Health Care Financing Task Force

***Vision:*** *Sustainable, quality health care for all Minnesotans*

Barriers to Access Workgroup

Friday, November 6, 2015; 8:30 a.m. – 10:15 a.m.

St. Paul, MN

Minutes

| **Item** | **Presenter** | **Discussion /Resolution**  |
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| **Welcome and Approval of Minutes** | Marilyn Peitso, MD | * The workgroup lead, Dr. Marilyn Peitso opened the Barriers to Access workgroup meeting. The workgroup approved the minutes from the 10/23/15 meeting for posting to the Task Force website.
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| **Discuss rural health access issues and potential options to address barriers to rural health access** | Mark Schoenbaum, MDH | * Mark Schoenbaum of MDH opened the session by reviewing the five components of access discussed in earlier meetings which includes: availability, accessibility, accommodation, affordability, and acceptability. Mr. Schoenbaum reminded the workgroup that coverage is only one component of access and that all components must work together to ensure effective access to care.
* Mr. Schoenbaum provided an overview of rural Minnesota. He defined rural areas as being divided based on commuting into four codes: metropolitan/urban, micropolitan/large rural, small town/small rural, and isolated rural. The area around Minneapolis had the highest concentration of urban areas and cities on the North and South perimeters of the state were the most rural and isolated.
* Mr. Schoenbaum reviewed data illustrating income, racial/ethnic, language and employment composition across the geography of the State. Mr. Schoenbaum highlighted that of the 20 counties with the highest percentages of non-English speakers at home, 15 are in greater Minnesota. He also discussed challenges associated with Minnesota having a majority of the economy represented by small businesses
* Mr. Schoenbaum specifically discussed challenges in accessing care related to availability and cultural appropriateness of services. He showed a map representing the availability of primary care and specialized services, including chemotherapy and dialysis, in the state which showed areas of high concentration of shortages. He commented on widespread mental health provider shortages in every county of the State with the exception of the twin cities and Rochester region. Mr. Schoenbaum also discussed the dental provider designation for Medicaid enrollees in the western half of the state. He noted that while individuals in these people may have dental coverage but are unable to obtain coverage as a result. Mr. Schoenbaum discussed the fact that the healthcare workforce’s racial composition often does not reflect the patient population.
* Mr. Schoenbaum discussed the key takeaways from the session stating that the components which comprise access to care varies significantly across the State. He concluded that while Minnesota’s race, ethnicity, and culture, especially in the rural part of the State, is quickly changing, the health care workforce has not changed. The State has significant shortages in providers, travel time to providers is often great, and key health indicators show that the population’s health is suffering as a result.
	+ A workgroup member asked if the state is using telehealth to address provider shortage issues. Mr. Schoenbaum said the technology is growing in popularity and is in use in certain hospital systems. Some hospital systems have telehealth for urgent care, some for mental health, and others have not yet adopted the technology at all. He noted that in the last legislative session, legislation was passed requiring all payers reimburse for telehealth equivalent to that of an in-person visit. He discussed state-wide central telehealth coordination which some states, other than Minnesota, have and indicated he could report back on the specifics of the model.
	+ Another workgroup member discussed the need to go beyond telehealth and analyze the availability of broadband internet connections to provide virtual medicine, as an investment in the future of telehealth. Mr. Schoenbaum mentioned that while the data on broadband show the availability has improved, the cost remains prohibitive. A member of the workgroup mentioned the need to think about the cultural competency of recommendations to address rural health issues, particularly when thinking about providing telehealth or virtual visits which may not be familiar with the culture.
	+ The workgroup discussed the need for further evaluation of access issues including consideration of transportation time to care, the rate of undocumented individuals and access to care, and issues in access for urban populations.
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| **Review Options and Preliminary Recommendations on:*** Consumer assistance/health literacy
* Provider/plan alignment
* Plan design
* Benefits Alignment
 | Manatt | * Ms. Patti Boozang of Manatt provided an overview of the goal of the session which was to drive consensus on consumer assistance, alignment, and affordability recommendations. She reminded the workgroup that there are only two meetings left prior to the development of the report. Ms. Boozang recommended development of an online survey for workgroup members to comments on recommendations over the next week prior to the next barriers workgroup meeting.
