DRAFT Working Paper to Support Recommendations

The purpose of this outline is to:

- Capture ideas from Hennepin Healthcare Advisory Task Force discussions thus far, and;
- Help the Task Force decide which ones to flesh out for inclusion in the first Task Force report as specific proposals, and which ones to set aside or refer to some other group to consider (such as the Health Subcabinet, MDH's Center for Health Care Affordability, UMN researchers, or others).

Policy Context

- What is health care? The nation has a very mixed and inconsistent view. Is it a market commodity, a right, a necessary public utility? A part of the economy and the stock market we count on to continue growing? All of the above?
- Financial instability is not unique to HHS but is exacerbated by its payer mix and served populations.
- Health care finance as Jenga tower. In a highly balkanized financing system with ever more separate and selected risk pools, delivered largely through a competitive private market, public goods get squeezed out. Growing costs squeeze out margins on all markets, making the old model of cross-subsidizing insufficient public program reimbursement rates with commercial rates less and less tenable. Providers continue to compete for market share and profitability, and they are neither responsible for nor incentivized to provide those public goods beyond their own sense of mission and rather limited legal requirements on not-for-profit status.

Conclusions relevant to recommendations

- Under current incentives and federal and state policy, rates of uncompensated care will continue to grow and will not be equitably distributed among populations or the providers that serve them.
- There are some factors in driving costs that are outside of HHS (and other hospitals') control. One notable factor is extended unreimbursed lengths of stay due to lack of discharge options. A strong message from our hospitals is that a large part of their cost structure is driven by providers' limited ability to negotiate lower input costs for equipment, IT, prescription drugs, and labor, costs which are rising much faster than inflation and in many cases are driven by for-profit sectors making very large margins.
- If/when HR1 is implemented in its current form, the more Medicaid patients HHS serves, the larger its operating losses will be. At present, HHS-specific enhancements to Medicaid rates do help to cover costs for that population but do not produce a margin sufficient to support its broader public mission.
- The state's whole health care system is interdependent. All providers count on HHS's capacity for trauma services, behavioral health, etc., and could not absorb its volume. If HHS were to close or significantly reduce its scope of services, groups consulted in recent months as part of the Advisory Task Force's work pretty unanimously agree that many Minnesotans would lose access to care.

- Some changes will be specific to Hennepin Healthcare System (HHS) in response to the statutory charge recognizing its role in the statewide health care ecosystem. Other changes should benefit all providers and help to adjust some of the market's perverse incentives.

DRAFT Areas of Recommendations

System-wide areas of possible recommendations

These proposals address the financial stability concerns of HHS but also those facing most Minnesota health systems. Beyond direct impacts, HHS's stability would also be improved by decreasing the significantly disproportionate share it currently carries of uncompensated care and public program patients.

1. Uniform definitions of key terms should be used to shape policy.

- The TF charge is to make recommendations to ensure that HHS can continue to deliver on its "public mission". We will define what that is and define the terms "safety net" and "public goods".
- **"Public mission"** is an umbrella term encompassing being a "safety-net" provider and delivering "public goods" such as teaching and readiness for large scale emergencies.
- **"Safety-net"** is defined as serving all patients without regard to insurance status or ability to pay. This is beyond emergency care which all hospitals must provide under EMTALA. This includes providing primary and preventive care to a complex patient population and is quantified by % of revenue above X from government payers, and uncompensated care volume above Y. Uncompensated care is further defined as the costs incurred for patient care provided that is not reimbursed. Uncompensated care is the combination of charity care provided to low-income patients, and the "bad debt" of patients who are relatively higher income, are un- or under-insured, and do not pay bills owed to health systems for care provided.
- **"Public goods"** is defined as services that the market does not provide but on which the public and the broader health care system rely.

2. Raise Medicaid rates.

- All providers would benefit from a change that creates incentives for all providers to serve public programs. Medicaid rates should be raised to a level at which efficient providers can at least break even.
- Increasing or maximizing Medicaid payment rates is an equitable lever that could ease cost shifting to commercial insurance.
- Medicaid rates should be further risk adjusted to account for social as well as clinical conditions and should be tied to patient and population outcomes.
- Currently health systems count Medicaid underpayment as the largest part of their "community benefit". If Medicaid no longer produced automatic losses, community benefit that is expected of non-profits could be focused on other "safety-net" services and other "public goods".

- There is broad acknowledgment that health care is already unaffordable for employers, state and local budgets, and people, so raising provider rates likely needs to be funded at least in part by offsetting savings somewhere in the system.

