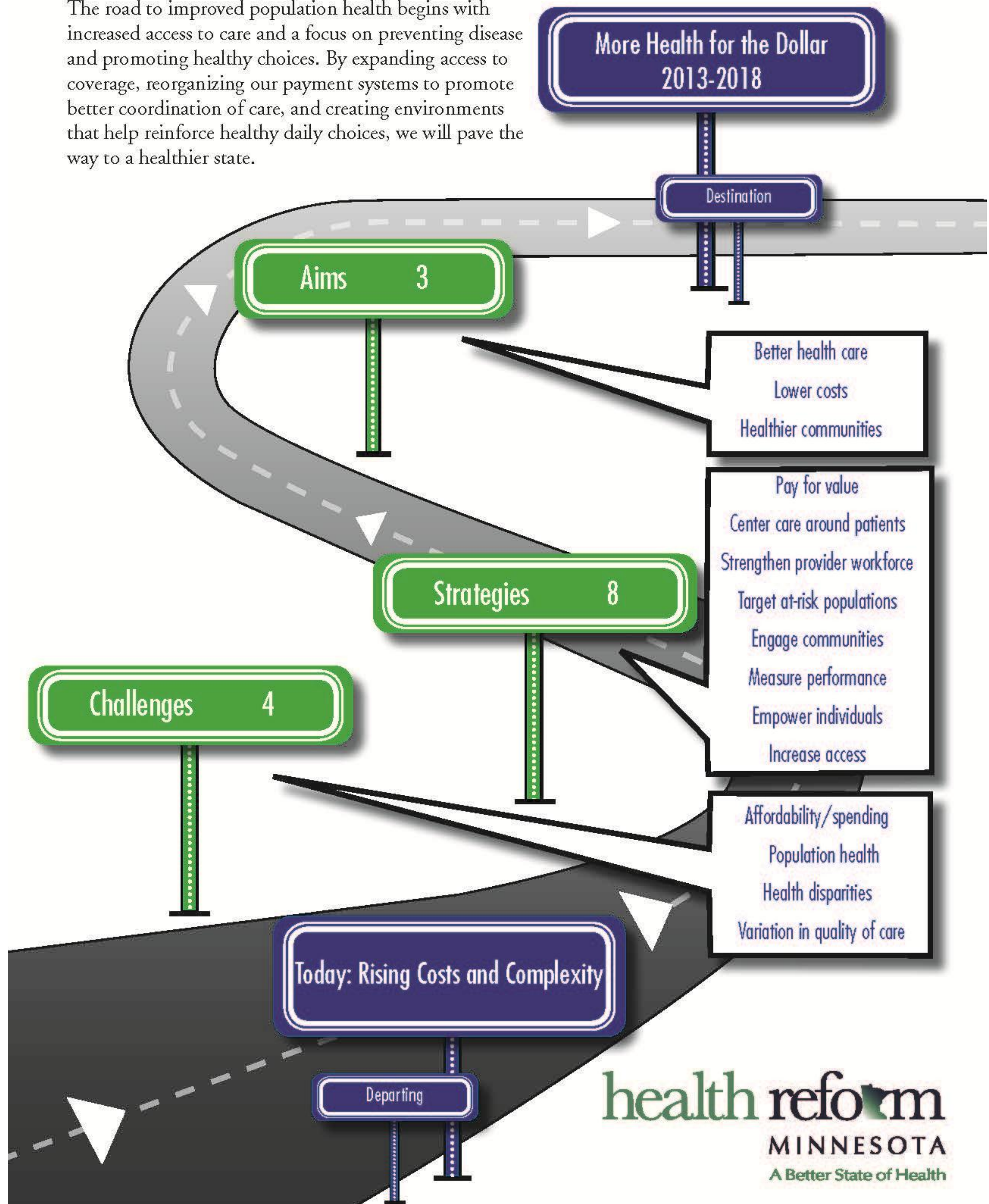
The Roadmap to a Healthier Minnesota

DHS-6640-ENG 12-12

The road to improved population health begins with increased access to care and a focus on preventing disease and promoting healthy choices. By expanding access to coverage, reorganizing our payment systems to promote better coordination of care, and creating environments that help reinforce healthy daily choices, we will pave the way to a healthier state.



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Executive Summary

Roadmap to a Healthier Minnesota

Recommendations of the Minnesota Health Reform Task Force
December 2012

Background: Minnesota has long been recognized as a leader in health and health care, based upon ou
unique cross-sector collaboration, commitment to quality improvement, and innovative coverage models. A
we move into the next of health reform, Minnesota is committed to achieving better health care, lower
costs, and healthier communities through implementation of both state and federal reforms.

In order to reach these goals, our state must address the realities of increasing costs for Minnesotans,
businesses, and the state budget, as well as rising rates of uninsurance. For those with access to healt
services are often fragmented and uncoordinated, with a focus on treating individual diseases rather tha
improving overall health. Another critical challenge for the state is the health disparities between populat
Although Minnesota has made some progress in this regard, communities of color and American Indians f
particular and persistent barriers to health.

Recognizing the urgency and scope of the challenges facing Minnesota, Governor Dayton appointed the
Health Care Reform Task Force in November 2011 to provide leadership and advice on implementation of
the federal Affordable Care Act and state reform initiatives. The recommendations in this *Roadmap to a
Healthier Minnesota* acknowledge that all Minnesotans have an essential role to play in transforming our heal
care system in order to get more health for the dollar.

Overview of the Health Care Reform Task Force and its Work Groups: The
Health Care Reform Task Force established four work groups charged with developing recommendations
within their respective domains: Access, Care Integration & Payment Reform, Prevention, & Public Health
and Workforce. (See Appendix B for founding documents.) The Task Force and work groups held 56 public
meetings between November 2011 and December 2012, including meetings in Rochester, Duluth, St. Clo
and St. Paul. (See Appendix C for the meeting calendar.) Approximately 1,500 people attended the meetings,
more than 115 individuals and organizations provided public testimony in the meetings, and more than 750
provided public comment letters. (See Appendix E for a summary of public comment.) In addition, the
Bush Foundation and the Citizen's League engaged citize
state on a range of health care topics. (See Appendix D for a summary of the Citizen Solutions initiative.)
The recommendations in the *Roadmap to a Healthier Minnesota* are based on Task Force and work group
discussion, work group recommendations, Citizen Solutions feedback, and public input.

Recommendations Summary: The Task Force recommends eight overarching, interconnected
strategies, summarized below:

Strategy I: Pay for Value. There is consensus that the current volume-based payment systems contribute
to health care cost growth, including overutilization and waste. Additionally, it is recognized that a sma
subset of patients with complex health care needs account for the majority of health care expenses. The Task
Force recommends that the publicly funded Minnesota Health Care Programs and contracted health plans
expand Total Cost of Care contracting whereby provider entities take responsibility for health

care costs of a population of patients. Additionally, the Task Force recommends continuing and refining primary care-based health care homes to provide incentives for care coordination and better health outcomes.

Strategy II: Support Patient-Centered, Coordinated Care. Patient-centered care recognizes that a d Y f g c b Ñ g ˙ \ Y U ` h \ ˙ ] g ˙ X Y h Y f a ] b Y X ˙ V m ˙ d \ m g ] W U ` ž ˙ d g m W \ c ` that empower patients while responding to his or her holistic needs. The Task Force recommends several steps to improve the coordination of care across primary care, behavioral health, long-term care, public health, and social services, including development of systems to improve communication and secure data sharing across providers, and provision of technical assistance to targeted providers to support this coordination and integration.

Strategy III: Prepare and Support the Health Provider Workforce. More than one-\ ] f X ˙ c Z ˙ A] b b Y g rural population lives in areas where there are significant provider shortages, particularly in primary care, dental, and mental health. As a large segment of the primary care workforce is nearing retirement and fe medical students are pursuing primary care, further shortages are anticipated across the state and nationally. The Task Force recommends a series of focused investments in the provider workforce to meet current anticipated future needs, recognizing that patient-centered care environments will demand new skills and competencies.

Strategy IV: Improve Health for Specific At-Risk Populations. Targeted interventions focus resources on high-need populations and communities experiencing health disparities. The Task Force recommends pursuing evidence-based programs including home visiting programs for low-income first-time mothers and parents, an evidence-based lifestyle intervention program for those at risk of developing diabetes, and school-linked mental health supports for children. Additionally, the Task Force recommends that a multi-agency body evaluate current school-based health reforms to guide future policy decisions.

Strategy V: Engage Communities. Recognizing that health is primarily determined by factors outside of the health care system, the Task Force recommends increasing opportunities for consumers and communities to make healthy choices through effective initiatives within the Statewide Health Improvement Program 5 X X] h] c b U ` ` m ž ˙ h \ Y ˙ H U g _ ˙ : c f W Y ˙ f Y W c a a Y b X g ˙ U ˙ d] ` c h ˙ c Z multidisciplinary, locally-based teams that partner with primary care practices, hospitals, behavioral health, public health, social services, and community organizations to provide coordinated care for the whole pa

Strategy VI: Measure Performance and Ensure System Stability. = b ˙ c f X Y f ˙ h c ˙ a Y Y h ˙ h \ Y ˙ H goals to achieve better health care, lower costs, and healthier communities, it is important to set clear and monitor performance against them. The Task Force recommends a private-public partnership to direct development of shared goals, define a mechanism for measurement of goal attainm and consider consequences if goals are not met. The Task Force also recommends development of best practices for the state and providers to collect data on race, ethnicity, and language in order to better understand and eliminate health disparities. Finally, the Task Force recommends development of a process h c ˙ X Y h Y f a] b Y ˙ h \ Y ˙ Î f Y-funded programs in order to effectively direct state funds.

Strategy VII: Design Benefits to Enhance Personal Responsibility. The Task Force recommends steps to increase the market availability of health insurance products that foster consumer accountability for h behaviors and create incentives for consumers to use high value providers. This strategy will make it easier for consumers to distinguish which health plans, providers, and services offer the best value for their m

Strategy VIII: Increase Access and Support Consumer Navigation. The Task Force recommends that Minnesota implement a Minnesota-based Health Insurance Exchange with a public-private governance

structure and that Exchange navigators include organizations familiar with public health insurance progra
and services for persons currently ineligible for insurance coverage assistance. The Task Force also
recommends that the state expand access to Medicaid for Minnesotans with incomes up to 138% of th
federal poverty level (FPL) and that the state provide coverage support for Minnesotans with incomes
between 138% and 200% FPL.

Conclusion: The recommendations in this *Roadmap* are interconnected strategies designed to transform
health care and improve health in Minnesota. While the report does not include a specific implementation
timeframe for each recommendation, the Task Force does envision implementation over the next five yea
in conjunction with other reform efforts underway across the state. The landscape of health care is
constantly evolving and \Y g Y ˙ f Y Wc a a Y b X U h] c b g ˙ \ U j Y ˙ V Y Y b ˙ X Y j Y ` c d Y X
culture and as a significant step in our continuous process of improvement. It is in this spirit that the
Care Reform Task Force offers the *Roadmap to a Healthier Minnesota*.

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I. Introduction

Minnesota has long been recognized as a national leader in health and health care. We have robust not-for-profit insurance companies and high-quality health care systems, along with a strong tradition of primary care. We have been at the forefront of providing affordable coverage and innovative health care through our public programs. And we have achieved these results through the collaborative Minnesota culture in which predominately non-profit health plans, health providers and government leaders come together to solve issues with a common commitment to improving the health of our state.

Despite our ongoing attention to improving health and health care, several formidable challenges face Minnesota. While we continue to compare favorably to other states, these challenges are reflected in A] b b Y g c h U Ñ g ` X f c health rankings: the state in 2006 to #5 in 2012, according to United Health : c i b X U h ] c b Ñ g ` < Y.[1] The *Roadmap to a Healthier Minnesota* acknowledges the challenges described below and provides recommendations for consideration by the Governor and Legislature to address these issues in the next one to five years by maximizing opportunities for better health care, costs, and healthier communities.

