Date: December 2, 2009

Health Care Access Fund

2009 Nov. Forecast

Figures in $ Thousands

	Closing FY 08	Closing FY 09	Projected FY 10	Projected FY 11	Projected FY 12	Projected FY 13
Actual and Estimated Resources						
Balance Forward from Prior Year	165,783	260,374	291,896	166,438	0	-371,109
Prior Year Adjustments	924	1,102				
Adjusted balance forward	166,707	261,476	291,896	166,438	0	-371,109
Revenues:						
2% Provider Tax	428,808	468,827	476,700	499,000	526,800	556,900
1% Gross Premium Tax	61,457	61,040	62,300	63,600	65,100	66,800
State Share of MnCare Enrollee Premiums[1]	19,355	15,510	20,008	25,834	26,751	27,198
Investment Income	9,845	6,552	2,221	928		
Federal Match on Administrative Costs	6,141	7,137	7,795	7,931	7,931	7,931
Revenue Refunds	-8,657	-13,075	-9,000	-9,000	-9,000	-9,000
All Other	31	106	106	106	106	1,306
Total Revenues	516,980	546,097	560,130	588,399	617,688	651,135
Transfers In:						
General Fund: To Meet MinnesotaCare Spending[2]				110,854		
Technology Carryforward from 2008		365				
Total Resources Available	683,687	807,938	852,026	865,691	617,688	280,026
Actual and Estimated Uses						
Expenditures:						
MinnesotaCare Direct Appropriation	303,958	342,452	513,274	751,793	904,819	1,034,292
State Share of MnCare Enrollee Premiums[1]	19,355	15,510	20,008	25,834	26,751	27,198
Federal Medicaid and S-CHIP Offsets [Non-Add]:	[127,039]	[149,879]	[173,163]	[164,584]	[164,071]	[207,245]
MA Direct Appropriation					3,187	6,995
Department of Human Services	29,384	28,905	36,284	35,151	36,157	36,932
COBRA Premium Subsidy - ARRA			22,593	6,890		
Interest on Tax Refunds	448	566	400	400	400	400
University of Minnesota (TR Out)	2,157	2,157	2,157	2,157	2,157	2,157
Department of Health	12,031	15,618	39,203	40,809	12,669	8,535
Dept. of Employment & Economic Development			1,000			
Legislature	178	178	178	178	178	178
Department of Revenue	1,623	1,739	1,761	1,749	1,749	1,749
Total Expenditures	369,134	407,125	636,858	864,961	988,067	1,118,436
Transfers Out:						
Special Revenue Fund: MAXIS/MMIS and Other	4,508	8,695				
General Fund: Critical Access Dental Payments	1,672					
General Fund: Provider and Gross Premium Tax Expansion[3]	48,000	48,000	48,000			
General Fund: Limited Tax Credit			730	730	730	730
General Fund: One-time Transfer/Loan		50,000				
Prior Year Transfer Correction		2,222				
Total Transfers Out	54,180	108,917	48,730	730	730	730
Total Uses	423,314	516,042	685,588	865,691	988,797	1,119,166
Balance	**260,373**	**291,896**	**166,438**	**0**	**-371,109**	**-839,140**

[1] Actual contributions made by enrollees include both federal and state share of premiums.

[2] M.S. 16A.724 requires a transfer from the general fund to the health care access fund in FY 2011 if necessary to meet MinnesotaCare expenditures.

[3] There are no available resources in the health care access fund to make the transfer to the general fund under M.S. 16A.724 in FY 2011-2013.

