesota affirms in its annual report to CMS that HCBS is a cost-effective solution. For example, spending on an enrollee in the Developmental Disabilities (DD) waiver program is 25 percent less than an enrollee in an intermediate care facility.[14] However, any cost reductions in HCBS should also be weighted against the risk of "pushing" more people to facility-based care.

Reductions could be made to the overall county waiver allocations while allowing the counties and consumers maximum flexibility in how to spend their waiver allocations. A 5 percent reduction in total services, which would be well in line with other states, would save $170 million in FY 2012-13.

Figure 5

Waivered programs expenditure has grown by $400 million in the last three years



SOURCE: Minnesota Departments of Finance and Human Services, February 2010 Forecast

Note: Expenditures represent state and federal funding

13 http://www.ahcancal.org/research_data/funding/Documents/HCBS_Research_Synthesis.pdf

14 Research Department of Minnesota House of Representative, "Medical Home- and Community-Based Waiver Programs" June 2010

3. Require prior authorization and care coordination for people exceeding 250 hours per year of PCA or Home Health services (similar to Wisconsin) ($35 million)

Personal care assistance (PCA), which cost $350 million in 2009, is a range of services that supports day-to-day activities which patients would do for themselves if they did not have a disability. Minnesota is one of the 31 states that offer this service, and is one of only 14 that do not limit the hours. Most states allow some flexibility through prior authorization. Limits vary from about 250 hour per year in Wisconsin and Maine to around 3,000 hours per year in California, Louisiana, Montana, Nebraska, Texas, Utah and West Virginia.[15] There is no clear correlation among limitations on hours or the PCA spending per enrollee. However, the average cost per enrollee in those states with hour limits on PCA utilization is lower than those without limits, which includes the six most expensive states (MN, NY, NH, MN, MA, and NE).[16]

The imposition of a requirement for prior authorization[17] to exceed 250 hours per year (Wisconsin), or of any other limit that aligns Minnesota to other states, may come at some additional initial cost; however, such requirements could also identify more cost-effective service options and help expose fraud and abuse. At $18,212 per enrollee, Minnesota has a large space to reduce its spending closer to Wisconsin's ($10,331) or New Jersey's ($11,998), which limit PCA hours per year. The impact of imposing this limit is difficult to calculate, but it is significant. Minnesota did make cuts in this area in the 2010 legislative session. *A conservative reduction of 10 percent would generate savings in FY 2012-13 of $35 million.*

4. Align MN benefits more closely with other state benefit packages ($50 million-100 million).

Minnesota should consider limiting some benefits, since recent FMAP increases prohibit states from changing the standards for eligibility as a means to constrain enrollment. According to the 2009 Health Care Innovation Initiative, Minnesota's Medicaid program has a more extensive package of optional services than does Wisconsin, Illinois, Massachusetts, Florida, Oregon, Maine and Texas. Prior authorization would help to ensure true need. *There are indications that an evidence-based benefit reduction is possible without impairing quality or safety. This analysis would be a critical filter for any benefit redesign initiative but is not assessed here.* In the appendix, we

15 http://medicaidbenefits.kff.org

16 Kaiser Foundation 2006 data, team analysis

17 In addition to changes set to take effect July, 2011 requiring an additional ADL or behavioral need to qualify for PCA services.

included a sample of benefits where Minnesota spends more than peer states that may serve as a starting point in the dialog regarding where to begin addressing the need to moderate current benefits programs. *We believe that if Minnesota adopts new benefit limits there could be savings of $100 million in FY2012-13.*

Of course any limits to benefits should be subject to thoughtful and deliberate evaluation by all stakeholders. Recognizing that some of Minnesota's incremental benefits could be justified (on an ROI or other basis), we have ranged this opportunity from $50 million to $100 million.

OPPORTUNITY AREA THREE: LONG-TERM CARE

Description

Long-term care (LTC) spending accounts for 35 percent of total state spending within Health and Human Services (HHS), or $3.7 billion annually. Within LTC, $1 billion (27 percent) is for facility-based long-term care; $2.7 billion (73 percent) is for medical, custodial, home and community based waivered services (HCBS) and independent care facilities for the mentally retarded and other mental health facilities.