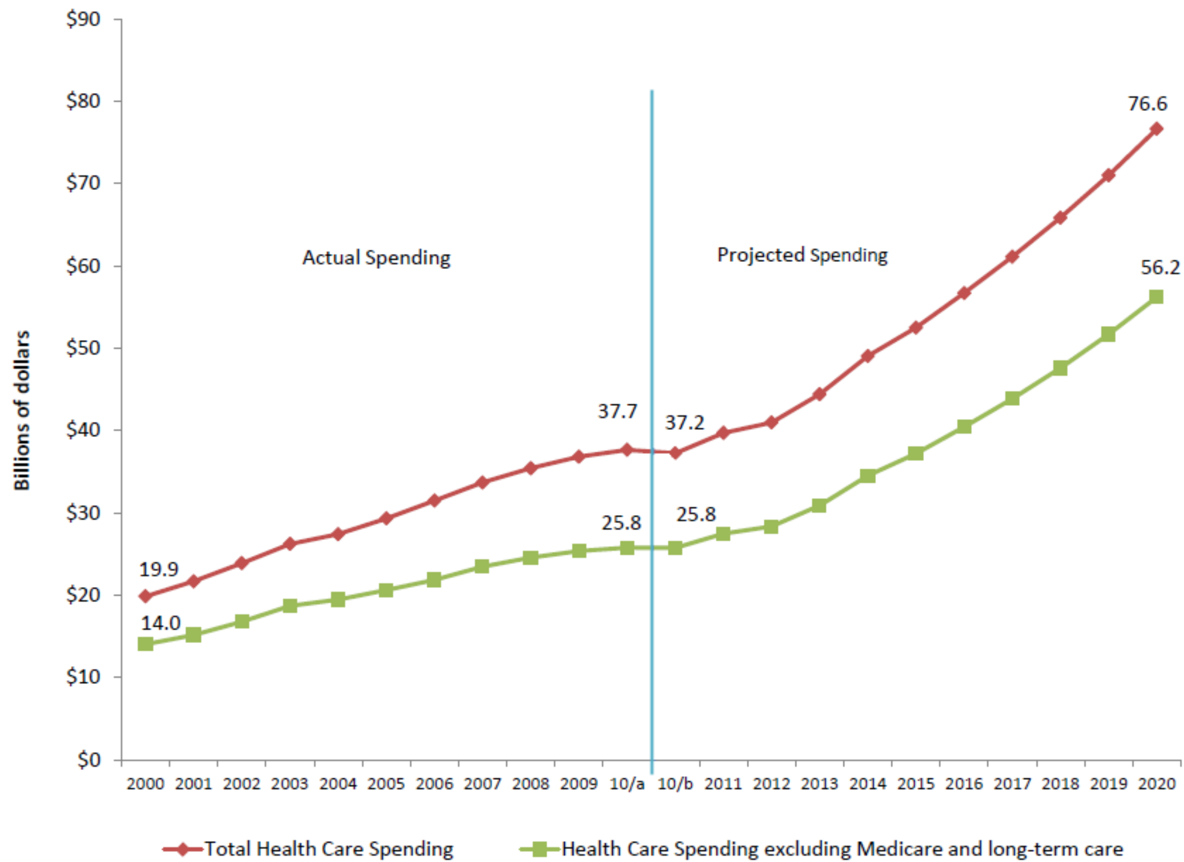
First and foremost among our challenges, according to Minnesotans, are increasingly unaffordable health care costs.[2] This opinion is corroborated by Minnesota Department of Health forecasts, showing that without reform, health care spending is projected to double over the coming decade.[3]

[1] United Health Foundation (2012). 5 a Y f] W U Ñ g 2 < Y U ` h \ F U b _ ] b [ g ` & $ % Minnesota. Retrieved from http://www.americashealthrankings.org/MN/2012

[2] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_MediumR%202.pdf

[3] Minnesota Department of Health, Health Economics Program, Division of Health Policy (2012). Minnesota Health Care Spending and Projections, 2010. Retrieved from www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

Figure 1. Health Care Spending in Minnesota 2000-2020

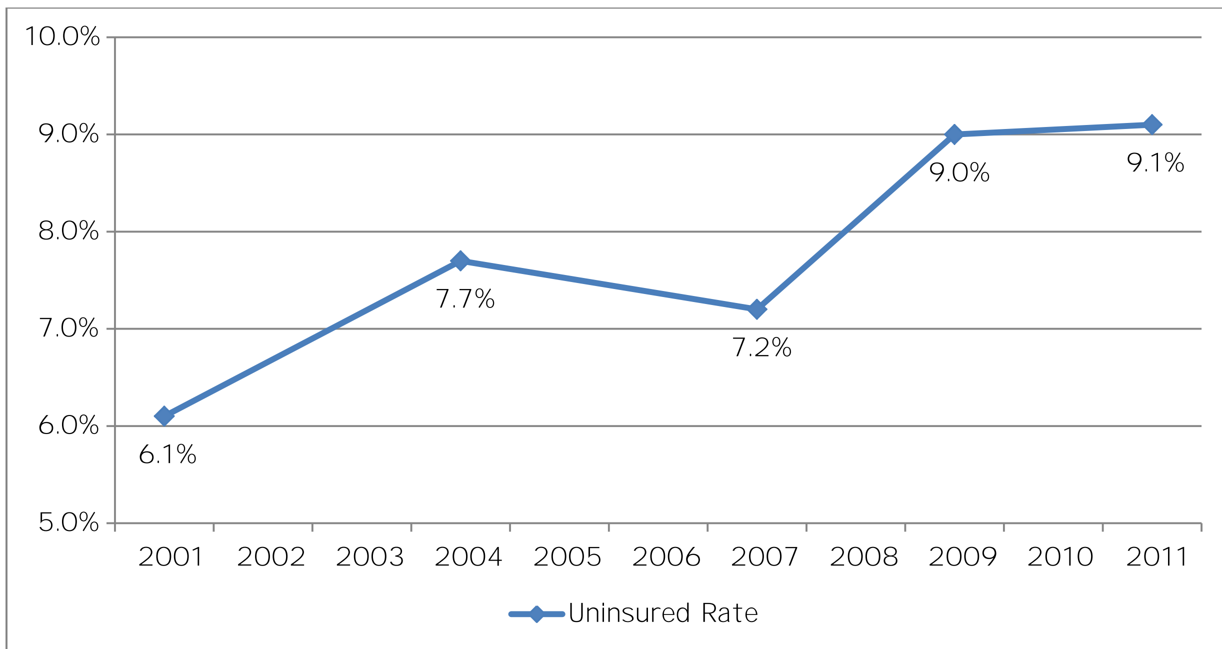


Source: Minnesota Department of Health, Health Economics Program (2012). Minnesota Health Care spending and Projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

As costs and spending have increased, our uninsured population has grown, up from only 6.1% in 2001 to 9.1% in 2011[4]. While new coverage options will be available in the health insurance exchange beginning in 2014, the challenge of growing health care spending will require attention and action through public health, health care delivery, and payment reform. If allowed to continue, these spending trends will threaten the health and economic vitality of individuals, families, businesses, and the state.

[4] Minnesota Department of Health (2012). Minnesota Health Access Survey. Retrieved from https://pqc.health.state.mn.us/mnha/PublicQuery.action

Figure 2 Uninsured Rate in Minnesota 2001-2011



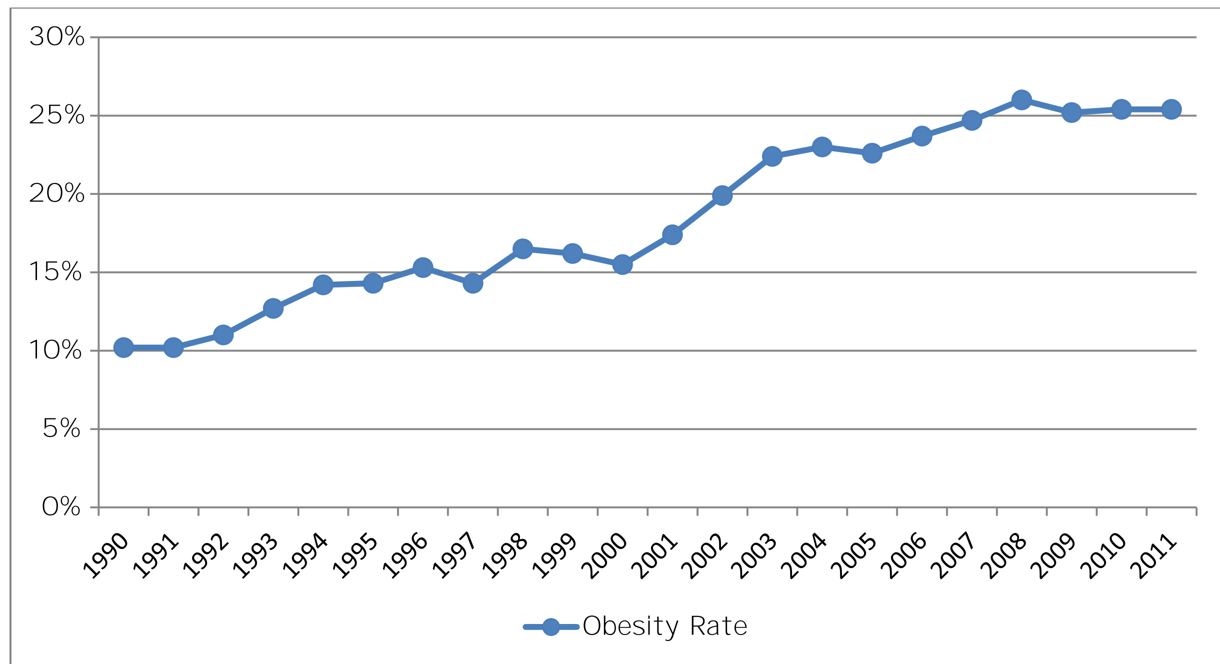
Source: Minnesota Department of Health (2012, March). Health Insurance Coverage in Minnesota: Early Results from the 2011 Minnesota Health Access Survey. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/has2011.pdf

The second major challenge for Minnesota is the health of our population. While Minnesotans now have generally good health relative to other states, health is poor in some areas of the state and trends are worsening. For example, a quarter of the population is obese, the state ranks 44th on adult binge drinking, and the population of diabetics increased 51% in the past decade.[5] If we do not reverse these trends, more Minnesotans will suffer preventable chronic conditions leading to continued growth in health care spending. Deteriorating health status trends that began to emerge in the last few decades already drive a large the health care cost growth that we see today, with 75% or more of total costs now being spent on significantly preventable chronic conditions.[6]

[5] I b] h Y X ˙ < Y U ` h \ ˙ : c i b X U h ] c b ˙ fl & $ % % Ł " ˙ 5 a Y f ] W U Ñ g ˙ < Y U ` h \ ˙ F U b _ from http://www.americashealthrankings.org/MN/2011.

