

Emergency Medical Assistance Report

Health Care Administration
January 2014

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Minnesota Department of **Human Services**

Legislative Report

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I. Executive summary

The Minnesota Department of Human Services (DHS) created this report in response to Laws of Minnesota 2013, Chapter 108, Article 6, sections 33 and 34 which require that the DHS Commissioner submit to the legislature by January 15, 2014 an Emergency Medical Assistance (EMA) report.

The EMA population consists of those individuals who would be eligible to enroll in Medical Assistance if not for their immigration status. Under current Minnesota statute and policy, the EMA program, consistent with federal requirements for federal financial participation, pays for the medical treatment required to care for a current or imminent emergency medical condition. While the current state of the EMA program is compliant with federal law, it does not provide the comprehensive coverage necessary to meet the critical needs of the enrolled population.

In 2013 the DHS issued a request for information (RFI) and convened a stakeholder group to discuss and formulate recommendations for the best mechanism to provide more comprehensive health care coverage for this population. Based on the RFI responses, department staff analysis and stakeholder input, the DHS makes the following recommendations for the future of the EMA program:

Expanded Benefit Set

DHS recommends that the benefit set available to EMA enrollees be expanded to include the MinnesotaCare benefit without a requirement for a Care Plan Certification (CPC). In addition, the department recommends including nursing facility and elderly waiver (EW) services in the benefit set.

Recommended Population Served

DHS recommends that the state make available the newly expanded EMA benefit set only to the population who would be eligible for Medical Assistance if not for immigration status. This is consistent with the current EMA eligibility requirements. Other uninsured individuals will likely have other options through public programs or MNSure after January 1, 2014.

Recommended Funding Source

DHS recommends a mix of federal and state funding for coverage of treatment of current and imminent emergencies and state-only funding for comprehensive preventive health care and other non-emergent care, including outpatient prescription drugs.

Recommended Delivery Model

DHS recommends that the proposed expanded EMA program be delivered using a fee-for-service (FFS) model given the small population and the operational complexity of the state and federal funding mix.

II. Legislation

Laws of Minnesota 2013, Chapter 108, Article 6, sections 33 and 34 require that the Commissioner of the Department of Human Services submit to the legislature by January 15, 2014 an Emergency Medical Assistance Report.

Sec. 33. **REQUEST FOR INFORMATION; EMERGENCY MEDICAL ASSISTANCE AND THE UNINSURED STUDY.**

(a) The commissioner of human services, in consultation with safety-net hospitals, nonprofit health care coverage programs, nonprofit community clinics, counties, and other interested parties, shall identify alternatives and make recommendations for providing

coordinated and cost-effective health care and coverage to individuals who:

- (1) meet eligibility standards for emergency medical assistance; or
- (2) are uninsured and ineligible for other state public health care programs, have incomes below 400 percent of the federal poverty level, and are ineligible for premium credits through the Minnesota Insurance Marketplace as defined under Minnesota Statutes, section 62V.02.

(b) The commissioner of human services shall issue a request for information to help identify options for coverage of medically necessary services not eligible for federal financial participation for emergency medical assistance recipients and medically necessary services for individuals who are uninsured and ineligible for other state public health care programs or coverage through the Minnesota Insurance Marketplace. The request for information shall provide:

- (1) the identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients;
- (2) delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide;
- (3) funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system;
- (4) how the funding and delivery of services will be coordinated with the services covered under emergency medical assistance;
- (5) options for administration of eligibility determination and service delivery; and
- (6) evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option.

(c) The commissioner shall issue a request for information by August 1, 2013, and respondents to the request must submit information to the commissioner by October 1, 2013.

(d) The commissioner shall incorporate the information obtained through the request for information described in paragraph (b) and information collected by the

commissioner of health and other relevant sources related to the uninsured in this state when developing recommendations.

(e) The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services and finance by January 15, 2014.

EFFECTIVE DATE.This section is effective the day following final enactment.

Sec. 34. REQUEST FOR INFORMATION; EMERGENCY MEDICAL ASSISTANCE.

(a) The commissioner of human services shall issue a request for information (RFI) to identify and develop options for a program to provide emergency medical assistance recipients with coverage for medically necessary services not eligible for federal financial participation. The RFI must focus on providing coverage for nonemergent services for recipients who have two or more chronic conditions and have had two or more hospitalizations covered by emergency medical assistance in a one-year period.

(b) The RFI must be issued by August 1, 2013, and require respondents to submit information to the commissioner by November 1, 2013. The RFI must request information

on:

(1) services necessary to reduce emergency department and inpatient hospital use for emergency medical assistance recipients;

(2) methods of service delivery that promote efficiency and cost-effectiveness, and provide statewide access;

(3) funding options for the services to be covered under the program;

(4) coordination of service delivery and funding with services covered under emergency medical assistance;

(5) options for program administration; and

(6) methods to evaluate the program, including evaluation of cost-effectiveness and health outcomes for those emergency medical assistance recipients eligible for coverage of additional services under the program.

(c) The commissioner shall make information submitted in response to the RFI available on the agency Web site. The commissioner, based on the responses to the RFI, shall submit recommendations on providing emergency medical assistance recipients with coverage for nonemergent services, as described in paragraph (a), to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2014.

III. Introduction

Under the 1986 Social Security Act, the federal government required states to provide emergency medical services to Medicaid-ineligible non-citizens; since 1987 Minnesota has complied with this requirement with its Emergency Medical Assistance (EMA) program. Until 2011 Minnesota's EMA program included coverage for both emergency and chronic conditions. The benefit set available to EMA recipients was similar in scope to the Medical Assistance benefit set with a few notable exceptions: the benefit set did not include coverage for transplants, family planning and primary preventive care.

In the mid-2000s, the federal Office of the Inspector General audited Medicaid programs throughout the country to verify that states were claiming federal funding for the undocumented, non-citizen population only for emergency treatment. These audits found the majority of audited states lacked adequate compliance controls; states were required to return federal funding claimed for non-emergency treatment.

Due to this heightened federal attention and the audit findings in other states, DHS recognized that its existing EMA program likely did not have sufficient internal controls to ensure federal funding for medical services provided to Medicaid-ineligible non-citizens. Therefore, the Minnesota legislature reduced program expenditures by \$30 million by limiting coverage to

- services performed in an emergency room, ambulance or inpatient setting following a hospital admission or
- situations where lack of care would reasonably be expected to result in an emergency department admittance or inpatient hospitalization within the next forty-eight hours.

Since this 2011 change, there has been wide concern that lack of preventative care for this population has resulted in

- poorer health outcomes and
- significant amounts of uncompensated care for providers when these individuals present to emergency departments and require post-emergency care that EMA does not cover.

As a result of these concerns, the Minnesota Legislature mandated this study in Laws of Minnesota 2013, chapter 108, Article 6, sections 33 and 34.

The intent of this legislation was for DHS to

- publish a Request for Information (RFI) on how to provide better coverage for those currently served by the EMA Program and for those who are not eligible for other Minnesota Health Care Programs (MHCP) or Advanced Premium Tax Credits (APTC) through MNsure and
- produce a legislative report that takes the RFI responses and presents a recommendation on how Minnesota can provide better coverage for this population.

This report

- begins with an overview of the EMA population,
- followed by a short history of the EMA program in Minnesota since 2011,
- then outlines the process we used to develop the study and
- concludes with a recommendation on how to better serve Minnesota's EMA population.

IV. EMA Population in Minnesota

The EMA population is made up of individuals who are otherwise eligible for Medical Assistance (MA) but for their immigration status. The majority of this population is undocumented immigrants. Other EMA populations are individuals with temporary visas and lawful permanent residents subject to the five-year bar to MA eligibility. In SFY 2013, the average monthly enrollment in EMA was 2,025.

V. History of Minnesota's EMA Program

Title XIX, Section 1903(v)(3) of the Social Security Act of 1986 requires that states provide medical care to unlawfully present non-citizens in the event of an emergency. The Social Security Act defines an emergency as an “emergency medical condition...manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of a bodily organ or part.”

In SFY 2010, in the absence of sufficient controls to ensure the EMA program was limited to coverage of emergency conditions, Minnesota’s program expenditures totaled \$47 million in combined state and federal funds.

In 2011, after the federal Office of the Inspector General determined that many states throughout the country did not have adequate parameters around what classified as emergency services, the Minnesota legislature reduced the program expenditures by \$30 million by limiting coverage to

- services performed in an emergency department, ambulance or inpatient setting following a hospital admission or
- situations where lack of care would reasonably be expected to result in an emergency department admittance or inpatient hospitalization within the next forty-eight hours.

In 2012, the legislature expanded the EMA benefit set to cover dialysis and cancer treatments from May of 2012 to June of 2013 at a cost of \$4.7 million.

In 2013, the legislature extended dialysis and cancer treatment indefinitely at a cost of \$3.1 million for the 14-15 biennium. In addition, the 2013 legislature included \$2.2 million to provide nursing facility care and the services found in DHS’s elderly waiver program for the EMA population on a first-come, first-served basis until funding is exhausted or through the end of SFY 2015, whichever occurs first.

VI. Study Process

The first step in this study was the release of the Request for Information as mandated by Laws of Minnesota 2013, chapter 108, Article 6, sections 33 and 34. The RFI was posted in the *State Register* on September 3, 2013, with a final submission date of October 1, 2013.

DHS received a total of ten submissions from the following organizations: (the entire responses begin on page 16.)

1. Hennepin County Medical Center
2. Minnesota Association of Community Health Centers
3. The Long-Term Care Imperative
4. Minnesota Health Care Safety Net Coalition
5. American Federation of State, County and Municipal Employees, Council 5
6. Ramsey County Community Health Services Department
7. Regions Hospital
8. Mid-Minnesota Legal Aid
9. Minnesota Hospital Association
10. Optum

The majority of the submitted RFI responses had similar recommendations. Most responses recommended

- at a minimum, expanding coverage for the current EMA population and, in some cases, expanding coverage for other uninsured populations that are not covered by other public programs.
- increasing coverage to include a benefit set similar to that found in MinnesotaCare, emphasizing the need to provide preventive care for this population.
- funding this additional benefit with state funds due to the limitations for receiving Federal Financial Participation (FFP) on services in the EMA program that do not meet the federal definition of emergency.

Optum took a slightly different approach. Their response focused on the top five percent of enrolled recipients who they believe may account for fifty percent of the medical expenditures. They suggested using data analytics to identify this top five percent and then combining strong care coordination with primary care provided at the client's location. Optum also recommended post-acute transition care for the 30 days after an EMA hospital stay to prevent readmissions.

In addition to reviewing the submitted RFI responses, DHS also hosted a 90 minute stakeholder meeting on November 13, 2013 that included 20 registered guests. The invitation was sent to all organizations and individuals who submitted an RFI response as well as to organizations and individuals who took part in the stakeholder process for the EMA study released in April 2013.

After this stakeholder meeting, DHS staff reviewed the submitted RFI responses as well as comments made at the stakeholder meeting and drafted this report and recommendations.

VII. Report Recommendations

DHS's suggested changes to the EMA program include four categories of recommendations: EMA benefit set, covered population, funding source and delivery model.

A. Recommended EMA Benefit Set

1. MinnesotaCare Benefit Set

DHS recommends that the EMA benefit set resemble the benefit set found in MinnesotaCare, with the exception of organ transplants. Furthermore, we recommend eliminating the requirement that the individual is facing an imminent medical emergency in order to receive the full range of medically necessary services included in the MinnesotaCare benefit set. This benefit set recommendation addresses the significant concern brought by stakeholders and providers that unavailability of preventive care for this population results in poorer health outcomes and higher amounts of uncompensated care for participating providers.

2. Nursing Homes and Elderly Waiver Benefit Sets

In addition to the MinnesotaCare benefit set, we recommend that nursing home services and benefits found in the Elderly Waiver (EW) also be available to the EMA population. Similar to the MinnesotaCare benefit set, nursing home services and elderly waiver benefits would not require the presence of an imminent emergency for approval of coverage.

a) Nursing Home benefits

Under today's policy, in order for an EMA recipient to receive nursing home benefits, his or her provider must submit a Care Plan Certification (CPC) documenting that the absence of nursing facility services would reasonably be expected to result in an emergency department admittance within the next forty-eight hours. The department's medical review vendor approves or denies each submitted CPC based on the information submitted. A nursing facility cannot deny admittance to an EMA recipient with an approved CPC for nursing facility care.

