

**Development of New Cost Containment Strategies**  
**Working Group Recommendations to the Health Care Access Commission**  
**November 5, 2007**

**Introduction**

The purpose of this working group was to explore and develop new cost containment strategies in the health care system recognizing that there is a need to find ways to curb the growing cost of health care without sacrificing efficiency and quality. The work group has identified several important initiatives that could create savings within the health care system, especially when compared to what the cost may be if such changes were not initiated. The working group also recognizes and acknowledges that these initiatives are not likely to, in and of themselves, address the long-term problems facing today's health care delivery system and that nothing short of a major reform is needed to effectively address the problems facing the current health care system. The reform must incorporate universal coverage that provides coverage and access to basic health care to all; coordinate care in order to deliver effective and appropriate care; increase quality and patient satisfaction by developing a definition of value based upon the needs and preferences of patients, outcomes, safety, and cost; and create payment reform that incentives for providers to coordinate care, improve care, and support informed patient decision making.

The specific recommendations that are being brought forth by this working group in order of ranked priority are:

1. Implement an evidence-based benefit set that emphasizes value and encompasses both procedures and technologies.
2. Identify ways to reduce costs within the state public health care programs both at the state and clinical level.
3. Increase investments in public health services.
4. Increase access to dental care services and improve the delivery of oral health.

There were a number of proposals that were discussed by the working group that were recognized as potentially having cost savings but were not included in the specific recommendations since it was the understanding of the group that these issues were being explored by other work groups. The work group felt that the importance of these issues were great enough to at least mention with the hope that they continue to remain as part of the overall reform discussion:

1. The need to increase payments for mental health services that would, if adequately funded, reduce costs in other areas such as emergency room visits.
2. Emphasize the need to invest in prevention and primary care services.
3. Emphasize the importance and the need to implement Amedical homes<sup>≡</sup> for enrollees of the public health care programs.
4. Ensure adequate funding for statewide health prevention plans for heart disease and stroke, asthma, diabetes, and cancer.

5. Reform the payment reimbursement system to ensure providers and plans are paid in a way that improves health and minimizes waste.

**Recommendation #1: Establish a methodology to create evidence-based benefit sets that encompasses both services and new technologies to ensure that the benefits, procedures, and technologies that are covered are safe, cost effective, and have been proven to be scientifically based.**

Encompassed in this recommendation is the use of scientific evidence to determine both broad-based policy decisions (coverage decisions encompassing benefit sets – services, new technologies, and procedures) and individual medical decisions (made by individual physicians and patients).

**Strategies:**

1. Develop benefit sets and policies that are evidence based.
2. Develop a program to conduct systematic evidence-based assessments on new health procedures and technologies.
3. Design cost sharing in order to encourage the enrollee to seek out the most effective evidence-based care.
4. Review current state mandated health benefits.

**Problem Issue:**

The working group, in ranking this recommendation as their number one priority, recognizes that there is a need to create benefit designs and to make purchasing decisions in a way that reduces inappropriate care, and identifies and rewards the use of evidence-based medicine and best practices. Current systems and designs all too often do not encourage the use of effective low-cost care nor do they discourage the use of services where medical evidence regarding efficacy is lacking or nonconclusive.

The working group also recognizes that a good portion of the increase in health care spending can be attributed to what has been commonly referred to as the medical arms race syndrome. Increasing utilization, specialization competition among providers, current payment policies, and consumer expectations are just a few of the issues that play a role in this syndrome. In discussing this issue, the group heard a presentation from Ann Robinow. Ms. Robinow contends that the way the payment reimbursement system is currently set up perpetuates this problem by requiring providers to be the first to have the best and the latest device or risk losing market share. Consumers see a plethora of expensive high-tech medical devices and expect their providers to have access to them. The result is that many technologies are getting used simply because they exist or because there are a lot of them and not necessarily because they improve patient outcomes. According to Ms. Robinow, there is a need to redesign the way providers are reimbursed by creating disincentives for using excessive technology. Payment should be based on results and reducing the use of services with excessive supply. The working group acknowledges the need to develop reimbursement policies that promote the flow of desirable technology, while at the same time, provide incentives that inhibit the use, misuse, or overuse of technologies that add little or no additional benefit to better health outcomes.



