Roadmap to a Healthier Minnesota

**Recommendations of the
Minnesota Health Reform Task Force**

November 29, 2012

DRAFT

Executive Summary

Will be drafted following review of the draft by the Task Force.

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I. Introduction

Minnesota has long been recognized as a national leader in health and in health care. We have robust insurance and high-quality health care systems. 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 and health providers come together to solve issues with a common commitment to improving the health of our state.

While we continue to compare favorably to other states and despite our ongoing attention to improving health and health cares, several formidable challenges face Minnesota. These challenges are reflected in Minnesota's drop from being the #1 overall most healthy state in 200X to being ranked 6th in 2011, according to United Health Foundation's Health Rankings report. The Roadmap 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, according to Minnesotans, health care costs in Minnesota are increasingly unaffordable.[1] This opinion is corroborated by Department of Health forecasts, showing that without reform health care spending is projected to double over the coming decade.[2]

GRAPH

As costs and spending have increased, our uninsured population has grown—up from only 6.1% in 2001 to 9.1% in 2011.[3] While new coverage options will be available in the health insurance exchange beginning in 2014, the issue 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.

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[1] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

[2] 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

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

The second major challenge for Minnesota is the health of our population overall, which, while generally good relative to other states, is poor in some areas and 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.[4] If unchecked, these trends will contribute to an increasing number of Minnesotans with preventable chronic conditions and continued growth in our health care spending. Deteriorating health status trends that began to emerge in the last few decades already drive a large portion of health care cost growth we see today, with 75% or more of total costs now being spent on significantly preventable chronic conditions.[5]

GRAPH

A third critical challenge for our state is the persistent disparities between the healthiest Minnesotans and the least healthy among us. Although Minnesota has made gains in reducing health disparities over the past twenty years, communities of color and American Indians still experience shorter life spans, higher rates of low birth weight and infant mortality, higher incidence of diabetes, heart disease, cancer and other conditions.[6]

Finally, we also face the challenge of variation in health care quality across the state. For example, Minnesota Community Measurement reports that 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.[7] These rates may actually exceed that of other states overall, but they are 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 for overuse of services, and for missed opportunities to coordinate and integrate care. Addressing these quality opportunities now is critical, as Minnesota's population is aging and with increased age comes an increased demand for health care services. [8, 9]

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

[5] 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

[6] 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

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

[8] The fasting 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

Recognizing the urgency and scope of the challenges facing Minnesota, Governor Dayton appointed the Health Care Reform Task Force in November 2011 under 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 reform, including the Affordable Care Act. The Health Care Reform Task Force recommendations address these challenges and recommend fundamental changes in provider payment and methods of delivering care, and consumer and community activation to build healthier lives and healthier communities.   The recommendations in the Roadmap recognize that every Minnesotan, including consumers, employers, providers, as well as health plans and government, has an essential role 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 our system and addressed difficult challenges head on, including the Minnesota Health Care Commission in the 1990's that created MinnesotaCare, 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. This willingness to continually improve is one of the reasons that Minnesota has one of the highest performing health care systems in the nation. The 2011-12 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 recognized that health reform is an evolving process and hoped 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 was appointed by the Governor with 17 members, and chaired by Commissioner Lucinda Jesson of the Department of Human Services.   The Commission members and their affiliations are detailed in Appendix A.

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[9] 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: 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

Executive Order 11-30 provided the Task Force with the authority to create and oversee work groups on key health issue areas 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.[10]

Members of the Task Force were tasked in the Executive Order with "providing 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 financing mechanisms to improve health care affordability and achieve equitable sharing of costs among all payers; and

c. Development any 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 Task Force established four distinct work groups charged with developing specific recommendations within their respective domains. All members of the Task Force were requested to be involved in at least one work group and Exchange Advisory Task Force members were also 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.

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[10] 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

- **Access** (Chaired by Ralonda Mason, St. Cloud Area Legal Services): The Access Work Group was charged with identifying opportunities to encourage consumer choices based on quality and cost of care, including adoption of shared decision making. 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 138-200% FPL; reviewing strategies for Minnesotans to easily learn and get answers about their coverage and 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): The Care Integration and Payment Reform 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): The Prevention and Public Health 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 the Minnesota Department of Health's statewide health needs assessment, Healthy Minnesota 2020.[11]

- **Workforce** (Chaired by Dr. Therese Zink, University of Minnesota): The Workforce 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 the development of the Roadmap, the Task Force established a series of principles to guide its work and recommendations.[12] Starting on November 14, 2011, the Task Force met on a monthly basis to hear from health care experts, discuss issues relevant to the mission of the Task Force and review the emerging recommendations of the work groups.

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

[12] The Task Force principles are attached as Appendix B to this report.