All CPCs are approved for one year or the amount of time until the emergency condition is expected to resolve, whichever is less, and can be renewed so long as the recipient continues to meet the criteria. On occasion, a CPC renewal for an EMA nursing facility resident is denied because the emergency condition necessitating nursing facility care, while still requiring medically necessary facility treatment, no longer threatens an imminent emergency department admittance or hospitalization.

In the absence of a CPC renewal, care and services provided by a nursing facility are no longer covered by the recipient's EMA benefit. However, federal law limits a nursing facility's ability to discharge residents. *See* Social Security Act §§ 1819(c)(2)(C) [42 U.S.C. § 1395i-3(c)(2)(C)] and 1919(c)(2)(C) [42 U.S.C. § 1396r(c)(2)(C)]; 42 C.F.R. §

483.12(a)(7). When a nursing facility does discharge a resident, the facility must ensure a safe and orderly transfer or discharge of the resident from the facility and prepare and orient the resident for such a transfer or discharge. For a resident still in need of nursing facility services (albeit not emergency services), a discharge to someplace other than to another health care facility, may not constitute a safe and orderly discharge. The net effect of these limitations is that some individuals remain in nursing homes indefinitely with no payer source to reimburse the nursing home for the services.

Due to the uncertainty of future CPC approvals and the limitations in discharging patients once they are in a nursing facility, DHS recommends expanding the EMA benefit set to include nursing homes to ensure a consistent and reliable payment stream for the nursing facility providers.

b) Elderly Waiver benefits

In recognizing the importance of covering the nursing home benefit for the EMA population, DHS also thinks it is equally important to cover the benefits found in the Elderly Waiver (EW) benefit set. Services covered in the EW benefit set include

- Adult day services
- Chore services
- Companion services
- Consumer-directed community supports
- Home health aides
- Home-delivered meals
- Homemaker services
- Licensed community residential services (customized living services or 24-hour customized living services, family foster care, residential care)
- Environmental accessibility adaptations
- Personal care assistant
- Respite care
- Skilled nursing services
- Specialized equipment and supplies
- Training for informal caregivers
- Transitional supports
- Transportation services

DHS has long supported providing services in community settings in lieu of institutional settings when medically appropriate. Including the EW benefit set for EMA recipients allows for individuals who are in need of services often found in institutional settings to remain in the community while receiving the needed services. Expanding coverage to include nursing homes without including EW services may have the unintended consequence of forcing individuals into more costly institutional settings because funding for the services is not available in the community.

Any services above and beyond the MinnesotaCare benefit set, nursing home services or EW services will be eligible for coverage, provided the service is needed for treatment of a current or imminent emergency. These services would require an approved CPC. The criteria for CPC approval will remain unchanged from the current standard, meaning approval will only be granted when the requested services would prevent admission to the emergency department within the next forty-eight hours.

B. Recommended Covered Population

The legislative language requested that this study analyze additional coverage options for the current EMA population as well as for other uninsured populations under four hundred percent of the federal poverty guideline (FPG) and not covered by other public health care programs. However, DHS recommends that the additional coverage be focused initially on only the current EMA population – those non-citizens that would be eligible for Medical Assistance if not for their immigration status – rather than expanding it to include other uninsured populations. DHS recommends coverage only for the current EMA population for the following reasons.

- Due to the large number of program changes passed in the 2013 legislative session that were mandated by the Affordable Care Act and that are currently being implemented, it has become nearly impossible to identify and quantify which populations may still be uninsured as of January 1, 2014.
- Not being able to identify these populations makes it difficult to design program eligibility that would cover all the remaining uninsured after the significant changes are implemented in 2014.

Although there may be other populations who choose to remain uninsured despite access to another public program or coverage through MNsure, the current EMA population may be the only category of individuals who do not have the option of enrolling for a public program or purchasing a plan through MNsure.

It is important to recognize that with the availability of an expanded EMA benefit set enrollment in the program is likely to increase. Under current law, coverage for medical services is predicated on the presence of a current or imminent emergency medical condition. If the EMA benefit set is expanded, as recommended above, individuals will no longer need to experience a current or imminent emergency medical situation to receive coverage for medical services. This reduction in barriers to medical care and coverage is expected to increase the number of people who enroll in EMA and utilize covered services.

However, an expanded EMA program may still grow slowly since the eligible population is often hesitant to present in government systems due to immigration status. Partner

organizations could assist the department in addressing this barrier and ensuring access to much needed preventive care through education efforts.

C. Recommended Funding Sources

1. Federal and State Funds for EMA Program

DHS recommends that funding for the EMA program be a combination of state and federal funding. Consistent with federal law, Federal Financial Participation (FFP) can only be claimed on services used to treat a current or imminent emergency medical situation. DHS must ensure adequate controls are in place so that FFP is only claimed for emergency treatment. For claims for services covered under the MinnesotaCare benefit, DHS will claim federal match for those claims submitted from an emergency room for emergency care, an inpatient hospital following an emergent admission or from a dialysis facility.

2. State Funds for Prescription Drug Coverage

The current EMA program allows for limited outpatient prescription drug coverage for instances when the use of the prescription drugs is necessary to avoid an imminent medical emergency. A CPC and a second layer of review (the pharmacy review agent) are necessary before a prescription drug will be approved for an EMA recipient.

Under the proposed changes, prescription drug coverage would not be limited to treatment of current or imminent emergency medical conditions. Rather, enrollees in EMA would receive the same prescription drug coverage as MinnesotaCare enrollees.

It would be operationally burdensome and administratively inefficient for the department, providers and recipients to utilize a CPC process to determine -- on an annual or more frequent basis -- whether or not each prescription could be considered an emergency and thus eligible for federal funding. As a result, the entire drug benefit would need to be paid for with state funds -- meaning that the department could claim neither FFP nor drug rebates for the prescriptions dispensed to EMA enrollees.

3. State Funds for Elderly Waiver Benefit Set

EMA enrollees also will have access to services found in the EW benefit set. Since it would be administratively burdensome to identify which of these services is directly related to a current or imminent emergency medical condition, the department recommends these services be covered solely with state funds. If DHS is able to develop an efficient mechanism to identify EW services that are used to prevent the occurrence of an emergency within the next forty-eight hours, the department will then submit those for FFP.

4. Federal or State Funds for Nursing Home Care

For services provided in a nursing home, providers will be required to submit a CPC prior to coverage approval.

- If the medical review vendor determines that the services are necessary to treat or prevent an imminent emergency and approves the CPC, DHS will submit those claims for FFP.
- If the CPC is denied but the services are still medically necessary, payment for those services will be made entirely from state funds.

Any payment to providers for nursing home claims will be predicated on submission of a CPC. If a CPC is not submitted, claims for these services will be denied.

Any medical services needed by a client outside the MinnesotaCare benefit, nursing home care or EW benefits, will follow the current process. These additional emergency services would require a CPC and would only be covered if lack of treatment would reasonably be expected to result in an emergency room visit or hospital admission within the next forty-eight hours.

D. Recommended Delivery Model

The Department recommends that the proposed expanded EMA program be delivered using a fee-for-service (FFS) model, as is the current program. The current EMA population is relatively small; the average enrollment in SFY2013 was just 2,025.

Expanding the benefit set and eliminating the need for the presence of an emergent condition for primary care will likely increase enrollment, but it is unlikely the increased enrollment will be sufficient to create the kind of economies of scale that would make a capitated model cost effective for any managed care organization.

In addition, the proposed program's mix of federally funded and state-funded components would add a layer of operational complexity that would be challenging to administer in a managed care environment.

VIII. Appendix

Below are the ten responses submitted as a result of the RFI.

Administration

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Hennepin County
Medical Center

October 1, 2013

Diogo Reis
Legislative Liaison
Health Care Administration,
Policy Development and Implementation
Minnesota Department of Human Services
Post Office Box 64984
Saint Paul, Minnesota 55164-0984

Dear Mr. Reis:

Hennepin Healthcare System, Inc., d/b/a Hennepin County Medical Center (HCMC), is pleased to provide the following recommendations in response to the Request for Information, "Coverage Options for Emergency Medical Assistance Services," recently issued by the Minnesota Department of Human Services. Serving as a safety net for the entire state, HCMC is particularly well-suited to propose options for providing coordinated and cost effective health care and coverage for individuals who meet eligibility standards for emergency medical assistance and for those who are uninsured and ineligible for other state public health care programs or for coverage through MNSure.

Over the last year, HCMC has treated over 35,000 patients who were uninsured, representing nearly 16 percent of our total patient population. Given our safety-net mission, we greatly appreciate the State's full support for Medicaid expansion, the creation of the Basic Health Plan, and the establishment of MNSure. We estimate nearly 65 percent of our uninsured patients will be eligible for some form coverage made available through the Affordable Care Act. However, even after these positive changes are implemented, HCMC expects to treat more than 12,000 uninsured in 2014. We commend the Department of Human Services for seeking information to identify coverage options for those who will remain uninsured in 2014 and welcome the opportunity to provide recommendations. Attached please find HCMC's response to the request for information.

Thank you for considering our recommendations. If you have any questions or would like additional information, please contact David Godfrey, HCMC's Public Policy Director, at 612-873-2196 or David.Godfrey@hcmed.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jon L. Pryor". The signature is fluid and cursive, with a large initial "J" and "P".

Jon L. Pryor, MD, MBA
Chief Executive Officer



**Response to Request for Information for
Coverage Options for Emergency Medical Assistance Services
Presented to the Minnesota Department of Human Services**

October 1, 2013

Introduction

Hennepin Health Care System, Inc. operates Hennepin County Medical Center (HCMC), a comprehensive academic medical center and 462-bed public teaching hospital in downtown Minneapolis. The system includes specialty and primary care clinics at the downtown location and nine clinics located in Minneapolis and the suburban community. HCMC and its clinic network serve as an important statewide resource for training of health care providers, as a source of innovative research and health care services, and as a major hub of the health care safety net in the region. HCMC is also an Essential Community Provider as designated by the Minnesota Department of Health.

Serving as the region's "safety-net" is central to the HCMC's mission. America's Essential Hospitals defines a safety net as *"a hospital or health system that provides a significant level of care to low-income, uninsured, and vulnerable populations. It is distinguished by its commitment to provide access to care for people with limited or no access to health care due to their financial or insurance status or health condition."* HCMC provides access to a full a range of health services without regard to the patient's ability to pay for these services. This is achieved through the use of a sliding-fee charge schedule and charity care policy. The capacity and willingness to provide comprehensive services to anyone in need sets HCMC apart from other providers.

HCMC commends the Department of Human Services (DHS) for seeking information to identify comprehensive coverage options for people who are either Emergency Medical Assistance (EMA) enrollees or who will be uninsured and ineligible for other public health care programs or coverage through MNsure. HCMC views the establishment of coverage programs for these populations as vital to the sustainability of its safety net mission.

Over the last year, HCMC has treated over 35,000 patients who were uninsured, representing nearly 16 percent of our total patient population. Given our safety-net mission, we greatly appreciate the Department of Human Services' full support for Medicaid expansion, the creation of the Basic Health Plan and the establishment of MNsure. We estimate nearly 65 percent of our uninsured patients will be eligible for some form coverage made available through the Affordable Care Act (ACA).

Even after these positive changes are implemented and the market obtains full compliance with insurance enrollment, HCMC would still expect to treat more than 12,000 uninsured patients annually. The cost of this care will be borne almost entirely by the hospital and property tax payers of Hennepin County. HCMC also has some serious concerns about the implementation of the ACA in 2014 based on the experience of safety-net hospitals in Massachusetts after the implementation of their health care reform law. Hospitals there faced a significant increase in demand but not an equal increase in revenue. We are also concerned, because of a misunderstanding of the impact of MA expansion on providers like HCMC, there will be a continued shift of resources away from funding that has typically supported safety-net hospitals. This has already occurred in Minnesota with the changes made to the 340B program, Emergency Medical Assistance and MERC funding formula. Many of these concerns would be mitigated by providing coverage options for the uninsured.

The future uninsured population will be a diverse group who will find themselves without insurance coverage for several different reasons. Given the variety of their circumstances, HCMC proposes a multi-pronged approach for making coverage for this population accessible and affordable. At the same time, in order to minimize the complexity of administration, HCMC recommends these coverage options be provided, to the extent possible, through existing platforms.

We feel the proposal below strongly supports the Administration's goal to provide seamless health care coverage and follows in the State's long-tradition of seeking to provide access to quality health care to as many residents as possible.