Minnesota's spending in these areas exceeds that of Wisconsin, our nearest neighbor and closest comparator state, by more than $1.2 billion in home health care and personal care alone despite having a nearly identical population.[18]

State	Intermediate care facilities for the mentally retarded	Mental Health Facilities	Nursing Facilities	Home Health & Personal Care	Total
Minnesota ($ million)	178	64	804	1,910	178
Wisconsin ($ million)	130	34	932	703	130

Kaiser Family Foundation: State Health Facts, FY 2008 (most recent available data)

The spending disparity is based partly on the significant difference in benefit levels. Adjusting LTC benefits to national benchmarks was addressed in the Benefit Design opportunity area of this report and is not double counted here.

[18] Kaiser Foundation: http://www.statehealthfacts.org

Although increasing Minnesota's focus on HCBS was an intentional reform effort to "rebalance" Minnesota state investment away from nursing homes (more expensive, not always the right care) to HCBS (less expensive, maintains independence), current trends in Medicaid spending are unsustainable.

Guiding principles

1. Ensure the delivery of long-term care services and support for those in greatest need
2. Deliver the best practice care and case management, seamless transitions across the care continuum and care coordination that delivers the best outcomes for the patients.

Opportunities

1. <u>Move Minnesota's FFS disability program into managed care</u>

$105 million - $300 million

Expanded managed care enrollment can slow Medicaid cost growth, provide more efficient service delivery, and promote high-quality integrated systems of care. Moreover, managed care also offers greater budget predictability compared to fee-for-service. Better case management, care coordination and transition management could prevent avoidable emergency department utilization and hospital admissions, improve pharmaceutical use and management, and support patients in establishing advance care planning to ensure that patient choices are honored. An example of cost reduction in this kind of program was highlighted in a 2010 study of Minnesota nursing facility cost models made by Milliman. The study compared fee-for-service model against that of managed care for Minnesota's long-term-care population and made two assertions that indicate a need for lowering the managed care cost model:[19]

This Milliman study should form a strong basis to transition to all-managed-care due to its compelling, Minnesota-based data.

The monthly admit rate for the FFS LTC population is approximately 50 percent higher than the monthly admit rate for the managed LTC population. The average length of stay, over the last five years, has been 2 to 10 percent lower for the managed LTC population versus the FFS LTC population. These stark differences point to the potential for dramatic savings.

A similar Milliman study conducted in Ohio in 2005 estimated potential savings seemingly in line with the findings of the 2010 Minnesota study. The

[19] "Analysis of Nursing Facility Utilization from 2005 Through 2009" Milliman

report expected a 7.6 percent managed care savings from fee-for-service expenditures for the non-dual adult disabled Medicaid population. Breakeven was forecast as 2 years.

As of June 2009, 61 percent of the Minnesota's Medicaid enrollees were in managed care, whereas some states are as high as 100 percent (Tennessee and South Carolina). The state's population not enrolled in managed care also incur a disproportionate share of costs. For example, only 32 percent of Minnesota's Medicaid spending in FY 2008 was in capitated payments[20], a very rough proxy for managed care expenditures. It is in the state's best interest for the whole of our Medicaid population to be under managed care. Rather than creating new mandates requiring all eligible participants to enroll in managed care, we suggest automatic enrollment of individuals with an opt-out option for those who do not want to be covered under managed care. Assuming that Minnesota could achieve 100 percent enrollment in managed care, the opportunity presented here would provide up to $300 million savings in Medicaid during FY 2012-2013 (depending on actual starting point).

Different beliefs about Minnesota's current level of managed care for Medicaid enrollees creates a range of possible benefits; while $300 million reflects upside based on figures from Kaiser, CMS and HMS, *we have included $105 as the lower end of the ranged based on 87% current participation in managed care.*

2. Promote personal responsibility and financial planning for long-term care $0 million

While personal responsibility and financial planning will not yield immediate-term saving for the state budget, the time to begin this planning in earnest has passed--we must move boldly to catch up and begin charting a better course.

We note the Citizen's League's successes in engaging those affected to address long term care financial planning. We support and encourage consideration of their work to redesign the Medicaid program. We also recognize that the impact of aggressive education and support for personal financial planning would be fully felt over the next 15 to 20 years, when Minnesota Medicaid costs related to LTC are expected to have swelled to $5 billion per year (from $1 billion).

3. Expand alternative housing and day program demonstrations to reduce over-utilization of personal care attendants $0 million

20 2008 Medicaid Statistical Information System (MSIS)

Programs currently underway like ARC and Wingspan, which provide daytime support to individuals in need outside of the home setting, show promise as lower cost alternatives to over utilization of home and community based services, including PCAs. Minnesota should invest for payoffs in three to four years.

