Roadmap to a Healthier Minnesota

Recommendations of the Minnesota Health Care Reform Task Force

December 13, 2012

The Roadmap to a Healthier Minnesota

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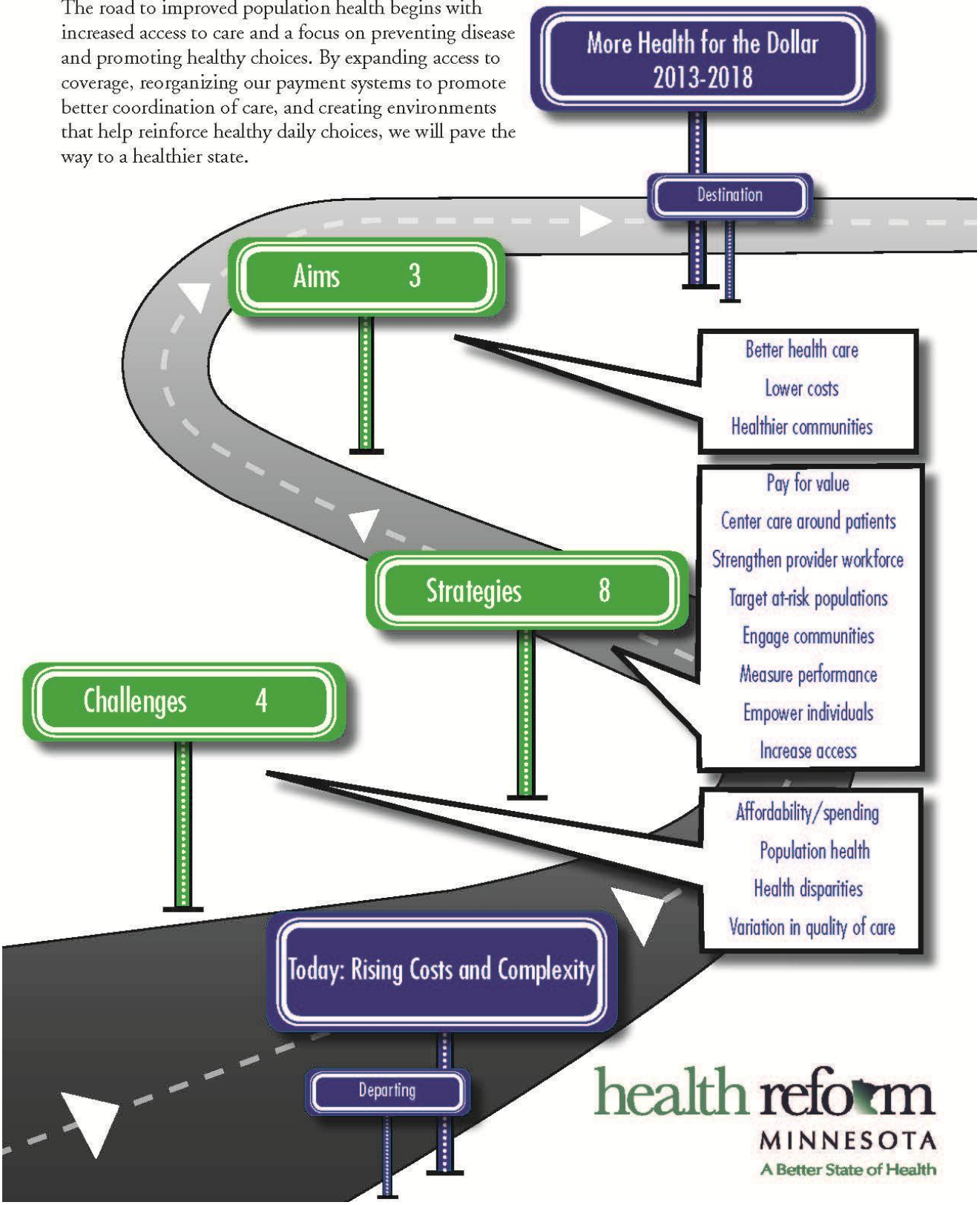
The road to improved population health begins with increased access to care and a focus on preventing disease and promoting healthy choices. By expanding access to coverage, reorganizing our payment systems to promote better coordination of care, and creating environments that help reinforce healthy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



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Executive Summary

Roadmap to a Healthier Minnesota

Recommendations of the Minnesota Health Reform Task Force
December 2012

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

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

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

Overview of the Health Care Reform Task Force and its Work Groups: The Health Care Reform Task Force established four work groups charged with developing recommendations within their respective domains: Access, Care Integration & Payment Reform, Prevention & Public Health, and Workforce. (See Appendix B for founding documents.) The Task Force and work groups held 65 public meetings between November 2011 and December 2012, including meetings in Rochester, Duluth, St. Cloud, and St. Paul. (See Appendix C for the meeting calendar.) Approximately 1,500 people attended the meetings, more than 115 individuals and organizations provided public testimony in the meetings, and more than 750 provided public comment letters. (See Appendix E for a summary of public comment.) In addition, the Bush Foundation and the Citizen's League engaged citizens in "Citizen Solutions" conversations across the state on a range of health care topics. (See Appendix D for a summary of the Citizen Solutions Initiative.) The recommendations in the *Roadmap to a Healthier Minnesota* are based on Task Force and work group discussion, work group recommendations, Citizen Solutions feedback, and public input.

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

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

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

Strategy II: Support Patient-Centered, Coordinated Care. Patient-centered care recognizes that a person's health is determined by physical, psychological, and environmental factors, and offers approaches that empower patients while responding to his or her holistic needs. The Task Force recommends several steps to improve the coordination of care across primary care, behavioral health, long-term care, public health, and social services, including development of systems to improve communication and secure data sharing across providers, and provision of technical assistance to targeted providers to support this coordination and integration.

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

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

Strategy V: Engage Communities. Recognizing that health is primarily determined by factors outside of the health care system, the Task Force recommends increasing opportunities for consumers and communities to make healthy choices through effective initiatives within the Statewide Health Improvement Program. Additionally, the Task Force recommends a pilot of "Accountable Communities for Health," multidisciplinary, locally-based teams that partner with primary care practices, hospitals, behavioral health, public health, social services, and community organizations to provide coordinated care for the whole patient.

Strategy VI: Measure Performance and Ensure System Stability. In order to meet the Task Force's goals to achieve better health care, lower costs, and healthier communities, it is important to set clear targets and monitor performance against them. The Task Force recommends creation of a private-public partnership to direct development of shared goals, define a mechanism for measurement of goal attainment, and consider consequences if goals are not met. The Task Force also recommends development of best practices for the state and providers to collect data on race, ethnicity, and language in order to better understand and eliminate health disparities. Finally, the Task Force recommends development of a process to determine the "return on investment" for state-funded programs in order to effectively direct state funds.