**Past Efforts:**

Efforts along these lines have been attempted in past years. As early as 1992, the Health Care Commission recommended the need for the evaluation of technology and major expenditures in terms of safety, clinical effectiveness, health outcomes, and cost effectiveness. The idea was that the results of these evaluations would be used by health plans, employers, and other purchasers and consumers in making decisions about purchasing, using, and paying for technology. With that in mind, the Health Technology Advisory Committee was created in 1992 to make recommendations regarding the use and distribution of new and existing technologies and procedures and major capital expenditures. Furthermore, the 1992 law required that providers notify the Commissioner of Health of any major expenditure establishing a health care service, new specialized service, or other major spending commitment in excess of \$500,000. Although this law did not give the commissioner any authority to deny such expenditures, the idea was that if the commissioner determined, based on specified criteria that the expenditure was inappropriate, the commissioner could require the entity to submit future expenditure proposals to the commissioner for prior approval. The advisory committee has since been repealed; however, the expenditure reporting with some modifications is still required. (Attached is a copy of a description of Minnesota's current capital expenditure law by Julie Sonier.)

During the past several years, there has been an attempt by the Legislature to cover only evidence-based services within the publicly funded health care programs. In 2005, the Department of Human Services was required to create a health services policy advisory council. This council is required to advise the commissioner on health services covered under the state public health programs. The commissioner is also required to develop policies to encourage high-quality, cost-effective care, including determining when and for whom certain procedures and services are appropriate.

Finally, there have been voluntary efforts among the stakeholders to improve quality and the use of best practices. The Institute of Clinical Systems Improvement (ICSI), created over ten years ago, is a collaboration of regional medical groups, hospitals, and health plans that works to identify, support, and promote the use of evidence-based health care. ICSI's mission is to "champion the cause of health care quality and to accelerate improvement in the value of the health care delivered by the participating organizations to the populations they serve." This mission is addressed through collaborating on care improvement, providing scientific groundwork, supporting care improvement, and participating in community outreach. The work of ICSI demonstrates that it is possible to achieve a more patient-centered and valued-driven health care system.

**Recommendation Specifics:**

The working group has expressed a desire to incorporate an evidence-based, decision-making process in determining benefit sets, establishing protocols, mandating specific benefits, and determining whether new technologies and procedures should be covered. This process should guide the coverage and payment decisions made by purchasers, employers, health plans, and consumers regarding the allocation of resources for health care coverage. The desire is also to make these decisions more accountable and better reflect both the best evidence available on clinical effectiveness and of the preferences of those affected by these health policy decisions.

That being said, the working group acknowledges that this is no easy task, and is well outside the expertise or the time frame of this working group. However, the working group did discuss some possible avenues to continue to explore that help to achieve these goals.

- < Develop and promote benefit sets and coverage policies that are based on quality, scientific evidence, and clinical effectiveness in order to ensure the efficient expenditure of health care dollars and to maximize the care provided.

The state could look to other states, such as Oregon, in order to develop a value-based benefit set. Oregon has established a prioritized list of health care services. In creating this list, Oregon first rank ordered general categories of health services based on relative importance as gauged by public input. Within these general categories, individual condition/treatment pairs were prioritized according to impact on health, effectiveness, and cost. The resulting prioritized list is used by the Legislature to allocate funding for Oregon's public health care programs. (A copy of David Godfrey's memo on anticipated savings that could be realized by requiring prior authorization for the services that Oregon does not cover is attached.) It should be noted that there was not a consensus on adopting the Oregon prioritized list.

- < Develop a program to conduct systematic evidence-based assessments on new health technologies in order to assess its safety, efficacy, and cost effectiveness.