HEALTH CARE ACCESS FUND

	Actual FY 2007	Actual FY 2008	Closing FY 2009	11-09 Fcst FY 2010	11-09 Fcst FY 2011	11-09 Plng Est FY 2012	11-09 Plng Est FY 2013
Actual and Estimated Resources							
Balance Forward From Prior Year	$115,522	$165,783	$260,373	$291,896	$166,438	$0	($371,109)
Prior Year Adjustments	481	924	1,103	0	0	0	0
Adjusted Balance Forward	$116,003	$166,707	$261,476	$291,896	$166,438	$0	($371,109
Receipts:							
2% Provider Tax	407,420	428,808	468,827	476,700	499,000	526,800	556,900
1% Gross Premium Tax	69,580	61,457	61,040	62,300	63,600	65,100	66,800
Revenue Refunds	(9,590)	(8,657)	(13,075)	(9,000)	(9,000)	(9,000)	(9,000)
Investment Income	10,200	9,845	6,552	2,221	928	0	0
MnCare Premium-Individuals	21,978	19,355	15,510	20,008	25,834	26,751	27,198
Federal Match Admin Costs	3,783	6,141	7,137	7,795	7,931	7,931	7,931
All Other	34	31	106	106	106	106	1,306
Net Receipts	503,405	516,980	546,097	560,130	588,399	617,688	651,135
Transfers from Other Funds:							
General Fund	0	0	0	0	110,854	0	0
Spec Rev Fund-Techn Cfwd	0	0	365	0	0	0	0
Total Transfers In	0	0	365	0	110,854	0	0
Total Resources Available	**$619,408**	**$683,687**	**$807,938**	**$852,026**	**$865,691**	**$617,688**	**$280,026**
Actual and Estimated Uses							
Higher Education							
University of Minnesota (TR OUT)	2,157	2,157	2,157	2,157	2,157	2,157	2,157
Subtotal- Higher Education	2,157	2,157	2,157	2,157	2,157	2,157	2,157
Property Tax Aids & Credits							
Tax Refund Interest (OPEN)	428	448	566	400	400	400	400
Subtotal- Property Tax Aids & Credits	428	448	566	400	400	400	400
Health & Human Services							
Human Services Dept	314,149	352,697	386,867	592,159	819,668	970,914	1,105,417
Health Dept	7,823	12,031	15,618	39,203	40,809	12,669	8,535
Subtotal- Health & Human Services	321,972	364,728	402,485	631,362	860,477	983,583	1,113,952
Economic Development							
Employment & Econ Development Dept	0	0	0	1,000	0	0	0
Subtotal- Economic Development	0	0	0	1,000	0	0	0
State Government							
Legislature	128	178	178	178	178	178	178

HEALTH CARE ACCESS FUND

	Actual FY 2007	Actual FY 2008	Closing FY 2009	11-09 Fcst FY 2010	11-09 Fcst FY 2011	11-09 Plng Est FY 2012	11-09 Plng Est FY 2013
Revenue Dept	1,773	1,623	1,739	1,761	1,749	1,749	1,749
Subtotal- State Government	1,901	1,801	1,917	1,939	1,927	1,927	1,927
Total Expenditures	326,458	369,134	407,125	636,858	864,961	988,067	1,118,436
Transfers to Other Funds:							
General Fund	59,105	48,000	98,000	48,730	730	730	730
General Fund Critical Access Dental	3,532	1,672	0	0	0	0	0
General Fund Provider Prem Tax	58,695	0	0	0	0	0	0
Special Revenue Fund	5,835	4,508	10,917	0	0	0	0
Total Transfers Out	127,167	54,180	108,917	48,730	730	730	730
Total Uses	**$453,625**	**$423,314**	**$516,042**	**$685,588**	**$865,691**	**$988,797**	**$1,119,166**
Balance Before Reserves	**165,783**	**260,373**	**291,896**	**166,438**	**0**	**(371,109)**	**(839,140)**
Reserves	0	0	0	0	0	0	0
Budgetary Balance	**$165,783**	**$260,373**	**$291,896**	**$166,438**	**$0**	**($371,109)**	**($839,140)**

GAMC Line-Item Veto and MinnesotaCare

Background

GAMC is a state-only funded program which pays for health care services for low income Minnesotans ineligible for MA or other publicly-funded health care programs. They are primarily adults between 21 and 64 who do not have dependent children. Funding for the program was appropriated by the Legislature in the 2009 session, but the appropriation for FY 2011 ($381 million) was line-item vetoed by the Governor. Without program funding in FY 2011, DHS projects it will be necessary to terminate the program by March 2010 in order to pay outstanding claims and settle contracts out of available funding. Virtually all GAMC enrollees are potentially eligible for MinnesotaCare. Funded out of the health care access fund, MinnesotaCare provides comprehensive medical benefits but has an annual $10,000 inpatient hospital cap and requires premium payments. Premiums charged to the GAMC population are expected to average $5 per month.

In November 2009, DHS announced plans to auto-enroll those GAMC enrollees with continuing GAMC eligibility in Transitional MinnesotaCare. Beginning March 1, 2010, new applicants who qualify for GAMC will also be enrolled in Transitional MinnesotaCare. If no legislative action occurs to change GAMC funding, the transfer of enrollment from GAMC to MinnesotaCare will greatly increase costs in the health care access fund.