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

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

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

Conclusion: The recommendations in this *Roadmap* are interconnected strategies designed to transform health care and improve health in Minnesota. While the report does not include a specific implementation timeframe for each recommendation, the Task Force does envision implementation over the next five years, in conjunction with other reform efforts underway across the state. The landscape of health care is constantly evolving and these recommendations have been developed as a result of Minnesota's collaborative culture and as a significant step in our continuous process of improvement. It is in this spirit that the Health Care Reform Task Force offers the *Roadmap to a Healthier Minnesota*.

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I. Introduction

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

Despite our ongoing attention to improving health and health care, several formidable challenges face Minnesota. While we continue to compare favorably to other states, these challenges are reflected in Minnesota's drop from the #1 overall healthiest state in 2006 to #5 in 2012, according to United Health Foundation's Health Rankings report.[1] The *Roadmap to a Healthier Minnesota* acknowledges the challenges described below and provides recommendations for consideration by the Governor and Legislature to address these issues in the next one to five years by maximizing opportunities for better health care, lower costs, and healthier communities.

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

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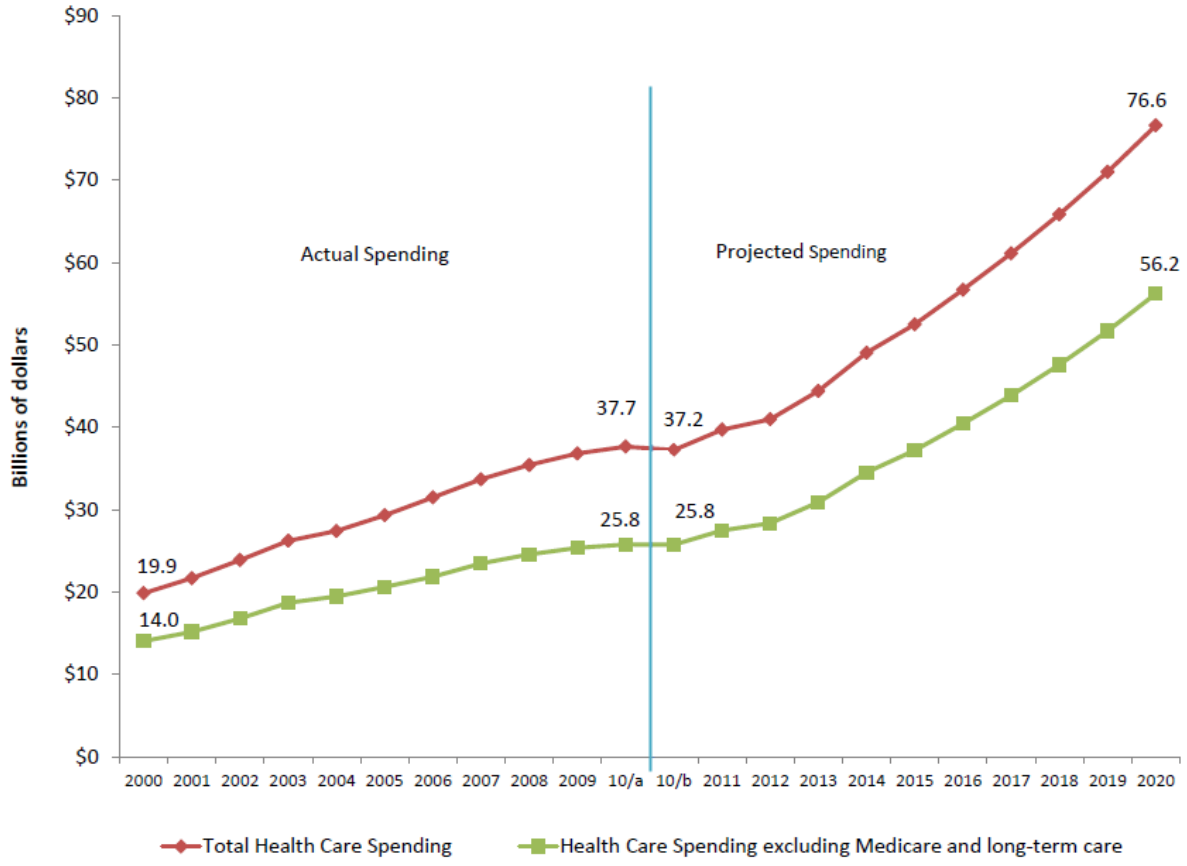
[1] United Health Foundation (2012). America's Health Rankings 2012: Minnesota. Retrieved from http://www.americashealthrankings.org/MN/2012.

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

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

Figure 1. Health Care Spending in Minnesota 2000-2020

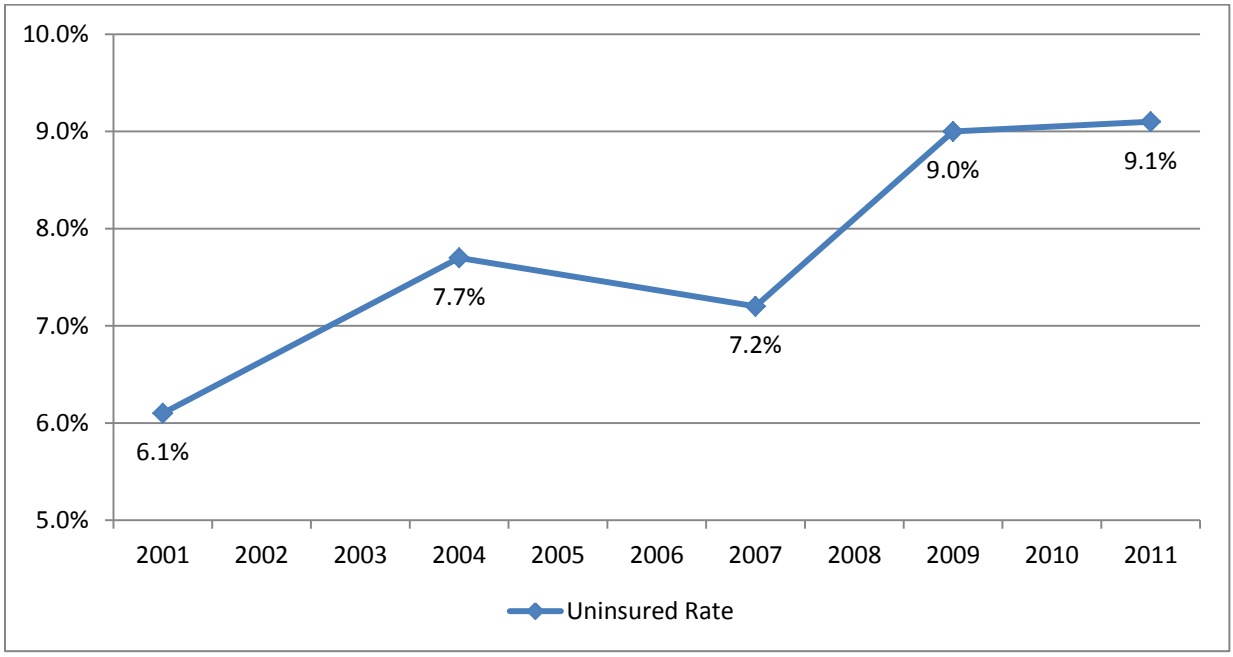


Source: Minnesota Department of Health, Health Economics Program (2012). Minnesota Health Care spending and Projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