The focus of the program would be to rely on scientific or evidence-based information regarding safety and effectiveness to make coverage decisions and improve quality within the state health care programs. In developing this program, the state could look at the health technology assessment program that was recently created in the State of Washington. The program in Washington was implanted in 2006 to ensure that health technologies purchased by the State of Washington are safe and effective and that coverage decisions made by different state agencies are consistent, transparent, and based on evidence-based information. The program selects several technologies for a rigorous review by a technology assessment center contracted to do the assessment. Based on this assessment, the state decides whether the technology is shown to be safe and effective and whether the state, through their state health programs, should pay for the technology and under what circumstances. Each state agency participating in this program is required to comply with this determination unless the determination conflicts with an applicable federal or state statute or regulation.

Minnesota has recently created the Health Services Advisory Council (HSAC) to advise the Department of Human Services on benefit design and coverage decisions for particular health services for the state public health programs. Furthermore, Minnesota is a member of the Medicaid Evidence-Based Decisions (MED) project, which is a collaboration of state Medicaid programs housed at the Center for Evidence-Based Policy at Oregon Health Sciences University. The MED project creates reports and recommendations based on clinical evidence on the use of certain technologies and procedures. HSAC and the state's current involvement in the MED project could be redesigned to work more like the program in Washington. Furthermore, the coverage decisions that are determined through this process should not be limited to whether or not prior authorization should be applied but should determine whether the technology is covered or not covered and, if covered, under what circumstances. Finally, the use of the program and the coverage decisions generated could be

extended to all state agencies that provide state-funded health care programs, including the Department of Human Services, the Department of Employee Relations, the Department of Corrections, and the Department of Veteran Affairs. The expansion of this program would provide greater savings, and it would be the hope that the state's collaborative decision to either cover or not cover a particular procedure or technology would eventually be adopted by the private market.

- < Design cost sharing that decreases an enrollee's liability in order to encourage the enrollee to seek out the most effective care or to think twice about pursuing services that have little or no added health benefit (i.e., create lower co-payments for specific services that have proven clinical benefits).
  
- < Review current state-mandated health benefits in terms of patient safety, outcomes, cost, and utilization B several members of the working group expressed the need for a review of the current state-mandated benefits in order to make sure that the procedures that are required to be covered are evidenced based and are cost effective. Although there is currently a statute (Minnesota Statutes, section 62J. 26) requiring the Commissioner of Commerce to conduct evaluations of mandated benefit proposals, the working group had concerns that this did not effectively address the issue. It should be noted that under this statute, only the chairs of the standing committees with jurisdiction over the subject matter could request an evaluation. Also, there is no ongoing funding to the Department of Commerce to conduct these evaluations but permits the commissioner to seek funds other than state funds if no funds are appropriated.

An example of the need for such an evaluation process can be seen in the proposal that was also discussed in the working group to mandate coverage for a new wound-healing protocol in long-term care and outpatient clinic settings. The proposal also included a request that the state health plans establish a "formulary wound prevention and care program" for enrollees who have been diagnosed with chronic wounds related to diabetes. While the advocates of this proposal provided information claiming savings, this type of proposal should be reviewed by an independent evaluation process before it should be mandated by the Legislature.

**Recommendation #2: Identify ways to reduce costs in the publicly funding health care programs by requiring enrollees to complete health assessments with follow up at the enrollee's medical home and by developing a shared decision-making process for nonemergency care.**

**Strategies:**

1. Encourage all enrollees to complete a health assessment.
2. Develop the use of a shared decision-making process for nonemergency care.

**Problem Issue:**

The work group recognizes that the state has control over the publicly funded health care programs and directly benefits from any savings that could be generated from specific initiatives that are successfully applied to these programs. The working group looked at two specific initiatives that have proven to be successful within the private market but have not yet been incorporated within the public health care programs. One of the initiatives discussed involves requiring enrollees to complete a health assessment. The second initiative that was explored was creating and incorporating where appropriate a shared decision-making process between the enrollee and their provider in nonemergency cases.

**Past Efforts:**

Last year, the Legislature appropriated \$500,000 to the Commissioner of Human Services for fiscal year 2009 for patient incentive programs. The specifics of these programs have yet to be determined by the commissioner. Part of this appropriation could be used to provide incentives for patients to complete health assessments. Furthermore, health assessments have been successfully incorporated into the state health plan by the Department of Employee Relations. For the past couple years, state employees who complete a health assessment have paid a lower co-payment.

