Health Care Financing Task Force

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

Barriers to Access Workgroup

Friday, November 20, 2015; 2:00 p.m. – 4:00 p.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 11/13/15 meeting for posting to the Task Force website. |
| **Data relating to undocumented individuals** | Mark Schoenbaum, MN Department of Health | * Mr. Schoenbaum of the MN Department of Health opened the session by discussing the limited data available on the count of unauthorized immigrants and the methods which were used to develop the data presented in the session. According to a University of Minnesota estimate, 99,000 unauthorized immigrants resided in Minnesota in 2010; Mr. Schoenbaum noted that the number is likely unchanged today. Estimates from national groups range between 80,000 – 100,000 unauthorized individuals with a margin of error of 10,000. Accordingly, the numbers which will be discussed rely on residual methods. Mr. Schoenbaum discussed two estimates of unauthorized immigrants in Minnesota. The first is from the University of Minnesota in 2010 which states 99,000 unauthorized immigrants. Other estimates from national groups provide a range of 80,000 – 100,000 with a margin of error of 10,000. * Mr. Schoenbaum reviewed the regions of birth of the unauthorized population in Minnesota. Approximately 61% of unauthorized immigrants come from Mexico and Central America, followed by approximately 19% of unauthorized immigrants coming from Asia. * Mr. Schoenbaum stated that unauthorized immigrants represent 22% of the total immigrant population and comprise 2.5% of the State’s labor force. * Mr. Schoenbaum discussed the lower health care utilization of unauthorized immigrants compared to U.S.-born citizens and other immigrants. When undocumented individuals do obtain care it is often from federally qualified health centers (FQHCs) including Migrant Health Centers, easy-access sites, public health agencies, and hospital emergency departments. The barriers for undocumented individuals in obtaining care includes: lack of satisfactory immigration status to qualify for federal programs, lack of means to otherwise access coverage, language barriers, fear of detention and/or deportation, and lack of accessible health care providers. * Mr. Schoenbaum reviewed common components of national strategies to make access to care available to undocumented immigrants including: not requiring information about immigration status, using existing provider systems, and emphasizing care coordination.   + One Workgroup member asked what percentage of the total population in Minnesota that undocumented immigrants represent. Mr. Schoenbaum stated that the total population is approximately 500,000,000 meaning the undocumented population is approximately 2%. The Workgroup then discussed how undocumented immigrants represent 2.5% of the workforce, a higher percentage than their representation in the total State population.   + One Workgroup member requested more information on the number of undocumented immigrants using emergency rooms and the percentage of uncompensated care attributable to undocumented immigrants. The Workgroup discussed that while the information on uncompensated care is easily available, obtaining a breakout of uncompensated care for undocumented individuals will be more difficult as often the individual’s immigration status is not known.   + Mr. Schoenbaum noted that one of the limitations of data on the undocumented population is being able to determine who in the immigrant population is undocumented; many public programs do not ask about immigration status to reduce the fear of deportation. A common methodology to obtain estimates on undocumented individuals is to extrapolate from Immigrations and Customs Enforcement (ICE) data. |
| **Assistance for undocumented individuals to access care** | Rebecca Lozano, Portico Health | * Ms. Lozano discussed the success of the Portico program in improving health literacy and decreasing cost to hospitals. Portico focuses on preventive and primary care and assistance in understanding the health care system. The organization was established by hospitals who wanted to use charity care funds for prevention and treat individuals upstream. * Ms. Lozano discussed how an individual obtains care through Portico’s network of hospital partners. Portico provides enrollees with access to specialty, urgent care, outpatient hospital services, and outpatient mental health. * Enrollees are subject to cost-sharing on a sliding scale based on income and household size, and monthly participation fees ranging from $25 – $50.   + A Workgroup member asked for further clarification on the cost-sharing to which an individual in Portico could be subject. Ms. Lozano reviewed that certain services, such as emergency department visits, are not covered. In the case of emergency department visits, Emergency Medical Assistance will cover the cost. Other outpatient services are covered with certain co-insurance rates depending on the service. In these instances, Portico will pay rates of 70% – 75% and the individual would turn to hospital charity care for the remaining amount. A Workgroup member asked what happens if a member cannot pay the monthly fee. Ms. Lozano stated that the care manager will inquire with the family to see why the individual could not pay and will try to establish a payment plan or reduced rate if there has been a financial crisis. * Ms. Lozano stated that Portico screens each individual for eligibility for other coverage programs, including MNsure, MinnesotaCare, and Medical Assistance. If an individual is eligible for one of these programs Portico will help facilitate enrollment. If an individual is eligible for a public program, Portico will help with care management to increase health literacy. One such care management activity is helping with submission of care plans as needed for individuals with certain chronic illnesses. * Ms. Lozano discussed the population Portico serves, which is mostly undocumented Spanish speakers. Portico serves locations with predominantly undocumented individuals without access to other resources. Prior to