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

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

Figure 2. Uninsured Rate in Minnesota 2001-2011



Source: Minnesota Department of Health (2012, March). Health Insurance Coverage in Minnesota: Early Results from the 2011 Minnesota Health Access Survey. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmhas2011.pdf

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

[5] United Health Foundation (2011). America's Health Rankings 2011: Minnesota. Retrieved from http://www.americashealthrankings.org/MN/2011.

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

Figure 3. Obesity Rate in Minnesota 1990-2011

Source: United Health Foundation (2011). America's Health Rankings 2011: Minnesota. Retrieved from http://www.americashealthrankings.org/MN/2011 .

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

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

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

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

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

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

Building on the Tradition of Health Reform in Minnesota

Minnesota has a long tradition of working collaboratively to maximize access, health status, quality, and efficiency in health care. Over the past decade, Minnesota has periodically evaluated its health system and addressed difficult challenges head on, including the Minnesota Health Access Commission in 1989-1991 that created MinnesotaCare, the Minnesota Health Care Commission of 1992 – 1997, Senator Durenberger's Minnesota Citizens Forum on Health Care Cost in 2003, the Health Care Transformation Task Force of 2007, and the Health Care Access Commission of 2008. The commitment of Minnesota to continually improve is one of the reasons that the state has one of the highest performing health care systems in the nation. The 2011-2012 Health Care Reform Task Force and the *Roadmap* outlined in this report build on the findings and recommendations of these preceding bodies, extending the strategies that have yielded success, and offering course corrections for those that have not. The members of the Task Force recognize that health reform is an evolving process and hope that in the spirit of continuous improvement, future bodies would similarly reflect on these recommendations with an eye towards further refinement and advancement.

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

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

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

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

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

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

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

a. Redesign of health care delivery, payment, and data systems to improve health and control costs, including integration with long-term care, behavioral health, public health and social services;
b. Reform of Minnesota's health financing mechanisms to improve health care affordability and achieve equitable sharing of costs among all payers;
c. Development and oversight of work groups and task forces established by individual Commissioners on issues such as the health insurance exchange, public health, workforce needs, delivery systems, and payment reform; and
d. Opportunities for consumer and community engagement in health reform efforts, including creation and maintenance of a public website and speaker's bureau to engage in a dialogue with Minnesotans about health reform."

Governor Dayton also charged the Task Force with reviewing the recommendations of the Health Insurance Exchange Advisory Task Force and considering the Exchange Advisory Task Force's work in the context of broader health reform efforts.

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

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

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

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

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

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

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

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

The Task Force and its constituent work groups held 65 public meetings between November 2011 and December 2012, including meetings in Rochester, Duluth, St. Cloud, and St. Paul. Over the course of the year, approximately 1,500 people attended these meetings with more than 115 individuals and organizations providing public comments at the meetings. In addition to verbal testimony at meetings, individuals and organizations also shaped the recommendations through more than 750 public comment letters – more than half of them from individuals.

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

Citizen Engagement in Health Reform Priorities of Minnesotans

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

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

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

citizen engagement process during the spring and summer of 2012 to seek guidance on a range of health care topics from nearly 1,100 Minnesotans from all political persuasions, income levels, and ethnic backgrounds. From these conversations, named "Citizen Solutions: A different conversation about fixing health care," the Task Force learned that Minnesotans believe that the two greatest challenges facing the health care system today are the affordability of care and the complexity of the system.[14] See Appendix D for a summary of the Citizen Solution's Initiative.

The consumers with whom Citizen Solutions met did not suggest that the government should retain sole responsibility for solving these problems. Rather, they indicated a desire to take an active role in achieving better health, make trade-offs and accept an equal balance of rights and responsibilities as Minnesota seeks to reform the health care system. Specifically, the participants identified the following "principles of action" that should guide the current health reform initiatives:

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

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

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

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

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

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

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

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

	statewide reimbursed benefit under Minnesota Health Care Programs.
	17. Expand school-linked behavioral health grants and include previously untreated children with high mental health needs, coordinate with suicide prevention texting and telephone supports, and offer screening and referral for substance abuse issues.
	18. Evaluate and perform gap analysis on school health reforms
V. Engage Communities	19. Identify the most proven Statewide Health Improvement Program (SHIP) initiatives to date and expand these preventive approaches statewide, as indicated.
	20. Pilot the concept of "Accountable Communities for Health" that engage communities in setting and achieving Triple Aim goals.
VI. Measure Performance and Ensure System Sustainability	21. Use a private-public process to set performance targets including goals for health care cost containment, health care quality, patient experience and population health.
	22. Implement best practices for collection and reporting of data on detailed categories of race, ethnicity, and language linked to health disparities.
	23. Develop recommendations for implementing a public health return on investment (ROI) methodology including recommended practices for programs funded by state government.
	24. Guide a process for comprehensive performance measurement of TCOC-contracted provider entities and other provider organizations in achieving health and cost goals.
VII. Design Benefits to Enhance Personal Responsibility	25. Increase the market availability of health insurance products that foster consumer accountability for health behaviors and create incentives for consumers to use high value providers.
VIII. Increase Access and Support Consumer Navigation	26. Expand Medicaid to include individuals with incomes up to 138% of the federal poverty level (FPL).
	27. Implement a Minnesota-based health insurance exchange, employing a public-private governance structure.
	28. Provide affordability and coverage support for adults with incomes between 138 and 200% FPL at a level equivalent to MinnesotaCare, at a minimum.
	29. Consider that Benchmark options for the Essential Health Benefits (EHB) based on Minnesota plans would provide generally similar benefits and that an ongoing mechanism for review and stakeholder feedback on the EHB is needed.

	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.
	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.

II. Roadmap Recommendations

This section provides the detailed recommendations of the Task Force, beginning with discussion of how the recommendations will work together to achieve Minnesota's goal of improved health and health status, and reduced health care cost growth.