**Recommendation Specifics:**

- < Require or encourage enrollees to complete a health assessment and to participate in health improvement programs if risk factors are identified.

The working group heard a presentation by Dr. Marcus Thygeson from HealthPartners on the value of enrollees participating in lifestyle improvement programs by improving the health of the enrollees, which in turn reduces costs. Dr. Thygeson presented a lifestyle improvement case study that was conducted from 2003 to 2006 with a large manufacturing employer. The study provided a benefit incentive to enrollees who completed a health assessment and who then participated in health improvement programs if the need was indicated. The results showed an increased sustained improvement in the health of the employees; a 17 percent reduction in non-OB hospital days and an identified 3.3 percent savings on total claims.

Several states have looked at incorporating the uses of incentives in their Medicaid programs to encourage enrollees to participate in healthy behaviors. West Virginia for example, offers

their Medicaid beneficiaries a choice of benefit plans that encourages responsibility, sets expectations, and rewards success. Under this reform, beneficiaries have the option of a basic benefit plan, which includes all of the federal and state mandatory services and an enhanced benefit plan. Under this plan, the beneficiary is required to sign a member responsibility agreement. The agreement outlines the beneficiary's rights and responsibilities, including establishing a medical home, completing a health assessment, and developing a health improvement plan. Beneficiaries who sign the agreement and who work with their primary care provider to meet their set plan have access to an enhanced benefit package that provides coverage for services not covered under the basic plan such as weight management, nutritional counseling, and tobacco cessation programs.

< Develop a shared decision-making process for nonemergency cases.

Dr. Thygeson's presentation also included a discussion on the benefits of incorporating a shared decision-making process for enrollees who are candidates for elective surgery. This process would include offering the opportunity for the patient to receive formal decision support by a "nurse navigator." This person would assist the patient/provider relationship by assisting in "educating" the patient about their specific condition and treatment options, including all risk and benefits. This "navigator" would also help clarify the values and preferences of the patient to the provider and provide support through the decision-making process. Dr. Thygeson presented results of a survey involving 146 participants of a shared decision-making study. The results of this study showed that 100 percent of the participants indicated that they were very satisfied or satisfied with the decision-making process, and 99 percent indicated that they were very satisfied or satisfied with the decision they made. A Mayo study on this same concept indicated with a shared decision-making process, in place there, resulted in a 30 percent decrease in patients choosing surgery (a coronary revascularization for angina) when this specific surgical treatment was not necessarily warranted.

< Require the Department of Human Services to report to the Legislature on the patient incentive program that is to be implemented next year. This report should include a discussion on the incentives that are provided any increases realized in wellness behaviors and any cost savings in a reduction of preventable inpatient and emergency room visits associated with an increase in preventive services.

**Recommendation #3: Increase investments in public health services.**

**Strategies:**

1. Fund the local government public health system to collaborate with health care providers and others on identified public health problems such as obesity and asthma by using well-documented primary prevention and population-based approaches.
2. Provide reimbursement for public health worker consultations with primary care providers serving public health program clients.
3. Fund the Comprehensive Statewide Health Promotion Plan.
4. Continue efforts to integrate the public health system into Minnesota's e-Health initiative.

**Problem Issue:**

Public health in the United States and Minnesota is severely underfunded. This is despite evidence that almost half of all deaths could have been prevented through changes in behavior, such as reduced smoking, obesity, inactivity and alcohol use (see attached Comprehensive Statewide Health Promotion Plan). Nationally, approximately five percent of health care spending is on public health/prevention efforts. In Minnesota, we spend approximately \$30 billion on health care (public and private spending), with a much smaller percentage (less than one percent) on preventative care. Minnesota already has in place an extensive local public health system. Unfortunately, the programs and services provided are not well integrated with primary care systems. The public health system is not connected to other electronic record systems, which makes it difficult to coordinate and deliver effective and efficient care.