OPPORTUNITY AREA FOUR: PLAN ADMINISTRATION

Description

Health care tends to lag behind other industries in the efficiency of back-office services and support.[21] To support effective healthcare transformation, Minnesota's public programs need to be redesigned to leverage the state-of-the-art administrative capabilities resident in the private sector, particularly as applied to eligibility and enrollment functions and capabilities. According to the Minnesota state Department of Human Services, "The complexity of these programs is great, due in large part to the iterative nature of their development and the need and desire to meet federal standards for Medicaid in order to secure favorable financing arrangements. This complexity has resulted in inefficiencies, errors in eligibility determination, public confusion, and controversy around program financing".[22] A study by Milliman found that administration of public programs accounts for roughly 5.2 percent of total claims costs.[23] *For Minnesota, that presents a potential $364 million overall spend to address, a portion of which is directly related to claims processing.*

Guiding principles

1. Expedite and streamline enrollment and eligibility functions
2. Apply state-of-the-art technology cost-effectively to drive efficiencies and savings
3. Eliminate redundant requirements
4. Align quality requirements with community standards and advance the Triple Aim

21 Association for Healthcare Resource and Materials Management, http://www.ahrmm.org/

22 Minnesota Department of Human Services, 2010 – 2011 Biennial Budget Report

23 http://www.milliman.com

Opportunities

1. Consolidate enrollment and eligibility functions for state public programs

$15 million

Minnesota could eliminate the redundancies of current enrollment administration costs between the state and 87 counties if those services were centralized. An "exchange" for these functions could be established over the longer term in alignment with federal health reform changes that are scheduled to be implemented in 2014. The state should consider which entities can deliver the best results, taking advantage of technology to eliminate redundancies and expedite the capture and dissemination of information. The state could also outsource functions to nonprofits and healthcare providers to streamline and speed enrollment. Multiple states, including New York and Wisconsin, have developed programs to centralize some or all elements of enrollment, eligibility and other Medicaid programs at the state level. The state and counties currently have 1,950 FTE spread across all financial assistance programs (e.g., health care, food support, child care assistance, etc.) Based on Medical Assistance share of overall DHS costs, an estimated 1,100 of the 1,950 FTE are administering MA programs. *In line with comparable state experience, the FTEs could be reduced by 30 percent through program consolidation resulting in a $15 million near-term savings accruing to the state*. More analysis should be done to determine how much of the savings will actually accrue in the near-term, particularly taking into consideration the investments in IT infrastructure associated with the current exchange implementation work.

2. Automate the current claims processing functions for state public programs

$10 million

Current encounter data, claims processing and IT systems are not HIPAA compliant, and the state budget cannot support the maintenance and upgrades necessary for effective, efficient and compliant processing. In addition, with up-to-date technology and software capabilities as a base, DHS can save by using the latest tools to prevent fraud and abuse, and modernizing its fraud prevention approach to claims processing.

Minnesota spends nearly $5 billion annually on FFS Medical Assistance for the elderly and disabled. An estimated 1.5 percent ($75 million) of this is for processing claims. This is in line with the commercial payor experience. Automation and claims process improvement initiatives commonly result in up to 15-20 percent savings. *A 15 percent savings in claims administration could save nearly $10 million including implementation costs.* Depending on how the effort to migrate FFS enrollees to managed care evolves, some or all of these savings may be absorbed in that initiative.

$11 million

3. Reduce printing and mailing of Medicaid materials

Minnesota could potentially save additional administration dollars by reducing expensive printing and mailing costs in the Medicaid program. Health plans print and mail materials that could be more easily accessed electronically. Counties spend $1 million annually mailing materials for the Prepaid Medical Assistance Program. $11 million could be saved annually by allowing electronic access to plan material.