[6] Centers for Disease Control and Prevention (2009). Chronic Disease: The Power to Prevent, The Call to Control: At A Glance 2009. Retrieved from www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm

Figure 3. Obesity Rate in Minnesota 1990-2011



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http://www.americashealthrankings.org/MN/2011

A third critical challenge for our state is the persistent disparities between the healthiest Minnesota least healthy among us. Health disparities are influenced by access to health care, as well as socio-economic status, geographic location, and other factors. Although Minnesota has made gains in reducing health disparities over the past 20 years, communities of color and American Indians still experience shorter life spans, higher rates of low birth weight and infant mortality, and higher incidence of diabetes, heart disease, cancer, and other conditions.[7]

Finally, we also face the challenge of variation in health care quality across the state, including low rates of optimal care for many conditions. For example, Minnesota Community Measurement reports that, overall, only 24% of children with asthma receive optimal care, 37% of Minnesotans with diabetes receive op care, and 40% of Minnesotans receive optimal vascular care.[8] While these rates may exceed those of other states, there is significant variation in optimal care between geographic areas and below expectations for a high performing health system. In addition, our care today is often provided on a fee-for- service basis focused on a particular service rather than the whole person, leading to the potential overuse of services, and for missed opportunities to coordinate and integrate care. Addressing these quality issues is

[7] Minnesota Department of Health, Center for Health Statistics (2009). Populations of Color in Minnesota: Health Status Report: Update Summary Spring 2009. Retrieved from http://www.health.state.mn.us/divs/chs/POC/POCSpring2009.pdf

[8] Minnesota Community Measurement (2011). 2011 Health Care Quality Report. Retrieved from http://mncm.org/site/upload/files/Book_6_21_2012.pdf

especially critical now as Minnesota's population ages rapidly and, as a result, demanding more health care services.[9,10]

Recognizing the urgency and scope of the challenges facing Minnesota, Governor Dayton appointed the Health Care Reform Task Force in November 2011 (Minnesota Laws 2010, 1st Special Session, article 22, section 4) to provide leadership and advice to achieve better health care, lower health costs and healthier communities through implementation of state and federal health reform, including the Affordable Care Act. The Health Care Reform Task Force recommendations address these challenges and recommend fundamental changes in provider payment and methods of delivering care and consumer and community activation to build healthier lives and healthier communities. The recommendations in the *Roadmap* recognize that all Minnesotans, including consumers, employers, providers, as well as health plans and government, have an essential role to play in achieving a positive transformation in the state. Collective action will lead to more efficient use of health care resources so that Minnesotans, local business and state government get more health for the dollar.

Building on the Tradition of Health Reform in Minnesota

Minnesota has a long tradition of working collaboratively to maximize access, health status, quality, and efficiency in health care. Over the past decade, Minnesota has periodically evaluated its health system and addressed difficult challenges head on, including the Minnesota Health Access Commission in 1989-1991 that created MinnesotaCare, the Minnesota Health Care Commission of 1990-1992, the Minnesota Health Care Commission of 1995, the Minnesota Citizens Forum on Health Care Costs in 2003, the Health Care Transformation Task Force of 2007, and the Health Care Access Commission of 2008. The commitment of Minnesota to continually improve is one of the reasons that the state has one of the highest performing health care systems in the nation. The 2011-2012 Health Care Reform Task Force and the *Roadmap* outlined in this report build on the findings and recommendations of these preceding bodies, extending the strategies that have yielded success, and offering course corrections for those that have not. The members of the Task Force recognize that health reform is an evolving process and hope that in the spirit of continuous improvement, future bodies would similarly reflect on these recommendations with an eye towards further refinement and advan

Overview of the Health Care Reform Task Force and its Work Groups

The Health Care Reform Task Force has 17 members and is chaired by Human Services Commissioner Lucinda Jesson. Task Force members and their affiliations are detailed on page 3.

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[9] The fastest growing group is those individuals 50-59 years of age, followed by those older than 85 years of age. Between 2000 and 2030, the 65-year and older age group is expected to increase by almost 700,000, a rate of 117%. Minnesota Department of Health (2009). Health Workforce Shortage Study Report: Report to the Minnesota L 2009. Retrieved from http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf

[10] According to estimates by the federal Health Resources Services Administration, populations over 65 years of age require twice as many primary care physician hours as younger populations and even more for specialists. See: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions (2006, October). Physician Supply and Demand: Projections to 2020. Washington, DC: Author. Retrieved from http://www.achi.net/HCR%20Docs/2011HCRWorkforceResources/Physician%20Supply%20and%20Demand 2020%20kl.pdf

Executive Order 11-30 gave the Task Force authority to create and oversee workgroups on key issues critical to the health of the State. The Executive Order specifically outlined the following vision of the Triple Aim:

a. Better health care: Expand health coverage and provide a better consumer experience throug effective and positive community engagement on issues related to health care, public health, and insurance;
b. Lower costs: Reduce unsustainable growth in per capita health costs while improving health quality and efficiency; and
c. Healthier communities: Improve the health of all Minnesotans and decrease health disparities.[11]

The Executive Order calls upon members of the Task Force to provide leadership and advice on the implementation of health care reforms including:

a. Redesign of health care delivery, payment, and data systems to improve health and control costs, including integration with long-term care, behavioral health, public health and social services;
b. F Y Z c f a ˙ c Z ˙ A] b b Y g c h U Ñ g ˙ \ Y U ` h \ ˙ Z] b U b W] b [˙ a Y W \ U b] equitable sharing of costs among all payers;
c. Development and oversight of work groups and task forces established by individual Commission on issues such as the health insurance exchange, public health, workforce needs, delivery syst and payment reform; and
d. Opportunities for consumer and community engagement in health reform efforts, including creation U b X ˙ a U] b h Y b U b W Y ˙ c Z ˙ U ˙ d i V `] W ˙ k Y V g] h Y ˙ U b X ˙ g d Y U _ Y about health reform.

Governor Dayton also charged the Task Force with reviewing the recommendations of the Health Insurance Exchange Advisory Task Force and considering the Exchange 5 X j] g c f m ˙ H U g _ ˙ : c f W Y Ñ g ˙ k c f broader health reform efforts.

The Health Care Reform Task Force established four distinct work groups charged with developing specific recommendations within their respective domains. All Task Force members were requested to be involved in at least one workgroup; Exchange Advisory Task Force members also were invited to participate on exchange-related issues. The Task Force determined that the recommendations would first be developed b the individual work groups and then brought to the full Task Force for consideration and adoption. overview of the four work groups follows.

- Access (Chaired by Ralonda Mason, St. Cloud Area Legal Services): This work group was charged with identifying opportunities to encourage consumer choice based on quality and cost of care. This included evaluating essential health benefits (as called for by the federal Affordable Care Act) and other opportunities to streamline coverage and increase portability; considering how to maximize enrollment for those eligible for public or private coverage, including evaluation of coverage needs and options for the population with incomes between 138 and 200% Federal Poverty Level (FPL); reviewing strategies for Minnesotans to easily learn and get answers about coverage

[11] Minnesota Executive Order 11-30: Establishing a Vision for Health Care Reform in Minnesota. Retrieved from http://mn.gov/health-reform/images/Executive-Order-11-30.pdf

care options, including links with the Health Insurance Exchange and assessing the strength of the safety net to serve the newly covered and meet the needs of those who will not be covered in 2014.

- Care Integration and Payment Reform (Chaired by Dr. Douglas Wood, Mayo Clinic): This work group was charged with identifying opportunities to improve quality of care, lower costs provide seamless services for Minnesotans as they move between systems of health care, lor care, mental health, dental, and social services.

- Prevention and Public Health (Chaired by Michael Connelly, formerly with Xcel Energy): This workgroup was charged with proposing activities to measurably improve the health of Minneso through strategies focused on prevention at both the individual and population levels. This work was done with the framework of the statewide health needs assessment, Healthy Minnesota 2020.[12]

- Workforce (Chaired by Dr. Therese Zink, University of Minnesota): This workgroup was charged with assessing the sufficiency of the health workforce statewide, including primary, mental h chemical health, oral health, and long-term care. The group worked to determine effective strategies and opportunities to identify, address, and prevent shortages.

As a first step in developing the *Roadmap*, the Task Force established a series of principles to guide its work and recommendations.[13] Starting on Nov. 14, 2011, the Task Force met on a monthly basis to hear from health care experts and the public, to discuss issues relevant to the mission of the Task Force, and to review the emerging recommendations of the work groups.

The Task Force and its constituent work groups held 65 public meetings between November 2011 and December 2012, including meetings in Rochester, Duluth, St. Cloud, and St. Paul. Over the course of the year, approximately 500 people attended these meetings with more than 115 individuals and organizations providing public comments at the meetings. In addition to verbal testimony at meetings, individuals and organizations also shaped the recommendations through more than 750 public comment letters, more than half of them from individuals.

The *Roadmap to a Healthier Minnesota* reflects the work of the Task Force, the work groups, and members of the public who weighed in throughout the process. As a result, the recommendations below represent a broad range of issues and priorities for our state. In voting to approve this *Roadmap*, Task Force members were asked to support the *Roadmap* as a whole. Thus, approval by members reflects support for the overall direction and majority of the work in the *Roadmap*, but does not necessarily translate into support from every member for each recommendation outlined below. [illegible] *Roadmap* does not necessarily imply the endorsement of their respective organizations.

Citizen Engagement in Health Reform Priorities of Minnesotans

The Task Force acknowledged the need for citizen engagement and discussions of the future of health and health care in Minnesota. The Bush Foundation generously funded the Citizens League and a

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[12] See: http://www.health.state.mn.us/healthymnpartnership/hm2020/

[13] The Task Force principles are attached as Appendix A to this report.

citizen engagement process during the spring and summer of 2012 to seek guidance on a range of health care topics from nearly 1,100 Minnesotans from all political persuasions, income levels, and ethnic backgrounds. Frc a ˙ h \ Y g Y ˙ Wc b j Y f g U h] c b g ž 5 b X] Z Z Y f Y b h ˙ Wc b j Y f g U h] c b ˙ U Task Force learned that Minnesotans believe that the two greatest challenges facing the health care sy today are the affordability of care and the complexity of the system.[14] See Appendix D for a summary of the 7] h] n Y b ˙ G c ` i h] c b Ñ g ˙ = b] h] U h] j Y "

The consumers with whom Citizen Solutions met did not suggest that the government should retain sole responsibility for solving these problems. Rather, they indicated a desire to take an active role in achieving better health, make trade-offs and accept an equal balance of rights and responsibilities as Minnesota seeks to reform the health care system. G d Y W] Z] WU ` ` m ž ˙ h \ Y ˙ d U f h] W] d U b h g ˙] X Y b h] should guide the current health reform initiatives:

1. Empower Minnesotans to be co-creators and co-managers of their health.
2. Equip Minnesotans to make healthy choices within the health care system.
3. Encourage the redesign of institutions and creation of environments that help reinforce healthy re daily choices.[15]

The Recommendations of the Task Force: Roadmap to a Healthier Minnesota

The Task Force provides the following *Roadmap* and recommends prompt action by the legislature and executive branch agencies given the time-sensitive and compelling need for change. The Task Force believes this course of action will ensure that Minnesotans receive more health for their public and private d they receive today. Specifically, the Task Force recommends eight interconnected strategies and the 33 elements within them, outlined in the table below and described in detail in this report.