**Past Efforts:**

The working group heard from local public health directors of Olmsted and Anoka Counties that more integrated systems are needed. A number of initiatives are being implemented at the local level, but it is often difficult to coordinate these efforts with larger systems without the technological, financial, and relational support. The stakeholders advocated for three things to help make their efforts more successful. These included:

1. Continue to fund existing programs.
2. Expand support for services delivered at the community level.
3. Development of an information system that can securely exchange data and improve services.

There have been many efforts to increase public health investments and coordination with other primary care systems. Unfortunately, many of these efforts have been unfunded, locally driven, or not systematically implemented. Some of the efforts have included:

1. Development of reports (2005, 2007) that outline a Minnesota Public Information Network that would link the public health system with the greater e-health initiative
2. Community collaboratives in Olmsted County that bring together health care providers in a variety of areas, including the treating of asthma
3. Community Dental Clinics
4. Minnesota Task Force on Childhood Obesity
5. Steps to a HealthierUS
6. Minnesota Heart Disease and Stroke Prevention Plan
7. Cancer Plan Minnesota
8. A Strategic Plan for Addressing Asthma in Minnesota
9. Minnesota Diabetes Plan
10. Tobacco Prevention and Control
11. Arthritis in Minnesota-A Working Plan for Action
12. Children's Mental Health Collaboratives
13. The Switch Program
14. The Minnesota Autism Project and Network

**Recommendation Specifics:**

The recommendation to make more investments in public health technology and services was the third priority of the Cost Containment, Identifying New Strategies work group. This recommendation acknowledges the great disparity in funding for public health and prevention services as well as the potential for great cost savings. As Dr. David Herman from the Mayo Clinic testified, "If you decided to fund all preventive care . . . your health care costs would go up tomorrow. But . . . five years from now Minnesota will be much more competitive as a state for industry and anything else you want to compete at because your health care costs will be lower." With that being said, the group recognized that there was a separate public health group working on preventative strategies, and that is why it was ranked third.

The expectation of the working group is that the Health Care Access Commission will include the above strategies in their full report to the Legislature.

Up-front costs for increasing funding to community collaboratives and reimbursement for consultations are expected to yield future savings by increasing communications, removing service duplications and redundancy, preventing future more costly illness, and cutting administrative costs. By reducing usage of the traditional health system through preventative and community-based interventions, costs will be better contained.

The cost for implementing the Comprehensive Statewide Health Promotion plan is \$26.5 million and purports that it will reduce cardiovascular disease, diabetes, cancer, arthritis and other chronic diseases. If adult smoking in Minnesota were reduced by less than 20 percent, the Department of Health estimates a savings of almost \$500 million in medical expenses. Obesity is currently estimated to directly cost Minnesota \$500 million. It can be reasonably assumed that if the Statewide Health Promotion Plan were implemented, there would be a great deal of savings realized.

In 2007, the Department of Health requested \$750,000 to develop its Public Health Network Initiative. The benefit of electronically connecting public health departments with larger systems is that it allows a secure way to communicate and exchange data, better support public health services, and streamline delivery so that cost savings can be achieved.

Prevention programs have been shown to reduce risk and save money. In Minnesota, public health is provided through a county-based system, which allows for responding to the needs at a local level, with a statewide system of standards and accountability. Local public health departments have been successful in helping to promote healthy behaviors, reduce chronic diseases, prevent the spread of infectious diseases, respond to disasters, and ensure environmental health at the community level. Projects throughout the state have been successful in providing quality and access to health services. Some of the programs= successes across the state have included:

- ⊖ a community collaboration on treating asthma in Olmsted County B has resulted in stabilizing the health status of children with asthma and removed duplication among different settings (community, medical, school);
- ⊖ family home visiting and WIC programs have resulted in healthier babies and better nutrition choices for mothers and families;
- ⊖ community dental clinics have provided dental care to people who do not normally have access to preventative care; and
- ⊖ wellness programs in schools have provided better food choices, resulting in less obesity among children.