Treatment in November Forecast

This forecast assumes that GAMC program funding in the general fund is eliminated for FY 2011 and beyond, and that GAMC coverage is terminated in March 1, 2010. The forecast includes approximately 11,000 additional monthly average enrollees in MinnesotaCare in FY 2010-11 and 18,000 in FY 2012-13. This increases MinnesotaCare costs $254 million in FY 2010-11 and $520 million in FY 2012-13. Factors other than the GAMC transition have put pressure on the health care access fund including increased enrollment and higher capitation rates – especially for adults with no children. Total MinnesotaCare expenditures increased $394 million in FY 2010-11 and $684 million in FY 2012-13. Approximately 64 percent of the increase in MinnesotaCare for FY 2010-11 is due to the transition of GAMC recipients to Transitional MinnesotaCare. In the planning estimates for FY 2012-13, the GAMC effect accounts for 76 percent of the changes. Combined, the changes result in a forecast deficit in the health care access fund in FY 2011.

Because of this forecast deficit, under M.S. 16A.724, the $48 million yearly transfer from the health care access fund to the general fund will not occur in FY 2011 through FY 2013. This is reflected as a general fund loss in each of those years. Also under M.S. 16A.724, the general fund is required to transfer funds to meet MinnesotaCare expenditures for any remaining deficit in FY 2011, which amounts to $111 million. Beginning in FY 2012, financial management provisions related to MinnesotaCare in M.S. 256L.02 give the DHS commissioner the authority to make adjustments to reduce the cost of the program and balance any shortfall in the health care access fund.

Effect of GAMC Veto & Executive Actions on MinnesotaCare Expenditures

(in millions)

	FY 2010	FY 2011	FY 2012	FY 2013
Total Projected Cost of MinnesotaCare	$513	$752	$905	$1,034
MinnesotaCare Increase for GAMC Recipients	69	185	239	281
Health Care Access Fund Balance[1]	166	-	(371)	(839)
Added General Fund Cost Due to HCAF Deficit[2]		159	48	48

[1]Balance before transfers associated with M.S. 16A.724

[2]Costs to the general fund result from requirements under M.S. 16A.724. Due to a projected negative balance in the health care access fund, a $48 million transfer will not occur. In addition, the law requires that a negative balance in the Health Care Access Fund be reimbursed by the general fund through FY 2011.

Status Quo Scenario

DHS has prepared an alternate scenario in which they assume the full funding for GAMC is restored and that the program continues in its current form. In this scenario, approximately 39,000 enrollees would continue to have coverage in GAMC at total a general fund cost of $765 million in FY 2010-11, and $928 million in FY 2012-13.

In this scenario, GAMC enrollees would not transition to MinnesotaCare. The health care access fund balance would be $96 million at the end of FY 2011, and there would be a deficit in FY 2013 of $223 million. The $48 million annual transfer from the health care access fund to the general fund would continue through FY 2011, and no transfer from the general fund to the health care access fund would be necessary to meet MinnesotaCare expenditures in FY 2011.

Projected GAMC Expenditures Excluding Effect of GAMC Veto & Executive Actions

(in millions)

	FY 2010	FY 2011	FY 2012	FY 2013
Total Projected Cost of GAMC	$361	$405	$452	$476
Health Care Access Fund Balance	235	96	(36)	(223)
Added General Fund Cost Due to HCAF Deficit[1]	-	-	48	48
Added General Fund Cost for GAMC	32	405	452	476

[1] Costs to the general fund result from requirements under M.S. 16A.724. Due to a projected negative balance in the health care access fund, a $48 million transfer will not occur.