The Task Force and its constituent work groups held 62 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 1500 people attended these meetings with over 100 individuals and organizations providing public comments at the meetings. In addition to the verbal testimony at meetings, individuals and organizations also shaped the recommendations through over 500 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 the 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 translate into support from every member for each recommendation outlined below.

Citizen Engagement in Health Reform Priorities of Minnesotans

The 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 generously funded a 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.[13]

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.

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[13] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

3. Encourage the redesign of institutions and creation of environments that help reinforce healthy daily choices.[14]

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 contracting for Minnesota Health Care Programs.
	2. Explore possible improvements to and expansions of the health care home program.
II. **Support Patient-Centered, Coordinated Care**	3. Facilitate improved integration of behavioral health and primary care services.
	4. Support appropriate coordination and integration of health care, long-term care, public health and social services in Minnesota Health Care Programs Total Cost of Care 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.
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 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

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[14] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

		targeted career advancement; increasing wages of direct care workers employed in nursing homes and in-home care; and by supporting innovative adult training programs, such as the existing FastTRAC program.[15]
		12. Increase the number of health professionals in underserved areas by increased 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 Program recipients.
		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 the evidence-based Diabetes Prevention Program as a 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 phone supports, and offer screening and referral for substance abuse issues.
		18. Monitor and evaluate the impact of recent school-health reforms (including the 2010 federal Healthy, Hunger Free Kids Act) on the health of K-12 students and develop a gap analysis to guide future state policy development.
V.	Engage Communities	19. Identify the most proven State 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.

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

		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. Enhance 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.
		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 138-200% of the Federal Poverty Level at a level equivalent to MinnesotaCare, at a minimum.
		29. Consider that the Minnesota-based benchmark options for the Essential Health Benefits 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. The strategies

outlined in this Roadmap realign the incentives throughout the system to better leverage our funds and enable us to slow our spending, 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, and
- 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.
- 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.[16] 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

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[16] 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

relationships among primary care clinicians, hospitals, specialty physicians, long-term care service providers 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 so that the practices can provide higher intensity support to patients with 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 system to enhance value.

Strategy Element #1: Advance Total Cost of Care contracting for Minnesota Health Care Programs.

There is growing indication that TCOC contracting produces better value than fee-for-service care on several dimensions, including cost and quality.[17] [18] 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,[19] 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 recommends that DHS advance TCOC contracting within Minnesota Health Care Programs by DHS and DHS-contracted health plans with provider organizations over three years, building off the existing Health Care Delivery System (HCDS) demonstrations

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

The Department of Human Services (DHS) and the Minnesota Department of Health (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. Mechanisms should include 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-

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[17] Mathmatica, 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

[18] 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

[19] 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

centered medical home. Such exploration should keep in mind the need for evidence-based support for both the current program and for alternative models.

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 Citizens Solutions, the Task Force heard that Minnesotans see a "healthy" life as one that seeks the balance of the mind, body and spirit.[20] The health care system, however, currently does not acknowledge this view of health, is fragmented 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. In contrast, patient-centered care is holistic and recognizes that a person's health is determined by 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.[21] 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.[22] As the number

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[20] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

[21] 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

[22] 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

of chronically ill patients rises, so too does the need to provide behavioral health intervention in a coordinated way. Therefore, the Task Force recommends supporting integration of behavioral and primary health care generally and specifically through a) 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[23] 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 for 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 contracts. While the TCOC-contracted provider entities[24] 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.[25] 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 the health of the patient. Specifically, the Task Force recommends that TCOC provider entities shall begin to coordinate medical/surgical and mental health/substance abuse 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.

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

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[23] 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

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

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

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 their uninsured populations.

Strategy Element #6: Address barriers to clinically appropriate data sharing while rigorously protecting against unauthorized sharing and disclosure. The ability to share information between health care providers—and public health, behavioral health, long term care, and social service providers—is essential to integration of care, advancement of Total Cost of Care 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, accountable care organizations, and total cost of care arrangements successful, all while preserving patient protections as advanced by the Minnesota Health Records Act.

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. 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), 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

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c) 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.

Strategy III: Prepare and Support the Health Provider Workforce

The Opportunity: Minnesota is suffering from a primary health care workforce shortage.[26] As a professional industry, health care depends on the presence of a robust, skilled health care, and in particular, a strong primary care workforce. Compounding the concern is the fact that a large segment of the primary health care workforce is nearing retirement while fewer medical students choose primary care as their specialty.[27] These workforce shortages are particularly acute in the 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).[28] 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 is 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:

- 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;

[26]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
[27]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
[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

- 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 extend workforce capacity.

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 would be 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. Understanding the licensing, supply/demand, working conditions and other issues possibly related to implementation of the Nurse Licensure Compact is important to workforce and health reform planning.