Strategy	Element
I. Pay for Value in Health Care	1. Advance Total Cost of Care (TCOC) contracting for Minnes Health Care Programs.
	2. Explore possible improvements to and expansion of the care home program.
II. Support Patient-Centered,	3. Facilitate improved integration of behavioral health a care services.
	4. Support appropriate coordination and integration of health care

[14] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_Mediu %202.pdf

[15] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_MediumRes %202.pdf

Coordinated Care	long-term care, public health and social services in Minne Health Care Programs TCOC contracts.
	5. Provide reimbursement for prevention and care coord services for the uninsured through safety net provid
	6. Address barriers to clinically appropriate data sharing while rigorously protecting against unauthorized sharing ar
	7. Provide technical assistance to targeted providers to providers succeed in the future within a system in w providers are contracting for Total Cost of Care (TCOC)
III. Prepare and Support the Health Provider Workforce	8. Invest in high-speed infrastructure for telehealth and w services that increase access and foster interprofess competency.
	9. Explore and remove regulatory barriers to advancement of the nursing workforce.
	10. Increase the supply of primary care workforce and stal support for health professions education by supporting existin health professions training sites and funding for new sit primary care physicians, advanced practice registered nurses, physician assistants and pharmacists through the Medical Education and Research Costs (MERC) program.
	11. Attract and retain the long-term care workforce by doing t career advancement; increasing wages of direct care workers employed in nursing homes and in-home care; and supporting innovative adult training programs, such as the existi FastTRAC program.[16]
	12. Increase the number of health professionals in under by [illegible] Health Professional Loan Forgiveness Program, especially for nurses and physic assistants, and opening the program to a wider grou professionals.
	13. Prepare for anticipated increased demand on safety services by increasing reimbursement to safety net provide primary care, mental health, substance abuse, and co based services provided to Minnesota Health Care Pr enrollees
	14. Increase diversity in the health care workforce by su range of health professions diversity programs.
IV. Improve Health for Specific At-Risk Populations	15. Expand the existing evidence-based family home visiting program for high-risk mothers and evaluate the impact o visiting on health disparities.
	16. Include an evidence-based diabetes prevention program as a

[16] See: http://www.mnfasttrac.org/

	statewide reimbursed benefit under Minnesota Healt Programs.
	17. Expand school-linked behavioral health grants and incluc previously untreated children with high mental health coordinate with suicide prevention and telephone supports, and offer screening and referral for substa issues.
	18. Evaluate and perform gap analysis on school health re
V. Engage Communities	19. Identify the most proven Statewide Health Improvement Program (SHIP) initiatives to add expand these preven approaches statewide, as indicated.
	20. D] ` c h ˙ h \ Y ˙ Wc b WY d h ˙ c Z ˙ Î 5 WWc engage communities in setting and achieving Triple Ai
VI. Measure Performanc and Ensure System Sustainability	21. Use a private-public process to set performance targets goals for health care cost containment, health care c experience and population health.
	22. Implement best practices for collection and reporting detailed categories of race, ethnicity, and language linked to health disparities.
	23. Develop recommendations for implementing a public h return on investment (ROI) methodology including recommended practices for programs funded by stat government.
	24. Guide a process for comprehensive performance measurem of TCOC-contracted provider entities and other provic organizations in achieving health and cost goals.
VII. Design Benefits to Enhance Personal Responsibility	25. Increase the market availability of health insurance pro foster consumer accountability for health behaviors a incentives for consumers to use high value providers.
VIII. Increase Access and Support Consumer Navigation	26. Expand Medicaid to include individuals with incomes u 138% of the federal poverty level (FPL).
	27. Implement a Minnesota-based health insurance exchange, employing a public-private governance structure.
	28. Provide affordability and coverage supports for adults with incomes between 138 and 200% FPL at a level equivalent to MinnesotaCare, at minimum.
	29. Consider that Benchmark options for the Essential Healt Benefits (EHB) based on Minnesota plans would provide generally similar benefits and that an ongoing mechan review and stakeholder feedback on the EHB is needed.

	30. Ensure the availability of Exchange navigators who are knowledgeable about public health care programs and skilled in connecting eligible applicants to the approp program.
	31. Create a referral process in the Exchange for people who ar initially eligible for Medicaid or premium tax credits to them to low-cost clinics and health resources in their a legal services for immigration assistance.

II. Roadmap Recommendations

This section provides the detailed recommendations of the Task Force, beginning with discussion of how the f Y Wc a a Y b X U h] c b g ˙ k] ` ` ˙ k c f _ ˙ h c [Y h \ Y f ˙ h c ˙ U W\ ] Y j Y ˙ A] b b reduced health care cost growth.

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The combination of declining health in the midst of rising costs, as described above, presents a challenge that can only be met by a system-wide transformation that maximizes the efficiency of A] b b Y g c h U Ñ g public and private health care dollars. In essence, Minnesota must get more health for the dollar. Every dollar g d Y b h ˙] b ˙ h \ Y ˙ g m g h Y a ˙ a i g h ˙ V Y ˙ U b ˙] b j Y g h a Y b h ˙] b ˙ h \ Y ˙ business of producing health with our health system. The strategies outlined in this Roadmap realign the incentives throughout the system to better leverage our funds and enable us to slow our spending and decrease the rate of uninsurance, while achieving better health.

The Interaction and Interdependency of Roadmap Strategies

The Task Force recommends eight primary strategies to achieve more health for the dollar. It is important to note that these strategies are not independent; rather, they are deeply entwined and interconnected, each strategy supporting and enabling one or more other strategies. For example:

- reforming our payment system creates incentives for providers to organize their systems to create better care coordination and integration. Providers, in turn, need more ready access to clinical data from other providers and in some cases need technical support to transition to an organization that can manage population health;
- underlying all reform is a recognition that an improved health care system will only have an impact on population health if individuals have access to care, and access requires coverage and the ability to navigate coverage choices; and
- g i d d c f h] b [˙ d Y c d ` Y ˙ h c ˙ ` Y U X ˙ \ Y U ` h \ ] Y f ˙ `] j Y g ˙ WU b ˙ illness before it begins, preventing exacerbation of existing conditions, and lowering costs to health care system.

Therefore, while policymakers may pick and choose from these recommendations in the coming one t years, it is important to note that it is in the aggregate that the recommendations have the most transformative power to set the state on the path to success: more health for the dollar.

Strategy I: Pay for Value

The Opportunity: There is a growing local and national consensus that the predominant current volume-based payment system plays a major role in high rates of health care cost growth and is a significant factor in overutilization of resources that are a source of waste in the delivery system.[17] Under the fee-for-service payment system, health care providers are paid based on the volume of services provided regardless of the quality of care provided to the patient. In contrast, a Total Cost of Care (TCOC) contracting provider entity receives risk-adjusted payment in exchange for assuming responsibility for the health and health care for a population of patients, including the cost and quality related to such care. The provider entity may take many organizational and corporate forms, but is expected to maintain a set of formally defined working relationships among primary care clinicians, hospitals, specialty physicians, long-term care providers, behavioral health, public health services, social services and other health care professionals and facilities. The use of TCOC contracts changes [illegible] incentives and rewards a high quality, patient-centric model of care.

Health care homes are evolved primary care practices in which payers provide targeted fee-for-service payments for coordination of care so that the practices can provide higher intensity support to patients with chronic conditions that place them at high risk of health status decline and future cost growth. Health care homes coordinate and manage care in partnership with patients in a patient-centered manner. Accordingly, the Task Force recommends the actions detailed below aimed at reforming payment systems to enhance value.

Strategy Element #1: Advance Total Cost of Care contracting for Minnesota Health Care Programs. There is growing evidence that TCOC contracting produces better value than fee-for-service care on several dimensions, including cost and quality.[18,19] TCOC contracting differs from early health maintenance organization programs because a) consumers are not necessarily limited to accessing certain providers, b) payments are risk-adjusted, c) payments incorporate quality considerations, d) payers typically provide better information support to participating providers, e) payers transfer less risk to providers and providers are at less risk of harm, f) participating providers usually have more infrastructure to manage population health. While TCOC contracting is increasingly common for commercial health plans in Minnesota, it is less so for the Minnesota Health Care Program populations. While it is important to be cautious in the implementation of TCOC contracting with providers serving low-income populations,[20] the potential benefits are such that a thoughtful and well-planned implementation of the payment model appears to be a prudent strategy for improving health, health care and reducing cost growth in Minnesota. Specifically the Task Force

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[17] Institute of Medicine (2012). Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press. Retrieved from http://books.nap.edu/openbook.php?record_id=13444

[18] Mathematica, Inc. (2009). Summary: Global Payment. Presented to the Massachusetts Special Commission on the Health Care Payment System, March 13, 2009. Retrieved from http://www.mass.gov/chia/docs/pc/2009-03-13-global-payment-c2.pdf

[19] Berwick, D. M. (1996). Payment by Capitation and the Quality of Care: Part 5 of 6. *New England Journal of Medicine, 335*(16), 1227-1231. Retrieved from http://content.nejm.org/cgi/content/short/335/16/1227

[20] : f U _ h ž 5 " / A U m Y g ž F " fl & $ % & Ł " 6 Y m c b X 7 U d] h U h] c b . < c k Amount Of Risk Providers And Payers Bear. *Health Affairs, 31*(9), 1951-1958. Retrieved from http://content.healthaffairs.org/content/31/9/1951.full

recommends that the Department of Human Services (DHS) advance TCOC contracting within Minnesota Health Care Programs by DHS and DHS-contracted health plans with provider organizations over three years with those providers that have the capability and interest to participate, building off the existing Health Care Delivery System (HCDS) demonstrations. H \ ] g ` ] b ] h ] U h ] j Y `] g ` U ` g c ` ] b W ` i X Y Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted Septem 2012).

For those providers that may be unable to participate because of size, DHS and its contracted healt should explore and pursue other fee-for-service-based payment models. The Task Force also recognizes that other effective payment innovations may develop and that these recommendations are not intended to constrain exploration of other new models or encourage additional consolidation among providers. DHS should expand ways to risk adjust for social determinants of health and include interventions around social determinants in these models.

Strategy Element #2: Explore improvements to and expansions of the health care home program

DHS and MDH should jointly explore a) mechanisms to reduce the burden for providers of tiering pat and/or submitting individual claims to get paid for health care home services, including exploration of ways to transfer the task of assessing patient complexity to payers; b) replacing the current health care home claims-based payment model with a prospective method that generates payments for all individuals served in health care homes; and c) the potential impact of expanding payment for care coordination to all patie not just those with chronic illness, because all patients would benefit from the structure of care as a patient-centered medical home. Such exploration should keep in mind the need for evidence-based support for both the current program and alternative models, and the fact that patients with chronic illnesses and those impacted by social and economic determinants of health have greater need for care coordination than those without illness.

For care systems involved in TCOC payment models, MDH should develop processes to evaluate the effectiveness of these integrated payment models on primary care investment and transformation. The evaluation should include outcomes for complex and special population patients and patient experience.

Strategy II: Support Patient-Centered, Coordinated Care

The Opportunity: Through the work of Citizen Solutions, the Task Force heard that Minnesotans see a Î \ Y U ` h \ m ` ` `] Z Y ` U g ` c b Y ` body, mind and spirit.[21] The health care system, however, is fragmented and currently does not acknowledge this view of health and lacks a unified approach to care. Providers often operate in silos that Z c W i g ` c b ` c b ` m ` c b Y ` U g d Y W h ` c Z ` U ` d Y f g c b  g ` \ Y U ` h \ - being and, as a result, patients are subjected to duplicative testing, inconsistent treatment plans, and conflicting medical advice.[22] In contrast, patient-W Y b h Y f Y X ` W U f Y ` ] g ` \ c ` ] g h ] W ` U b X ` f Y W c [b] n

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[21] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_Medium%202.pdf

[22] Institute of Medicine (2012). Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press. Retrieved from http://books.nap.edu/openbook.php?record_id=13444

physical, psychosocial, and environmental factors and offers an approach that empowers the patient responding to [illegible] interconnected, multidisciplinary needs. Coordination across care settings improves the quality of care by ensuring that all providers are aware of and follow the appropriate treatment results in a better care experience for patients. Further, providing more coordinated, better care for targeted high-risk patients can cut costs by reducing duplicative testing, emergency department visits, and inpatient admissions associated with preventable exacerbations of chronic conditions. Given these findings, the Task Force recommends the following actions:

Strategy Element #3: Facilitate improved integration of behavioral health and primary care services
The combination of behavioral health disorder with any chronic health condition significantly increases costs and results in poorer health.[23] Yet the long-standing separation of behavioral and primary health care, which occurred in part due to the use of behavioral health payment systems and insurance product carve vendors, fails to recognize the inextricable link between [illegible] physical health. Further, this fragmented approach perpetuates the stigma associated with behavioral health needs and results in many patients receiving suboptimal treatment in primary care settings.[24] As the number of chronically ill patients rises, so too does the need to provide screening and behavioral health intervention in a coordinated way. Therefore, the Task Force recommends supporting integration of behavioral and primary health care generally and specifically through: a) use of Section 2703 Health Homes programs for adults and children with severe mental illness and complex conditions; b) Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs for substance abuse in primary care settings; c) incorporating behavioral health integration into training[25] and technical assistance provided through MDH Health Care Home Statewide Learning Collaborative and other channels, and d) incorporating co- and non-co-located behavioral health providers into the training; and e) psychiatric consultation pilot programs to support primary care providers to be able to provide mental health services in both rural and urban areas.