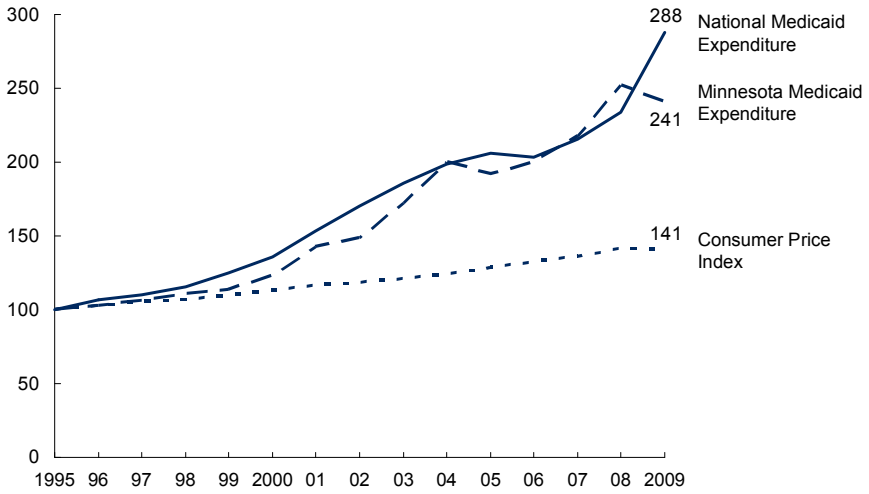
OPPORTUNITY AREA FIVE: ALTERNATIVE REVENUE

Description

Given the diversity of revenue sources and competing priorities for funding from each, healthcare financing has been historically volatile and subject to economic shifts. High growth of healthcare costs generates unsustainable financial pressure.

Figure 6

Medicaid expenditure growth versus inflation
Base year 1995 = 100



SOURCE: WMM (Global Insight), National Association of State Budget Office and team analysis

Guiding principles

1. Pursue all federal dollars that are available to fund healthcare services and system transformation
2. Identify opportunities to create “bridge funding” during the transition from FFS to a self-sustaining managed care system

3. Fund new revenue targeted to health care from products and services that if taxed would promote healthy behavior

Opportunities

1. Maximize matching funds, grants and other revenues from the federal government[24]

Included in 2.1

Minnesota should make concerted efforts to apply for and seek federal grant funding related to health care, particularly since it has not availed itself of all federal funding opportunities to date (such as the $1.4 billion discussed earlier).

A number of states are actively engaged in planning for insurance exchanges provided for under health reform legislation. ACA grant funds were made available to states to fund the planning. Though Minnesota was one of two states to refuse the $1 million funding (along with Alaska), there will be significant federal grant funds available to states for planning and development of innovative programs related to health care.

Though grants do not reduce the state deficit directly, they can help to plan for redesign that will generate savings in the future. Minnesota should not miss an opportunity to receive such funds where helpful and unencumbering.

2. Increase federal matching funds through tax levies and surcharges on providers

$0 - $400 million

Current financial challenges may require all stakeholders to act now rather than being acted upon and look for solutions that may require significant financial commitment to solve the deficit crisis. There are numerous opportunities to increasing federal funding, such as the NY self-insured tax. Rather than create new charges, we propose an increase in existing surcharges to providers that is offset by increases in managed care rates in order to draw dawn more federal funds from CMS.

As an example, Minnesota could first increase the provider tax by 1 percent above the current 2 percent ($525 million for the biennium) and increase the hospital surcharge by 1.96 percent up from the current 1.56 percent ($300 million for the biennium).

Next, offset the impact of the 1 percent surcharge by receiving approval from CMS to increase provider reimbursement rates. This has been done successfully in at least two states this year. A July 2010 Georgia request is expected to increase revenue by $150 million per year. Similarly, a number of

[24] $1,315 million is also included in benefits design and should not be additive to the opportunity addressed there

California hospitals started in October 2010 to collect a fee from themselves that will generate up to $3.1 billion per year for the Medicaid program. CMS approved the legislation that allows the hospitals to self-impose the fees and the federal government will match up to $2.6 billion[25]. Ideally, the providers industry as a whole would break even[26]. In addition to generating more funds for Medicaid, this solution redistributes the funds among hospitals, since hospitals in more affluent areas with little Medicaid exposure will pay the fee just like their peers with greater Medicaid portfolios that receive no additional Medicaid reimbursements.

Finally, with the CMS approval Minnesota would qualify for a federal match that, if set at the current level of 50 percent, *would bring about $400 million to the state General Fund in FY 2012-13.*

While there is precedent for such programs in other states, there is some question about the viability of such arrangements today. As such, we have included $0 as the low end of our range for this initiative.