In the event that DHS is unable to support or bring forward a recommendation to provide a full set of coverage options for this population, HCMC highly recommends that available resources be focused on improving EMA. Prior to 2012, the program served this sick and vulnerable population with a much more robust benefit set than the one that currently exists. The benefit set today is inadequate and promotes the use of expensive and inefficient care. It does not contain any payment mechanisms that encourage the reduction of costs and the improvement of quality. The program ultimately leads to poorer patient care and experiences than what results from any of the other Minnesota Health Care Programs. This situation could be significantly remedied by applying many of the ideas below to the EMA program, even if the larger coverage options are not found to be feasible.

Populations and Coverage Options

HCMC proposes a multi-pronged approach for making coverage accessible to those populations who will remain uninsured after implementation of the Affordable Care Act. The following table provides a brief description of these populations and HCMC's recommendations for coverage.

Uninsured Population**Proposed Option for Coverage**

Group #1: Individuals ineligible for coverage through ACA due to immigration status, including those eligible for EMA

Extension of Basic Health Plan that mimics BHP and MNSure cost-sharing; enrollees assigned to limited and closed networks

Group #2: Dependents dropped from employer sponsored coverage

Based on total family adjusted gross income, subsidize premiums of plans available on Exchange to levels considered affordable (as defined by ACA)

Group #3: Individuals with incomes 200-400% FPL who are exempt from individual mandate for financial reasons

Subsidize premiums of plans available on Exchange to levels considered affordable (as defined by ACA)

Group #4: Individuals who choose not to insure

No additional options

The majority of this response will address the coverage option for Group #1 above. Group #2 and Group #3, through subsidies, will be able to access the coverage via MNSure. Ideally, subsidies would be provided prospectively through MNSure in the same manner as the Exchange tax credits; if that is not possible, then subsidies could be paid directly to enrollees on a retrospective basis. HCMC does not recommend any additional options for those who choose not to insure and remain non-compliant (Group #4).

Proposed Services

HCMC recommends building upon current programs in order to expand coverage to those who will remain uninsured after implementation of the Affordable Care Act. As previously mentioned, a multi-pronged approach will ensure different uninsured populations are able to access coverage.

For those individuals ineligible for coverage through the ACA due to immigration status, including those eligible for EMA (Group #1 above), HCMC proposes a new component to the Basic Health Plan for this specific population. This State-funded extension of the Basic Health Plan will provide access to the continuum of services offered through the State's MinnesotaCare Program/Basic Health Plan. Covered services would be provided through narrow, restricted networks and would be enhanced with expanded care coordination for primary care and behavioral health services. Covered services would also include care provided by skilled nursing facilities and home-based and community-based services for those enrollees who are determined to require Nursing Facility level of care but are not eligible for such services via Medicaid. HCMC would also propose that due to the fact those who are currently eligible for EMA are presenting with an urgent/chronic condition in need of immediate medical attention that presumptive eligibility from the date of service be part of the enrollment process.

To address the needs of individuals who have two or more chronic conditions and have had two or more hospitalizations covered by emergency medical assistance in a one-year period, HCMC recommends reimbursing specialized health care homes for this population, similar to what is envisioned by Section 2703 of the ACA. These primary care settings could be modeled after HCMC's Coordinated Care Center, an "ambulatory ICU" staffed by a multidisciplinary team that provides comprehensive primary care, behavioral health services, medication therapy management, and assistance addressing social needs of complex patients. Because participating networks will be affiliated with hospitals, HCMC envisions hospital in-reach service coordination will also be available for this population.

If the enrollee's income is between 133% and 200% FPL, premiums and other cost sharing would be identical to the Basic Health Plan. If between 200% and 400% FPL, the premiums and cost-sharing would be identical what the enrollee would have received if he or she had purchased the median-priced Silver plan. If the enrollee's income is greater than 400% FPL, he or she may purchase, at full-cost premium value, into the state-funded extension of the BHP. Third parties should be able to subsidize the premium on behalf of the enrollee and providers may waive co-payments.

Delivery System

HCMC recommends that the State-funded extension of the Basic Health Plan provide covered services via narrow, restricted networks defined by health care systems, health plans and Local Access to Care Programs. Participating networks would have the capacity to provide a full continuum of care, including prescription medication and behavioral health services, and covered services would be limited to those provided within an enrollee's respective network. Recognizing that EMA services for which the State receives federal matching funds allow provider choice for enrollees, HCMC proposes that the State explore options for federal authority to provide covered services within closed networks. We recommend narrow, restricted networks for two reasons. First, a small network allows for the most effective care management for a complex population for which little is known from a claims standpoint. Second, a restricted network based on a provider system is conducive to an effective payment system that allows for the successful coordination of care, monitoring quality of care and management of total cost of care.

HCMC envisions that networks would undergo an approval process with the State in order to participate in the extended Basic Health Plan. To ensure equitable distribution of enrollees among networks, HCMC recommends DHS consider enrollment caps for networks. Services will be covered by multiple funding streams and payment mechanisms, as described in the following section. From the perspective of enrollees, however, coverage will appear seamless.

Funding Options and Payment Mechanisms

The State-funded extension of the Basic Health Plan would be financed by a mix of federal and state funds, with the State utilizing appropriations from the Health Care Access Fund and General Fund and leveraging federal matching funds through EMA when possible.

HCMC recommends reimbursing providers participating in the extension of the Basic Health Plan through a fee-for-service payment model with incentives based on those found in Health Care Delivery System Demonstration (HCDS) project. Because very little cost and quality data exist for this population, we recommend that the first year of the program be used to develop a baseline for the cost and quality measures. In the second year, we would propose implementing the incentives used by HCDS. HCMC's proposal would also allow for a capitation payment option for systems or plans who may be more interested in a direct contracting approach. We don't believe at this time there would much interest or capacity in undertaking a capitation arrangement for this population, given its unknown nature and the high level of risk associated with much of this population (EMA).

Not all provider systems/networks will be equipped to manage total cost of care, especially small independent systems in Greater Minnesota, therefore a straight fee-for-service payment without HCDS incentives should also be an option. If the State opts to only improve the EMA program by providing additional covered services, then fee-for-service with incentives would be the preferred payment mechanism.

Coordination with EMA

The extension of the Basic Health Plan will appear as a seamless coverage program to enrollees, who will be covered for current EMA services (emergency department, inpatient, etc.) as well as preventive services and long-term care (when criteria for Nursing Facility level of care are met). There will be no distinction for enrollees between services covered by federally-matched emergency medical assistance and other covered services; the distinction will be made by the State, which will identify services to be matched with federal funding. The fee-for-service payment mechanism recommended in this response, as opposed to possible capitation payments, will ease the Department's efforts to manage the EMA program's federal claim.

Options for Administration of Eligibility Determination and Service Delivery

HCMC recommends that enrollment for the State-funded extension of the Basic Health Plan to occur in multiple venues. Uninsured patients ineligible for coverage through the ACA due to immigration status who seek care from a provider associated with an approved network will enroll in the coverage program through their provider and they will be assigned to their respective provider's network. Enrollment via MNsure is also proposed, with enrollees choosing an approved network available within their county, or if no network is chosen,

enrollees will be assigned. MNsure would also be the venue to access the subsidies proposed in this response.

HCMC proposes that the Minnesota Health Care Programs application and determination processes be utilized for the extension of the Basic Health Plan. Some enrollees will initially be covered through presumptive eligibility and will need to transition to the State-funded extension of the Basic Health Plan once they are determined ineligible for Medicaid and the presumptive eligibility period of coverage has ended. In such a case, efforts should be made to enroll the individual in an approved network that is associated with the system that provided the majority of the person's care during the presumptive eligibility period.

Evaluation Methods to Measure Cost-Effectiveness and Health Outcomes

The cost-effectiveness and quality of the services provided by the systems and other coverage entities that participate in the State-funded extension of BHP will be measured according to the metrics of the HCDS program. HCDS measures for quality and cost must be sufficiently risk-adjusted to recognize the specific challenges faced by the population served by this new program.

The State will measure its success through the overall cost and quality of care provided to enrollees of the BHP extension. The State would also measure its success based on a reduction of the number of uninsured in Minnesota.



October 1, 2013

Diogo Reis, Legislative Liaison
Health Care Administration
Policy Development and Implementation
Minnesota Department of Human Services
PO Box 64984
Saint Paul, MN 55164-0984

Re: Request for Information: Coverage Options for Emergency Medical Assistance Services (38 State Register 337)

Dear Mr. Reis:

Thank you for the opportunity to comment on the above referenced Request for Information (RFI) regarding coverage options for Emergency Medical Assistance Services. The Minnesota Association of Community Health Centers (MNACHC) represents the interests of the state's 17 Federally Qualified Health Centers (FQHCs). Collectively, our members serve nearly 185,000 low-income Minnesotans. Roughly 40% -- 70,000 -- of Health Center patients are currently uninsured.

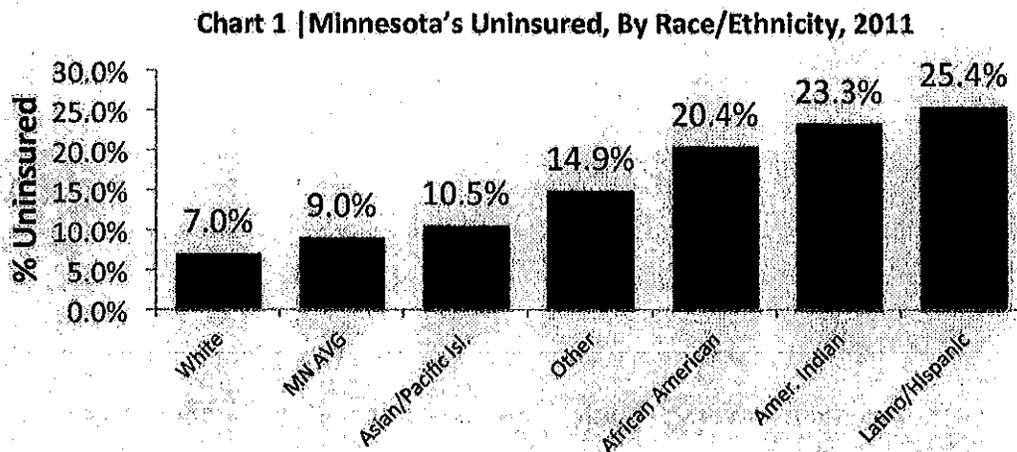
While Medicaid expansion, a re-purposed MinnesotaCare program and access to private insurance coverage through MNsure will reduce the number of uninsured at Minnesota's Health Centers, we expect a significant portion of our currently uninsured patients will remain uninsured. Health Centers in Massachusetts experienced only a 20% reduction in their uninsured caseloads after reform, while the state's general rate of un-insurance dropped over 50% after health care reform implementation.

Clearly, Minnesota's Health Centers will continue their 45-plus year tradition in Minnesota of providing primary medical, dental and mental health services to the uninsured and low-income individuals after full implementation of the ACA law in Minnesota.

General Comment:

MNACHC believes that the State of Minnesota should establish a coverage program for the remaining uninsured after full implementation of the Affordable Care Act (ACA) law along with the persons eligible for the Emergency Medical Assistance (EMA) program. Minnesota has a strong tradition of providing low-income Minnesotans with coverage programs -- e.g., MinnesotaCare and Medicaid expansion.

Currently, Minnesota's communities of color experience dramatically different health insurance coverage. While the statewide uninsured rate is roughly nine (9) percent, the uninsured rate in communities of color approach nearly three times the state rate.



Source: MDH, Health Economics Program, Access Survey, 2011

MNACHC strongly believes that access to affordable health care coverage and services will begin to help eliminate the glaring health disparities that exist for communities of color in Minnesota. While the ACA will dramatically reduce the levels of un-insurance in our state's communities of color, it will not reduce the rate below the statewide average.

Moreover, MNACHC believes that a coverage program for the remaining uninsured and EMA populations **must emphasize the role of primary care services and care coordination**. Consequently, a coverage program is consistent with the health care reform efforts in Minnesota that began in earnest in 2008. These reforms are consistent with the Triple Aim: improving quality, reducing costs and improving the patient experience. MNACHC believes that elevating primary care is a key component to achieving the Triple Aim in Minnesota.

The remainder of this correspondence will focus on the areas requested by the Department of Human Services (DHS).