Strategy Element #4: Support appropriate integration/coordination of health care, long-term care and public health and social services in Minnesota Health Care Programs in Total Cost of Care (TCOC) contracts. While the TCOC-contracted provider entities[26] shall initially be responsible for the provision of preventive, acute, post-acute, and chronic illness services, over time the scope of services should expand to include the tight coordination of behavioral health, long-term care, public health, and social services.[27] While integration will not be possible across all providers and in all parts of the state, including a broader range of these services in TCOC contracts will promote the integrated delivery of such services and support providers to work together to promote patient health. Specifically, the Task Force recommends that TCOC provider entities shall begin to coordinate medical/surgical and mental health/substance abuse

[23] Kathol R (2012). [illegible] Reform Work Group, Minnesota Health Care Reform Task Force. Retrieved from http://mn.gov/health-reform/images/WG-PR-2012-06-04%20Cartesian-Solutions.pdf

[24] Wang, P. S., et al (2005). Twelve-Month Use of Mental Health Services in the United States. *Archives of General Psychiatry*, 62. Retrieved from http://archpsyc.jamanetwork.com/article.aspx?articleid=208673

[25] See: Collins, C., et al (2010) Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund. Retrieved from http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf

[26] [illegible]

[27] These services include both institutional and community-based services. Long-term care integration would also benefit privately funded users of long-term care services.

services with local public health and social services agencies, initially through coordinating activities a
within three years. Medicaid begin to do so through an integrated funding and service provision pilot. In
addition, phasing in over three years, such entities shall also become responsible for integrating Med
funding for those dually eligible for Medicaid and Medicare. These efforts would be done in coordination
and alignment with the existing CMS demonstration programs U b X U f Y] b W` i X Y X] b A] b b Y State
Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted Septen
2012)

Strategy Element #5: Provide reimbursement for prevention and care coordination services for the uninsured through safety net providers. Focusing on prevention and primary care among the uninsured will improve health, reduce uncompensated care costs, and maintain provider continuity regardless of coverage status. While many care coordination services will be offered at least in part through payer-based entities, it will be important to find other ways to provide vulnerable, uninsured populations with the benefit of such supports. In order to ensure a focus on prevention, primary care, b X d U h] Y b h g Ñ U V] `] h provider continuity regardless of their coverage status, the Task Force recommends that safety net providers receive reimbursement for providing such prevention and care coordination services to uninsured populations.

Strategy Element #6: Address barriers to clinically appropriate data sharing while rigorously protecting against unauthorized sharing and disclosure. The Task Force heard significant public testimony regarding the barriers to sharing information between health care providers, public health, behavioral health, long-term care, and social service providers. Effective use of data across providers is essential to integration of care, advancement of TCOC models, and elimination of waste in the form of unnecessary duplication of tests and procedures. Improved data sharing is also essential to reducing the administrative burden of prior authorization for diagnostic and therapeutic interventions, as well fac prior authorization/refill authorization for prescription drug dispensing. Such sharing, however, cann disclose information counter to patient desires. Therefore, the Task Force recommends that MDH co rigorous analysis of perceived and actual barriers to data sharing, including between behavioral health and somatic health clinicians, and how these may be remedied, achieving the goals for improvement in population health and reductions in health care spending. Following this assessment, MDH should recommend to the legislature W \ U b [Y g] b g h U h i h Y h \ U h k c i ` X g i d d c f h g \ U f] b [expanding provisions to encompass the information sharing necessary to make health care homes, homes, accountable care organizations, and TCOC arrangements successful, all while preserving patient protections as advanced by the Minnesota Health Records Act. Elements of this recommendation are also] b W` i X Y X ] b A ] b b Y g c h U Ñ g G h U h Y = b b c j U h ] c b A c X Y ` g i Innovation (submitted September 2012).

Strategy Element #7: Provide technical assistance to targeted providers to help these providers succeed within a system in which providers are contracting for the Total Cost of Care (TCOC). There are significant geographic variations in the distribution of integrated systems in Minnesota. While some areas of Minnesota boast highly sophisticated medical systems, in other regions care is provided primarily by independent providers often of small size, in conjunction with small hospitals, some of w designated as Critical Access Hospitals, and small post-acute care providers. Because these types of providers face special challenges when seeking to transform themselves to operate as health care h TCOC-contracted entities or as a part of TCOC-contracted entities, the Task Force recommends that MDH, in consultation with DHS and the State Employee Group Insurance Plan (SEGIP), provide technical

assistance to Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), small and medium-size primary care practices, rural providers and providers specializing in care of populations with complex needs, including post-acute and community-based long-term care providers, to help these providers succeed. Technical support should include a) a learning community of all interested provider organizations, b) the creation of regional collaboratives, c) MDH-facilitated discussions among interested payers and providers regarding the development of multi-payer arrangements to aggregate payer population segments into a larger risk pool, and d) facilitation by DHS and MDH of discussions among health care and community partners to support integration of community mental health, substance abuse and social services with health care providers in TCOC contracting. Elements of this recommendation are also included in Minnesota's State Innovation Model submiss [cut off] Innovation (submitted September 2012).

Strategy III: Prepare and Support the Health Provider Workforce

The Opportunity: Minnesota is suffering from a primary care health workforce shortage.[28] As a professional industry, health care depends on the presence of a skilled workforce, and in particular, a strong primary care workforce. Compounding the concern is the fact that a large segment of the primary care workforce is nearing retirement while fewer medical students choose primary care as their specialty.[29] These workforce shortages are particularly acute in rural parts of the state. Thirty-seven percent of Min [cut off] rural population lives in a federally designated Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA).[30] Without an adequate supply of health care professionals with the appropriate core skills and competencies, quality diminishes, care becomes inaccessible, and the overall health of the community declines. Preparing the future workforce for delivery system transformation and to work in a more coordinated, integrated and patient-centered environment will require targeted educational opportunities and professional development. Additionally, clinical practices need help to redesign their workflows and care teams to accommodate these new models of care delivery, and to incorporate new professions such as community health workers and community paramedics, and a pipeline for career development for them. Therefore, the Task Force recommends the following actions.

Strategy Element #8: Invest in high-need infrastructure and workforce services to increase access and foster inter-professional competency. State and national trends suggest that the emerging medical and behavioral workforces are not prepared to deliver services in the current health care environment. This is due, in part, to significant changes in the behavioral health field and the difficulty of academic training programs to keep pace with these changes. Educational grants and training are needed to develop a diverse workforce that is prepared to deliver mental health and substance abuse care in an inter-professional setting. In this vein, the Task Force recommends:

[28] Minnesota Department of Health (2009). Health Workforce Shortage Study Report: Report to the Minnesota Legislature 2009. Retrieved from http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf

[29] Minnesota Department of Health (2009). Health Workforce Shortage Study Report: Report to the Minnesota Legislature 2009. Retrieved from http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf

[30] Minnesota Department of Health (2009). Health Workforce Shortage Study Report: Report to the Minnesota Legislature 2009. Retrieved from http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf

- investing in the mental health and substance abuse workforce by providing educational and tr
  grants, and fostering inter-professional mental health and substance abuse competencies;
- improving access to dental care by supporting start-up changes and practice redesign for dental therapists and advanced dental therapists; and supporting state-level administrative actions to enable dental hygienists with a collaborative agreement with a dentist to perform oral exam portions as part of Child and Teen Checkups; and,
- improving access to care in rural areas of Minnesota by supporting and expanding telehealth and related technology to improve quality and access, and to extend workforce capacity.

It is important to note that while workforce investments are critical, they are not sufficient to address the shortages we face. Another critical component of workforce planning is the delivery system reforms that coordinate care and make better use of existing providers.

Strategy Element #9: Explore and remove regulatory barriers to the advancement of the nursing workforce. B i f g] b [˙] g ˙ V m ˙ Z U f ˙ h \ Y ˙ ` U f [Y g h ˙ g Y Wh c f ˙ c Z ˙ A] b b Y play critical roles in all health care settings. In order to plan for and promote a robust nursing workforce, the Task Force recommends:

- Removing practice barriers for advanced practice registered nurses (APRNs) by adopting the Advanced Practice Registered Nursing Consensus Model and enacting the APRN Model Act and Rules. Currently, APRNs are not allowed to practice to the fullest extent of their education and h f U] b] b [˙ V Y WU i g Y ˙ c Z ˙ g h U h i h c f m ˙ A] b b Y g c h U ˙ g ˙ B i f g] b [˙ D f U Wh] W Y Act mandates APRN practice must occur in settings that provide for a collaborative arrangement between an APRN and a physician in order to care for and manage patients, and limits prescrip authority to those APRNs who maintain a signed written prescriptive agreement with a physi

- Funding a study of the impact of Minnesota joining the Interstate Nurse Licensure Compact, including an analysis of the state reciprocity issue and barriers to advancing telehealth. The Nurse Licensure Compact (NLC) is an agreement between states to mutually recognize the license of a nurse as authority to practice in other states that are party to the agreement. The basic concept of the mutual recognition model of nurse licensure is to issue a nurse one license by state of res and allow the nurse to practice in other states. Y ˙ U b X ˙ t g h U h Y Ñ g ˙ Health W U f Y ˙ f reform and workforce planning necessitate analysis of issues possibly related to the NLC including the licensing, supply/demand, and working conditions.

Strategy Element #10: Increase the supply of the primary care workforce and stabilize support for health professions education by supporting existing health professions training sites and funding new sites for primary care physicians, APRNs, physician assistants and pharmacists through the Medical Education and Research Costs (MERC) program. Workforce needs tie X] f Y Wh ` m ˙ h c ˙ h \ Y ˙ \ Y U ` h \ ˙ WU f Y ˙ X Y `] j Y f m ˙ g m g h Y a ž ˙ U b X system of clinical training. Increased MERC funding will greatly stabilize health professions training, and investing new resources specifically in new primary care training capacity will support the redesig practice to the team-based, primary-care centered approach needed to achieve health reform goals and transform primary care. Communities depend on sufficient numbers of physicians to provide care for their populations in both primary care and specialty practices. While many factors affect population

health, the presence of sufficient numbers of physicians is a key ingredient of the care system. Therefore, the Task Force recommends:

- Increasing MERC formula grants with the existing formula.
- Seeking CMS authorization to allow formula revisions to associate some portion of MERC funding with training costs and activity.
- Funding a new state-only MERC pool for primary care training of physicians, advanced practice nurses, physician assistants, and pharmacists.

Strategy Element #11: Attract and retain the long-term care workforce by doing targeted career advancement; increasing wages of direct care workers employed in nursing homes and in-home care; and supporting innovative adult training programs such as FastTRAC. A t] R b Y g c h U Ñ g ` d c d i ` rapidly aging and as a result there will be a high corresponding demand for caregivers working in long-term care settings, including nursing homes, housing with services, and home care. Minnesota is currently unprepared to meet this demand, with high vacancy rates, high turnover, and difficulty recruiting for these positions. Wages for long-term care workers are significantly below those of hospital workers with comparable licensure.[31] Many adults who could be suitable for these positions need help with basic acad skills and career-specific training. Traditional educational programs assume a certain level of academic readiness, and offer these services separately and sequentially. FastTRAC integrates these trainings, offers support services and allows nontraditional learners to reskill themselves quickly in a cost effective approach tailored to worker and employer needs.

Strategy Element #12: Increase the number of health professionals in underserved areas by increasing Z i b X] b [` Z c f ` h \ Y ` g h U h Y Ñ g Health Professional Loan Forgiveness Program, especially for nurses and physician assistants, and opening the program to a wider group of health professionals. Loan forgiveness is a proven strategy to induce health professionals to practice where they are most needed. Research also confirms that providers who are incented to practice in underserved areas stay, making a long-term contribution in response to a relatively modest upfront investment in loan forgiveness. H \ Y ` g h U h Y Ñ g Health Professional Loan Forgiveness Program does not have sufficient funds to respond to the needs of rural and underserved communities in the state, especially following a budget reduction in 2011. The program can fund fewer than 30% of the applications received. In addition, several professions important to transforming care delivery are not included in the program. The Task Force recommends increasing funding annually for four years and expanding the eligibility to include mental health professionals, licensed alcohol and drug counselors, dental therapists and advanced dental therapists, dental hygienists, occupational therapy practitioners, and physical therapy practitioners.