3.Levy or increase so-called "sin taxes" on products and services that negatively affect people's health

These taxes can have a significant financial impact, and include an added benefit to improve healthy lifestyles, which is a major driver of healthcare outcomes and costs. Revenue could be increased by $150+ million annually if we assume that it is possible to increase taxes on tobacco and alcohol. In general, these taxes incur little resistance from consumers. On the other hand, concentrated opposition comes from product producers. They contend that sin taxes motivate the creation of black or gray markets, disproportionately affect lower-income people, and do not adequately alter behavior. Taxing these kinds of products, while influencing the behavior of the "sinner" to varying degrees, do tend to generate revenue.

Beyond the economic incentive to levy taxes on these products is the issue of improving public health. There is irrefutable evidence that the use of tobacco causes cancer. Alcohol consumption can likewise lead to accident, injury and death. From this list of unhealthy behaviors, it is easy to see why health outcome is impacted not only by good medical care but also by what Minnesotans consume. Unhealthy behavior (tobacco use, diet and exercise, alcohol use and unsafe sex) correspond to 30 percent of the health factor that

[25] http://www.fiercehealthfinance.com/story/california-hospitals-impose-fee-themselves/2010-10-12
[26] http://www.ctmirror.org/story/5429/panel-adopts-tax-hikes-estates-hospitals

impacts health outcomes[27], but the state has few levers to influence the population. By increasing taxes, we can hopefully bend not only the cost trend but also the poor health trend as well. The new governor should have a clear proposition of why specifically these taxes are important for the state.

3.a Tobacco tax

$125 million - $250 million

Forty-seven states already tax cigarettes above and beyond the federal cigarette tax of $1.01 per pack, and some cities such as New York City even impose city taxes above and beyond federal and state taxes. Minnesota's $1.58 per-pack tax is only slightly above the national average of $1.45 per pack and below Wisconsin's $2.52 per pack. The states with the highest state tax are all above $3.00 per pack (NY, RI, WA, CT, HI).[28] The viability of a higher cigarette tax in Minnesota is unclear. In New York for example, the bill including the higher taxes passed narrowly, with all 32 Democrats voting yes and all 29 Republicans present voting no.[29] *A $1.50 per-pack tax increase, which would bring Minnesota into the top state-tax tier for tobacco, would generate an estimated $252 million in additional revenue for FY2012-13.*[30]

3.b Alcohol tax

$30 million

Minnesota taxes alcohol at a lower-than-average overall rate.[31] For beer, Minnesota ranks 33rd out of the 50 states (Minnesota is 21 percent lower than median), and only five states have a lower excise tax on wine (Minnesota is 55 percent lower than median). *An increase in beer and wine taxes to match median of US states would generate about $30 million during FY 2012-13*[32].

ADDITIONAL IDEAS

We believe that our list of opportunities is a meaningful way to reduce the deficit while continuing to provide accessible quality health care to our Medicaid population. There are additional opportunities and issues to consider that are either not easily quantifiable or well enough developed to be included in the current list of opportunities. They are worthy of mention, however, and should be evaluated by an organization such as the proposed Minnesota Medicaid Institute mentioned earlier.

27 County Health Rankings model by University of Wisconsin; other factors are clinical care (20 percent), social economic factors (40 percent) and physical environment (10 percent)

28 http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf

29 http://www.nytimes.com/2010/06/22/nyregion/22budget.html

30 http://www.tobaccofreekids.org/reports/state_tax_report/

31 http://www.mnjointogether.org/FACTScurrenttax.htm

32 http://www.marininstitute.org/site/component/alcoholtax/index.php?option=com_alcoholtax&view=result&controller=result&Itemid=

A. Align MinnesotaCare benefits with small employee plan

MinnesotaCare has spent nearly $900 million per biennium to subsidize a program that provides coverage to more than 100,000 people each month. MinnesotaCare could adopt benefits similar to a typical small employee program, which includes deductibles and coinsurance on hospital services and copayments on office visits and pharmaceuticals. We have extrapolated health plan experience with small employee plans to the MinnesotaCare population in order to quantify the savings from members cost-sharing, utilization reduction and annual out-of-pocket maximum. We did not consider benefits covered in the small employee plan that are not covered under MinnesotaCare (e.g., the inpatient benefit maximum applied to some MinnesotaCare members).