1. **Identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients:**

According to national studies, Health Centers are vital community-based organizations that **reduce unnecessary emergency department visits and inpatient hospital utilization** for low-income individuals. Some examples include:

- A study of 135,000 adults enrolled in a managed care plan in California found that Health Center patients had 64% lower rates of multi-day hospital admissions, 18% lower rates of

emergency department (ED) visits and total health care costs were 20% lower compared to non-Health Center patients¹;

- A study of rural Georgia found that counties with a Health Center had 25% fewer uninsured emergency department visits per 10,000 uninsured population compared to counties without a Health Center²; and
- Health Centers save nearly \$1,300 per year per patient through reduced ED and hospital inpatient utilization.³

While Health Centers provide primary care services to nearly 70,000 uninsured, a frustration for both our patients and providers is the lack of access to specialty care providers. Uninsured patients with chronic diseases such as diabetes have difficulty securing specialty appointments to treat their conditions. With a coverage program for such patients, the chances of them controlling their condition – and leading a healthier, productive life – greatly increase.

MNACHC recommends that the remaining uninsured and EMA populations receive the services available through the state's re-purposed MinnesotaCare program (or Basic Health Plan-BHP).

2. **Delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide.**

Minnesota recently embarked on payment reform experiments reflecting Total Cost of Care (TCOC) or Accountable Care Organizations (ACOs) principles. It is expected that these reforms will promote the Triple Aim of higher quality, lower costs and better patient experience. While these reforms are still in the demonstration stage, central to their success will be ability of organizations to coordinate care across a variety of care settings (e.g., primary care clinic, specialty provider, social services and hospitals). Essential to this care coordination function is the free exchange of information across care settings – i.e., real time data that is interoperable.

In addition, some areas of the state – particularly rural, frontier areas – may not have the critical patient population mass to financially sustain a TCOC or ACO model. This is because these rural areas of the state may not have the volume of uninsured/EMA to populations to support the TCOC/ACO model. However, it should be noted that in many

¹ California Primary Health Care Association. Value of community health centers study: Partnership HealthPlan of California case study. 2013 January

² Rust George, et al. "Presence of Community Health Center and Uninsured Emergency Department Visits Rates in Rural Counties." *Journal of Rural Health*, Winter 2998 25(1):8-16

³ Ku L, et al. Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University. June 30 2010. Policy Research Brief No. 19

rural counties of Minnesota, the number of uninsured individuals expressed as a percentage of the total county population exceed the averages in Hennepin and Ramsey Counties.

Table 1: Uninsured as Percent of Total County Population, Top 10 & Hennepin/Ramsey Counties

County	% Uninsured
1- Nobles	15.8%
2- Watonwan	15.8%
3- Clearwater	15.2%
4- Todd	15.0%
5- Beltrami	14.6%
6- Cass	14.4%
7- Mahnomon	14.1%
8- Traverse	13.9%
9- Aitkin	13.3%
10- Fillmore	13.3%
27- Ramsey	11.5%
30- Hennepin	11.4%

Source: Census Bureaus, Small Area Health Insurance Estimates, 2011

MNACHC recommends a delivery system that emphasizes and incents care coordination for the remaining uninsured and EMA populations. This recommendation, however, recognizes the need: 1) achieving true data interoperability in the state; and 2) maintaining a fee-for-service mechanism in areas of the state where ACOs and TCOC arrangements are not feasible.

3. Funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system;

Similar to the delivery system options outlined in response #2, the use of a TCOC or ACO payment mechanism may incent providers to coordinate care for their patients. In areas of the state where a TCOC or ACO arrangement is not feasible, the fee-for-service system should be coupled with existing state or federal Health Care Home certification in order to ensure proper care coordination activity is available for patients.

As we transition to payment mechanisms that emphasize "better patient outcomes," the measurement should incorporate specific social determinants of health when comparing provider outcomes. Under current measurement activity (e.g. Statewide Quality Reporting & Measurement System-SQRMS and MN Community Measurement), incorporating social factors such as poverty, homelessness, culture is very limited. As a consequence, the

reported outcomes do not incorporate non-clinical measures that have a profound impact on a patient's health outcome.⁴

Health Center patients experience a wide variety and number of social factors in their daily lives. For example, nearly 30% of Health Center patients would prefer to be served in a language other than English and 95% of Health Center patients have incomes below 200% of poverty.

MNACHC recommends:

- **Payment mechanisms that incent care coordination along with quality outcomes – provided that the outcomes are adjusted for specific social factors impact patient outcomes;**
- **A FFS system coupled with state or federal Health Care Home certification in areas where TCOC and ACO models are not feasible; and**
- **Use of the health care access fund as a source of financing a coverage program for EMA and uninsured populations.**

4. How the funding and delivery of services will be coordinated with the services covered under emergency medical assistance:

In order to minimize program complexity – both from the patient and administrative perspectives – the EMA population will receive the MinnesotaCare benefit set that other eligible enrollees will receive. This will address the “patient churn” whereby individuals experience shifts in program eligibility from one public program to another program.

MNACHC recommends providing the “EMA eligible” individuals with the MinnesotaCare benefit set. Moreover, MNACHC strongly recommends that the Department of Human Services extend the MinnesotaCare benefit set to the remaining uninsured individuals in the state after full implementation of the ACA.

5. Options for administration of eligibility determination and service delivery:

As MNsure is the conduit for low-income individuals to enroll in Medicaid, MinnesotaCare or a Qualified Health Plan, many of the remaining uninsured and EMA enrollees will use MNsure to assess their eligibility. Moreover, the state network of Navigators and In Person Assisters will help guide individuals through this eligibility assessment process. Community Health Centers have already hired Navigators and In-Person Assisters as significant portion of our 185,000 existing patients and many new patients will require assistance using MNsure.

⁴ Roughly 20% of a patient's health outcome is due to the clinical care that patient received. Nearly 40% of the outcome is influenced by social and economic factors. Booske Athens et al. County Health Rankings Working Paper. Different Perspectives for Assigning Weights to Determinants of Health. February 2010, University of Wisconsin, Population Health Institute

MNACHC recommends that any EMA/Uninsured coverage program “link” to MNsure. By formally connecting with MNsure, the state will create a referral process for coverage for individuals who are not eligible for Medicaid, MinnesotaCare or a QHP.

6. Evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option:

The evolution of away from a FFS health care system to one based on outcomes is highly reliant on accurate measurement of outcomes – especially when comparing providers with other providers. As previously mentioned under #3, the current SQRMS methodology is flawed in the sense that it does not recognize a broad set of factors that influence a patient’s health care outcome. MNACHC is of the opinion that socio-economic factors beyond the provider’s control, have a significant impact on a patient’s health outcomes (e.g., availability of healthy food, poverty, genetics, etc.)

Current outcomes under SQRMS only account for social determinants by adjusting the outcomes based on a patient’s insurance status, and in some measures, by age. MNACHC strongly believes that insurance status is by no means a proxy for the socio-economic complexities that our patients face.

In addition to “outcomes focused” measures, Health Centers invest significant resources into “enabling services” that are targeted to populations that are traditionally difficult to reach from a primary care setting. Examples of these “enabling services” include: transportation, health education and outreach, and language translation services. These services are reflective of the populations – namely low-income and racially/ethnically diverse -- Health Centers serve. In 2003, the 17 Health Centers in the state invested roughly \$8 million in these services. Recognizing the value of these services, Health Centers today invest \$15.4 million into enabling services – roughly 11% of Health Center operating budgets.

MNACHC recommends that any evaluation methods take into consideration a more robust measurement that includes the social determinants of health. In addition, MNACHC recommends a measurement that also incents improvement over time and recognizes the amount of resources a particular provider invests in services that engage patients into the primary care system.

Conclusions

MNACHC appreciates the opportunity to provide input regarding coverage options for Emergency Medical Assistance (EMA) and uninsured populations. Our member Health Centers are anticipating that a portion of the 70,000 uninsured Minnesotans they serve will secure health care coverage through the implementation of the ACA.

At the same time, Health Centers are also preparing to serve the remaining uninsured. Recent state estimates suggest that roughly 200,000 individuals will remain uninsured after full implementation of the ACA in Minnesota. Creating a coverage program for this remaining population will reduce overall health care spending and improve the health of many underserved communities.

MNACHC's recommendations also are consistent with the 2012 Governor's Health Care Reform Task Force report: *Roadmap to a Healthier Minnesota Report*. We hope the tremendous effort and time taken to develop the recommendations outlined in the report can inform the state's RFI process as well.

Our member Health Centers stand at the ready to work with you and your Department to develop a coverage program based on strong tradition coverage in Minnesota along with recent innovations related to payment reform.

Please feel free to contact me at any time to discuss any questions or comments. I can be reached at 612.253.4715, ext. 11 or at jonathan.watson@mnachc.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonathan Watson', written in a cursive style.

Jonathan Watson
Associate Director/Director of Public Policy

The
 **Long-Term Care
IMPERATIVE**
A Minnesota Collaboration for Changes in Older Adult Services

Date: September 27, 2013

To: Diogo Reis, Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984
E-mail: diogo.reis@state.mn.us
Fax: (651) 431-7422

From: Gayle Kvenvold, President/CEO, Aging Services of Minnesota
Patti Cullen, President/CEO, Care Providers of Minnesota

Re: Response to Notice of Request for Information (RFI): Coverage Options for
Emergency Medical Assistance Services

The 2011 changes to the Emergency Medical Assistance (EMA) Program have created significant issues for EMA clients that receive services in a hospital, and then require post-acute skilled nursing facility services as well as long-term care services in a nursing facility and/or Home and Community Based Services (HCBS) setting.

The EMA program's current use of a certified care plan, "*to pay for services and medications if an emergency medical condition was treated in an emergency room or inpatient hospital setting and the enrollee went to a nursing facility or a home-or-community-based setting where they continue to receive services and medications that, if they were stopped, would quickly create an emergency condition (typically within 48 hours)*," has created inefficiencies and likely cost increasing barriers for EMA clients and the providers providing care.

Hospitals are unable to find post-acute or long-term care for EMA clients who will not qualify under the certified care plan, and nursing facilities have a number of clients for which no payment is made. Significant resources are being incurred by multiple stakeholders in layers of appeals and in seeking alternatives for needed services that are not covered under the current EMA program. In addition, although required as a provided service by state and federal regulations, the current EMA program does not pay for ancillary services such as therapies and medications for clients in a long-term care setting.

In order to better align services and need, we propose that:

- Rather than utilizing the current EMA care plan criteria, the state instead adopts the new Nursing Facility Level of Care (NF-LOC) standard and policy to judge whether EMA clients leaving a hospital are eligible for nursing facility and HCBS services and payment, including ancillary services and medications.
- Likewise, with a few adaptations, the newly designed pre-admission screening and long-term care face to face assessment system known as First Contact offers a dynamic way to quickly allow the hospitals and Senior Linkage Line to judge eligibility.

Taken together, the two bullet points above offer a policy to better care for EMA clients and efficiently use the state's resources by providing for care at the right time and in the right place. It is very important to note, that the new higher standard for nursing facility level of care is intended to:

- 1) Utilize more objective criteria for accessing nursing facility and waiver services, and
- 2) Better allocate resources to those clients that most need them.

For more information about the new standard for Nursing Facility Level of Care go to Minnesota Statute 144.0724 Subd. 11.

For more information on First Contact: Pre-Admission Screening and Resident Review (PASRR) Redesign, go to <http://www.mnaging.net/en/News/PASRR.aspx>

While we understand that the suggested expansion of service eligibility we are making here may not be allowed under existing federal regulations for EMA, we would encourage the state to consider implementing these changes anyway on a state-funded basis or by requesting a federal waiver. Even if the additional long-term care services authorized under this approach had to be fully funded by the state, we believe that the ultimate impact on state costs will be limited because more efficient use of services to manage ongoing needs will result in a reduced number of expensive emergency room admissions.

In addition, for EMA clients who require either nursing facility care or home and community based services, there are several options to consider for payment for the medication and/or ancillary services that are required to be provided per the client's plan of care and physician's orders. One option would be to include these clients into the dual demonstration in Minnesota, known as the MN Senior Health Options Program or MSHO. Under that program, health plans receive payments in their contracts to cover not only the nursing facility stay but also the ancillary services and medication. A secondary option would be to follow the Medicare Prospective Payment System schedule, which provides an all-inclusive add on for ancillary services. A third option would be to allow for state-only payment on a fee for service basis for those services/medications which EMA clients need to maintain their optimum level of functioning outside of the acute care setting.