Strategy Element #13: Prepare for anticipated increased demand on safety net provider services by increasing reimbursement to safety net providers for primary care, community mental health, substance abuse, and community-based services provided to Minnesota Health Care Program enrollees. When insurance coverage options expand in 2014, it will be critical for the newly insured to receive timely access to the quality health care services they need. To this end, Minnesota must have an adequate supply of providers for the newly insured, as well as those who will remain uninsured after 2014. Therefore,

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[31] K c f _ Z c f WY ` K c f _ ` ; f c i d ` D f ] c f ] h m ` F Y W c a a Y b X U h] c b g ` h c ` h \ Y ` ;
Retrieved from http://mn.gov/health-reform/images/TaskForce-2012-07-12-WFWG-Priority-Recommendations.pdf

the Task Force recommends increasing the level of reimbursement for safety net providers to ensure these providers are able to meet this anticipated increased demand for services.[32]

Strategy Element #14: Increase diversity in the health care workforce by supporting a range of health professions diversity programs. Ethnic and racial minorities are not proportionately represented in A] b b Y g c h U Ñ g ' \ Y The pathway to successful health careers can be lengthy and require students to make deliberate academic choices early on. ... A] b b care workforce, Z i h i f investments ... through post-secondary and into the post-graduate level are critical. Programs targeting traditionally underrepresented students (non-traditional, minority, rural, low-income, foreign-trained physical and mental health professionals) that offer early health career awareness and ongoing support such as academic enrichment, mentorship, scholarships, and training/residency opportunities need to be expanded to build a diverse health care workforce that offers culturally competent care and reduces disparities in access and care outcomes. Specifically, the Task Force recommends: a) providing health career exploration experience through health careers programs and enhancement of Science, Technology, Engineering, and Math (STEM) competencies; b) supporting programs that train and mentor underrepresented students to pursue health careers; and c) assisting foreign-certified physical and mental health professionals in obtaining Minnesota licensure.

Strategy IV: Improve Health for Specific At-Risk Populations

The Opportunity: Specific populations that are at risk for poor health outcomes for manageable conditions present unique opportunities for care improvement. Toward this end, the Task Force recommends that the targeted interventions detailed below be implemented to address the special health care needs of specific populations.

Strategy Element #15: Expand the existing evidence-based family home visiting program for high-risk mothers and evaluate the impact of home visiting on health disparities. Minnesota children who experience economic hardship, maltreatment, and other trauma face distinct risks to their overall health and development.[33] In Minnesota, 13.7% of pregnant women received inadequate (2nd or 3rd trimester) prenatal care,[34] 15.2% of pregnant women smoked during their pregnancy,[35] and 4.3 per 1,000 children 12 years and younger are abused or neglected.[36] Evidence-based family home visiting has been shown to be an effective service strategy for very young children and their families, improving outcomes in lifelong health

[32] Ku, L., et al. (2011). Safety-net providers after health care reform: lessons from Massachusetts. Arch Intern Med, 171(15): 1379-84. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21824954

[33] Kragthorpe, C. (2012, May). Mental Health Panel. Presentation to Prevention and Public Health Work Group, Minnesota Health Care Reform Task Force. Retrieved from mn.gov/health-reform/images/WG-PPH-2012-05-14-Panel-MH-Kragthorpe.pdf

[34] Minnesota Department of Health (2010). Natality Table 4: Prenatal Care in Minnesota. 2010 Minnesota County Health Tables. St. Paul, MN. Retrieved from www.health.state.mn.us/divs/chs/countytables/profiles2010/bbirth09.pdf

[35] Minnesota Department of Health (2010). Natality Table 7: Minnesota Teen Birth and Pregnancy Rates. 2010 Minnesota County Health Tables. St. Paul, MN. Retrieved from www.health.state.mn.us/divs/chs/countytables/profiles2010/bbirth09.pdf

[36] Minnesota Department of Health (2010). Minnesota Title V Block Grant Needs Assessment. St. Paul, MN. Retrieved from www.health.state.mn.us/divs/cfh/na/documents/MN2010NeedsAssessment.pdf

and well-being, school readiness, and economic self-sufficiency.[37] Research-based family home visiting models have proven that for every public health dollar invested, up to $5.70 can be expected in savings to programs including Medicaid and food support.[38,39] Therefore, the Task Force recommends expanding the family home visiting program to include voluntarily enrolled first-time mothers on Medicaid and pregnant and parenting teenagers in the Minnesota Family Investment Program (MFIP).

<u>Strategy Element #16: Include evidence-based diabetes prevention programs as a statewide reimbursed benefit under Minnesota Health Care Programs.</u> A growing number of people in Minnesota have diabetes or are at high risk for developing diabetes. In 2010, about 260,000 adult Minnesotans, or 6.5% of the adult population, had been diagnosed with diabetes.[40] National studies suggest around 35% of people have pre-diabetes, which translates into an estimated 1.5 million Minnesota adults today.[41,42,43] Diabetes has tremendous chronic societal and personal costs. Estimates from 2006 suggest that people with diabetes incur around $11,744 in medical expenditures each year in comparison to $2,935 for people without diabetes. About $6,600 of this difference is directly attributable to diabetes.[44] One example is the Diabetes Prevention Program (DPP), a 16-week, evidence-based lifestyle intervention that is provided in a group setting and can be delivered in a wide range of community locations. Tested in a multi-site, randomized controlled trial, the DPP lifestyle intervention reduced new cases of diabetes by 58% over a 2- to 3-year period compared to placebo.[45] Ten years from the start of DPP study, there was a 34% reduction in diabetes incidence among participants who received the lifestyle intervention.[46] Therefore, the Task Force recommends directing DHS to make DPP a statewide reimbursed benefit under Minnesota Health Care Programs.

If DHS subsequently identifies other evidence-based lifestyle intervention programs that reduce the incidence

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[37] Minnesota Department of Health (2012). Family Home Visiting Program. St. Paul, MN. Retrieved from http://mn.gov/health-reform/images/WG-PH-2012-05-14-Panel-MH-Kragthorpe.pdf

[38] Karoly, L., Kilburn, M., Cannon, J. (2005). Early Childhood Interventions: Proven Results, Future Promise. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/pubs/monographs/2005/RAND_MG341.pdf

[39] H \ Y ˙ h Y f a ˙ Î d i V `] W ˙ \ proactive and structures of maintaining and improving the health of the entire state.

[40] Centers for Disease Control and Prevention: National Diabetes Surveillance System (2011). Diabetes Data & T
Retrieved from http://apps.nccd.cdc.gov/DDTSTRS/Index.aspx?stateId=27&state=Minnesota&cat=prevalence&Data=data&view=
OP&trend=prevalence&id=1

[41] Cowie, C. C., et al (2009). Full Accounting of Diabetes and Prediabetes in the U.S. Population in 1988-1994 and 2005-2006. *Diabetes Care*, 32:287-294. Retrieved from http://care.diabetesjournals.org/content/32/2/287.long

[42] Centers for Disease Control and Prevention (2011). National Diabetes Fact Sheet, 2011. Retrieved from www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

[43] U.S. Census Bureau (2011). State & County QuickFacts: Minnesota. Retrieved from http://quickfacts.census.gov/qfd/states/27000.html

[44] American Diabetes Association (2008). Economic Costs of Diabetes in the U.S. in 2007. *Diabetes Care*, 31(3). Retrieved from http://care.diabetesjournals.org/content/31/3/596.full.pdf+html

[45] Diabetes Prevention Program Research Group (2002). Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. *The New England Journal of Medicine*, 346. Retrieved from www.nejm.org/doi/full/10.1056/NEJMoa012512#t=abstract

[46] Diabetes Prevention Program Research Group (2009). 10-year Follow-up of Diabetes Incidence and Weight Loss in the Diabetes Prevention Program Outcomes Study. *Lancet*, 374(9702). Retrieved from www.sciencedirect.com/science/article/pii/S0140673609614574

and/or impact of chronic illness, improve population health, are culturally appropriate, and provide net cost savings to the state, DHS should consider also making such programs statewide reimbursed benefits under Minnesota Health Care Programs.

Strategy Element #17: Expand school-linked behavioral health grants and include previously untreated children with high mental health needs, coordinate with suicide prevention texting and telephone supports, and offer screening and referral for substance abuse issues. There is the potential to identify and treat mental and chemical health issues in childhood and adolescence so that more sig issues are avoided in adulthood. Mental, emotional, and behavior disorders affect about 20% of children at any given time. These disorders annually cost about $247 billion in treatment, lost productivity, and crim[47] Current research also shows Adverse Childhood Experiences (ACEs) to be a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violenc re-victimization, disease, disability, and premature mortality. ACEs have been found to disrupt neurodevelopment, and can have lasting effects on brain structure and function. ACE-informed policies can mobilize resilience and recovery, serve to defray costly ACE consequences, and prevent ACE transmiss the next generation.[48]

School-based services offer an opportunity to address ACEs and improve physical and mental health while problems are smaller and more manageable. This program specifically has proven to be effective in identifying children with mental health needs, eliminating barriers to treatment (such as transportation, workforce issues) and in helping children improve their educational outcomes. Expansion of school-based mental health services and coordination with school-based physical health services also [illegible] aim to lengthen the lifespan of people with serious mental illnesses by 10 years within 10 years.[49]

Strategy Element #18: Evaluate and perform gap analysis on school health reforms. The Departments of Education, Health, and Human Services shall convene a multi-agency body to evaluate the impact of recent school and health reforms (including, but not limited to the Healthy, Hunger Free Ki of 2010 and the Affordable Care Act of 2010) on student health and K-12 school wellness policies. Nutrition education and the physical activity opportunities of K-12 students shall be a part of this evaluation which will be utilized by the multi-agency body to develop a gap analysis to guide future state policy development.

Strategy V: Engage Communities

The Opportunity: Consumers in Minnesota clearly recognize that the health care system alone does no define good health.[50] Rather, health status is the product of many conditions and factors including living

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[47] The National Academies (2009, March). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. *Report Brief*. Washington, DC. Retrieved from www.bocyf.org/prevention_costs_benefits_brief.pdf

[48] Felitti V.J., Anda R.F., Nordenberg D., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4). Retrieved from www.ajpm-online.net/article/PIIS0749379798000178/abstract

[49] See: http://goo.gl/hRVKM

[50] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_Medium%202.pdf

conditions and social and economic opportunity. According to the Centers for Disease Control and Prevention (CDC), 70% of what influences health status (health behaviors at 50% and environment a can be addressed through prevention.[51] Recognizing that health is primarily determined by factors outside the health care system demands that we look beyond the systems of care and toward our communities for solutions. Yet, only about 5% of health expenditures are spent on population-level prevention efforts.[52] Minnesotans have expressed a willingness to shift this emphasis and assume a greater role in supporting health in their communities.[53] Therefore, the Task Force recommends that Minnesota move toward a new paradigm of health that is founded on the notion of community engagement and citizen involvement and which seeks to address the social determinants of health through the integration of community-based public health, social service, and educational systems.

Strategy Element #19: Identify the most proven Statewide Health Improvement Program (SHIP) initiatives to date and expand these preventive approaches statewide as indicated. Three-fourths of health care costs are attributable to chronic conditions. While chronic conditions represent the largest expense in the health care system, much of the time, they are preventable and related to four common unhealthy behaviors: tobacco use, excessive alcohol use, physical inactivity, and unhealthy eating.[54] In 2008, the legislature passed landmark health reform legislation, with SHIP as a cornerstone to address these leading preventable causes of chronic disease. Due to state financial concerns, funding for SHIP was reduced by nearly 70%. Current funding for SHIP is $17 million per biennium and will expire in June of 2013. The program faces termination in 2013 without additional funding. The Task Force recommends that MDH identify the most proven SHIP initiatives to date and expand these preventive approaches statewide sustained investment to support healthier populations and reduce health care costs including. Consider community prevention strategies that are informed by research regarding Adverse Childhood Events. Consider mechanisms, including the Healthy Eating Coalition, to facilitate coordination of nutrition-related SHIP interventions across the state.