"More Health for the Dollar"

The combination of declining health status in the midst of rising costs, as described above, presents a challenge that can only be met by a system-wide transformation that maximizes the efficiency of Minnesota's public and private health care dollars. In essence, Minnesotans must get *more health for the dollar*. Every dollar spent in the system must be an investment in the future health of our state's population: we are in the business of producing health with our health system. The strategies outlined in this *Roadmap* realign the incentives throughout the system to better leverage our funds and enable us to slow our spending and decrease the rate of uninsurance, while achieving better health.

The Interaction and Interdependency of Roadmap Strategies

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

- reforming our payment system creates incentives for providers to re-organize their systems to create better care coordination and integration. Providers, in turn, need more ready access to clinical data from other providers and in some cases need technical support to transition to an organization that can manage population health,
- underlying all reform is a recognition that an improved health care system will only have an impact on population health if individuals have access to care, and access requires coverage and the ability to navigate coverage choices, and
- supporting people to lead healthier lives can move Minnesota "upstream" so we are preventing illness before it begins, preventing exacerbation of existing conditions, and lowering costs to the health care system.

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

Strategy I: Pay for Value

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

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

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

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

[18] Mathematica, Inc. (2009). Summary: Global Payment. Presented to the Massachusetts Special Commission on the Health Care Payment System, March 13, 2009. Retrieved from http://www.mass.gov/chia/docs/pc/2009-02-13-global-payment-c2.pdf

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

[20] Frakt, A. & Mayes, R. (2012). Beyond Capitation: How New Payment Experiments Seek To Find The 'Sweet Spot' In Amount Of Risk Providers And Payers Bear. *Health Affairs*, *31*(9), 1951-1958. Retrieved from http://content.healthaffairs.org/content/31/9/1951.full

recommends that the Department of Human Services (DHS) advance TCOC contracting within Minnesota Health Care Programs by DHS and DHS-contracted health plans with provider organizations over three years with those providers that have the capability and interest to participate, building off the existing Health Care Delivery System (HCDS) demonstrations. This initiative is also included in Minnesota's State Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted September 2012).

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

Strategy Element #2: Explore improvements to and expansions of the health care home program. DHS and MDH should jointly explore a) mechanisms to reduce the burden for providers of tiering patients and/or submitting individual claims to get paid for health care home services, including exploration of ways to transfer the task of assessing patient complexity to payers; b) replacing the current health care home claims-based payment model with a prospective mechanism that generates payments for all individuals served in health care homes; and c) the potential impact of expanding payment for care coordination to all patients, not just those with chronic illness, because all patients would benefit from the services and structure of a patient-centered medical home. Such exploration should keep in mind the need for evidence-based support for both the current program and alternative models and the fact that patients with chronic illnesses and those impacted by social and economic determinants of health have greater need for care coordination than those without illness.

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

Strategy II: Support Patient-Centered, Coordinated Care

The Opportunity: Through the work of Citizen Solutions, the Task Force heard that Minnesotans see a "healthy" life as one that seeks the balance of the mind, body, and spirit.[21] The health care system, however, is fragmented and currently does not acknowledge this view of health and lacks a unified approach to care. Providers often operate in silos that focus on only one aspect of the patient's health and well-being and, as a result, patients are subjected to duplicative testing, inconsistent treatment plans, and conflicting medical advice.[22] In contrast, patient-centered care is holistic and recognizes that a person's health is determined by

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

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

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

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

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

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[23] Kathol R (2012, June). Behavioral Health/Primary Care Integration." Presented to the Care Integration and Payment Reform Work Group, Minnesota Health Care Reform Task Force. Retrieved from http://mn.gov/health-reform/images/WG-CIPR-2012-06-04-%20Cartesian-Solutions.pdf

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

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

[26] These entities may sometimes be referred to as "accountable care organizations" (ACOs).

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

services with local public health and social services agencies, initially through coordinating activities and within three years have Medicaid begin to do so through an integrated funding and service provision pilot. In addition, phasing in over three years, such entities shall also become responsible for integrating Medicare funding for those dually eligible for Medicaid and Medicare. These efforts would be done in coordination and alignment with the existing CMS demonstration programs and are included in Minnesota's State Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted September 2012).

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

Strategy Element #6: Address barriers to clinically appropriate data sharing while rigorously protecting against unauthorized sharing and disclosure. The Task Force heard significant public testimony regarding the barriers to sharing information between health care providers, public health, behavioral health, long-term care, and social service providers. Effective use of data across providers is essential to integration of care, advancement of TCOC models, and elimination of waste in the form of unnecessary duplication of tests and procedures. Improved data sharing is also essential to reducing the administrative burden of prior authorization for diagnostic and therapeutic interventions, as well facilitating prior authorization/refill authorization for prescription drug dispensing. Such sharing, however, cannot disclose information counter to patient desires. Therefore, the Task Force recommends that MDH conduct a rigorous analysis of perceived and actual barriers to data sharing, including between behavioral health and somatic health clinicians, and how these may hinder achieving the goals for improvement in population health and reductions in health care spending. Following this assessment, MDH should recommend to the legislature changes in statute that would support sharing information among "unrelated entities" by expanding provisions to encompass the information sharing necessary to make health care homes, health homes, accountable care organizations, and TCOC arrangements successful, all while preserving patient protections as advanced by the Minnesota Health Records Act. Elements of this recommendation are also included in Minnesota's State Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted September 2012).

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

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

Strategy III: Prepare and Support the Health Provider Workforce

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

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

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

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

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

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

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

Strategy Element #9: Explore and remove regulatory barriers to the advancement of the nursing workforce. Nursing is by far the largest sector of Minnesota's licensed health care workforce, and nurses play critical roles in all health care settings. In order to plan for and promote a robust nursing workforce, the Task Force recommends:

- Removing practice barriers for advanced practice registered nurses (APRNs) by adopting the Advanced Practice Registered Nursing Consensus Model and enacting the APRN Model Act and Rules. Currently, APRNs are not allowed to practice to the fullest extent of their education and training because of statutory barriers in Minnesota's Nurse Practice Act. Minnesota's Nurse Practice Act mandates APRN practice must occur in settings that provide for a collaborative arrangement between an APRN and a physician in order to care for and manage patients, and limits prescriptive authority to those APRNs who maintain a signed written prescriptive agreement with a physician.

- Funding a study of the impact of Minnesota joining the Interstate Nurse Licensure Compact, including an analysis of the state reciprocity issue and barriers to advancing telehealth. The Nurse Licensure Compact (NLC) is an agreement between states to mutually recognize the license of a nurse as authority to practice in other states that are party to the agreement. The basic concept of the mutual recognition model of nurse licensure is to issue a nurse one license by state of residence, and allow the nurse to practice in other states subject to each state's practice regulations. Health reform and workforce planning necessitate analysis of issues possibly related to the NLC including the licensing, supply/demand, and working conditions.

