

Summary of GAMC Statewide Hospital Visits

Minnesota House of Representatives
Health Care and Human Services Policy Committee
Representative Paul Thissen, Chair

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Overview

From June 29 to July 6, 2009, hospitals around the state hosted roundtable discussions for members of the Minnesota House of Representatives Health Care and Human Services Policy Committee and local legislators regarding the line-item veto of the General Assistance Medical Care (GAMC) program. Hospitals were selected based on a Minnesota Hospital Association estimate of the financial impact of the veto, and ten identified as some of the hardest hit were invited to participate in the discussions. Nine hospitals agreed to host meetings and invite local area community partners such as homeless shelters and county human service agencies to attend and share their experiences serving the GAMC population (see Appendix A for a list of hospitals and participants). The purpose of the meetings was not to revisit the line-item veto, but rather learn how local hospitals and communities care for GAMC-eligible individuals and discuss policy alternatives the legislature could consider next session in order to help the GAMC population retain access to health care and insulate hospitals from financial losses.

Findings

While each hospital identified unique programs and systems that aid in caring for the GAMC population, a number of common themes emerged:

- The GAMC population is diverse with a varying ability to make and keep appointments, enroll in health care coverage, manage chronic conditions, and maintain stable housing. As an example of this diversity, hospitals are seeing many GAMC recipients who suffer from a traumatic brain injury incurred while fighting in the Iraq war or due to domestic violence in the home. Tailoring treatment to meet the unique and individual needs of GAMC recipients is a primary goal of hospitals seeking to provide effective care.
- Access to medication and consistently taking the appropriate dosage of medication is of utmost importance to keeping GAMC individuals stable, reducing emergency room visits, and cutting down on inpatient admissions.

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"People are being forced to choose between milk and meds. If the choice is between paying the electric bill and getting the lights turned back on or refilling a

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prescription,
people are going to pay the electric bill.”

- MinnesotaCare is an option for some GAMC recipients but not all. Those who are eligible for the program still may face barriers to coverage, as the application process itself could prove difficult, and many may be unable to afford even minimal premiums. Participants also expressed concern about the adequacy of the MinnesotaCare benefit set for this population.

- Many individuals rely on GAMC for care as a stopgap measure while awaiting eligibility determinations for federal supplemental security income (SSI) due to a permanent disability. The application process for SSI is in itself a challenge, as many GAMC recipients lack the medical records needed to substantiate a disability, and the lengthy appeals process means that qualification can take months.

- Electronic medical records have enabled hospitals to better monitor patients' medical histories, avoid duplication, and improve care management. As many GAMC recipients are transient, the interoperability of electronic medical records across the state and across systems will be an asset to managing their care.

- Hospitals provide financial counselors to assist uninsured individuals who present in the emergency department with enrolling in public programs. A major draw for enrolling individuals in GAMC is that the program provides retroactive coverage to the date of application, allowing hospitals to receive payment for provided care. Without this retroactive coverage, hospitals would lose money and along with it the immediate financial incentive to help the uninsured secure health care coverage.

- Access to services in rural areas is particularly hindered by the lack of transportation. While hospitals and social service agencies assist GAMC recipients by scheduling follow up visits and primary care appointments, oftentimes these appointments are missed because patients have no way to get to the clinic. “We schedule the appointment for them and might give them a bus token. Then they either lose it or give it to a friend who needs it so they end up missing the appointment. Then, if we try to call them to follow up and help them reschedule the appointment, the line is disconnected. It’s really a challenge.”

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Unintended Consequences

“People need to realize that the line-item veto isn’t creating a crack in the system but a gulf.”

Participants at the roundtable discussions also shared some of their concerns regarding additional potential consequences of the veto:

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- Many hospitals are the largest employer in their county, providing jobs to thousands of area residents. Loss of GAMC funding could mean layoffs, extended hiring freezes, and closure of unprofitable programs such as behavioral health units and chemical dependency programs, the very programs many GAMC recipients depend on and which typically have the highest “secondary” costs to the state (in the form of public safety and corrections costs).

- Community partners such as county human service agencies will also feel pressure from the veto. Some have indicated that they will be actively enrolling GAMC recipients into other public programs such as MinnesotaCare, but expressed concern that many people will be ineligible and most will be unable to afford their premiums. Unallotments to county aid, including Emergency Minnesota Supplemental Aid and Emergency General Assistance, will also create a burden for county workers as they try to link people with services.

