MINNESOTA COUNCIL of HEALTH PLANS

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House Ways and Means Committee
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Chair Olson and Committee Members:

The Minnesota Council of Health Plans appreciates the opportunity to work closely together to address complex issues related to health care costs, health equity, and access to high-quality health services. The Council supports many of the items included in the House omnibus finance packages, including investments in our state's mental health infrastructure, extension of public health care coverage to undocumented children and parents, and addressing the high cost of prescription drugs. There are two bills included in, HF 2930, the Health and Human Services Finance omnibus bill, which will negatively impact the care members in public programs receive. This letter and the accompanying handouts seek to provide the committee insight into the value of care coordination for both enrollees and the state. Importantly, the fiscal note recognizes case management and care coordination will be eliminated with this shift away from managed care, however the cost estimate is "unquantifiable" and not included in fiscal note. 1) HF 693 eliminating managed care in the administration of Medical Assistance and MinnesotaCare; and 2) HF 816 requiring the Department of Human Services to offer a managed care opt-out. The Council of Health Plans respectfully requests the Ways and Means Committee receive complete fiscal notes for these portions of the bill prior to taking action.

An excerpt from the fiscal note for HF 816 describes the work of MCO employees to serve these disadvantaged populations:

> *MCOs are reimbursed to provide specialized care coordination services across all Minnesota Health Care Programs (MHCP), some of which involve partnerships or initiatives aimed at addressing the specific needs of their enrollee population. The purpose of these services, which are not currently offered through fee-for-service, is improving quality of care, reducing health care costs, and addressing racial disparities in health care outcomes. Initiatives known to DHS include chronic disease management, behavioral health care coordination for individuals with mental health or SUD treatment needs, and scheduling appointments, transportation, and interpreter services, among others. For enrollees participating in these programs through their MCO, opting out would remove this care coordination and would shift the responsibility to the individual, which could have an impact on health care outcomes. For SNBC and seniors, dedicated care coordinators are responsible for creating care plans for enrollees that coordinate health care services and address social needs through referrals to housing and food programs, legal aid, and other community supports. Enrollees with higher levels of need could be impacted by a managed care opt out option through losing resources that help them navigate both their health care plan and any necessary social supports through community organizations or public programs.*
>
> *The impact of the loss of care coordination services offered by MCOs likely has a fiscal impact but is unquantifiable.*

As demonstrated in the attached handout, care coordination provides Minnesotans with optimal care, providers are better informed, and there is less wasteful spending on things like unnecessary testing or duplicative procedures. Minnesota's MCOs provide this service to targeted populations free of charge to enrollees, whereas under Fee-for-Service, care coordination is not a covered benefit. There are resources available to quantify the fiscal impact of eliminating those services for state public programs, including a hospital system in Wisconsin concluding that for every $1 invested in care coordination for their highest-risk population, the hospital realized an $8 reduction in health care charges because inpatient visits were less frequent, less critical, and were, on average, 30% shorter.[1] Another study commissioned by the Institute of Medicine reported on the analysis of over nine million Medicaid and dual Medicare/Medicaid claims records for five large states to determine patterns and costs associated with uncoordinated care.[2] That study found that, on average, patient costs of those with uncoordinated care were 75% higher than similar patients whose care was coordinated. The study concluded that enhanced care coordination can reduce costs by 35%. Finally, a study of Texas Medicaid enrollees found that patients receiving waiver-funded care coordination had a 19% lower probability of hospitalization after receiving care coordination relative to patients who received usual care, for a mean savings of approximately $1500 per year per patient.[3]

The omnibus bill includes the content of HF 693, which eliminates managed care in the administration of the state's Medical Assistance and MinnesotaCare programs beginning in 2027. The spreadsheet for this bill estimates a $115 million savings in the General Fund, despite no fiscal note or financial analysis of this legislation having been released to date. There is also no impact to the Health Care Access Fund, which pays for MinnesotaCare, accounted for on the spreadsheet. In our estimation, this proposal has significant costs in fiscal year 2027 based on the following factors:

- **Accounting Shifts**: At the end of each fiscal biennium, two months of payments to Managed Care Organizations (MCOs) are delayed until July. Based on estimates from the February forecast, two months of FY 2027 state payments to MCOs represents $350 million for the Prepaid Medical Assistance Program (PMAP) alone. This is one of three programs served by managed care and in which the state shifts payments at the end of every biennium and would therefore generate a significant financial liability for the state.

- **Performance Withholds:** The Department of Human Services (DHS) contracts with MCOs include an 8% performance withhold, which means 8% of revenue owed to MCOs is not paid for the contract year. If a MCO achieves part or all of the performance measures described in the contract, the MCO is paid back a portion or all of this 8% the following July. If managed care is eliminated in 2027, the state cannot withhold the 8% of payments for health care services, generating a new $84 million liability for the first six months of calendar year 2027 for PMAP alone.

[1] Gundersen Lutheran Health System. (n.d.). Transforming healthcare: Patient care coordination.
[2] Owens, M. K. (2010). Costs of uncoordinated Care. In P. L. Yong, R. S. Saunders, & L. A. Olsen (Eds.). The healthcare imperative: Lowering costs and improving outcomes: Workshop series summary. Washington, DC: National Academy Press. (109-140).
[3] Ellen D. Breckenridge, Bobbie Kite, Rebecca Wells, and Tenaya M. Sunbury. Effect of Patient Care Coordination on Hospital Encounters and Related Costs. Population Health Management. Oct 2019. 406-414.

- **Increased Medical Costs:** The aforementioned performance withholds require MCOs to achieve measurable and specific reductions in emergency room utilization, hospital admissions, and hospital readmissions. MCOs apply significant resources to achieving these results and to lower health care costs for the state of Minnesota. When populations are no longer enrolled in managed care, these efforts will cease and result in higher health care costs. DHS has year-by-year data showing the success or lack thereof of these efforts. This information can be used to estimate cost increases due to elimination of these cost-containment efforts.

- **Lost Tax Revenue:** In fiscal year 2027, the 1% tax on HMO premiums is expected to generate $168.4 million in revenue and the 0.6% surcharge on HMO premium revenues is anticipated to generate $101 million. These revenues would drop significantly if this section of the bill is enacted into law.

The omnibus HHS Finance bill also includes the content of HF 816, which allows MA enrollees to opt-out of PMAP and enroll in fee-for-service (FFS) – resulting in DHS directly serving more individuals on Medical Assistance and MinnesotaCare. In reviewing the fiscal note for HF 816, DHS estimates 10% of enrollees in managed care are expected to migrate to a DHS-administered platform. Only one of the factors (performance withhold) documented above appears to be accounted for in the fiscal note for HF 816.

The Minnesota Council of Health Plans respectfully requests the Ways and Means Committee receive fiscal analysis of the aforementioned provisions of HF 2930 prior to taking action on the bill. Thank you for your consideration and I look forward to continuing working closely with you to support Minnesotans with broad access to high-quality care, at a more affordable cost.

Sincerely,

Lucas Nesse
President and CEO