Strategy Element #10: Increase the supply of the primary care workforce and stabilize support for health professions education by supporting existing health professions training sites and funding new sites for primary care physicians, APRNs, physician assistants and pharmacists through the Medical Education and Research Costs (MERC) program. Workforce needs tie directly to the health care delivery system, and MERC is the state's foundation investment in Minnesota's system of clinical training. Increased MERC funding will greatly stabilize health professions training, and investing new resources specifically in new primary care training capacity will support the redesign of practice to the team-based, primary-care centered approach needed to achieve health reform goals and transform primary care. Communities depend on sufficient numbers of physicians to provide care for their populations in both primary care and specialty practices. While many factors affect population

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

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

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

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

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

[31] Workforce Work Group Priority Recommendations to the Governor's Health Care Reform Taskforce, July 7, 2012. Retrieved from: http://mn.gov/health-reform/images/TaskForce-2012-07-12-WFWG-Priority-Recommendations.pdf

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

Strategy Element #14: Increase diversity in the health care workforce by supporting a range of health professions diversity programs. Ethnic and racial minorities are not proportionately represented in Minnesota's health care workforce. The pathway to successful health care careers can be lengthy and require students to make deliberate academic choices early on. To prepare Minnesota's future health care workforce, investments in the workforce "pipeline," beginning at the K-12 level through post-secondary and into the post-graduate level, are critical. Programs targeting traditionally underrepresented students (non-traditional, minority, rural, low-income, foreign-trained physical and mental health professionals) that offer early health career awareness and ongoing support such as academic enrichment, mentorship, scholarships, and training/residency opportunities need to be expanded to build a diverse health care workforce that offers culturally competent care and reduces disparities in access and care outcomes. Specifically, the Task Force recommends: a) providing health career exploration experience through health careers program and emphasis of Science, Technology, Engineering, and Math (STEM) competencies; b) supporting programs that train and mentor underrepresented students to pursue health careers; and c) assisting foreign-certified physical and mental health professionals in obtaining Minnesota licensure.

Strategy IV: Improve Health for Specific At-Risk Populations

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

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

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

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

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

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

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

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

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

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

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

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

[39] The term "public health" refers to the policy, proactive and structures of maintaining and improving the health of the entire state.

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

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

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

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

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

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

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

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

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

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

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

Strategy V: Engage Communities

The Opportunity: Consumers in Minnesota clearly recognize that the health care system alone does not define good health.[50] Rather, health status is the product of many conditions and factors including living

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

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

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

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

conditions and social and economic opportunity. According to the Centers for Disease Control and Prevention (CDC), 70% of what influences health status (health behaviors at 50% and environment at 20%) can be addressed through prevention.[51] Recognizing that health is primarily determined by factors outside the health care system demands that we look beyond the systems of care and toward our communities for solutions. Yet, only about 5% of health expenditures are spent on population-level prevention efforts.[52] Minnesotans have expressed a willingness to shift this emphasis and assume a greater role in supporting health in their communities.[53] Therefore, the Task Force recommends that Minnesota move toward a new paradigm of health that is founded on the notion of community engagement and citizen involvement and which seeks to address the social determinants of health through the integration of community-based public health, social service, and educational systems.

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

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

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

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

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

Strategy Element #20: Pilot the concept of "Accountable Communities for Health" (ACHs) that engage communities in setting and achieving Triple Aim goals. While there is some recognition among the public that health is determined predominantly by factors that are not affected by clinical care or health spending, the systems established by payers, providers, businesses, and government do not reflect this reality.[55] The coordination of services affecting these factors is currently fragmented, leading to poorer outcomes and higher costs. Therefore, the Task Force recommends that Minnesota pilot the idea of "Accountable Communities for Health" and engage local communities as a key component of transforming health care delivery and payment systems, as described in Strategies I and II above. These pilots will build upon the existing Community Care Teams pilots which are multidisciplinary, locally-based teams that partner with primary care practices, hospitals, long-term care, behavioral health, public health, social services and community organizations to ensure strong, coordinated support for the whole patient. ACHs will implement population-based prevention strategies and integrate care across the spectrum of health care and social services through development of multi-disciplinary teams, which may include emerging professions such as community health workers, community paramedics, and dental therapists. ACHs will empower and involve citizens to set measurable and measured community-based goals for improved population health, health care and cost management, and take specific steps to achieve those goals. This process will ensure that state-level cost, quality, and health targets (Strategy Element #21 below) are informed by and translated into specific community-level goals and action plans. Specifically the Task Force recommends that MDH should select up to 10 diverse ACH two-year pilots and work to implement integrated delivery system and payment models within the ACHs. This recommendation is also included in Minnesota's State Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted September 2012).

Strategy VI: Measure Performance and Ensure System Stability

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategy Element #23: Develop recommendations for implementing a public health "return on investment" (ROI) methodology including recommended practices for programs funded by state government. Information regarding ROI for publicly funded health care programs could help inform policymakers regarding decisions for investment in the programs that provide the greatest value or have longer-term benefits. Additionally, program investments made by one state agency may not lead to cost savings in that agency, but could trigger savings in other departments or sectors (such as business, health insurance, and local government). Although overall savings gains may be significant, there may not be an incentive for one agency to make the initial investment absent the implementation of this ROI methodology. The Task Force recommends that MDH, in consultation with Minnesota Management and Budget (MMB), undertake an assessment of ROI initiatives in other states, design implications for Minnesota, and identification of one or more institutions capable of providing rigorous and consistent nonpartisan institutional support for ROI and develop a proposed ROI methodology for Minnesota. The ROI methodology should identify opportunities to understand ROI and the value of investments within an agency, and also measure ROI and value across agencies for program alignment to maximize resource allocation and positive outcomes, and reduce redundancies. Once this ROI methodology is developed, it may be utilized by the Legislature to support consideration of benefits and risks outside of the state budget window.

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

Elements of this recommendation are also included in Minnesota's State Innovation Model submission to the Center for Medicare and Medicaid Innovation (submitted September 2012).

Strategy VII: Design Benefits to Enhance Personal Responsibility

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

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

Strategy VIII: Increase Access and Support Consumer Navigation

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

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

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

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

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

Strategy Element #27: Implement a Minnesota-based Health Insurance Exchange, employing a public-private governance structure. Rather than allowing the federal government to determine the design, structure, and implementation of our exchange, the Task Force recommends that Minnesota implement its own state-based exchange. The Task Force recognizes that the federal government has yet to describe the federal exchange and the future evaluation of options may be needed. However, considering what is known today about a federal exchange, the Task Force believes that maintaining state control of the exchange and using a public-private partnership to lead implementation will enable the exchange to be responsive to local priorities and ultimately better reflect the unique needs of Minnesota's consumer and employer populations. The Task Force also recognizes the need to provide Minnesotans with information and education regarding the exchange through a communications strategy and plan.