the ACA, Portico served many legal residents subject to the 5-year bar. * Ms. Lozano stated that one of Portico’s focuses is on health literacy including when an individual should see a primary care provider, use urgent care, or use the emergency room. Portico tries to remove the fear from individuals who may be hesitant to use the health care system due to their immigration status. Ms. Lozano stated that the program allows individuals to gain experience in using the health care system appropriately so that if the individual enrolls in a public program they will be an effective, health literate consumer. Portico conducts a family health literacy assessment upon entry and annually throughout enrollment in the program. These assessments have shown that participants reduce emergency room visits by over 50%, use of primary care increases by 42%, and participants waiting to visit a physician for a crisis decreases to less than 5%.   + One Workgroup member asked how the program is funded. Ms. Lozano stated that Portico receives funding through the hospital partners. Each hospital allocates a certain amount of their charity care funding to Portico, which is then reimbursed for certain services. A Workgroup member mentioned that the partner hospitals are likely to provide as much funding as what they believe the program will save them in uncompensated care, effectively placing a cap on the program of the size of the uncompensated care pool. A Workgroup member asked for specific information on Portico costs and Ms. Lozano indicated she will follow up.   + The Workgroup discussed the success of other similar programs. Often hospitals have their own charity care model unaffiliated with programs such as Portico. In Minnesota there are other programs which focus on chronic care management but none have Portico’s unique focus on preventive care. |
| **Emergency Medical Assistance for undocumented individuals**   * Eligibility * Services | Kim Carolan, MN Department of Human Services  Julie Marquardt and Sara Drake, MN Department of Human Services | * Ms. Kim Carolan of the Minnesota Department of Human Services reviewed the eligibility standards for Emergency Medical Assistance (EMA). Generally, if an individual is not eligible for Medical Assistance only because of their immigration status and meets all other eligibility criteria, they will be eligible for EMA. Individuals who are legally present through DACA are eligible for EMA only, unless they are pregnant in which case they will receive additional benefits. Individuals with DACA status are not eligible for Medical Assistance, MinnesotaCare, or MNsure according to guidance from the Centers for Medicare and Medicaid Services. * Ms. Sara Drake of the Minnesota Department of Human Services reviewed the covered services under EMA including: emergency services, free-standing dialysis, treatment for cancer includes surgery and chemotherapy, and treatment for certain conditions if the patient will end up in an emergency situation within 48 hours without the treatment. EMA covers nursing home care, certain prescription drugs, and certain other services through this mechanism. The services must be approved by a DHS medical review agent through a care plan submitted by a provider. The most common reasons an individual receives care through EMA include cancer, kidney failure, and trauma including motor vehicle accidents.   + One Workgroup member asked about the reimbursement schedule for EMA. Ms. Drake stated that the reimbursement schedule is the same across Medical Assistance and EMA. * Mr. Mark Schoenbaum of the Minnesota Department of Health reviewed the number of individuals enrolled in EMA in each county in Minnesota. Mr. Schoenbaum noted that the number of individuals in EMA can be used to extrapolate the number of undocumented individuals. |
| **Discuss potential options to improve access to care for undocumented individuals** | Manatt, MN Department of Human Services, MN Department of Health | * Ms. Alice Lam reviewed the goal of discussing potential options and determine whether a recommendation will be advanced by the WWorkgroup regarding access to care for undocumented individuals. As the Workgroup discusses options and shapes potential recommendations, Ms. Lam noted they should consider what population will be served and how the recommendation will be will be funded. * Ms. Lam provided an overview of potential options to improve access to care for undocumented individuals: a wraparound program for EMA beneficiaries, an expanded, local, access to care program, an uncompensated care pool, and a grant program for providers. Ms. Lam asked the WWorkgroup to consider in all options what the preferred target population to be served is, i.e., EMA only or undocumented individuals up to a certain income level, and how potential recommendations will be funded. * Ms. Lam discussed the first option to create a wraparound coverage program with a more comprehensive set of benefits for individuals currently eligible for EMA. The mechanism of providing this benefit would be to directly reimburse the treating provider for approved, medically necessary services. Ms. Lam noted that this option would allow the State to oversee the reimbursement however it would require a significant system build to manage.   + One Workgroup member asked where undocumented individuals receive EMA services. Ms. Drake stated that much of the care is provided in hospitals including outpatient and emergency room visits and not at FQHCs. The Workgroup noted that data on FQHCs is limited in the State because the coverage is not paid for by Medical Assistance. A small cohort of individuals may receive mental health services or diabetic care through EMA at an FQHC using the care plan mechanism. * Ms. Lam presented a second option to expand the Portico Healthnet Program model to additional areas with additional partners. This option would provide a defined set of benefits administered by a provider network contracted with local providers for undocumented individuals up to 275% FPL. While hospitals and systems will be incentivized to contribute to the program to reduce more costly uncompensated care, the option requires support from DHS and funding for administrative activities.   + The Workgroup discussed whether this option would be targeted to certain counties or be State wide. The Workgroup agreed that the Portico model targets underserved counties using hospitals that are willing to serve as partners and without that relationship, the Portico model would not be possible. The partner hospitals provided all start-up funding and are vital to the 12-year sustainability of Portico.   + A Workgroup member asked how an individual enters the Portico system. Ms. Lozano stated that often referrals come from the hospital’s financial advisors and word-of-mouth. Individuals who enter the program generally are looking for specific services. Once individuals enter looking for services, they are taught about the importance of prevention and how to use the appropriate level of care, increasing their health literacy. * Ms. Lam discussed a third option to create an pool to support medically necessary uncompensated care services. Providers would submit claims for care delivered to undocumented individuals. This option would allow access to funding without guaranteeing payment or benefits however, it results in a fee-for-service system. Ms. Lam noted that providers would need to have a means for identifying an individual was undocumented, which raises privacy concerns.   + The Workgroup asked about available opportunities for federal funding of an uncompensated care pool. One Workgroup member mentioned that in certain counties, the State already draws down federal funds for in-patient and out-patient care up to the maximum. In order for facilities to draw federal funding they must have a connection to the government, such as a county hospital.   + Dr. Peitso observed that if a program like Portico reduces ER visits and increases primary care visits it would be reasonable to look at a pilot for using the savings generated from a Portico-like program towards an uncompensated care pool. The Workgroup discussed the possible reasons for hospitals not having made investments in a Portico type of structure if the upstream approach is more effective. One Workgroup member recommended reviewing the program requirements and outcomes of the DHS program CHAMP. * Ms. Lam reviewed a fourth option to provide a direct grant program to safety net providers for uncompensated care. This grant would not be tied to specific individuals but rather to providers who serve undocumented individuals. The option would provide a capped amount of funds to providers and may encourage a more cost-effective coordinated care model. However, the flexibility may result in funds not being used appropriately if it is difficult to determine which providers serve a higher proportion of undocumented individuals. * Next, Ms. Lam highlighted several models from other states:   + The *Healthy San Francisco Program* provides access to services for San Francisco residents who are uninsured and not eligible for other public programs. Individuals obtain services through a medical home model or medical home network hospital. The financing is a mix of federal, co-payments, and fees on businesses who do not provider employer insurance. The model has been in operation for approximately 3 years with some adjustments due to the ACA. One Workgroup member asked how federal funding is being used in the program and Manatt agreed to come back with more information.   + Recently enacted legislation in California expands Medi-Cal benefits to all children under age 19 who qualify for Medicaid. The legislation uses State funding for individuals ineligible for federal Medicaid eligibility and, thus, federal funding. Ms. Lam noted that the bill originally called for a 1332 waiver to allow undocumented immigrants to purchase unsubsidized QHPs which was ultimately removed from the legislation.   + The *Direct Access Program* in New York City will provide primary and preventive care services through a network of existing New York City health care providers, and care coordination services, starting Spring 2016. The goal of the program is to use the data from the pilot experience to design a model for providing care to immigrants ineligible for other programs. Direct Access is funded through a combination of private and city funds.   + The Workgroup discussed how all the programs presented are not just available to undocumented individuals but all uninsured individuals because asking about immigration status often presents a barrier to care. A Workgroup member also mentioned that as a matter of policy, it would not be reasonable to exclude those who are documented but do not qualify for public programs (i.e., individuals with DACA status).   + One member of the Workgroup raised that the options presented do not include the examples in New York, California, and San Francisco. Ms. Lam noted that the options presented represent a starting point and that the Workgroup may elect to advance one of the options from the state models.   + The Workgroup discussed their preferences for the available options. The Workgroup agreed with the option to extend EMA benefits to individuals who would be eligible for EMA but wanted to ensure that an individual would not need to first experience an emergency to be eligible for services. The Workgroup agreed to keep EMA in its current state so that EMA eligible individuals who experience an emergency can have their services covered under federal funding. A Workgroup member raised concern with the provider network of wraparound EMA benefits, which was addressed by agreeing that the provider network would be the same as Medical Assistance.   + The Workgroup discussed the potential cost associated with providing undocumented individuals with coverage. It was agreed that when modeling the cost of any of the options the number of eligible undocumented individuals will be higher than the EMA population and lower than the approximately 100,000 undocumented immigrants in Minnesota. * Manatt agreed to develop a survey on the options presented in this session for discussion on December 4th. |
| **Public Comment** |  | * No public comment was provided |