Strategy Element #10: Increase the supply of 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 in

Minnesota, 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:

- Increase MERC formula grants with the existing formula.
- Encouraging CMS 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 150 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 by supporting innovative adult training programs such as FastTRAC. Minnesota's population is rapidly aging and as a result there will 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. 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 increased 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're 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 psychologists, social workers, Licensed Alcohol

and Drug Counselors, dental therapists and advanced dental therapists, dental hygienists occupation therapists and physical therapists.

Strategy Element #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 Program recipients. When insurance coverage options expand in 2014, it will be critical for beneficiaries 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, 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.[29]

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 requires 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) 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 physicians 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.

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[29] 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

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.[30] In Minnesota, 13.7 percent of pregnant women received inadequate or late (2nd or 3rd trimester) prenatal care,[31] 15.2 percent of pregnant women smoked during their pregnancy,[32] and 4.3 per 1,000 children 12 years and younger are abused or neglected.[33] 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 and well-being, school readiness, and economic self-sufficiency.[34] 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.[35] 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 the evidence-based Diabetes Prevention Program 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.[36] National studies suggest around 35% of persons have pre-diabetes, which translates into an estimated 1.5 million Minnesota adults today.[37,38, 39] Diabetes has tremendous chronic societal and personal costs. Estimates from 2006 suggest that

[30] 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.

[31] 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.

[32] 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.

[33] 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.

[34] 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.

[35] 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

[36] 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.

[37] 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 .

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

people with diabetes incur around $11,744 in medical expenditures each year in comparison to $2,935 for persons without diabetes. About $6,600 of this difference is directly attributable to diabetes.[40] The Diabetes Prevention Program is 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 Diabetes Prevention Program's (DPP) lifestyle intervention reduced new cases of diabetes by 58% over a 2-3 year period compared to placebo.[41] Ten years from the start of a DPP study, there was a 34% reduction in diabetes incidence among participants who received the lifestyle intervention.[42] Therefore, the Task Force recommends directing the Department of Human Services to make the Diabetes Prevention Program (DPP) a statewide reimbursed benefit 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 phone 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.[43] School-based services offer an opportunity to 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.

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

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

[40] 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.

[41] 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.

[42] 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.

[43] 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.

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.[44] Rather, health status is the product of many conditions and factors including living 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.[45] Recognizing that health is primarily determined by factors outside of the health care system demands that we look beyond the systems of care and towards our communities for the solutions. Yet, only about 5% of health expenditures are spent on population-level prevention efforts.[46] Minnesotans have expressed a willingness to shift this emphasis and assume a greater role in supporting health in their communities.[47] Therefore, the Task Force recommends that Minnesota move towards 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. 75% 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.[48] 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

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[44] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

[45] 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.

[46] 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.

[47] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

[48] 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

funding for SHIP is at $17 million per biennium and will expire in June of 2013. The program faces termination in 2013 without additional funding. The Task Force recommends evaluation of the impact of SHIP infrastructure and programs to determine return on investment for the approach and whether funding should be continued past June 2013. Although SHIP supports and funds specific and targeted initiatives, the results are often diffuse across systems and spread out over time. Specificity regarding outcomes will be necessary to provide rationale to support expanded funding for the program.

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.[49] 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." These will build on the existing Community Care Teams pilots: multidisciplinary, locally-based teams that partner with primary care practices, hospitals, 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. Specifically the Task Force recommends that MDH should select up to 10 diverse Accountable Communities for Health two-year pilots and work to implement integrated delivery system and payment models within the ACHs.

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 what is in place in 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

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[49] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

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 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% annual commercial premium increase between 1999 and 2009) is unsustainable. Together the strategies detailed throughout this Roadmap will create the systemic transformation necessary to slow this growth while improving quality. However, in order to ensure that all stakeholders are doing their part to help the system is making sustained progress over time, the Task Force recommends the creation of a public-private partnership that will make recommendations to the Legislature for annual, publicly-reported performance targets over five years, including targets for 1) maximum per capita change in medical expense; 2) annual improvement in population health (i.e., the health status of Minnesotans); 3) 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 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:

Target	SFY15	SFY16	SFY17	SFY18	SFY19
Growth	CPI[50]+1%	CPI	CPI -1%	CPI -2%	CPI -2%

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[50] The 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.

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 Minnesota Departments of Health and Human Services 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 is to improve identification and tracking of health disparities by addressing gaps in existing data collection on race, ethnicity and language among the state agencies and health care providers.[51]   In 2012, the Race Ethnicity Language (REL) Data Workgroup issued an initial set of best practice recommendations for collection of REL data, and a standard set of granular REL categories that all providers and payers should consider using.[52] Currently, many clinics and hospitals are beginning to collect, report on, and use REL data, but collection is not consistent across payers, making it difficult to compare results or to develop resources and support for practice improvements that might reduce disparities. Therefore, the Task Force recommends , developing streamlined and cohesive collection and reporting practices and mechanisms for race and ethnicity data, and supporting providers and payers in implementing the collection of expanded REL data categories. This improved methodology will enable the state to more effectively target and evaluate interventions aimed at eliminating health disparities.