One of the most successful examples of investing in prevention comes from the reduction in smoking and smoking-related illness. Through research, public campaigns, policy, and legal action, smoking among adults is half what it was 40 years ago. The amount of money saved in health-related illness is significant and continues to be the number one target for prevention and public health programs. The Center for Disease Control has found that community-wide campaigns are effective in increasing

physical activity. Community collaborations have also been shown to be effective. Additional successes and results can be found in the bibliography of the AComprehensive Statewide Health Promotion Plan≡ (see attached).

#### **Recommendation #4: Increase access to dental care services and improve oral health.**

##### **Strategies:**

1. Explore the development of a midlevel dental practitioner.
2. Encourage the collaboration with public health, community organizations, and community colleges to expand clinical services and raise awareness of the importance of oral health in underserved areas.

##### **Problem Issue:**

Oral health has been described as one of the “single greatest unmet health care needs” in the country. Without access to basic dental care services, dental care for many is postponed until symptoms become so acute that care is sought in the emergency room or leads to far worse health conditions, even death. The progressive nature of dental diseases coupled with the lack of access, especially among low-income families, can significantly diminish the general health of these individuals. Evidence is mounting that suggests that individuals with periodontal disease may be more at risk for heart disease, stroke, preterm low-birth weight babies, more severe diabetes, and pneumonia and have nearly twice the risk of having a fatal heart attack. The consequence of this lack of access is not only wasteful and costly to the health care system but unconscionable. The cost of investing in preventive dental care, such as regular screening, and early intervention, and adequate access to restorative procedures is low compared to the possible savings that would be realized within the health care system.

##### **Past Efforts:**

The need for better access to dental care services has been an issue that the Legislature has struggled with for years. Last year, the Legislature appropriated \$400,000 to fund oral health care innovation grants to organizations to provide access to oral health services to low-income and uninsured individuals. The Department of Health has also organized a statewide oral health advisory committee. This committee is charged with identifying state oral health goals and the action steps necessary to meet these goals and to improve the overall oral health of all Minnesotans. Furthermore, several years ago, the Legislature expanded the scope of practice for dental hygienists working within a collaborative agreement with a dentist to perform limited oral health services to unserved populations that do not have direct access to a dental office. While this has helped, the lack of access to restorative services, which cannot be performed by these dental hygienists is still a problem. Finally, the Legislature has created a higher reimbursement rate for providers who meet the criteria of a critical access dental provider. However, this higher rate is still inadequate to meet the access crisis facing dental health.

##### **Recommendation Specifics:**

The working group heard several presentations regarding oral health. One of these presentations was on the introduction of the creation of an advanced dental hygiene midlevel practitioner master=s degree level program at Normandale Community College. There was concern expressed by at least

one member of the work group that time was not provided to the Dental Association to present their proposed initiatives for increasing access and so for the group to provide support for this initiative was premature. Furthermore, while all members were in agreement as to the importance of improving access to dental care, several members expressed the need for more information on this new level of practitioner before they could feel comfortable endorsing it. There was, at least, a consensus that this initiative should continue to be explored.

With that caveat in mind, it should be noted that the advanced practice concept is not new. Established precedents in this type of practice exists in New Zealand, Canada, parts of Europe, and over 40 other countries. An example of the successful use of dental health aides can be found in the Alaska Dental Health Aide Initiative, which is part of Alaska's Community Health Aide/Practitioner Program. This program was developed in the 1960s by the Indian Health Services, in cooperation with Alaska native tribes, to address critical health problems in rural Alaska. The Alaska Dental Aide Initiative incorporates several levels of dental health aides (DHA) ranging from a primary DHA, who provides exclusively preventive services, to a dental health aide therapist (DHAT), who is trained to do cleaning, fillings, and uncomplicated extractions, in addition to a wide range of preventive services. Both DHAs and DHATs work under the general supervision of dentists at regional hospitals. Training for a primary DHA is provided in Alaska. DHATs are educated at a two-year program at the Otago University School of Dentistry in New Zealand because there is not currently a midlevel dental practitioner training in the United States. This should change in light of the new educational program currently underway at Normandale.