Peter Nelson, Policy Fellow, Center of the American Experiment

1600 Tower, 1600 Utica Avenue South, St. Louis Park, MN

September 24, 2010

Present: Verne Johnson (Chair); David Broden, Janis Clay, Marianne Curry, Bill Frenzel, Paul Gilje, Jim Hetland (phone), Sallie Kemper, Dan Loritz, Tim McDonald, Jim Olson (phone), Wayne Popham (phone), Clarence Shallbetter, Bob White

Summary of Nelson's comments : *Minnesota stands out as a state that has chosen to cover medical services for poor childless adults through its General Assistance Medical Care (GAMC) program. The program was restructured this past legislative session through efforts of stakeholders in response to budget pressures. What had been a program that paid providers a fee for each service (reimbursing below cost) has now become a program that pays a lump-sum 'global payment' to participating hospitals. The goal of this change Nelson says is to incentivize hospitals to find new ways to reach out to and treat the target population. Minnesota is at the forefront of healthcare redesign with this reform, but it is costly and the current funding for the program does not adequately cover every eligible person to take part in the program. Its future may be affected by coming changes in Medicaid.*

A. Context of the meeting -Many individuals worked through the past legislative session to find ways to provide care to the poorest citizens of Minnesota through General Assistance Medical Care (GAMC). One of the people involved deeply in the topic-Peter Nelson of the Center of the American experiment-will describe what they did to redesign the program, how healthcare services to this population may evolve as a result, and, with the expected shortage of funds, what the outlook might be into the future.

B. Welcome and introductions - Peter Nelson is a Policy Fellow at the Center of the American Experiment, a conservative think tank. As such, he spends most of his time researching and writing on issues related to health care and energy. On health care, Nelson primarily focuses on issues involving insurance regulation, Medicaid, and long-term care. He regularly consults with state policy makers on these issues and contributes commentaries to the Star Tribune and other local newspapers across Minnesota. Nelson received his B.A. in economics from Wheaton College and a law degree from the University of Minnesota Law School where he was a member of the Minnesota Law Review.

C. Comments and discussion -During Nelson's visit with the Civic Caucus, the following points were raised:

As background, Nelson explained that the CAE focuses mainly on health care and education issues, since these are the two largest components to the state budget, and the most thoroughly regulated. The organization regularly hosts nationally recognized speakers at public forums, every one or two months, to help inform the public on issues related to CAE's primary interests. Nelson pointed out that he is the only member of CAE who interacts regularly with the legislature, and that CAE is funded almost entirely by individual Minnesotans.

Responding to the Caucus's interest in re-design of government services, he proceeded to describe the recent changes that occurred in the General Assistance Medical Care (GAMC) program.

Character of the GAMC population

GAMC is a program that began in 1976 to cover childless adults that were not covered by Medicaid, a federal entitlement program created to cover children, families, and those with disabilities.Nelson said that Minnesota might have been the first state to step up and say that this excluded population is very troubled and needs our assistance. So we created this program for those individuals with income below 75 percent of the poverty guideline. Single adults qualifying for GAMC today earn less than about $8,000 a year.

Minnesota also has a program called MinnesotaCare, which serves the same group of people, but offers a slightly different product. There is a limit of $10,000 on hospital benefits and it requires more cost sharing. Thus, Minnesota Care is not an ideal product for impoverished people with significant health problems.

There is some overlap: MinnesotaCare serves families *and* childless adults; GAMC serves only childless adults. Of people on GAMC, 45 percent have an alcohol or drug diagnosis, 42 percent have a mental health diagnosis, and up to 60 percent have one and/or the other. Furthermore, 25 percent are homeless, and 69 percent male. A majority live in the central cities, but it should also be noted that the only participating hospitals in the program are located in the central cities.

Over 90 percent of the people in the program are under 25 percent of the poverty guideline. They are desperately poor, homeless, and struggle making their own health care decisions. About 31,000 people are in the program on average.

Problems with the old program

GAMC is a very costly program, running almost $300 million per year. That comes out to be about $9,000 per patient. Regions Hospital said their costs for GAMC patients reach $12,000 per patient. That is double the costs associated with other public health programs. In the old GAMC program there may have been some systems in place to help treat chronic health conditions, but fundamentally it was a reactive program, working with people from one personal health crisis to the next.

In practice GAMC has been less a health-care program for the poor, and more a financing arrangement for hospitals.

Motivation for the change

The motivation behind rethinking GAMC was budgetary. In 2009 the Governor came forward with his budget. The original budget left GMAC unchanged, but midway through the session Pawlenty brought forth a modified budget, which included a new GAMC program that was about half the cost. It recommended transferring GAMC funds to a pool of money covering uncompensated care.

The legislature basically ignored the proposal-as the session ended there was no change, and the Governor line-item-vetoed the program entirely. This forced the state to rethink the program. Otherwise the program would go away. So the interested parties got together with thoughtful legislators, and began working on restructuring the program.

The original proposal on the table was to keep the same program, but to spend less. It became apparent that this would not be sufficient; so two key legislators-Erin Murphy (DFL-64a), and Matt Dean (R-52b)-worked on a new proposal in consultation with interested groups. "Many of the advocates have been from housing," Nelson observed, in response to questions about the systemic-nature of the challenge of assisting those in extreme poverty. The primary policy makers involved with restructuring GAMC were legislators, but the Governor's office stayed involved as well.