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 return on investment for state-funded public health programs could help to 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 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

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[51] 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

[52] 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.

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. In order 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, the Task Force recommends that MDH, in close consultation with community-based quality improvement and performance measurement groups and the Department of Human Services, should guide, but not necessarily perform, a comprehensive performance review of TCOC-contracted provider entities and individual provider organizations using standardized measures. Specifically the Task Force recommends that MDH, drawing on 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, should 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.

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.[53] Further, health plans may not offer or be successful in selling products that provide consumers with benefits for selecting higher value providers or services.

Strategy Element #25: Increase the market availability of health insurance products that foster consumer accountability for health behaviors and creating 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

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[53] Citizen Solutions (2012). Public Conversations & Public Solutions: Making Health and Health Care Better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

high value providers and/or high value services. Specifically, the Task Force recommends that the Department of Commerce, in partnership with MDH, should identify existing commercial insurance products that foster consumer accountability for health behaviors and create incentives for use of high value providers and high value services, 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, MDH and SEGIP 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: Increasing Access and Supporting 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.[54] In order to ensure that 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. The Affordable Care Act (ACA) allows states to expand Medicaid eligibility to low income Minnesotans up to 138% FPL. For states like Minnesota that already cover individuals above and beyond minimum federal requirements, this will mean availability of additional federal resources to help the state pay for people who they already cover. As a result of this increased federal funding, the Medicaid expansion to 138% of the federal poverty level (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.

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

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[54] 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.

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 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 138-200% of the Federal Poverty Level. 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 supports to make coverage affordable and meaningful, similar to those available through MinnesotaCare today. These supports could be provided either through a Basic Health Plan or through provision of enhanced benefits and premium supports in the exchange. Given the lack of guidance from the federal government on these options at this time (and the corresponding financial unknowns for the state budget), the Task Force recommends that the state maintain its goal of providing nominal cost-sharing and comprehensive benefits for this population, consistent with our current approach in MinnesotaCare. As is financially possible, the state should also strive to reduce those premiums to address the existing affordability gaps in MinnesotaCare.

Strategy Element #29: Consider that the Minnesota-based benchmark options for the Essential Health Benefits would provide generally similar benefits and that an ongoing mechanism for review and stakeholder feedback on the EHB is needed. Consider that the Minnesota-based benchmark options for the Essential Health Benefits for 2014-16 would provide generally similar benefits and an ongoing mechanism for stakeholder feedback on the EHB is needed. The Task Force reviewed the Minnesota-based benchmark options under federal guidanceand found that the differences between the options did not appear to be substantial.[55] 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 conduct periodic review of the Essential Health Benefits (EHB) to ensure that it maintains an appropriate balance of coverage and cost. This review should include an on-going mechanism for community and stakeholder discussion and

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[55] 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

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, the connection with these consumers presents an opportunity 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 the 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 that 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.

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 system of health care providers and communities 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. 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 Members

Member Name	Affiliation	Work Group
Commissioner Lucinda Jesson, Task Force Chair	Minnesota Department of Human Services	Access, Prevention/Public Health
Commissioner Mike Rothman	Minnesota Department of Commerce	Access
Commissioner Ed Ehlinger	Minnesota Department of Health	Care Integration/Payment Reform
Senator Sean Nienow	Minnesota State Senate	Care Integration/Payment Reform
Senator Michelle Benson	Minnesota State Senate	Prevention/Public Health
Representative Steve Gottwalt	Minnesota House of Representatives	Access
Representative Joe Schomacker	Minnesota House of Representatives	Workforce
Peter Benner	former Executive Director for AFSCME Council 6	Care Integration/Payment Reform
Mary Brainerd	President and CEO, HealthPartners	Access
Michael Connelly	former Senior Vice President for Strategy and Planning, Xcel Energy	Prevention/Public Health
MayKao Hang	President/CEO, Amherst H. Wilder Foundation	Access
Jan Malcolm	CEO, Courage Center	Prevention/Public Health, Care Integration/Payment Reform
Ralonda Mason	Supervising Attorney, St. Cloud Area Legal Services	Access (Chair)
Judy Russell-Martin	Board Member, Minnesota Nurses Association	Workforce
Dale Thompson	President and CEO, Benedictine Health System	Care Integration/Payment Reform
Dr. Doug Wood	Professor, Mayo Clinic	Care Integration/Payment Reform (Chair)
Dr. Therese Zink	Professor of Medicine, University of Minnesota	Workforce (Chair)

Appendix B: 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.

Additional appendices here