3. Fund uncompensated care above a defined level with an uncompensated care fund.

- All hospitals provide some charity care that results in uncompensated care, some care to public program enrollees, for whom reimbursement does not fully acknowledge cost of providing that care, and care to un- or underinsured patients who do not pay for care. This should be expected of all non-profit hospitals, and an expected threshold for uncompensated care should be explored
- Safety net hospitals (as defined above) should be eligible for payment of uncompensated care above a set level. This could be funded by a tax mechanism assessed on all providers, in which documented uncompensated care could be fully deducted.

4. Address gaps in the continuum of care that cause lengths of stay in acute care hospitals beyond what is clinically needed.

- Specify these gaps (step down rehab, secure behavioral health units, nursing homes, and home and community-based services, etc.), direct funding to fill the gaps (could be a task for a network of specifically public entities with appropriate funding), and change policy to ensure admittance when capacity allows

5. Acknowledge dynamics of current reimbursement structure.

- Unless and until the current private market delivery model and reimbursement systems are fundamentally changed, the state (and federal government) should decouple funding for safety net functions and public goods from competitive, privately negotiated rates for populations covered for medical care services and create a more robust safety net and public goods strategy to support HHS and others providing these functions.

6. Identify and address data needs to identify where gaps in care occur and where concentration of public goods occur and inform how they might be addressed.

- In partnership with the Department of Health and Task Force Members, explore what additional information the Task Force needs to identify and address gaps in care ahead of the final report, and what additional information the legislature and state agencies need from all systems to inform future policymaking

Hennepin-specific areas of possible recommendations

Hennepin Healthcare System's public mission in addition to its role as Minnesota's largest safety net health system can be described in three categories on which the overall health care system and other public functions relieve (like public safety, corrections, etc.). (Working to quantify added costs requiring subsidy):

- Established regional assets (e.g., Level 1 trauma, burn/complex wound, hyperbaric, Poison Control)
- Less-visible specialty access gaps (e.g., behavioral health, dental, eye care, addiction medicine)
- Complex-needs care across specialties (e.g., housing instability, interpreter needs, extreme poverty)

1. Expand the funding, ownership and governance of HHS to reflect its status as a critical statewide asset.

Hennepin Healthcare System's role as a statewide asset has been well established. Hennepin County should no longer be the sole financial backstop for HHS operating losses, or its sole governing authority. There should be ongoing and predictable support from a variety of sources. Funding should be tied to operational, financial, and quality performance.

- Different organizational forms for HHS should be considered (hospital district, consortium of partners, etc.)
- If the current corporate structure is kept, Hennepin County should no longer be the sole member of the entity. The County should have a role in governance, assuming it continues to own the facilities and provide consistent funding to support care of County residents and public health functions, but not a controlling role.
- Financial risk and governance must be aligned. Financial support should be reflected in the governance structure.
- Governance and management roles must be clarified and adhered to. Accountability must come with operational authority.
- All board members should have the same level of responsibility and influence on the board, except where positions as Officers suggests otherwise; all board members should share the same fiduciary responsibilities and adhere to the same standards regarding conflict-of-interest, and; the Board's role should be overall governance of Hennepin Healthcare, which should be distinct from day-to-day operational management, which is delegated to the Leadership Team of HHS, Inc.
- Assure public accountability through organizational structure, governance and bylaws.

2. Expand HHS's public mission by increasing availability of the services which benefit the whole ecosystem.

- Add new funding mechanisms/direct appropriations/subsidies not tied to patient care rates to support specific services (similar to how Poison Control is funded now).

3. Explore partnerships consistent with HHS's public mission.

May include:

- Whether more coordination among trauma centers is helpful
- How best to optimize the relationship with UMN
- Coordination with other public systems (Direct Care and Treatment, MN Dept. Of Veterans Affairs, others?)
- Explore service line coordination with other tertiary hospitals

4. As an alternative to expansion, evaluate the consequences of narrowing HHS services.

- Consider impacts of winnowing HHS services down to a "core" that would still likely require subsidy by public support from some source. What that core should be would need to be defined and would likely include services necessary to maintain Level 1 Trauma accreditation, and maintenance of Burn, Hyperbaric, Mental Health and Addiction Medicine, Medical Education, and others.)
- Must consider tradeoffs to loss of services, downstream effects on other systems, and public services (e.g., corrections and public safety)
- If HHS stops any services, identify who will fill the gap (including non-clinical services)

Summary of HHS and system-wide impacts of possible recommendations

- A new and expanded organizational model for HHS with new and strengthened partnerships
- Expanded funding sources for HHS with commensurate expanded governance, and for other defined safety net and public goods providers
- A strengthened public mission for HHS
- Improved cost structure via collaborations
- A more robust safety net and public goods approach for Minnesota
- Increased Medicaid rates
- Increased medical education funding
- A larger statewide uncompensated care pool
- Additional revenue sources for other identified public goods