Minnesota Health Care



Safety Net Coalition

Greater Twin Cities United Way
Hennepin County Medical Center
Minnesota Association of Community Health Centers
Minnesota Association of Community Mental Health Centers
Regions Hospital

September 30, 2013

Diogo Reis
Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

RE: Request for Information Response: Coverage Options for Emergency Medical Assistance Services

Dear Mr. Reis:

The Minnesota Health Care Safety Net Coalition appreciates this opportunity to provide input on the Department of Human Services' Request for Information: *Coverage Options for Emergency Medical Assistance Services*, published September 3rd, 2013. The Safety Net Coalition (SNC) represents Minnesota's community-based safety net health centers, mental health centers, dental clinics, safety net hospitals and other nonprofit organizations that serve low-income, uninsured and disadvantaged Minnesotans. The following recommendations outline the SNC's preferred options for coverage of services for emergency medical assistance recipients and for individuals who are uninsured and ineligible for other state public health care programs or for coverage through the Minnesota Insurance Marketplace.

Background

The federal Affordable Care Act (ACA) will cover many Minnesotans who are currently uninsured, through a combination of Medicaid program expansions and the Insurance Exchange coverage options and subsidies. It is estimated, however, that 201,000 Minnesotans¹ will remain uninsured in 2016, including:

- Individuals who are not eligible for coverage due to immigration status;
- Those who are exempt from the coverage mandate including individuals who have to pay more than 8% of their income on health insurance; and
- Those below 400% FPL who are offered self-only coverage by an employer, but whose families are ineligible for subsidized family coverage in the Exchange.

The consequences of not having health insurance or access to affordable health care are well understood: uninsured Minnesotans are in poorer health, receive less preventive care, delay treatment for medical conditions until they become more serious and costly to treat, and are

¹ Gruber/Gorman Analysis, Impact of ACA & Exchange in Minnesota, Feb. 2013

higher users of emergency rooms and nonprofit, community-based safety net clinics when they seek care. The health care needs of the uninsured continue whether or not they are covered, but the burden of providing unpaid health care services is borne disproportionately by a small number of safety net providers and a small number of local governments.

Lessons from Massachusetts, which expanded coverage similarly in 2006, have shown that safety net providers will continue to be a key source of care for low-income, vulnerable populations. Safety Net providers in Massachusetts continued to be providers of choice for these populations and the demand for services has continued to grow significantly. For example, Massachusetts' health centers saw total caseloads grow by 31 percent between 2005 and 2009. While the number of uninsured dropped 50% overall in Massachusetts, the number of uninsured seen at health centers only dropped by 20%. In Minnesota, Safety Net providers must prepare for the increased demand for their unique services from newly insured patients, but they also must continue to be the essential access point for many of Minnesota's remaining 201,000 uninsured.

In 2012, the Governor's Health Care Reform Task Force recognized the need to deliberately examine the impact of health reform on the remaining uninsured and Minnesota's safety net, and included a number of recommendations in their *Roadmap to a Healthier Minnesota Report* that specifically addressed ways to strengthen the safety net in order to respond to the needs of the newly insured and those who will not be covered in 2014. (The recommendations that we think are especially relevant in this situation are underlined):

- **Strategy II: Support Patient-Centered, Coordinated Care**
 - o Element #5: "Provide reimbursement for prevention and care coordination services for the uninsured through safety net providers."
- **Strategy III: Prepare and Support the Health Provider Workforce:**
 - o Element #8: "Invest in high-need infrastructure and workforce services to increase access and foster inter-professional competency."
 - o Element #13: "Prepare for anticipated increased demand on safety net services by increasing reimbursement to safety net providers for primary care, mental health, substance abuse and community-based services provided to Minnesota Health Care Program recipients." (We recommend adding oral health.)
 - o Element #14: "Increase diversity in the health care workforce by supporting a range of health professions diversity programs."
- **Strategy VI: Measure Performance and Ensure System Stability:**
 - o Element #22: "Implement best practices for collection and reporting of data by health care providers and payers on detailed categories of race, ethnicity, and language linked to health disparities." (We recommend collecting and reporting data on the uninsured as well.)
- **Strategy VIII: Increasing Access and Supporting Consumer Navigation:**
 - o 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."

- o 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."

With the Governor's Health Reform Task Force's recommendations in mind, the following responses outline the SNC's recommendations for covering health care services for EMA eligible and low-income uninsured Minnesotans who are unable to obtain or afford health coverage from other sources. We strongly believe a coverage program for the remaining uninsured should provide access to primary and preventive care services, specialty services as needed, prescription medications, ER and hospital services, as well as care coordination to assist enrollees with accessing the services they need at the most appropriate level of care.

Our Overall Recommendation. The SNC strongly encourages DHS to establish a state-funded coverage program for the EMA population and the remaining uninsured who are not eligible for any other program with benefits, eligibility criteria and cost-sharing that would be aligned with the state's new Basic Health Plan, MinnesotaCare. The purpose of this coverage program would be:

- To improve the health of the uninsured through access to primary and preventive care and a health care home;
- To reduce health care costs by diagnosing and treating medical conditions earlier before they become more costly to treat;
- To reduce health care costs by managing chronic conditions to reduce the need for crisis services, hospital and ER admissions, and long-term disability and chronic care services;
- To reduce health care costs by providing access to primary and preventive home and community-based services in order to reduce utilization of emergency rooms;
- To reduce costs of social services, economic assistance, and other non-health care services that are often needed as a result of untreated medical and mental health conditions;
- To distribute the costs of services for the uninsured fairly across Minnesota populations, providers, geographic regions and levels of government;
- To create a "unified, seamless" program for all recipients.

(1) Identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients:

- o The SNC recommends that the new program be part of the MinnesotaCare (Basic Health Plan) program and have the same coverage and services as MinnesotaCare.
- o Unless outpatient, preventive, pharmacy and other services are covered, many patients will not receive services at the right time, leading to higher rates of illness, chronic disease, and use of costly ER, hospital and specialty services.
- o In addition, this will reduce the inequity of the burden on those safety net providers who attempt to provide patients with needed services even if not covered.

(2) Delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide:

- The SNC recommends using the State's new delivery system models such as Health Care Delivery Systems and Accountable Communities for Health to serve this population within the structure of the DHS fee-for-service (FFS) payment system so that payments will be made even in geographic areas where there are no HCDS or ACH projects.

(3) Funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system:

- The SNC recommends the payment of for claims under the FFS system, with incentives to providers to manage Total Cost of Care (as is done currently in the Health Care Delivery System demonstration projects payment methodology) or Total Cost of Service under an Accountable Community for Health model. A FFS payment mechanism will help ensure the program is available statewide.
- EMA eligible services would remain the same in order to maximize federal match (see below).
- The health care access fund with an additional provider tax as needed may be a fair method of financing the coverage program. In addition to raising revenue for the program, a provider tax serves to more fairly distribute the burden of serving the uninsured across all providers, so that those who have a higher percentage of uninsured are not put at a competitive disadvantage.

(4) How the funding and delivery of services will be coordinated with the services covered under emergency medical assistance:

- The SNC recommends that those populations who are "EMA eligible" will receive same benefit set (MinnesotaCare) as other subsets in target population, regardless of funding stream, so that coverage appears seamless to enrollees and will not change as enrollees shift from one public program to another.
- Behind the scenes, DHS will handle the accounting and eligibility information to distinguish which EMA eligible services are matched with federal money and which non-EMA eligible services are paid with state-only dollars.
- The SNC recommends that the State seek approval from the federal government to use a modified form of HCDS model for the federally subsidized EMA program with a budget neutrality requirements, to give the State and providers flexibility to provider other services not normally covered by EMA, such as outpatient, pharmacy and continuing care services, if these services will result in a net savings to the State by reducing preventable use of emergency and inpatient hospital services.

(5) Options for administration of eligibility determination and service delivery:

- To simplify access for uninsured individuals, the new MNsure navigation and application system, including navigators and assisters, should be used to identify and enroll eligibility individuals in this new component of the MinnesotaCare program.

- Individuals should be able to be enrolled:
 - o Through MNSure
 - o Through the MHCP application process
 - o In network at site of service by network provider
- Allow for enrollment/eligibility determination for "EMA eligible" in non-ED venues.

(6) Evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating this alternative coverage option:

- The current lack of adequate risk adjustment along with a lack of alternative and culturally appropriate data collection methods create major flaws in the Statewide Quality Reporting Measurement System (SQRMS). The current SQRMS methodology and quality standards are inadequate to account for the social and health complexities of patients that affect access, health status and treatment outcomes. Left unchanged, these flaws will ultimately financially penalize those providers. The SNC strongly supports the development of more robust risk adjustment methodologies that would address social determinants of health.
- If an appropriate risk-adjustment method can be developed, evaluation of the new coverage program and care delivery systems may be done with the same quality measures (SQRMS and other measures) that are used for other Minnesota Health Care Programs, although some additional features will be needed to ensure budget neutrality and cost-effectiveness compared to the existing EMA program.

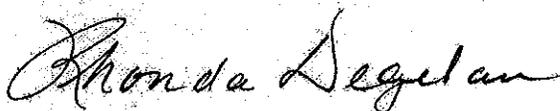
Any response to the problem of the uninsured and the weakness of the current EMA program must be built upon the best possible data about the population to be served, both the EMA population and the remaining uninsured not currently eligible for EMA. We strongly encourage DHS to identify and publically share the following information based on historical information and best analysis and forecast of likely characteristics of the uninsured after implementation of ACA available. This type of information is crucial for safety net providers in planning for who the remaining uninsured will be and how to best care for them:

1. Detailed demographic characteristics of the EMA and expected remaining uninsured populations:
 - a. Gender, race and ethnicity, language, income
 - b. Immigration status
 - c. Geographic location – county or zip code
 - d. Housing status – homeless
 - e. Length of uninsured period and churn between uninsured, public programs and private coverage
2. Health status and risk profile of the EMA population:
 - a. What health conditions/diagnosis do they have?
 - b. What are their care utilization patterns?
 - c. What types of services do they use?
 - i. Inpatient (admissions per 1000 members)
 - ii. Outpatient (visits per 1000 members)
 - iii. Specialty care (visits per 1000 members)

- iv. MH/CD (visits per 1000 members)
 - v. Pharmacy
 - vi. Social Services
 - vii. Long term care (days per 1000 members)
 - d. In what settings do they typically receive services?
 - e. Do they have a designated primary care provider?
3. EMA Financial Data:
- a. Number of people 2010 – 2013
 - b. Cost of services per member per month:
 - i. Inpatient
 - ii. Outpatient
 - iii. Primary physician?
 - iv. Specialty physician
 - v. MH/CD
 - vi. Pharmacy
 - vii. Long term care
 - viii. Social services
 - ix. Charity Care data on EMA population (hospital, clinics and nursing homes) 2010 – 2013
4. Estimated Future Costs of care for EMA and uninsured populations:
- a. Medical costs by type of service per member per month
 - i. primary physician
 - ii. specialty physician
 - iii. Hospital inpatient
 - iv. Hospital outpatient/ED
 - v. MH/CD
 - vi. Pharmacy
 - vii. Long term care (EMA population)
 - b. Cost of care management/care coordination
 - c. Claims administration
 - d. Data and data analytics
 - e. Other administrative costs

Thank you again for the work of the Department of Human Services and for actively seeking our input on these issues. We would welcome the opportunity to continue to discuss these ideas with you. If you have any questions please contact me, or the Safety Net Coalition's Policy Director Michael Scandrett at miscandrett@hh-lpac.com.

Sincerely,



Rhonda Degelau, Chair MN Safety Net Coalition

American Federation of State, County and Municipal Employees

One strong united voice for Minnesota workers

300 Hardman Avenue S.
South St. Paul, MN 55075
(651) 450-4990
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September 30, 2013

Diogo Reis, Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164

Dear Mr. Reis:

Emergency medical assistance (EMA) is a critical funding source for the hardest to reach Minnesotans. This population is served by members of AFSCME Council 5 in our role as safety-net providers for the state and counties. We urge continued and increased coverage for this population, including preventative care and mental health services necessary to reduce emergency department and inpatient hospital utilization.

Additionally, it is critical that the state do more to coordinate the multitude of public services to sustain this population. Affordable housing, transportation, career assistance, job training, child care and continued education, for instance, must be considered in tandem with health care delivery—and with the necessary resources—to ensure the best results for Minnesotans. The most successful health care models across the globe include coordination of and investments in these critical social services.

On behalf of AFSCME Council 5's 43,000 members, we urge the Minnesota Department of Human Services to make the funding, delivery and coordination of emergency medical assistance a top priority of the state's health care system.

Sincerely,

A handwritten signature in black ink, appearing to read "Eliot Seide". The signature is written in a cursive, flowing style.

