HEALTH CARE ACCESS COMMISSION

MINUTES

Chair Thomas Huntley called the thirteenth meeting of the Health Care Access Commission to order at 10:21 a.m. on Wednesday, December 12, 2007, in Room 10 of the State Office Building. A quorum was not present. The clerk noted the roll:

Commission Members Present:

Rep. Huntley, Co-Chair
Sen. Berglin, Co-Chair
Rep. Abeler
Rep. Thissen
Rep. Loeffler
Sen. Paul Koering
Sen. Tony Lourey
Sen. John Marty

Commission Members Excused:

Rep. Steve Gottwalt
Sen. Julie Rosen

Other Members Present:

Sen. Ann Lynch
Rep. Erin Murphy

Scott Leitz, Assistant Commissioner, Department of Health, gave a presentation on the Governor's Transformation Task Force, Payment Reform. Discussion followed.

Dr. Jamie Sledd, DDS, President, Minnesota Dental Association, expressed the Association's concerns about one of the Abeler/Lynch Work Group recommendations. Also testifying:

Dominic Sposeto, Minnesota Dental Association

Discussion followed. Chair Huntley stated the commission will hear from the dental hygienists at a later date.

Health Care Home Recommendations

1, Minnesota should establish health care homes in the state public programs. (Identifying Health Care Costs/Savings Recommendation #1). See below:

Health Care Home Recommendations

1. Require DHS to implement a health care home and disease management program for all Medicaid fee-for-service enrollees. The program would:

-- provide incentives for enrollees to choose a health care home, and when appropriate, participate in a disease management program;

-- deliver care through local community health networks, comprised of

physicians and other providers, hospitals, health departments, and departments of social services;

-- require each network to designate at least one clinical director and a medical management committee, and to implement ongoing quality improvement activities;

-- provide each community health network with a per member per month case management fee, to pay for case management and disease management activities, and to hire case managers and other staff;

-- provide each health care home provider with a per member per month health care home fee for access and disease/population management activities;

-- require each network to implement program-wide disease management initiatives, and allow networks to implement local disease management demonstration projects;

-- provide administrative support and clinical support and training to networks; and

-- set outcomes using claims data, electronic records, and chart reviews.

2. Require managed care plans, as a condition of contract, to adopt a health care home model for serving state health care program enrollees. DHS would collect from plans any data necessary to monitor implementation, measure quality, and determine plan savings. Savings from the use of health care homes would be split among the state, providers, and the managed care plan. DHS would provide a performance incentive for expenses related to the operation of health care homes, that would reimburse up-front costs after a one-year lag, rather than the normal two-year lag.

3. Require managed care plans, as a condition of contract, to operate disease management programs. Plans would be required to operate disease management programs for those conditions for which programs are required under fee-for-service. Managed care plans could operate additional disease management programs. DHS would collect from plans any data necessary to monitor implementation, measure quality, and determine plan savings. Savings from the use of disease management programs would be split among the state, providers, and the managed care plan. DHS would provide a performance incentive for expenses related to the operation of disease management programs, that would reimburse up-front costs after a one-year lag, rather than the normal two-year lag. DHS would establish quality and performance standards for disease management programs, and these standards would be subject to a capitation rate withhold.

Senator Lourey moved to amend health care home Recommendation 1, the fourth bullet, as follows:

replace "case management" with "care coordination" in two places

replace "case managers" with "care coordinators" in one place

-- provide each community health network with a per member per month ~~case management~~ care coordination fee, to pay for ~~case management~~ care coordination and disease management activities, and to hire ~~case managers~~ care coordinators and other staff;

The motion prevailed.

Co-chair Berglin discussed providing incentives for the health care holder (Randall Chun, House Research, will provide language to insert at a later date).

Rep. Loeffler wants to tie to performance standards before getting paid.

Co-chair Berglin moved Recommendation #2 incorporating Rep. Loeffler's idea to expand funding for primary care and provide incentives for training primary care physicians in underserved areas. The motion prevailed.

Co-chair Berglin moved adoption of Recommendation #3. The motion prevailed. and out of time. Tom adjourned the meeting.

Rep. Murphy advised that there was concensus on the issue of people working to the top of their license and that discussion continue within the commission.

Berglin directs Randy Chun of House Research to add language later adding "providing incentives for people at risk for developing health care homes based on assessment…" fee for service and managed care system the care coordination …health care plan's responsibility to

Randy Chun, House Research, outlines subparagraphs of discussion:

1. **Expand funding for primary care and rural physician training incentives. U of M and Mayo Medical School (Identifying Health Care Costs/Savings Recommendation #2a)**
2. **Expand funding for an existing health care professional loan forgiveness program administered by MDH. (Identifying Health Care Costs/Savings Recommendation #2b)**
3. **Support efforts a Community Paramedic pilot program by MDH. (Identifying Health Care Costs/Savings Recommendation #2d)**

   According to Mark Schoenbaum of the MDH's Office of Rural Health and Primary Care, a pilot with the American Indian tribe in Prior Lake is being planned. In addition, pilots are being considered for other rural areas (locations not specified). The concept would be of most use in rural areas, especially in areas without a medical clinic or hospital.
4. **Develop 'Advanced Dental Hygiene Midlevel Practitioner'. (New Cost Containment Recommendation #4)**

   See Attached Handouts On This Subject
5. **Insurance products should be required to cover preventive care and early diagnostic tests, at 100% before the deductible. (Insurance Market Reform Recommendation #2)**

   See Attached ICSI Guidelines On Preventive Care
6. **Insurance products should be required to cover chronic care coordination and cost effective prescriptions at 100% before the deductible. (Insurance Market Reform Recommendation #3)**

   See Sample ICSI Guideline On Diagnosis And Management Of Asthma Guideline For Patients And Families
7. **Establish a set of limited statewide health improvement and health outcome goals and encourage the use of them by insurers as the**

standardized basis of 'pay for performance'. (Insurance Market Reform Recommendations #4)

Adopted health care home recs.

Chair Huntley adjourned the meeting at approximately 12:26 p.m.

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Thomas E. Huntley, Chair

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Jan Horner, Committee Legislative Assistant