* Ms. Alice Lam of Manatt discussed two options for improving consumer assistance resources (i.e. navigators, in-person assisters, and community health workers): (1) ensure that the state’s selection of Navigators prioritizes entities able to provide linguistically and culturally appropriate assistance and (2) expand scope and payment of consumer assistance resources to include support in accessing coverage (i.e. health and financial literacy). Ms. Lam noted that based on previous meetings, the workgroup appears to be in agreement with advancing recommendations to improve consumer assistance resources.
	+ The workgroup discussed expanding the role of consumer assistance resources and appropriately compensating assisters for a broader range of services. The workgroup discussed expanding the role of consumer assistance to encompass obtaining health insurance and navigating the health care system, as well as broader social services.
	+ The workgroup discussed how consumers migt benefit from having a single individual they can trust to navigate services form obtaining insurance through accessing a provider and obtaining other state benefit programs (i.e. SNAP and TANF). To achieve this goal, one workgroup member recommended developing a framework with the community to knit social services with local entities that individuals already trust and visit frequently (e.g., religious institutions) and training those resources to enroll people in coverage.
	+ The workgroup discussed the financing and governance of expanding consumer assistance resources. One workgroup member recommended the consumer assistance program be governed by an entity other than MNsure to allow for the financing and structure to reflect the broad scope of the new program.
* Ms. Lam provided an overview of a previously presented recommendation to align plan and provider differences across the coverage continuum. She reminded the workgroup that MNsure QHPs are significantly different from Medical Assistance and Minnesota Care which are greatly aligned. Ms. Lam provided two potential options for achieving plan and provider alignment including: (1) encourage or require issuers to participate in Medical Assistance, MinnesotaCare, and MNsure and (2) encourage or require issuers to offer same provider networks in Medical Assistance, MinnesotaCare, and MNsure
	+ One workgroup member asked if requiring issuers to offer the same provider network would require the same fee schedule across programs. Ms. Lam stated that it did not and mentioned Nevada as an example which does not require the same fee schedule but rather requires Medicaid plans to offer at least one silver and one gold QHP with comparable geographic region and provider network.
	+ The workgroup discussed whether a recommendation on plan and provider alignment should be brought forward to the Task Force. One workgroup member stated that current State law protects consumers in a variety of ways including requirements on issuers for time and distance standards. The member discussed the State possibly utilizing the NAIC Model Act, a model bill currently in development to be used by States to enact network adequacy standards. One workgroup member raised concern that standardization could limit the available options for consumers, particularly those interested in HMO type of models.
	+ It was recommended that the workgroup explore a potential more limited recommendation to improve the consumer experience by requiring plans to inform a consumer when they are shopping for plans which plan does not participate across programs for mixed families or those on the threshold of eligibility.
* Ms. Lam provided an overview of options previously presented to address high deductible QHP products: (1) low or no deductible plans, (2) exempt high-value services, (3) require standard designs, and (4) limit non-standard designs.
	+ One workgroup member provided an additional option of aligning QHPs purchased on and off the Marketplace by unbundling cost-sharing reductions (CSR) into a Health Reimbursement Account (HRA). Consumers would be determined eligible for CSR through the Marketplace and could use that CSR in a plan purchased on or off-Marketplace at any metal level for paying for health care services (i.e., copayments for office visits and prescriptions). This potential option will be discussed in next week’s barriers to access workgroup meeting.
	+ One workgroup member stated that insurance companies would likely be willing to standardize plan design, provided the State would allow for flexibility with guaranteed renewability requirements. This would allow some plans to be taken off the market while other new standard plan designs are added to decrease the total of number of plans being administered.
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| **Public Comment** | Marilyn Peitso, MD | * No public comment was provided
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| **Joint session: Seamless Coverage and Barriers to Access Workgroups** | Manatt | * See Seamless Coverage Key Takeaways
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