Eliot Seide, Executive Director
AFSCME Council 5

ES/eh



Community Human Services Department

160 Kellogg Blvd. E.
St. Paul, MN 55101-1494

Financial TDD: 651-266-3750
Services TDD: 651-266-4002
General Info: 651-266-4444

October 1, 2013

Diogo Reis
Legislative Liaison
Health Care Administration
Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

Dear Diogo,

Currently the Emergency Medical Assistance Program applicants are applying for a Health Care Program due to an initial Emergency Room visit resulting from a severe medical condition. To improve continuity of care, increase the chances of avoiding a repeat visit to ER for the same condition, and to streamline the medical program coverage process, there needs to be a broader level of care for a limited period for out-patient follow-up to cover the full event of the health condition.

Here are some examples of the medical conditions seen that could benefit significantly from prescription drug coverage and a follow-up with a primary doctor for monitoring and adjustment of those medications:

- Hypertension/High Blood Pressure,
- Diabetes ,
- Mental Health,
- Pre-Dialysis,
- COPD, Emphysema or other lung disease.

If you have further questions about this information and recommendation, please contact Tina Curry, Director of Financial Assistance Services (651-266-4365; tina.curry@co.ramsey.mn.us) or Dave Haley, Executive Assistant (651-266-4114; dave.haley@co.ramsey.mn.us).

Sincerely,

Monty Martin
Director



October 1, 2013

Diogo Reis, Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

Submitted Via Email: diogo.reis@state.mn.us

Dear Mr. Reis:

Regions Hospital appreciates the opportunity to respond to the Notice of Request for Information (RFI): Coverage Options for Emergency Medical Assistance (EMA) Services. As a major provider of care for EMA patients, Regions Hospital (Regions) is in a unique position to address the questions which the RFI poses.

General Comments

Regions strongly supports all Minnesotans having access to healthcare coverage. In 2012 alone, Regions provided \$22.3 million in charity care (costs) for 43,237 patients who did not have insurance or could not afford care. In fact, Regions is the second largest provider of charity care in the state.

The state's decision to expand Medical Assistance coverage to qualified enrollees up to 133% of the federal poverty level was a huge boost to coverage and access. However, the changes made during the 2011 legislative session to the EMA program that targeted services for non-qualified non-citizens have resulted in significant challenges. The following are a few examples:

- ***EMA Eligibility and Care Plan Certification***
 - The EMA eligibility process and the Care Plan Certification process are not aligned which has led to patients "falling off" coverage. This inability to determine eligibility has increased hospital stays and delayed several patients from receiving treatment in the appropriate place.
 - The majority of patients affected by the changes to EMA are illegal non-citizens. However, Regions has had a number of legally sponsored non-citizens impacted as well. The restrictive income guidelines for EMA and the strict sponsorship income guidelines for other government programs such as MinnesotaCare have led to EMA being the only coverage choice. Despite being a legal permanent resident, patients are not able to access higher levels of coverage when their sponsors' household income exceeds income guidelines.
 - The EMA care plan certification process covers patients with severe chronic conditions that are deemed immediately life threatening. Patients are being denied because they do not meet the "immediate" threshold. This requirement will have a long-term economic impact on the system and potentially put patients at risk for severe complications.

- ***Discharge Planning***
 - Prior to the changes enacted in 2011, EMA covered a broad array of outpatient services including specialized medical and support services, medications, and continuing care including long-term, nursing facilities and home care.
 - Regions clinics, emergency department, ancillary services and inpatient units depend on efficient discharge of patients. The newly created gaps have created barriers to finding community providers willing to accept patients after discharge. This has resulted in patients staying at Regions over 100 days past discharge at a cost of over \$1 million dollars.
- ***Chemotherapy and Dialysis Coverage***
 - Coverage for chemotherapy and dialysis services was permanently funded during the 2013 session. Unfortunately, this coverage does not include any of the screenings or surveillance visits that are the standard of care for patients in remission. Patients are not eligible for treatment until the cancer recurs and is symptomatic. This delayed care approach is contrary to quality care prevention efforts.

The decision to eliminate services for EMA enrollees has deviated from the medical community standard of care of encouraging primary care. As we move toward full implementation of the Accountable Care Act (ACA), it is critical that DHS develops a coverage model that not only serves the EMA population but also groups determined ineligible for federal coverage under the ACA. This overarching goal informs our responses to the RFI.

RFI Responses:

1. ***The identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients***
 - a. DHS should continue to maximize federal funding for services that are currently being provided to EMA patients.
 - b. A holistic, comprehensive approach is critical to support patients previously covered through EMA. Services that have been effective in reducing hospital admissions and unnecessary emergency department use include:
 - i. access to and coverage of primary care;
 - ii. access to and coverage of behavioral health services (mental and chemical health);
 - iii. access to and coverage of dental services;
 - iv. access to and coverage of medications;
 - v. access to and coverage of hospice care;
 - vi. access to and coverage of specialty services; and
 - vii. access to and coverage of long term care services (skilled nursing facility services, transitional care facility services, home care and nursing home services).
 - c. In addition, enhanced enrollment services, care coordination and case management services are very important to assess, triage, connect, and care for the patient initially and ongoing for necessary clinical and social services. With such a transitory population, it is

critical that care coordination services include organizations that specialize in working with the EMA population (i.e. immigration services, community clinics etc.).

2. ***Delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide***
 - a. After the elimination of GAMC, Regions became one of few providers that delivered care to through the Coordinated Care Delivery System (CCDS). Under the CCDS model Regions was required to “perform” health plan like functions such as paying for claims and contracting with networks. This model was unsustainable and inefficient. Hospitals should focus on providing care that meets the Triple Aim.
 - b. Regions recommends serving the EMA population within the structure of the DHS fee-for-service (FFS) payment system. The model should be patient centered and focused on preventive care and lowering the total cost of care.
 - c. Principles from integrated care models like health care homes, behavioral health homes, and accountable care organizations could be voluntarily incorporated into the model. Examples include access to primary care services, dental, behavioral health, pharmacy and social supports to ensure enrollees receive appropriate, timely care, before a chronic condition develops or worsens.
3. ***Funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system***
 - a. A state funded care model for EMA enrollees and those uninsured after 2014, should be aligned with the Basic Health Plan (BHP). Building off of the BHP would most likely be the easiest for the state to administer as well as for enrollees, providers and health plans to participate in and implement.
 - b. Regions recommends that the funding mechanism for any care model come from the Health Care Access Fund (HCAF) which is intended for providing healthcare access. The payment of claims should operate under the FFS system. A FFS payment mechanism will help ensure the program is available statewide and the risk is not borne by a few providers.
 - c. Federally qualified services for EMA enrollees should remain the same in terms of how the state manages federal matching dollars.
4. ***How the funding and delivery of services will be coordinated with the services covered under emergency medical assistance***
 - a. EMA enrollees should receive same benefit set under the BHP as other qualified enrollees, regardless of funding stream, and coverage should be seamless for enrollees. It is critical that the benefit set include access to emergency, acute, inpatient, outpatient, primary, and preventative services.
 - b. DHS should continue to be responsible for determining which services can be matched with federal dollars.
5. ***Options for administration of eligibility determination and service delivery***

- a. In efforts to limit the amount of charity care, any new care model for EMA enrollees should include presumptive eligibility. As with Medicaid, hospitals should be authorized to determine presumptive eligibility. If allowed by the federal government, final eligibility determination could be made via MNSure, just as determination for Medicaid, MinnesotaCare, and advanced premium tax credits will be made.
 - b. DHS should take advantage of the new tools being developed for MNSure to determine eligibility.
 - c. Additionally, enrollment and eligibility determination for EMA enrollees should occur in venues outside of the emergency department.
6. *Evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option.*
- a. Evaluating rates of emergency department utilization, avoidable hospital readmissions, hospital lengths of stay, ease and timeliness of transfer to post-acute or long-term care settings, and primary care utilization through individual claims data will provide insight into which services individuals receive and whether those services help decrease hospital utilization.
 - b. When designing a care mode for the EMA population, it is important to design the coverage and the metrics used for assessment in a manner that recognizes the fact that many EMA-eligible individuals seek to avoid contact with health care providers, social workers, government entities or other social systems unless and until such contact becomes unavoidable. Accordingly, Regions suggests that metrics or evaluations focus on the health care providers' services and care for each individual patient following the initial contact and thereafter rather than on the EMA-eligible population as a whole.

The changes to EMA have led to disruption in the continuum of care and poor patient outcomes. If we seek to lower the cost of care, we must develop a sustainable, care delivery and financing model that meets the needs of a population that has traditionally sought their care in the emergency department. The above recommendations, coupled with implementation of state and federal healthcare reform efforts, would be a significant step to ensure that our most vulnerable patients have access to coverage in the right place and at the right time.

Thank you for providing us with the opportunity to provide these recommendations. As the DHS EMA coverage strategy becomes available, we look forward to the opportunity to remain in dialogue. If you have questions or need additional information, please contact Shawntera Hardy, Government Relations Manager at shawntera.m.hardy@healthpartners.com or 952.883.7201.

Sincerely,



Heidi Conrad
Chief Financial Officer



MID-MINNESOTA LEGAL AID
MINNEAPOLIS OFFICE
Anne S. Quincy • (612) 746-3745 • aquincy@mylegalaid.org

October 1, 2013

Diogo Reis, Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota DHS
P.O. Box 64984
St. Paul, MN 55164-0984

Sent via fax: (651) 431-7422

RE: Response to Request for Information: Coverage Options for Emergency Medical Assistance (EMA) Services

Dear Mr. Reis:

Mid-Minnesota Legal Aid (Legal Aid) provides legal representation to low income individuals throughout Hennepin County. Our clients include families with children, persons with disabilities, single adults and seniors. Many of our clients are immigrants. Our clients are in critical need of access to quality health care. Part of the mission of our organization is to protect the legal rights of low-income and underserved people with respect to this critical need.

During 2011 and 2012, when Minnesota's Emergency Medical Assistance (EMA) program underwent legislative and administrative changes, Legal Aid represented a significant number of clients who had previously received their medical care through EMA. We participated in appeals, conducted outreach and advised people regarding alternative sources of health care. Legal Aid also assisted immigrants who qualified to adjust their immigration status and thus became eligible for more comprehensive medical services. Because of this work, Legal Aid understands the challenges faced by noncitizens in Minnesota in accessing quality health care. It is from this perspective that we are responding to the RFI regarding coverage options for EMA services, published in the State Register on September 3, 2013.

Legal Aid participated in the stakeholder group meetings conducted by DHS in 2012 and we have reviewed the report "Emergency Medical Assistance," issued by the DHS Health Care Administration on April 19, 2013, and will cite to the report by page number.

As Minnesota looks for a better way to deliver health care to the uninsured, we recommend:

- 1) Addressing the needs of the entire population of people who are not eligible for health care coverage, to diversify and increase the likelihood of continuous funding;
- 2) Building a strong system of referrals and eligibility checks to ensure individuals end up in the right program, accessing the most needed services.

October 1, 2013

RFI: Coverage Options for Emergency Medical Assistance (EMA) Services

As the report on EMA details, the current system of delivering health care to some individuals solely by treating emergency conditions is neither cost-effective nor medically prudent. It perpetuates perverse incentives for both patients and providers. Patients are not encouraged to identify or treat chronic medical conditions but are instead told to wait for an emergency to arise. Providers are not compensated for preventing illness, effectively managing chronic medical conditions or directing the patient to an appropriate level of care after the emergency room. Instead, they are compensated primarily when treatments fail and a new emergency occurs. Because of these conflicting incentives, we recommend the state take a multi-modal approach to developing a new plan to provide more coordinated, cost-effective care to people who are using EMA, as well as others who find themselves ineligible for health care under Minnesota's new system.

The new plan should be aimed at all those who will not be eligible for health care coverage under Minnesota's public health care programs, Medical Assistance (MA) and MinnesotaCare (MNCare), or the new health care insurance exchange, MNSure, rather than only those who are eligible for EMA. A program aimed at the larger group of uninsured allows for different approaches for individual consumers, instead of a one-size-fits-all approach. Building a referral mechanism into the newly launched MNSure health insurance marketplace would catch people looking for health coverage and redirect them to a system that does not use federal funds, avoiding the need for federal waiver or permission for a demonstration project.