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

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

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

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

b. Premiums should be based on a sliding fee for those with incomes between 151-200% FPL with the scale at $0 for 150% and increasing incrementally up to the current MinnesotaCare cost at 200% FPL.

2. At a minimum, benefits should include those currently available through MinnesotaCare without the hospital cap.

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

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

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

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[63] More information regarding federal requirements and the essential health benefits in Minnesota is available in the following fact sheet: http://mn.gov/health-reform/images/WG-Access-EHB%20Fact%20Sheet%20and%20FAQs%2010-05-12.pdf

III. Conclusion

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

IV. Appendices

Appendix A: Task Force Working Principles

Adopted by the Task Force to guide and inform its work

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

Appendix B: Founding Documents

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

Sec. 4. **HEALTH CARE REFORM TASK FORCE.**

Subdivision 1. **Task force.** (a) The governor shall convene a Health Care Reform Task Force to advise and assist the governor and the legislature regarding state implementation of federal health care reform legislation. For purposes of this section, "federal health care reform legislation" means the Patient Protection and Affordable Care Act, Public Law 111-148, and the health care reform provisions in the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:

(1) two legislators from the house of representatives appointed by the speaker and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

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

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

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

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

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

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

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

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

(b) The task force, in consultation with the governor and the legislature, shall also establish timelines and criteria for future reports on state implementation of the federal health care reform legislation.

STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-30

Establishing a Vision for Health Care Reform in Minnesota

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The Commissioner of Commerce, in consultation with the Task Force, shall:

    a. Design and develop a Minnesota health insurance exchange to ensure access to affordable, high-quality health coverage that maximizes consumer choice and minimizes adverse selection; and

    b. Develop legislative recommendations to improve the private health insurance market in conjunction with changes to state and federal law.

5. The Commissioner of Human Services, in consultation with the Task Force, shall:

    a. Work to improve the quality, operations, and access to Minnesota's public health insurance programs through purchasing and delivery system redesign initiatives; and

    b. Develop legislative recommendations for additional affordable health coverage options and changes to improve state long-term care, mental health and chemical dependency policies and programs.

6. The Commissioner of Health, in consultation with the Task Force, shall:

    a. Work to reduce the use and cost of the health care system through prevention and health promotion initiatives and ensure appropriate use of health care cost and quality data by consumers and purchasers; and

    b. Develop legislative recommendations for changes in state law to ensure that Minnesota's health workforce is sufficient and properly trained to serve and improve the health of all Minnesotans.

Under Minnesota Statutes 2011 § 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State and shall remain in effect until rescinded by proper authority or it expires in accordance with Minnesota Statutes 2011 § 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on October 31, 2011.

Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State

FILED
OCT 2011
SECRETARY OF STATE

3

Appendix C: Task Force and Work Groups Meeting Calendar

November 2011			
14	2:30 – 4:30	Task Force	Andersen
16	10:00 – 12:00	Workforce	SOP
December 2011			
5	2:30 – 4:30	Task Force	Andersen
21	4:30 – 6:30	Workforce	SOP
January 2012			
5	1:00 – 2:30	CIPR*	Andersen
5	2:30 – 4:30	Task Force	Andersen
9	1:00 – 3:00	Access	Andersen
11	4:00 – 5:00	Workforce	Conference Call
25	1:00 – 3:00	Access	Andersen
February 2012			
3	2:30 – 4:30	PPH*	Andersen
6	12:30 – 2:30	CIPR*	Andersen
6	2:30 – 4:30	Task Force	Andersen
8	2:30 – 6:00	Workforce	MDH
9	12:30 – 2:00	Access	Andersen
16	11:00 – 12:30	CIPR*	Andersen
23	11:00 – 1:00	Access	Andersen
24	9:30 – 11:30	Exchange	Golden Rule
March 2012			
1	9:00 – 12:00	Workforce	Andersen
1	2:30 – 5:30	Task Force	Andersen
8	12:30 – 2:30	Access	Andersen
16	10:00 – 12:00	PPH*	Andersen
16	1:00 – 3:00	CIPR*	Conference Call
21	3:30 – 7:00	Workforce	MDH
29	1:00 – 3:00	Access	Andersen
30	9:30 – 11:30	Exchange	Credit Union
April 2012			
2	12:30 – 2:30	CIPR*	Wilder
2	2:30 – 5:30	Task Force	Wilder
12	12:30 – 2:30	Access	Wilder
16	2:30 – 3:30	PPH*	Conference Call
20	9:00 – 11:00	Workforce	MN DOT
20	9:30 – 11:30	Exchange	Credit Union
20	1:30 – 3:30	CIPR*	Conference Call
26	1:30 – 3:30	Access	Wilder
May 2012			
3	12:30 – 2:30	CIPR*	IIM
3	2:30 – 5:30	Task Force	IIM
10	12:30 – 2:30	Access	UROC
14	1:00 – 5:00	PPH*	Andersen
18	9:30 – 11:30	Exchange	Credit Union
June 2012			
4	12:30 – 2:30	CIPR*	Rochester
4	2:30 – 5:30	Task Force	Rochester
5	8:30 – 10:30	PPH*	Andersen

June 2012 (cont.)			
14	1:00 – 2:00	Access	Conference Call
21	10:00 – 1:00	Access	Wilder
21	2:00 – 4:30	Workforce	Credit Union
July 2012			
9	1:00 – 3:00	PPH*	SOP
12	12:30 – 2:30	CIPR*	UM - Duluth
12	2:30 – 5:30	Task Force	UM - Duluth
16	1:00 – 3:00	PPH*	Credit Union
23	9:00 – 11:00	Access	Vet Services
26	1:00 – 3:00	Exchange	Concordia
August 2012			
6	12:30 – 2:30	CIPR*	St. Cloud
6	2:30 – 5:30	Task Force	St. Cloud
16	1:00 – 3:00	Access	Wilder
22	12:00 – 1:00	CIPR*	Conference Call
27	3:00 – 4:30	PPH*	Conference Call
28	1:00 – 3:00	Access	Wilder
29	1:00 – 3:00	Exchange	New Ulm
September 2012			
6	12:30 – 2:30	CIPR*	Metro State
6	2:30 – 5:30	Task Force	Metro State
13	10:00 – 12:00	Access	Wilder
27	10:00 – 12:00	Exchange	Cloquet
October 2012			
1	12:30 – 2:30	CIPR*	Wilder
1	2:30 – 5:00	Task Force	Wilder
8	1:00 – 2:30	PPH*	MN DOT
10	9:00 – 12:00	Exchange	State Office Bldg.
22	12:00 – 2:00	CIPR*	Conference Call
26	3:00 – 5:00	PPH*	Andersen
November 2012			
1	2:30 – 6:00	Task Force	Kelly Inn
8	9:00 – 11:00	Access	Kelly Inn
15	2:30 – 5:30	Task Force	Kelly Inn
16	2:00 – 3:00	CIPR*	Conference Call
29	2:30 – 5:30	Task Force	Wilder
December 2012			
13	2:30 – 5:30	Task Force	Kelly Inn