	MinnesotaCare	***Small Employer Plan***	***Proposed***
Deductible	*None*	*$500*	*$500*
Hospital coinsurance	*None, but $10,000 yearly cap (as noted above)*	*20 percent coinsurance*	*20 percent coinsurance, but $10,000 yearly cap*
Prescription drugs	*$3 co-pay*	*$12 co-pay on generics; $35 co-pay on brand names*	*$12 co-pay on generics; $35 co-pay on brand names*
Office visits	*$3 co-pay/none for mental health visit*	*$15 co-pay*	*$15 co-pay*
ER visits	*$6 co-pay for non-emergency ER visit*	*$75 co-pay per visit*	*$75 co-pay per visit*

To be conservative, we also assumed that utilization would be reduced by only 50 percent of what we would expect from the commercial population. Deductibles and co-pays need to be set at levels that can actually be collected, and not merely shifted to the rest of the system as bad debt or uncompensated care. *The estimated savings from this opportunity are $190 million for FY 2012-13.*

B. <u>Contract/outsource the current fee for service claims processing functions for state public programs to align with community standards</u>

Current encounter data, claims processing and IT systems are not HIPAA compliant, and the state budget cannot support the necessary maintenance and upgrades. In addition, with up-to-date technology and software capabilities as a base, DHS can save money by using the latest tools to prevent fraud and abuse, and by adopting a modernized fraud prevention approach to claims processing.

C. <u>Ensure that all measurement and incentive programs for quality are aligned with community standards, developed through ICSI, MNCM, and the Statewide Quality Reporting System</u>

Actively support collaboration across plans and with providers for Performance Improvement Projects (PIP), to leverage the health plan energy on select priorities. Set clear priorities aligned with MN community goals to support providers and plans in achieving improved outcomes.

While not discussed in this document, we recognize that the determinants of health care (e.g., social, educational, environmental) extend well beyond providers and insurers. We encourage the state to consider these broader issues and support the public health initiatives that help to achieve them.

Prioritization

We have prioritized each opportunity area based on three criteria: economic impact in the FY2012-13 budget cycle, ease of implementation, and how well it meets the three guiding principles--access, cost, quality.

Figure 7

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This prioritization reflects the necessary tradeoffs between resources, likelihood of success and potential impact on Minnesota. We strongly believe that Minnesota must act swiftly to begin reform across any of these dimensions.

Conclusion

Minnesota's current healthcare payment system and underlying healthcare model are unsustainable. Minnesota is in a budget crisis that must be addressed. Medicaid is a large and growing area of spending. The Medicaid cost curve will be bent either through proactive and collaborative implementation of payment reform and a prudent transition to managed care or through arbitrary reductions that are not necessarily consonant with providing appropriate access to high-quality care at a reasonable cost.

The signatories on this document believe that it is reasonable to create an environment of trust and collegiality wherein it is possible to develop opportunities that can lead to a healthier Minnesota. From an expansive list of potential initiatives, we have developed a set of opportunities to consider that could provide upwards of $1.5 billion dollars of economic value. Though much work needs to be done to comprehensively evaluate each opportunity. we offer them up as an opening to a dialog that we hope will resonate with the new administration and provide an opportunity to act rather than being acted upon.

Appendix

Appendix 1 – Opportunity summary

Opportunity area	#	Opportunity	Economic impact in FY2012-13 ($ million)	System objective support		
				Access	Cost	Quality
Medicaid cost & utilization	1.1	Reduce hospital admit rates by 5 percent annually	55	✔	✔	
	1.2	Reduce emergency department utilization rates by 5 percent annually	15	✔	✔	✔
	1.3	Reduce hospital readmission rates by 5 percent annually	10	✔	✔	✔
	1.4	Optimize supplies and preference-sensitive care spending	20		✔	
Benefits design	2.1	Sign legislation authorizing early Medicaid Expansion *Completed*	800[1]	✔		✔
	2.2	Make targeted reductions to home and community-based waiver services	100-170		✔	
	2.3	Require prior authorization and care coordination for PCA	35		✔	
	2.4	Align MN benefits more closely with other state benefit packages	50-100		✔	
Long Term Care	3.1	Move Minnesota's FFS disability program into managed care	105-300		✔	✔
	3.2	Promote personal responsibility and financial planning for LTC	0	✔	✔	
	3.3	Expand alternative housing and day program demonstrations to reduce over-utilization of PCAs	0	✔	✔	✔
Plan administration	4.1	Consolidate enrollment and eligibility functions for state public programs	15	✔	✔	
	4.2	Automate claims processing	10	✔	✔	
	4.3	Reduce printing and mailing of Medicaid materials	11		✔	
Alternative revenue sources	5.1	Maximize matching funds, grants and other revenues from the federal government	0[1]	✔	✔	✔
	5.2	Increase federal matching funds through provider taxes	0-400		✔	
	5.3	Add $1.50/pack to tobacco tax	250		✔	✔
	5.5	Increase beer and wine taxes to median	30		✔	✔
Total FY2012-13 budget impact			**1,506-2,221**			

[1]Items 2.1 and 5.1 include the same $1.3 billion in Federal money. These funds include new programs, so only $800 million of the $1.3 billion has been allocated to MN.