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[51] Minnesota Department of Health (2012). SHIP: The Statewide Health Improvement Program – Healthy Kids, Healthy Communities. St. Paul, MN. Retrieved from www.health.state.mn.us/ship/docs/SHIPpresentation2012.pdf

[52] McGinnis, J.M., Williams-Russo, P., & Knickman, J.R. (2002). The Case For More Active Policy Attention to Health Promotion. *Health Affairs*, 21(2). Retrieved from http://content.healthaffairs.org/content/21/2/78.full.pdf. Note: Recent data suggests a similar breakdown of health spending, see: CMS (2012). Table 2 – Health Expenditures Aggregate. Retrieved from www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf

[53] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_Mediur %202.pdf

[54] Centers for Disease Control and Prevention (2009). Chronic Diseases – The Power to Prevent, The Call to Control: At A Glance 2009. Retrieved from www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm

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engage communities in setting and achieving Triple Aim goals. While there is some recognition among the public that health is determined predominantly by factors that are not affected by clinical care or health spending, the systems established by payers, providers, businesses, and government do not reflect this reality.[55] The coordination of services affecting these factors is currently fragmented, leading to po outcomes and higher costs. Therefore, the Task Force recommends that Minnesota pilot the idea of Î5WWcibhUV`Y 7caaib]h]Yg Zcf <YU`h\Ï ¿57<gÀ health care delivery and payment systems, as described in Strategies I and II above. These pilots will build upon the existing Community Care Teams pilots which are multidisciplinary, locally-based teams that partner with primary care practices, hospitals, long-term care, behavioral health, public health, social services and community organizations to ensure strong, coordinated support for the whole patient. ACHs will implement population-based prevention strategies and integrate care across the spectrum of health care and soc services through development of multi-disciplinary teams, which may include emerging professions such as community health workers, community paramedics, and dental therapists. ACHs will empower and involve citizens to set measurable and measured community-based goals for improved population health, health care and cost management, and take specific steps to achieve those goals. This process will ensure that state-level cost, quality, and health targets (Strategy Element #21 below) are informed by and translated into specific community-level goals and action plans. Specifically the Task Force recommends that MDH should select up to 10 diverse ACH two-year pilots and work to implement integrated delivery system and payment model within the ACHs. This recommendation is also included]b A]bbYgcHUÑg GhUhY =bbcj to the Center for Medicare and Medicaid Innovation (submitted September 2012).

Strategy VI: Measure Performance and Ensure System Stability

The Opportunity: Success in achieving goals for improved population health, health care, and reduction in cost growth requires an effective measurement capacity and the capacity to make system improvem based on the results of well-performed analysis. It is essential that we be able to evaluate the results of any strategy intended to improve health and reduce cost growth. While Minnesota has a foundation of provider-level reporting to the public that exceeds most other states, we must continue to develop and implement measures of health and cost, and communicate them in a way that is understandable for consumers. Therefore, the Task Force recommends supporting emerging measurement efforts, sharing best practices, and developing a robust analytic capacity to evaluate the effects of interventions.

Strategy Element #21: Use a private-public process to set performance targets, including goals for access, health care cost containment, health care quality, patient experience and population health. Health care costs in Minnesota, although lower than most other states in the nation, are increasingly unaffordable and the rate of growth in health spending (an average 8.7% commercial premium increase between 1999 and 2009)[56] is unsustainable. Together the strategies detailed throughout this *Roadmap* will create the systemic transformation necessary to slow this growth while improving quality.

[55] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/CommunitiesIPSFlyer_MediumRes%202.pdf

[56] Health Insurance Premiums and Cost Drivers in Minnesota, 2009. Minnesota Department of Health, Economi Program. March 2011. Accessed at www.health.state.mn.us/divs/hpsc/hep/publications/costs/costdrivers2011.pdf

that all stakeholders contribute to sustained progress, the Task Force recommends the creation of a private-public partnership that will make recommendations to the legislature for annual, publicly reported performance targets over five years, including targets for 1) access; 2) maximum per capita change in medical expense; 3) annual improvement in population health (i.e., the health status of Minnesotans); and 4) health care (i.e., the health services and patient experience provided to Minnesotans). The partnership should also make recommendations regarding what entity(ies) will assess whether the targets have been met by health plans, TCOC-contracting provider entities and all primary care organizations.

The Task Force further recommends that the partnership make recommendations to the legislature regarding potential consequences to be applied should performance targets not be met, or should the market fail to reasonably contain health care cost growth or achieve adequate improvements in quality or improvements in health status.

Finally, the Task Force recommends that if the partnership is unable to complete these tasks, MDH should assume responsibility for recommending targets and consequences to the legislature and the Governor. In doing so, MDH should consider the following potential cost target recommendations for a possible maximum per capita annual change in medical expense:

	SFY15	SFY16	SFY17	SFY18	SFY19
Growth target	CPI[57] +1%	CPI	CPI -1%	CPI -2%	CPI -2%

<u>Strategy Element #22: Implement best practices for collection and reporting of health care data by providers and payers on detailed categories of race, ethnicity, and language linked to health disparities</u>. Since 2010, MDH and DHS have co-led a broad stakeholder advisory group tasked with developing recommendations for collection of granular race, ethnicity, and language data by health care providers and payers. The purpose of this work has been to improve identification and tracking of health disparities by addressing gaps in existing data collection on race, ethnicity, and language among state agencies and health care providers.[58] In 2012, the Race Ethnicity Language (REL) Data Workgroup issued an initial set of best practice recommendations for collection of REL data and a standard set of granular REL categories that all providers and payers should consider using.[59] While many clinics and hospitals are beginning to collect, report, and use REL data, collection is not consistent across payers because the state has not implemented or endorsed standards. This lack of consistency makes it difficult to compare results or to develop resources and support for practice improvements that might reduce disparities. Therefore, the Task Force recommends that MDH and DHS complete the REL Data WorkGroup process and develop standards for streamlined and cohesive collection and reporting practices and mechanisms for race, ethnicity,

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[57] The Consumer Price Index (CPI-[illegible]) figure wou[illegible] be taken [illegible] selected from an agreed upon forecast source, the most commonly used inflation index in the U.S.

[58] Minnesota Department of Health and Minnesota Department of Human Services (2011). Collection of Racial/[illegible] Health Data by the Minnesota Departments of Health and Human Services. Retrieved from http://www.health.state.mn.us/ommh/publications/racialethnicdata2011.pdf

[59] Race, Ethnicity, and Language Data Work[illegible], Health Care (2012, [illegible] Reform Task Force. Presented to the Prevention and Public Health Group, Minnesota Health Care Reform Task [illegible] Retrieved from http://mn.gov/health-reform/images/WG-PPH-2012-05-14-Panel-IDI-Noor.pdf

and language data. This includes standards that support providers, payers and state agencies in implementing the collection of expanded REL data categories, including American Sign Language. The improved methodology will enable the state to more effectively evaluate interventions aimed at eliminating health disparities for all populations, including disadvantaged and hard-to-reach populations.

GhfUhY[m 9`YaYbh , &' . 8YjY`cd fYWcaaYbXUh]cbg Zcf]bjYghaYbh methodology (ROI) including recommended practices for programs funded by state government. Information regarding ROI for publicly funded health care programs could help inform policymakers regarding decisions for investment in the programs that provide the greatest value or have longer-term benefits. Additionally, program investments made by one state agency may not lead to cost savings in that agency, but could trigger savings in other departments or sectors (such as business, insurance, and local government). Although overall savings gains may be significant, there may not be an incentive for one agency to make the initial investment absent the implementation of this ROI methodology. The Task Force recommends that MDH, in consultation with Minnesota Management and Budget (MMB), undertake an assessment of ROI initiatives in other states, design implications for Minnesota, and identification of one or more institutions capable of providing rigorous and consistent nonpartisan institutional support for ROI and develop a proposed ROI methodology for Minnesota. The ROI methodology should identify opportunities to understand ROI and the value of investments within an and also measure ROI and value across agencies for program alignment to maximize resources and positive outcomes, and reduce redundancies. Once this ROI methodology is developed, it may be utilized by the Legislature to support consideration of benefits and risks outside of the state budget window.

Strategy Element #24: Guide a process for comprehensive performance measurement of TCOC-contracted provider entities and other provider organizations in achieving health and cost goals. The Task Force acknowledges the need to inform provider efforts to improve patient health while reducing costs, assess provider performance, evaluate the effectiveness of different delivery systems and strategies goals, and guide consumer selection of high quality, efficient providers. Toward this end, the Task Force recommends that MDH perform the following: a) coordinate with one or more existing community measurement entities to define a core measure set for TCOC-contracted entities and provider performance measurement for the array of patient populations drawing on measures including but not limited to the Statewide Quality Measurement and Reporting System (SQRMS), measures currently reported by hea to Minnesota Community Measurement, the CMS ACO quality measures, and performance measures u by DHS; b) guide, but not necessarily perform, a comprehensive performance review of TCOC-contracted provider entities and individual provider organizations using the standardized measures, in close consu with community-based quality improvement and performance measurement groups; and c) make TCOC-contracted provider entity and participating provider performance transparent to consumers, potentially through partnership with one or more existing community measurement entities. The core measures should include patient-reported outcomes, especially of role functioning, since such measures provide a more patient-centric functional measurement of health. The measurement strategy should be e for patients to use and interpret.

Elements of this recommendation are also includYX]b A]bbYgchUÑg GhUhY =bbcjU Center for Medicare and Medicaid Innovation (submitted September 2012).

Strategy VII: Design Benefits to Enhance Personal Responsibility

The Opportunity: Current health insurance offerings often do not help consumers make choices to seek high value health care providers or high value services. Minnesotans have reported that while some health plans provide information to help consumers distinguish the high value services and providers from the lower value, it is often not presented in a way that is accessible for consumers. Additionally the information may not be actionable or clearly connect consumer health behaviors with health care costs, or on the implications of choosing unneeded services.[60] Further, health plans may not offer or be successful in selling products th provide consumers with benefits for selecting higher value providers or services. Therefore, the Task Force recommends the following actions

Strategy Element #25: Increase the market availability of health insurance products that foster consumer accountability for health behaviors and create incentives for consumers to use high value providers. Successful implementation of this strategy appears likely to motivate consumer health behaviors and thereby improve health status and lower overall costs by getting more consumers covered by health products that solely contract with high value providers or by plans which help consumers choose hig providers and/or services. Specifically, the Task Force recommends the Department of Commerce, in partnership with MDH, identify existing commercial insurance products that foster consumer accoun for health behaviors and create incentives for use of high value services and providers, and query health plans, brokers, employers and consumers regarding barriers to adoption of these products by employers and consumers. Based on the assessment, the Department of Commerce and MDH, in consultation with SEGIP and other purchasers, should develop a plan, in partnership with the Health Insurance Exchange and any navigators with whom the exchange contracts as well as brokers operating outside of the Health Insurance Exchange, to address barriers, educate employers and provide outreach to consumers.

Strategy VIII: Increase Access and Support Consumer Navigation

The Opportunity: Access to high-quality health care services for all Minnesotans is essential for promoting [illegible] disparities, and ensuring that every individual has the [illegible] opportunity to reach his or her full potential. In Minnesota, approximately 9.1% of the population or 489,000 individuals were uninsured in 2011. The rates of insurance coverage have largely remained unchanged since 2009 and coverage through employer-sponsored insurance has not rebounded from the impact of the recession. While the uninsured in 2011 were as likely to be employed as the general p they were more likely to be of middle income (300% of FPL or less), self-employed or work at small companies, hold more than one job, and be African American and/or Hispanic/Latino. In addition, even those Minnesotans with insurance coverage often face barriers to care, such as cost.[61] In order to ensure that

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[60] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://www.bushfoundation.org/sites/default/files/Web_Content/Communities/PDFs/CS_ResultsFlyer_Medium%202.pdf

[61] Kemmick-Pintor, J. & Gildemeister, S. (2012, March). Health Insurance Coverage in Minnesota: Early Results from the 2011 Minnesota Health Access Survey. Presented to the Access Work Group, Minnesota Health Care Refor Force. Retrieved from http://mn.gov/health-reform/images/WG-Access-2012-03-29-MN%20Health-Access-Survey.pdf

everyone gets the health care access they need and deserve, the Task Force recommends the actions below.