The new plan should include flexible program options and a gatekeeper, such as the non-profit entity Portico Healthnet, to guide consumers to the right coverage and the right care. Individual consumers find it hard to tell whether they are eligible for a program or not, and errors in determining eligibility are costly to the system. For instance, according to the population profiles contained in the April 2013 EMA report, EMA enrollees in both years included citizens, a group not eligible for EMA (pgs. 37, 39). In 2011 and 2012, this error likely cost the state more than \$400,000 each year (id.). A gate-keeper informing the consumer in a timely and confidential manner about their options would both correct some of the misdirection in the system and alleviate patients' fears about revealing their immigration status or incurring medical bills. Finally, referring patients to an outside source for this advocacy lessens the conflicts of interest, perceived and real, in relying on the emergency care provider for information.

We also support the concept of enrolling individuals in EMA before an emergency or health crisis arises, as described in the EMA report (p. 30). The state should allow people to get a determination of their eligibility for EMA, financial and based on immigration status, the same way individuals are determined eligible for MA, either through the county agency or through MNSure. Early enrollment has several advantages for the individuals enrolled: they can be referred to legal assistance to help them gain the "lawfully present" status which means access to more comprehensive health coverage programs; they can provide more complete information because the individual is not in a health care crisis; and they can be directed to low-cost or free health care available in their community. Early enrollment would also allow the state to plan for future needs in the EMA program by identifying potential users, and possibly reduce costs later on.

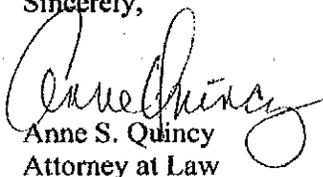
October 1, 2013

RFI: Coverage Options for Emergency Medical Assistance (EMA) Services

Minnesota is making significant strides in reducing the number of its residents lacking access to health care coverage. MNSure, the primary component of that effort, can be strengthened by simultaneously addressing the needs of those who will *not* be eligible for health insurance or public health care programs. In doing so, Minnesota can assist low-income individuals in need while at the same time preventing unnecessary costs to the system as a whole.

Thank you for considering our comments.

Sincerely,



Anne S. Quincy
Attorney at Law

ASQ:asq

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Minnesota Hospital Association

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October 1, 2013

Diogo Reis, Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984
Diogo.reis@state.mn.us

Dear Mr. Reis:

On behalf of our 144 member hospitals and associated health systems, the Minnesota Hospital Association (MHA) thanks you for the opportunity to respond to the Request for Information regarding Coverage Options for Emergency Medical Assistance Services. MHA thanks the Department of Human Services (DHS) for addressing the issue of funding and service options for people receiving or needing care through the Emergency Medical Assistance (EMA) or similar program.

Minnesota's hospitals provided \$509.5 million of uncompensated care in 2011; much of that care went to people who were unable to receive coverage from state or federal programs and could not afford traditional health insurance.

As the department is aware, this is not just a hospital issue. Other health care providers are financially affected by providing treatment to patients without coverage. Hospitals often face this fact when trying to discharge a patient who no longer needs emergency or inpatient services and cannot find a community provider willing to accept the patient. Creating an adequate funding source for a sustainable, coordinated service delivery model to cover a group of people who have traditionally sought care only in emergency circumstances is absolutely necessary. Minnesota's hospitals are committed to working with DHS to help find that solution.

Identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients.

Reducing emergency department and inpatient hospital utilization for people previously covered through EMA is no different than reducing utilization for other groups – outreach, preventive and primary care, and ongoing care coordination. Prevention and primary care should include mental and behavioral health services, including chemical or substance abuse services, as well as dental services and prescription medications. Accordingly, when the terms “prevention” and

“primary care” are used throughout these comments, they are intended to include mental and behavioral health care, dental services and prescription medications.

Delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide.

Options should incorporate integrated care models like health care homes, behavioral health homes, and accountable health organizations that incorporate primary care services, dental, and behavioral health with pharmacy and social supports to ensure enrollees receive appropriate, timely care, before a chronic condition develops or worsens.

Hennepin Health and the Health Care Delivery System (HCDS) demonstration projects are good examples. The HCDS demonstration projects are already a statewide initiative that allows health care providers to design a delivery model that best suits their population.

Coordinated care will be especially important for the largest group needing services under EMA: women over age 65 with chronic conditions. These patients often require long term care (LTC) services that hospitals do not provide. In a HCDS-like model, LTC providers, like nursing homes and home and community-based services, could contract with the hospital or health system to provide needed care beyond the hospital under a total cost of care arrangement.

Minnesota’s State Innovation Model (SIM) grant offers another opportunity to provide coordinated care and social supports to individuals. The accountable health model specifically addresses these concerns.

An option could be to allow hospitals and health systems to cover EMA patients under current coordinated care initiatives, like HCDS or other total cost of care agreements, with a separate funding mechanism. This would ensure that all enrolled patients receive the same care coordination and allow hospitals and health systems that may not have many EMA recipients to provide coordinated care in a cost-efficient manner, as one program would not have to be created for only a few (sometimes only one) patients.

Funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care with better patient outcomes than the current system.

MHA offers the following funding suggestions to start a conversation regarding alternative funding sources for an expanded EMA program. MHA’s board has not taken a position with respect to any particular funding option. Our members have different views regarding various proposals that might be put forward. Accordingly, these suggestions are not meant to be exclusive of other proposals, but rather they are intended to serve as examples of the kinds of options and alternatives the state should consider as it designs a policy solution to this important issue.

Minnesota's hospitals, health systems and other health care providers cannot unilaterally shoulder the responsibility or costs of solving the gaps in the overlapping complexities of immigration and health care policies. It would be best if the funding mechanism used to provide services for this patient population should come from a source that simultaneously leads to health improvement of all Minnesota residents. Examples of such funding sources include but are not limited to taxes, assessments or surcharges on alcoholic beverages, sugary beverages, unhealthy snacks, and tobacco products.

Targeting these kinds of revenue streams will generate funding to cover EMA services and help reduce costly chronic diseases, such as diabetes and emphysema, for the EMA and general population. According to the report *Emergency Medical Assistance*, 54 percent of EMA enrollees in 2012 were enrolled due to a chronic condition. Clearly, steps should be taken to address chronic conditions for all residents of Minnesota, including those served by EMA.

Another funding option is the Minnesota Comprehensive Health Association (MCHA) assessment currently levied on health plans. With MCHA scheduled to phase out during 2014, the assessment could be redeployed to fund health insurance for individuals receiving care through EMA. The assessment could be structured as an alternative: health plans could either offer free coverage as part of their community benefit efforts and receive an exemption from the assessment up to the value of the free coverage provided, or simply pay the assessment. One option is to use these funds to purchase private insurance for individuals covered under EMA, much as MCHA provided. Another option is to use the funds to support their inclusion in a state-only Medical Assistance program or MinnesotaCare, as suggested by the EMA report. Either option offers greatly enhanced benefits to the individual and would address the need for prevention and primary care services. Enrollees would also benefit from participating in coordinated care models such as those mentioned above. And, the costs of their care could be aggregated to some degree with the larger population to potentially mitigate overall costs to the state.

The report and RFI identify four possible funding and delivery models for providing services to EMA enrollees. There are concerns with all four mainly due to their lack of a specific funding source. MHA does not support funding EMA coverage through provider taxes, surcharges, assessments or other vehicles that would leave health care providers responsible for the costs of care of the EMA population in addition to the existing surcharges and taxes providers pay to support the costs of care of the Medicaid and MinnesotaCare populations.

In a manner of speaking, the **uncompensated care pool** has been tried before under the auspices of the Coordinated Care Delivery System (CCDS) program in 2010. The uncompensated care pool was not adequately funded to support the number of enrollees and level of services they required. In addition, a funding source for the uncompensated care pool is not identified. MHA is concerned hospitals and other health care providers will be responsible for funding the uncompensated care pool.

A **state funded grant program for providers** is less desirable because it could be vulnerable to state budget cuts and also not provide adequate reimbursement for the services provided by hospitals and health systems. Nine MHA members recently experienced elimination of state

grant funds when the Operating Subsidy Grant was cut. The \$5.3 million grant was for hospitals to serve patients with severe mental illnesses who were without coverage for extended inpatient mental health care. While the grant provided some relief from fully uncompensated care, the program reimbursed under half of the Medical Assistance rate, a rate which itself is below the cost of delivering care.

A state funded program for EMA enrollees, similar to MinnesotaCare, seems to be the most sensible way to cover and deliver services to enrollees, and would most likely be the easiest for the state to administer as well as for enrollees, providers and health plans to participate in and implement. This option, however, is only viable if another funding mechanism, such as the alcohol or sugary beverage taxes or MCHA assessment, is used to pay for coverage for EMA enrollees.

A partnership with a Local Access to Care Program depends on voluntary, free services from providers in a community. Depending on increased charity care to support EMA enrollees is not the way to ensure a sustainable system moving forward and fails to address current problems associated with barriers to transfers when patients need different levels of care.

How the funding and delivery of services will be coordinated with the services covered under emergency medical assistance.

If funding is used to provide insurance coverage to individuals covered through EMA, the coverage benefit should include emergency, acute, inpatient, outpatient, primary, and preventative services. A health care home or accountable health model under a total cost of care contract will enable coordinated care delivery that would include the social supports often required by individuals receiving services under EMA.

Options for administration of eligibility determination and service delivery.

Individuals should be presumptively eligible for the program. As with Medicaid, hospitals should be authorized to determine presumptive eligibility. If allowed by the federal government, final eligibility determination could be made via MNsure, just as determination for Medicaid, MinnesotaCare, and advanced premium tax credits will be made.

Evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option. Providing coverage for nonemergent services for recipients who have two or more chronic conditions and have had two or more hospitalizations covered by EMA in a one-year period.

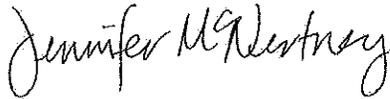
Evaluating rates of emergency department utilization, avoidable hospital readmissions, hospital lengths of stay, ease and timeliness of transfer to post-acute or long-term care settings, and primary care utilization through individual claims data will provide insight into which services individuals receive and whether those services help decrease hospital utilization. Ideally, emergency room utilization, avoidable readmissions and hospital lengths of stay would decrease, while primary care utilization would increase. If a health care home or accountable health model

is used to deliver services, those evaluation criteria could be considered as well. The health care home and accountable health models provide the best opportunity to encourage the use of primary care services to manage chronic conditions while ensuring enrollees receive social supports to help address the social determinants of health.

However, when designing the coverage alternative, it is important to design the coverage and the metrics used for assessment in a manner that recognizes the fact that many EMA-eligible individuals seek to avoid contact with health care providers, social workers, government entities or other social systems unless and until such contact becomes unavoidable. Accordingly, MHA suggests that metrics or evaluations focus on the health care providers' services and care for each individual patient following the initial contact rather than on the EMA-eligible population as a whole.

Thank you again for the opportunity to provide comments regarding services and funding for EMA. Please do not hesitate to contact me with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Jennifer McNertney".

Jennifer McNertney
Policy Analyst



October 1, 2013

Diogo Reis
Legislative Liaison
Health Care Administration, Policy Development and Implementation
Minnesota Department of Human Services
PO Box 64984
St. Paul, MN 55164-0984

RE: Optum Response to Request for Information (RFI) Coverage Options for Emergency Medical Assistance Services

Dear Mr. Reis,

Optum appreciates the opportunity to explore ways to support the Department of Human Services (DHS) in its effort to identify alternatives and improvements in providing coordinated and cost effective health care and coverage to Emergency Medical Assistance (EMA) recipients.

Optum is one of the premiere organizations supporting medically complex and chronically ill populations in a number of different models that have achieved success in effectively reducing hospital admissions and lowering costs. Optum supports these chronically ill patients in their own environments and targets interventions to provide health care services that reduce the need for acute care services. We believe an approach like this will benefit EMA recipients and help DHS achieve effective healthcare coverage.

If you have any questions regarding our attached response or would like to request additional information, please contact me by phone or email. My contact information is provided below.

On behalf of the team who prepared our response and Optum as a whole, thank you again for the opportunity to provide you with our ideas and we appreciate your consideration.

Sincerely,

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Optum Response to Minnesota Department of Human Services RFI: Coverage Options for Emergency Medical Assistance Service

Optum appreciates the opportunity to respond to this Request for Information (RFI) and the consideration of the Minnesota Department of Human Services (DHS) to our suggestions and ideas for improving coordination and health care coverage for the Emergency Medical Assistance (EMA) population.

Optum provides innovative, provider-driven, patient centric health care solutions designed for high-risk, medically complex populations. Delivering the right care, to the right patients, at the right time—resulting in improved quality and lower health care costs.

Optum has been providing this high-quality provider-driven care for more than thirteen years. This has involved more than 450,000 provider in-home interventions and more than 3,000 qualified clinicians providing hands-on care to these complex populations in over 35 states.