Notes:

- *CIPR: Care Integration & Payment Reform
- *PPH: Prevention and Public Health
- Links to Task Force, Access, Care Integration and Payment Reform, Prevention and Public Health, and Workforce webpages and meeting locations.
- Link to Exchange website and Technical Work Group

Abbreviation	Full Name	City
Anderson	Elmer L. Andersen Human Services Building	St. Paul
Credit Union	Hiway Federal Credit Union	St. Paul
IIM	International Institute of Minnesota	St. Paul
Kelly Inn	Best Western Kelly Inn	St. Paul
MDH	Minnesota Department of Health	St. Paul
Metro State	Metropolitan State University – St. Paul Campus	St. Paul
MN DOT	Minnesota Department of Transportation Aeronautics Building	St. Paul
Rochester	Mayo Clinic, Downtown Campus	Rochester
SOP	Snelling Office Park, Minnesota Department of Health	St. Paul
St. Cloud	Le St. Germain Hotel	St. Cloud
UM-Duluth	University of Minnesota - Duluth	Duluth
UROC	Urban Research and Outreach-Engagement Center, University of Minnesota	Minneapolis
Vet Services	Veterans Service Building	St. Paul
Wilder	Amherst H. Wilder Foundation	St. Paul

Appendix D: Citizen Solutions Public Engagement Initiative

The Health Care Reform Task Force acknowledged the need for citizen engagement and input into their discussions regarding the future of health and health care in Minnesota. The Bush Foundation and Citizen's League generously funded a citizen engagement process during the spring and summer of 2012 to seek guidance on a range of health care topics from Minnesotans from all political persuasions, income levels, and ethnic backgrounds. The charge of the project, named "Citizen Solutions: A different conversation about fixing health care," was to:

- Understand what citizens value about the current health and health care systems and learn where they are willing to make trade-offs.
- Learn what Minnesotans perceive as barriers and gaps in health and health care as experienced in their own lives.
- Provide qualitative information about values and experiences to inform task force policy recommendations and future policy decisions.

Nearly 1,100 people attended meetings and engaged in dialogue at 40 community, employer, and constituency meetings across the state. Online discussions were held with adults and teens and there were over 4,150 visits to the websites. Underrepresented communities were targeted for inclusion in the discussions, and a diverse coalition of partners assisted with recruitment. From these conversations, the Task Force learned that Minnesotans believe that the two greatest challenges facing the health care system today are the affordability of care and the complexity of the system.

The consumers with whom Citizen Solutions met did not suggest that the government should retain sole responsibility for solving these problems. Rather, they indicated a desire to take an active role in achieving better health, make trade-offs and accept an equal balance of rights and responsibilities as Minnesota seeks to reform the health care system. Specifically, the participants identified the following "principles of action" that should guide the current health reform initiatives:

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

The participants shared an expansive view of health, stating that health is a balance of emotional, physical, and spiritual well-being. Factors that contributed to health could be found in relationships, neighborhoods, healthy living and activity, healthy foods, access to affordable care, and quality care. Consumers consistently focused on strategies to improve health that were outside the healthcare system.

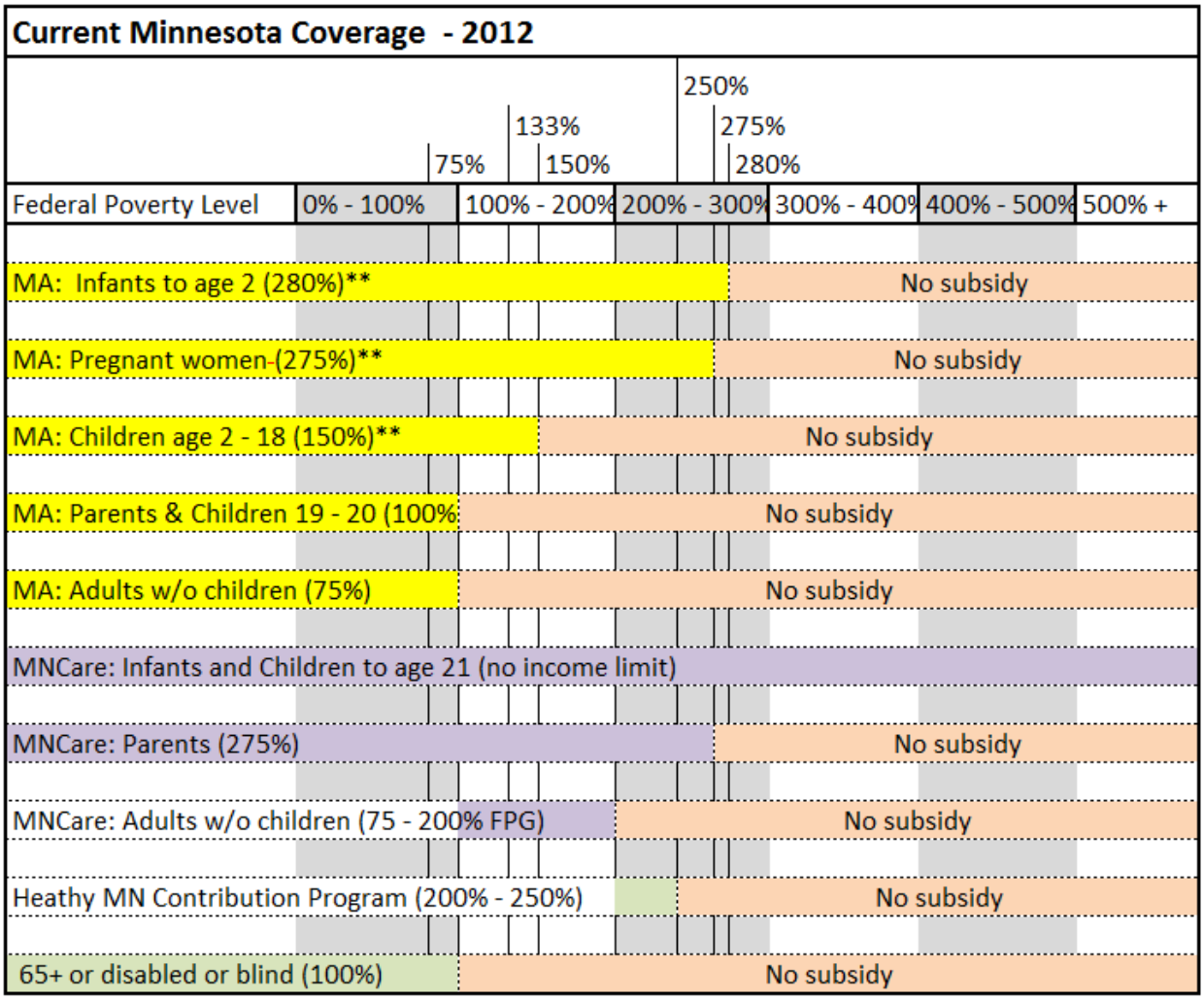
The Engagement Results, Online Participation Report, Teen Participation Report, and Polling Data Appendix can be found on the Citizen Solutions website at www.BushFoundation.org/CitizenSolveHealth