“The EGA dollars for our county were cut from \$2,600 to \$840. We could help maybe four families struggling through a crisis. We won’t be able to afford to help anyone else.”

- Area nonprofits are also under economic duress and may be unable to meet the needs of the people seeking their assistance. As hospitals and counties rely on community providers to aid with housing, social services, and primary care, reductions in funding create an unstable safety net, hindering discharge planning and perpetuating the cycling of GAMC individuals through hospital emergency departments.

- Public safety is another area that may be impacted by the GAMC line-item veto. If GAMC recipients are unable to manage their mental health needs, they are likely to display erratic behavior and engage in criminal activity, ending up in county jails.

“This cut creates the illusion of savings. GAMC recipients will now depend even more on emergency rooms as their first line of care. In a typical year, a stable case will cost us \$27,000. An unstable case, presenting in the ER needing greater episodes of care and intensive care, will cost us \$400,000. The harm that arises is almost incalculable.”

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Possible Solutions

A key component of the statewide hospital visits involved discussing alternative care models and policy strategies for meeting the needs of GAMC individuals. Participants provided feedback on committee members’ ideas and shared information regarding care models that have been

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effective in their own communities. While not exhaustive, the following highlights some of these alternatives:

- Insurance first: An overwhelming number of hospitals indicated that they prefer an insurance model to an uncompensated care pool. Participants cited studies that demonstrate that insurance coverage in and of itself is tied to better health outcomes, and some felt that an uncompensated care pool would be too difficult to administer and likely to promote inefficient use of funds. An alternate insurance model could redesign the benefit set, but would ideally include essential benefits such as prevention and primary care, retroactive hospital coverage, mental health coverage, dental benefits, and prescription drug coverage.

- Health care homes: Care coordination for this population would ideally provide wraparound services that tie medical care to human services and housing. The health care home model would promote primary care and provide holistic services to address the multiple needs of GAMC recipients.

- Integrated care: Hospitals in Detroit Lakes, Brainerd, and Cambridge have already developed or are in the process of developing integrated health systems that link hospitals and on-site clinics. Some hospitals have used this arrangement to divert patients from their emergency rooms who do not need emergency care to their clinics. Such integration promotes care coordination and cost-effectiveness.

- Better prevention and discharge planning: GAMC recipients will benefit from focused care that keeps them stable and prevents them from entering the hospital in the first place or cycling through the emergency department. Hospitals unanimously agreed that policies designed to keep GAMC recipients out the emergency room will not only be good for the hospitals but will promote better care of the patient.

- Primary care workforce development: Better care coordination necessarily involves primary care doctors, however many rural areas around the state have difficulty recruiting and retaining primary care doctors. Access to primary care can only be improved if primary care physicians are available throughout the state.

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- Stable, consistent funding: Non-profit organizations depend on a web of funding to support their programs such as grants, foundation support, and state funding, among other sources. Ensuring the economic viability of social services and housing programs that serve the GAMC population is key to their continuation.

- Administrative simplification: Disabled Minnesotans seeking SSI would benefit from a State Medical Review Team process that simplified applications, reduced paperwork, streamlined eligibility determinations, and prevented lengthy appeals processing.

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Enrollment in Minnesota health care programs and renewal procedures could also be simplified to promote ease of enrollment and prevent churning.

- Retaining flexibility: workers on the ground level know what works best for their communities. Often, geographic and cultural factors, such as the proximity of the American Indian reservations around Bemidji, require hospitals and county workers to

adapt to the care needs of their specific population. Allowing flexibility in program design and funding will enable each community to best meet the needs of their residents.

“We have a lot of Norwegian pride in our area, so it is difficult for us to get people to come into our offices to fill out health care program applications because they perceive it as welfare. We have more success with outreach, but cultural factors remain a barrier to getting people enrolled.”

Conclusion

The General Assistance Medical Care program is expected to expire at the beginning of March 2010. A feasible solution will therefore need to be developed quickly in order to prevent the 30,000 enrollees from losing coverage. Their health is at risk, as is the financial health of hospitals around the state. As such, the statewide hospital visits are intended to be a starting point for discussions regarding new care models for GAMC individuals. As policy alternatives are further developed, legislators will need the continued input from Minnesota hospitals, physicians, nurses, community health clinics, counties, social service agencies and other service providers about which strategies hold the most promise and how they should be funded. We welcome your ideas.

Sincere thanks to all who participated and to each of the nine hospitals for hosting these discussions.

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