This submission provides our responses to the RFI and questions posed by DHS.

(4) The identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients.

Under the EMA program, Federal Financial Participation (FFP) is available to treat an emergency medical condition requiring immediate medical attention. Minnesota has further defined an emergency medical condition to be one treated in an emergency room or hospital setting.

Recognizing that over 50 percent of current EMA participants have chronic conditions, limiting reimbursement to only emergency care has resulted in expensive hospital services that could have been prevented with targeted community based care. Clearly there are many preventative services that can promote a healthier population, but the goal for this program should be to identify services necessary to prevent an acute exacerbation of a chronic condition.

Without more knowledge of the types of emergency conditions experienced by the EMA population, we are hesitant to provide a list of covered services for all participants that would reduce cost. Instead we recommend a flexible coverage based on the risk of hospitalization. For some members that would include community-based medical, dental, and behavioral health services that are necessary to reduce emergency department and inpatient hospital utilization. For other lower risk members, providing State-funded coverage for these services might prove costly.

Optum uses our predictive modeling and risk stratification technology, ImpactPro, to identify and stratify beneficiaries. Our ImpactPro software utilizes claims and pharmacy data to provide member-level health analyses that quickly identifies specific cost drivers related to diagnoses and gaps in care. Impact Pro identifies key risk factors and places people in risk levels according to their care coordination needs.

Risk is assessed in the following areas:

- **Utilization patterns** – hospitalizations, nursing home stays, emergency room visits, home care services and costs, etc.
- **Disease condition/progression** – number of chronic conditions, preventable complications, preventable acute exacerbation of existing condition(s), risk of new condition(s), and risk of preventable functional loss
- **Placement needs** – short-term hospitalization, including rehabilitation or long-term facility placement needs

For those members identified as the highest risk for on-going chronic care needs, we recommend that the State target interventions that will reduce the likelihood of emergency department and inpatient admissions. Our response to question two below outlines a service delivery model that has proven to reduce overall cost of care and improve the quality of care and quality of life for these individuals.

We will be happy to analyze for DHS the EMA 2011 and 2012 claims to identify the high cost members who are likely to continue to seek costly emergency care. Optum will provide this service for DHS at cost or less, if there is an interest.

(2) Delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide.

The key to any health care delivery system is identifying at risk members. In addition to our risk stratification and predictive modeling analysis, we believe that a Health Risk Assessment (HRA) is an important tool for determining where to focus care coordination resources.

The State can use the results of the HRA together with the risk stratification results to target high risk members in need of care coordination. For low and medium risk members, we recommend that the State employ some low cost strategies to promote better health care utilization. For the high risk members, Optum believes the best delivery model for persons with complex chronic conditions involves strong care coordination and bringing primary care to members where they live. By bringing the care to the person, we prevent emergency department visits and hospitalizations that confuse and further weaken this complex care population.

Service Delivery Model for Persons with Complex, Chronic Care Needs

An example of a proven intervention for the highest risk/ highest cost population is our CarePlus program. We started this program 13 years ago and it is now implemented in 30 states. It is based on an old fashioned house call program enhanced with modern technology and care management processes. CarePlus is a care and case management program focused on improving quality of life and care for the medically complex, chronically ill, frail, and elderly where they reside. CarePlus targets the top five percent of the medically complex, chronically ill, frail, and elderly who utilize 50 percent of the medical expenditures. Through a local network of employed physicians, nurse practitioners, and physician assistants, we offer in-home primary care, evaluation, and assessment. Members have 24/7 access to their dedicated provider. The program is offered to beneficiaries who present with one of the two following criteria:

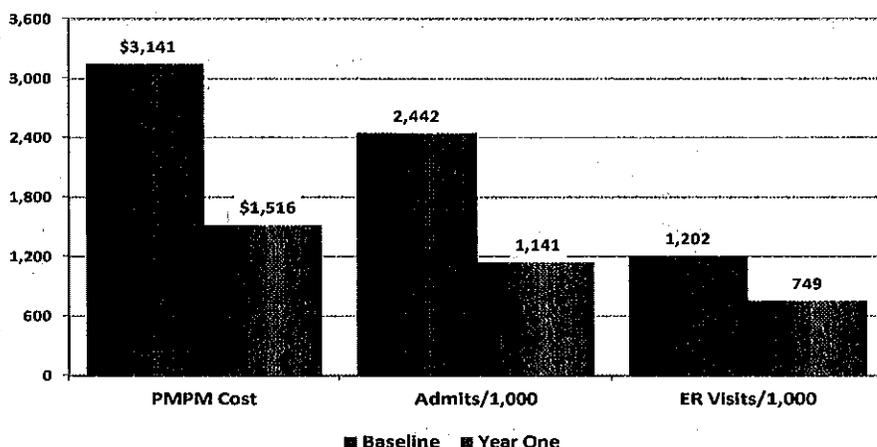
- Beneficiaries with eight or more total chronic conditions
- Beneficiaries with two or more chronic conditions who have had two or more acute care admission in the past 12 months

The goal of the program is to engage beneficiaries of highest risk in their own environment and to provide them with the health care services that minimize their need for acute care services. Under this program, physicians and/or nurse practitioners visit the member where they reside, regardless of whether the member lives at home or in a shelter, a long-term care facility, a residential care facility or nursing home.

The results of this intervention have consistently demonstrated a 50-60 percent reduction in hospitalization for the enrolled members. Cost savings achieved are a direct result of reduction in emergency hospital admissions. We employ nurse practitioners for both community-based and nursing facility care in order to reduce admissions and improve the quality of care. A recent study published in the Journal of American Medical Association noted that, in the Massachusetts Senior Care Options (SCO) program, onsite nurse practitioners in nursing homes resulted in better outcomes, as well as individuals more likely to have do-not-hospitalize orders and less likely to be transferred to an acute care hospital.¹ Optum's nurse practitioners are a strong component of the Massachusetts SCO program.

Below is an example of our program's results in the TennCare program. The per-member-per-month medical costs were one-half the expected cost for the Medicaid members enrolled in the CarePlus program.

Optum CarePlus Reduction of Members PMPM Cost (versus regression adjusted base)



Optum CarePlus Outcomes Study on Medicaid Plan Members in Tennessee, 2010–2011. Tennessee Medicaid Plan. Data compiled by Optum Data Analytics.

Post-Acute Transition Care

The prevalence of 30 day hospital readmissions among the Medicare population is one in six, with 75 percent of those readmissions being potentially preventable. Many times these individuals are not able to follow or don't understand discharge instructions including medication requirements. We suspect the same is very true among the EMA population.

¹ Goldfeld, Keith et al, "Health Insurance Status and the Care of Nursing Home Residents with Advanced Dementia", *JAMA Internal Medicine online*, September 23, 2013

We recommend that the EMA program include post-acute transition care to prevent hospital readmissions. Even for the EMA population that does not have on-going chronic care needs, making certain that members have, and are compliant with, hospital discharge plans is extremely important in preventing readmissions.

Optum Transitions Program

Our Transitions program is targeted to monitor members for 30 days following discharge. It begins by addressing needs and drafting a plan of care before discharge. We use RNs who have relationships at each hospital to establish communication with patients as a "trusted advisor" within 24 hours of admission. These nurses partner with treating physician and hospital staff, identify barriers to compliance, participate in discharge planning process with treatment team, and schedule and prepare for follow-up appointments and tests.

After discharge, the Transitions program includes:

- Establishing communication with patient/caregiver within 24 hours of discharge
- Making certain the patient understands and is compliant with discharge plan
- Medication management and reconciliation making certain all prescribed medications are filled and are being taken
- Facilitating post-discharge services/equipment/ancillary care ensuring availability and use
- Preparing for follow-up appointments
- Making certain any acute symptoms/complications are addressed and managed including appropriate steps for what to do if a problem arises
- Patients are monitored for the next 30 days for continued compliance with the hospital discharge plan

Our post-acute intervention Transitions model has effectively reduced readmissions by 50 percent for the members we serve. We believe that, through our analysis of the 2011 and 2012 EMA claims, we can identify the prevalence of readmissions and the predicted cost savings for the State of implementing the post-acute Transitions program.

(3) Funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system.

As pointed out in the EMA Study conducted by DHS, payment methodologies should consider the desired outcome and not base payment strictly on an FFS basis. Minnesota has been in the forefront with testing alternative payment methods in its Medicaid program. We think that a cost-effective EMA program must consider how to incentivize providers to provide the right care at the right time.

For high risk populations, a per-member-per-month (PMPM) care coordination payment should be considered. As evidenced by the ACA Section 2703 Health Homes, strong care coordination results in overall savings in serving the chronic care population. For our CarePlus model, the PMPM payment includes the primary care services we provide and there is no separate FFS medical billing. Our PMPM payment model is coupled with expected outcome measures. A portion of the fee is tied to performance so that if the intervention fails to generate savings, the State could recoup some of the cost.

Alternatively, the State could implement a gain sharing model where the provider would be paid a minimal amount initially for care management services and the primary care services would be billed FFS. If the intervention effectively reduces expected expenditures for the enrolled population, the provider could share in those savings.

The Optum CarePlus model is usually structured as either a risk based fee or a PMPM with performance guarantees. Since our model is flexible to meet the needs of chronic care members 24/7, we use employed providers that are incentivized to keep persons healthy and out of institutions. We employ other staff to provide care coordination, call center services, and outreach. We offer high value to our clients through guaranteed reductions in acute care costs. We would be happy to explore with the State possibilities for alternative payment methodologies including shared savings.

(4) How the funding and delivery of services will be coordinated with the services covered under emergency medical assistance

We recognize that one of the challenges for the State is to provide benefits to EMA members beyond what is eligible for FFP in a way that will lower the overall cost of care for the EMA population. Our proposed delivery model targets care coordination and primary care resources to the highest need individuals who drive the majority of the emergency care expenditures. Although care coordination and primary care are not current benefits, it would be cost-effective for the State to provide these benefits to the high risk population. We recommend a carve-out of this high needs population and enrollment in a service delivery model that brings primary care to them where they live. Our program, CarePlus, has achieved return on investment (ROI) ratios between 2.0 to 5.1 for the different populations we serve. We believe a minimum ROI of 2.0 can be achieved for the EMA high needs population.

The new uninsured population that will be covered in the future by the EMA model will be younger and likely have less chronic care needs. For this population, outreach and education on health care options available in the community through the Local Access to Care Program could be funded by the State or perhaps through some of the other vehicles proposed in the EMA Study commissioned by the State.

(5) Options for administration of eligibility determination and service delivery

We think the use of the Local Access to Care Program, particularly Portico HealthNet, is a good option for determining eligibility for EMA and other health care programs. United Health Group, Optum's parent company, provides funding for Portico and believes it plays a vital role in the community. Portico and other Local Assess Care programs are experienced with this population and can effectively direct individuals to other services as needed. They are also well positioned to assess eligibility for Medicaid and other assistance programs.

While Portico is an excellent service delivery provider for the majority of the EMA current and future populations, it is not experienced with models to serve the most complex and chronic care population. These persons experience frequent hospitalizations due to acute exacerbations of chronic conditions that require emergency medical services. They are most always directly admitted to the hospital due to their frailty and multiple medical conditions. These EMA members require a different intervention to keep them from needing emergency care.

Consequently, for the EMA population identified through risk assessment/stratification or other means as very high risk, we recommend that they be enrolled in a CarePlus type program. Optum can provide intensive care coordination and deliver primary care to these high risk members where they live. We can place our fees at risk or perform under a gain-sharing arrangement to support cost savings to the State.

(6) Evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option.

Our CarePlus and Transition programs have been evaluated by a number of external parties, many of them our clients, as they seek to validate the cost-effectiveness of the intervention. The evaluation of cost-effectiveness is similar to that being employed by CMS in the Medicare Shared Savings Program (MSSP) where there is a comparison of expected medical expenditures to actual medical expenditures for the enrolled/attributed population. For our program, the analysis includes an annual evaluation of the actual medical cost for Optum managed members compared to the regression adjusted baseline medical cost to determine the net savings. In addition to cost-effectiveness, consumer satisfaction and quality measures are performed to determine the overall impact of the intervention.

This document is a response to a Request for Information (RFI) and is provided by Optum for planning purposes only. This RFI response is not an offer capable of acceptance and is subject to change or revision at any time without notice. Any legally binding commitments will be established through the negotiation and execution of a definitive written agreement between the parties that will contain pricing for an agreed upon scope of work.