Changing from fee-for-service to a lump-sum, 'global' payment to hospitals

The old version of the program was fee for service: if you get an MRI, or drugs, the hospital receives a payment for the service provided. The state did pay a capitated payment to managed care health plans for many GAMC enrollees, but these plans pay providers on a fee-for-service basis as well.

This model is coming under fire generally because of its poor incentives. Generally, the fee-for-service model is criticized for paying providers for volume, not value. Providers are paid more when they provide more services. Thus, fee-for-service encourages doctors to overprovide. However, the GAMC program reimburses providers below cost. As a result, GAMC creates an incentive to underprovide because it does not cover the providers costs. Furthermore, because they are not covering the cost of GAMC services, hospitals are shifting costs to other private pay customers. Data show that as public reimbursement goes down, private pay goes up. Nelson illustrated an uneasy picture: "I've heard that when private insurers go to the table to negotiate reimbursements, it's all on the table." That is, costs of uncompensated care are expected to be part of the formulas for private insurance rates.

The GAMC program has not contained an incentive to work toward quality and the future health of the patient. There was no incentive for incorporating value into the process. That is why there is much talk today about 'payment reform,' trying to get providers to think about the quality of the outcome of services they perform.

So those working on the GAMC reforms began to think, "Let's give these health plans some incentive for healthcare providers to go out and meet the needs of the patients." The key component of the new program is a "global payment," or lump sum payment to the hospital to serve the GAMC patients they work with. It is a form of "capitation" for the entire population. For instance, Hennepin County Medical Center knows they have a certain number of GAMC people coming through their doors, and any part of the lump sum provided they don't spend on care for GAMC patients they can keep.

Because so many GAMC enrollees depend on prescriptions to maintain chronic conditions, especially mental health conditions, the new GAMC program also set up a new prescription drug pool.

Shortcomings of the new program

This program has a lot of challenges, Nelson admitted. Usually the concept of a global payment is attached to an individual, like the "capitated" HMO payment that calls for a limited amount of payment per patient. With this plan's single outlay for the entire GAMC population, there will be challenges overseeing the use of the lump-sum payment by the hospital. There is incentive for the hospital to coordinate the care of this individual in order to improve outcomes and reduce redundant care. Nelson told the group that he has seen evidence that new clinics are being set up for this purpose.

Another challenge of the program is its metro focus. There is still a need for some type of statewide uncompensated-care pool, as the new program does not address care of outstate GAMC patients. Since there is no outstate Minnesota plan, if you need particular services you must come to the participating hospitals in the central cities.

A member expressed skepticism at the capacity of hospitals to deal much beyond immediate care for the GAMC population. Their problems require residential care-the basic hierarchy of needs is not being met. Nelson admitted that this was not part of the policy conversation. There are housing needs that are not being met. There is nothing to say that hospitals can't work to help solve those needs. There is nothing in the program now that would prohibit a hospital from partnering with a halfway house that could help manage taking of medication, for example. This is an important part of the reform; the hospitals don't need to go to the legislature for approval.

There is one enormously significant problem with the incentives to provide and obtain care under this program: If all people eligible for GAMC signed up for and used the program, costs would overrun the capacity of the program. In fact, the program is already over capacity. Only Hennepin County Medical Center is accepting new enrollees. This naturally raises a practical frustration with those tasked to administer the program.

Hospitals now have incentive to reach out

"The hospitals are in the best position to know what these people need," Nelson asserted. At a policy level the goal should be to put in place the right incentives.

A participant wondered whether a person in poverty, living homeless, and struggling with addiction or mental illness would have sufficient incentive themselves to enter into preventative medicine treatment. Instead won't they do as most people do and wait until something is wrong? "It is an enormous challenge," Nelson admitted, adding that GAMC should not be seen as asking the hospitals to solve all social ills.

Another participant asked how much communication about this program has taken place with the eligible population-especially those outstate that qualify for the program. This is a good question, Nelson responded. In the past GAMC has been a hospital financing scheme first and a health care program second. Thus, communication with the user was less of a priority. One possibility is that clinics will reach out into communities and provide that communication.

Minnesota is at the forefront

Minnesota was at the forefront of offering these health benefits to childless adults, Nelson said, and it is now at the forefront of trying to rethink its design. "There is not a whole lot going on," he said, to a question about the status of other states in this area. Some have programs, but are not as generous: "I use Texas as an example of a state that has a good program but is only serving those at or below 25 percent of the poverty line."

Another participant wondered whether the global payment mechanism should be used for Minnesota Care? No, Nelson said, "global payment is a good solution for a population of patients that are not generally responsible for themselves, and need a clinic to actively reach out to them." But his concern with using global payments for a larger program is that health care then becomes administered on a population level, and not an individual level.

Nelson is cautious about federal money: If Minnesota were to early-adopt new Medicaid provisions to cover this population, then the GAMC program would be discarded, along with its incentives to proactively reach out the to population in need. For all its imperfections, Nelson argued, this is an important ingredient for innovation.

D. Closing

To close, Nelson proposed that the state must further refine the GAMC program so that hospitals and communities are incentivized to come up with solutions that save money and better meet needs. "I've worked at the capitol long enough to know that those kinds of creative ideas need to be created by the providers, not manufactured at the capitol." The fundamental problem now, Nelson said, is that the program is severely underfunded, although there are opportunities to get additional money from the federal government.

A participant observed that GAMC is one of the few examples of the state's budget crisis having compelled a rethinking in the legislative process, within both the legislature and the governor's office. Another said of the redesign of GAMC: "We want to offer an endorsement for this work you are doing."

The Chair expressed our thanks to Peter Nelson for a good meeting.