Appendix 2 – Select Medicaid benefits where Minnesota offers richer programs than peer states[33]

Prior approval required
Quantity limitations
Other limits

Benefit	Minnesota	Wisconsin	Illinois	Massachusetts	Florida	Oregon	Maine	Texas
Chiropractor	24 visits per year	20 visits per year		20 visits per year	24 visits per year		Limited to acute conditions	12 visits per year
Dental	Limited orthodontia coverage	1 exam or cleaning per year; no orthodontia	Assessing oral health, dx and treatment plan	2 adult exams or cleaning per year	Limited to pain or infection or related to dentures	Limited to ER treatment for pain and infection	Specified procedures; limited to trauma, diagnosis for acute pain, ER	Adult coverage limited to ICF/MR
Podiatrist		1 routine visit per 61 days		Medically necessary for life and safety	Visit frequency limits; foot care for some conditions	Prior approval for specific services and appliances	Routine foot care only for specific systemic conditions	
Psychologist				Psychological testing 1 session per 6 months			16 one hour visits per year	30 visits per year
Prescription drugs		34 days supply, but 100 days supply for some	3 brand Rx per month	$1 generic co-pay $3 brand co-pay	Prior approval some Rx step therapy	Prior approval for specific drugs, growth hormone	Prior approval for non-preferred; 5 brand Rx per month for some	Lower of AWP-15% or WAC+12% ind. RX
Occupational therapy				20 visits per year		Prior approval required		
Physical therapy				20 visits per year		Prior approval required		180 days per year for chronic or long term conditions
Speech, hearing and language disorders			Physician order required	35 speech path visits per year	Limited to augmentative assistive community system	Prior approval required	Decline in ability demonstrations; rehab potential required	
Home Health	2 nursing or home health aid visits per day	30 visits per year		Limited by eligibility category	4 nursing or HH aid visits per day up to 60 per life	Prior approval on medical equipment and supplies over a certain amount	Prior approval required	Cost base per visit; medical equipment and supply
Personal Care Service		250 hours per year				Prior approval required	Prior approval required; 2-4 hours per week based on LOC criteria	Criteria must be met; limited to 50 hours per week
Private Duty Nursing services				112 hours per week		Prior approval required	Prior approval required; must meet specific LOC criteria	

[33] Kaiser Foundation

Appendix 3 - Benefit options

The following examples of benefits are areas where Minnesota could realize cost-savings through service innovation, prior authorization and/or benefit reduction to be better aligned with the Medicaid benefit structure in other states. These benefit options are presented here as options only, not as recommendations. As noted earlier, any consideration of benefit adjustments must consider the equity and scope of the change to the affected population. Benefit design is one of the most contentious and difficult issues to reduce costs. It must be undertaken through a thoughtful and deliberate process that engages all concerned stakeholders.

- Reduce spending on Durable Medical Equipment (DME) by 10 percent by allowing purchase of "certified used" equipment such as wheelchairs and scooters. Members would be required to return a wheelchair or a scooter if their needs change within one year of receipt of the equipment. DME providers would need to reimburse the state for a portion (amount to be determined later) of all returned equipment that is lightly used and available for resale. DME providers would also be responsible for all repairs to certified used equipment purchases for a period of 90 days – a lemon law for scooters. This proposal may require a federal waiver. MN already requires prior authorizations for DME.
- Require FFS prior authorization for prosthetic and orthotic devices. The state currently uses Medicare base rates for these devices. Prior authorizations will ensure that the device is the appropriate device for the member, meeting both cost and function requirements.
- Re-evaluate dental benefit for adults. The governor proposed this elimination in his 2009 budget and we believe this warrants further analysis, including a fair assessment of impact on the relevant Medicaid population and how it could affect emergency department volume. Minnesota has reduced this benefit somewhat over the past year, but there may be room for further reasonable limits.