Strategy Element #26: Expand Medicaid to include individuals with incomes up to 138% of the federal poverty level (FPL). The Affordable Care Act allows states to expand Medicaid eligibility to low-income Minnesotans up to 138% FPL. For states like Minnesota that already cover individuals beyond minimum federal requirements, this means availability of additional federal resources to help the state pays for people who they already cover. This increased federal funding from a Medicaid expansion to 133% FPL, in combination with the early expansion of Medicaid, is estimated to save the state budget $1 billion for the five-year fiscal period from 2011 to 2015. (See Appendix F for a coverage comparison of 2012 versus 2014.)

Strategy Element #27: Implement a Minnesota-based Health Insurance Exchange, employing a public-private governance structure. Rather than allowing the federal government to determine the design, structure, and implementation of an exchange, the Task Force recommends that Minnesota implement its own state-based exchange. The Task Force recognizes that the federal government has yet to describe the federal exchange and future evaluation of options may be needed. However, considering what is known today about a federal exchange, the Task Force believes that maintaining state control of the exchange and using a public-private partnership to lead implementation will enable the exchange to be responsive to local priorities and ultimately better f Y Z ` Y Wh ` h \ Y ` i b ] e i Y ` b Y Y X g ` c Z ` A] employer populations. The Task Force also recognizes the need to provide Minnesotans with information and education regarding the exchange through a communications strategy and plan.

Strategy Element #28: Provide affordability and coverage support for adults with incomes between 138 and 200% FPL at a level equivalent to MinnesotaCare, at a minimum. In order to ease the transition from Medicaid to the exchange-based commercial market, the Task Force recommends that Minnesota provide this population with additional support to make coverage affordable and meaningf Task Force recognizes that this population is particularly vulnerable, currently accounting for a considerable share of the uninsured in Minnesota.[62] This population is statistically sicker than the general population and is extremely price sensitive. In order to improve coverage, the state must address both the curren affordability constraints and access to a full benefit package.

These supports could be provided either through a Basic Health Plan or through the provision of enh benefits and additional premium supports through the exchange. Given the lack of guidance from the federal government on these options at this time, the Task Force is not making a recommendation between options. Instead the Task Force is recommending that the following criteria are met in whichever op ultimately selected:

1. Cost-sharing and premium costs should be nominal: no higher than current MinnesotaCare leve without the hospital cap
    a. Premium costs should be eliminated for those with incomes between 138-150% FPL

[62] Sixty percent of those currently uninsured in Minnesota are eligible for a public health care program including MinnesotaCare, the program currently serving this population. See: Minnesota Department of Health (2012). Minnesota Health Access Survey. Retrieved from https://pqc.health.state.mn.us/mnha/PublicQuery.action

b. Premiums should be based on a sliding fee for those with incomes between 150-200% FPL with the scale at $0 for 150% and increasing incrementally up to the current MinnesotaCare c 200% FPL.

2. At a minimum, benefits should include those currently available through MinnesotaCare withou hospital cap

Strategy Element #29: Consider that Minnesota benchmark options for the Essential Health Benefits (EHB) based on Minnesota plans would provide generally similar benefits and that an ongoing mechanism for review and stakeholder feedback on the EHB is needed. The Task Force reviewed the Minnesota-based benchmark options under federal guidance and found that the differences between the options did not appear to be materially significant.[63] Given this, the Task Force did not have significant concern with the default benchmark, the largest plan in the small group market. In addition, recognizing that the benefit needs of a community and the costs associated with such benefits char time, the Task Force recommends that a body be appointed to conduct a periodic review of the EHB to ensure that it maintains an appropriate balance of coverage and cost. This review should include an ongoing mechanism for community stakeholder discussion and feedback on the EHB as it evolves over the next few years, especially as the federal government modifies its methodologies and requirements for 2016 and beyond.

Strategy Element #30: Ensure the availability of Exchange navigators who are knowledgeable about public health care programs and who are skilled in connecting eligible applicants to the appropriate public program. As consumers and small employers apply for benefits through the Exchange, an opportunity is presented to connect potentially eligible individuals with appropriate prevention and support services offered by organizations outside of the Exchange. In order to maximize the benefit of the interactions with Exchange navigators and provide consumers and small employers with an entry point for a range of health-related services, the Task Force recommends that training for Exchange navigators include information about connecting applicants with local public health and social service supports. In addition, the Task Force recommends that safety net organizations with established relationships with populations that will move into the Exchange be offered the option of serving as navigators so that they may leverage this knowledge and experience to the benefit of their clients. This recommendation does not preclude non-safety net providers from also serving as navigators.

Strategy Element #31: Create a referral process in the Exchange for people who are not initially eligible for Medicaid or premium tax credits to connect them to low-cost clinics and health resources in their area and legal services for immigration assistance. Since there will inevitably be a number of individuals who cannot afford health care services without support but are not eligible for Medicaid or premium tax credits, the Task Force recommends establishing a mechanism for connectin individuals with alternative resources and services to help meet their health care needs.

[63] More information regarding federal requirements and the essential health benefits in Minnesota is available in the following fact sheet: http://mn.gov/health-reform/images/WG-Access-EHB%20Fact%20Sheet%20and%20FAQs%2012.pdf

III. Conclusion

The recommendations proposed in this *Roadmap* offer a series of interconnected strategies for transforming health care and improving health in Minnesota. The result should be a proactive, integrated, wellness-focused commitment to affordable improvement of health and quality of life for all Minnesotans. While the Task Force is confident that taken together these strategies will offer more health for the dollar, it is important to recognize that this set of recommendations is not all-inclusive, nor is it the final word in health reform. (See Appendix G for a list of issues for consideration outside the scope of this report.) Indeed the Task Force expects that even with the successful implementation of these strategies, the evolving landscape of hea and process of scientific discovery will demand continued and collective effort to improve our public health and health care delivery, payment and financing systems. As a state, we must be conscious of the elusive nature of success, be humble in our estimations, and continually strive to offer better health and better lives for the people of our great state. It is in this spirit that the Task Force offers the *Roadmap to a Healthier Minnesota*.

IV. Appendices

Appendix A: Task Force Working Principles

Adopted by the Task Force to guide and inform its work

- The outcome of health reform should be to maximize health and functioning for all Minnesotans at a cost that is sustainable for our economy.
- All Minnesotans should have affordable, portable health care coverage and accessible hig quality health services at predictable costs.
- We must create and restructure health delivery services and payment approaches to support high-value care that centers around the needs of all Minnesotans.
- Minnesotans should be engaged in their own health and health care, including awarenes the costs, risks, and benefits of health services and health behaviors.
- Health reform should take into consideration that other areas such as education, economi development, housing and transportation have powerful influences on health outcomes.
- Prevention of avoidable health problems/complications should be central to health refor
- We must reduce health disparities and increase health equity throughout all efforts.
- Minnesotans must prepare for decisions and needs they will face as they age, and we r ensure that our systems of care and financing—acute care, long term care, home and community-based services—are prepared to meet these needs.
- We must make the best use of existing resources and build on what's working in the c system.

Appendix B: Founding Documents

Minnesota Laws 2010, 1st Special Session, Article 22, Section 4

Sec. 4. HEALTH CARE REFORM TASK FORCE.

Subdivision 1. Task force. (a) The governor shall convene a Health Care Reform Task Force to advise and assist the governor and the legislature regarding state implementation of federal health care reform legislation. For purposes of this section, "federal health care reform legislation" means the Patient Protection and Affordable Care Act, Public Law 111-148, and the health care reform provisions in the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:
(1) two legislators from the house of representatives appointed by the speaker and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(2) two representatives appointed by the governor to represent the governor and state agencies;

(3) three persons appointed by the governor who have demonstrated leadership in health care organizations, health plan companies, or health care trade or professional associations;

(4) three persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement of whom two must be from a labor organization and one from the business community; and

(5) five persons appointed by the governor who have demonstrated expertise in the areas of health care financing, access, and quality.

The governor is exempt from the requirements of the open appointments process for purposes of appointing task force members. Members shall be appointed for one-year terms and may be reappointed.

(b) The Department of Health, Department of Human Services, and Department of Commerce shall provide staff support to the task force. The task force may accept outside resources to help support its efforts.

(c) Task force members must be appointed by July 1, 2010. The task force must hold its first meeting by July 15, 2010.

Subd. 2. Duties. (a) By December 15, 2010, the task force shall develop and present to the legislature and the governor a preliminary report and recommendations on state implementation of federal health care reform legislation. The report must include recommendations for state law and program changes necessary to comply with the federal health care reform legislation, and also recommendations for implementing provisions of the federal legislation that are optional for states. In developing recommendations, the task force shall consider the extent to which an approach maximizes federal funding to the state.
(b) The task force, in consultation with the governor and the legislature, shall also establish timelines and criteria for future reports on state implementation of the federal health care reform legislation.

STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-30

Establishing a Vision for Health Care Reform in Minnesota

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, Minnesota's future economic and fiscal success requires a healthy population, high quality health care at lower cost, and greater efficiency in health care delivery; and

Whereas, Minnesota families and small businesses are faced with increasing and unsustainable health care costs; and

Whereas, Minnesota is a national leader in health care innovation; and

Whereas, Minnesota's goals for health care reform are to increase access to health insurance coverage, invest in public health, incentivize disease prevention and health care quality, and hold insurance companies accountable for our health care dollars.

Now, Therefore, in order to achieve better health care in Minnesota at lower cost, I hereby order that:

1. The Health Care Reform Task Force ("Task Force") created by Minnesota Laws 2010, 1st Special Session, article 22, section 4 shall advise the Governor and the Legislature on health care reform consistent with enacted law and the following vision:

    a. Better health care: Expand health coverage and provide a better consumer experience through effective and positive community engagement on issues related to health care, public health and insurance;
    b. Lower costs: Reduce unsustainable growth in per capita health costs while improving health care quality and efficiency; and
    c. Healthier communities: Improve the health of all Minnesotans and decrease health disparities.

2. The following are newly appointed members of the Task Force pursuant to the requirements of Minnesota Laws 2010, 1st Special Session, article 22, section 4:

    a. The Chair shall be the Commissioner of Human Services;

    b. The Commissioners of Human Services and Commerce, as representatives of the Governor and state agencies;

    c. The Commissioner of Health, based on his demonstrated expertise in the area of health care financing, access and quality;

    d. Three people who have demonstrated leadership in health care organizations, health plan companies, or health care trade or professional associations;

    e. Three people who have demonstrated leadership in employer and group purchaser activities related to health system improvement of whom two must be from a labor organization and one from the business community;

    f. Four people who have demonstrated expertise in the areas of health care financing, access, and quality;

    g. Two legislators from the house of representatives appointed by the speaker and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration; and

    h. All task force activities shall be organized and facilitated by an existing assistant commissioner, with costs shared by the Departments of Human Services, Health and Commerce.

3. The Task Force shall provide leadership and advice on the implementation of health care reforms including:

    a. Redesign of health care delivery, payment, and data systems to improve health and control costs, including integration with long-term care, behavioral health, public health and social services; and

    b. Reform of Minnesota's health care financing mechanisms to improve health care affordability and achieve equitable sharing of costs among all payers; and

    c. Development and oversight of work groups and task forces established by individual Commissioners on issues such as the health insurance exchange, public health, workforce needs, delivery systems, and payment reform; and

    d. Opportunities for consumer and community engagement in health reform efforts, including creation and maintenance of a public website and speaker's bureau to engage in a dialogue with Minnesotans about health reform.