Appendix E: Summary of Public Comment Volume

		Organization		Individual		
		Written	**Presented**	**Written**	**Presented**	
Task Force	Q1	-	1	-	3	4
	Q2	-	7	-	3	10
	Q3	2	11	-	3	16
	Q4	43	13	201	0	257
		45	**32**	**201**	**9**	287
Access	Q1	57	1	142	2	202
	Q2	6	12	1	9	28
	Q3	3	19	1	4	27
	Q4	7	3	2	0	12
		73	**35**	**146**	**15**	269
CIPR	Q1	0	0	0	0	0
	Q2	1	0	0	2	3
	Q3	8	5	10	2	25
	Q4	30	2	18	0	50
		39	**7**	**28**	**4**	78
PPH	Q1	0	2	0	1	3
	Q2	67	0	24	2	93
	Q3	41	2	22	3	68
	Q4	16	5	58	0	79
		124	**9**	**104**	**6**	243
Workforce	Q1	0	0	0	0	0
	Q2	12	0	0	0	12
	Q3	0	0	1	0	1
	Q4	0	0	0	0	0
		12	**0**	**1**	**0**	13
		293	***83***	***480***	***34***	**890**

Note: Unless presented at a specific meeting, letters addressed to the Task Force before 11/29/12 are counted towards the Work Groups

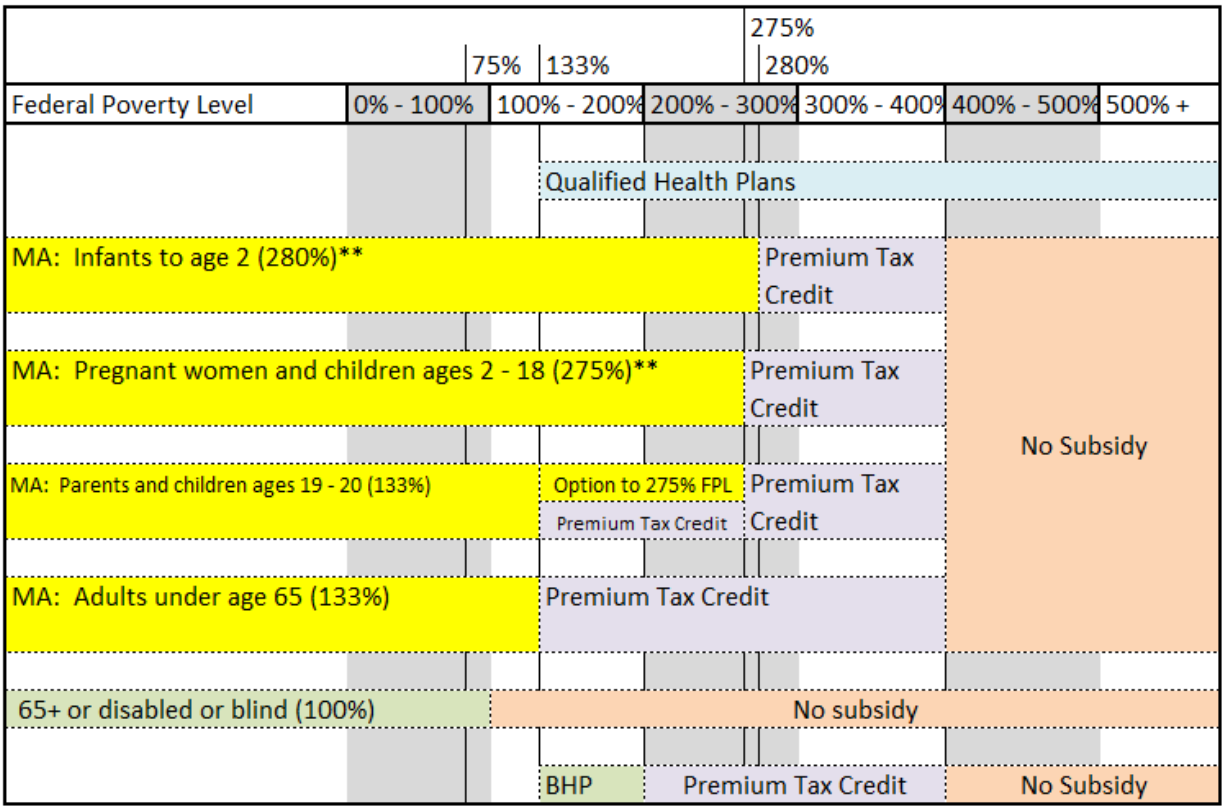
Appendix F: Coverage Comparisons: 2012 versus 2014



**Income standard must be maintained to comply with the CHIP maintenance of effort.

Abbreviations: MA: Medical Assistance
BHP: Basic Health Plan or Wrap-around
MNCare: Minnesota Care

Minnesota Coverage Options - 2014*



*Subject to additional federal guidance related to maintenance of effort.

**Income standard must be maintained to comply with the CHIP maintenance of effort.

Abbreviations:

MA: Medical Assistance

BHP: Basic Health Plan or Wrap-around

Appendix G: Issues for Consideration outside the Scope of this Report

During discussions, the Task Force identified a number of issues that merited consideration but were outside the scope of their work. The list below is provided as a reference for future work in health reform.

- Move to a model where long term care (LTC) is rolled into Medicare.
    - With this model, LTC funding would not compete with funding for the poor.
    - There was a previous Medicare benefit for LTC.
    - Most nursing home benefits are for post-acute care.
- Consider an all-payer recommendation for the state.
- Work with federal partners to develop new funding mechanisms for medical education and research.
- Evaluate the state of public health infrastructure, including funding for the core functions of Minnesota's state and local health departments.
- Develop a more robust oral health plan to address access for all Minnesotans.