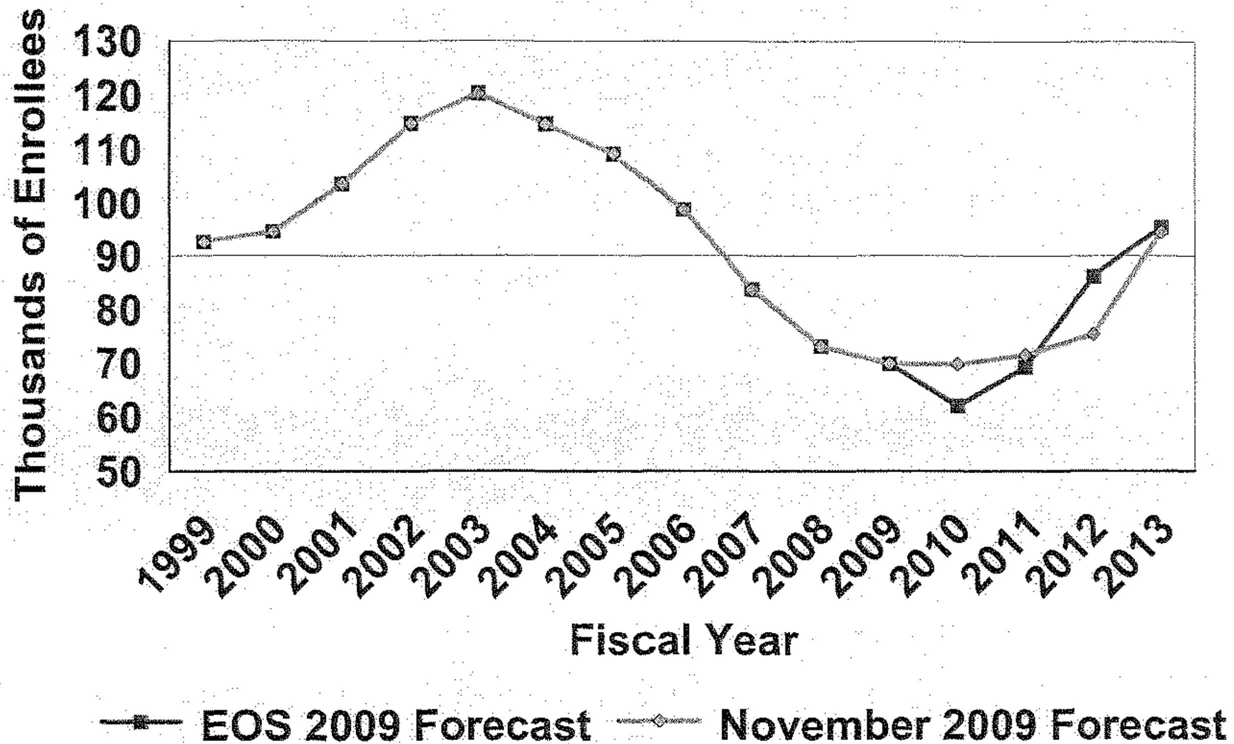
MINNESOTACARE

	'08-'09 Biennium	'10-'11 Biennium	'12-'13 Biennium
Forecast change this item ($000)	(3,463)	394,230	683,872
Forecast percentage change this item	-0.5%	45.3%	54.5%

Summary of Forecast Changes	**'08-'09 Biennium ($000)**	**'10-'11 Biennium ($000)**	**'12-'13 Biennium ($000)**
Families with Children			
Enrollment changes	(973)	18,916	(5,347)
Average payment changes	(144)	(23,581)	(53,925)
Premium revenue changes	0	(5,711)	(2,975)
Remove 3% withhold not included in statute	0	5,797	3,245
Families with Children Subtotal	(1,117)	(4,579)	(59,002)
Adults without Children			
Enrollment changes	(1,810)	51,589	75,890
GAMC veto shift	0	253,725	519,705
Average payment changes	(536)	81,515	149,129
Premium revenue changes	0	(4,034)	(5,552)
Remove 3% withhold not included in statute	0	16,014	3,702
Adults without Children Subtotal	(2,346)	398,809	742,874
Total Program	(3,463)	394,230	683,872

Families with Children

Average monthly enrollment of children and parents fell by 4% in FY 2009 compared with the previous fiscal year. Despite this drop, enrollment bottomed out at about 70,000 enrollees during the last half of CY 2008 and started a subtle rise in the first half of CY 2009. This enrollment growth is projected to increase gradually until FY 2012 when enrollment jumps upward due to eligibility expansions primarily affecting children. Noteworthy is that implementation of these eligibility expansions is delayed in the November forecast due to delays in obtaining federal approval and systems implementation timeframes. A later start for these expansions results in lower enrollment projections for the next biennium. Thus, relative to the end-of-session forecast, enrollment projections for children and parents in the November forecast are about 7% higher for the current biennium but about 6% lower in the next biennium.



HMO rates effective January 2010 are about 10% lower than CY2009 rates for MinnesotaCare families with children. This rate change is substantially lower than the 7.5% increase anticipated in the end of session forecast. These lower HMO rates are partially offset by higher than anticipated average payments during the last half of CY 2009. The net result is a reduction in projected average payments for MinnesotaCare families with children of about 10% in the current biennium and about 14% in the next biennium.

Average monthly premium revenue for MinnesotaCare families with children was slightly higher than anticipated during the first few months of FY 2010. This results in small cost savings due to slightly higher projected premium revenue of about 2% in the current biennium and about 1% in the next biennium.

Finally, the 2009 legislature budgeted savings for increasing the HMO withhold in MinnesotaCare by 3 percentage points, resulting in an 8% withhold effective January 2010 and savings of about 2-3% in the current biennium and about 1% in the next biennium. However, the language for this policy was not included in statute at the end of the 2009 session. As a result, this change is eliminated from the November forecast resulting in a cost relative to the end of session forecast.

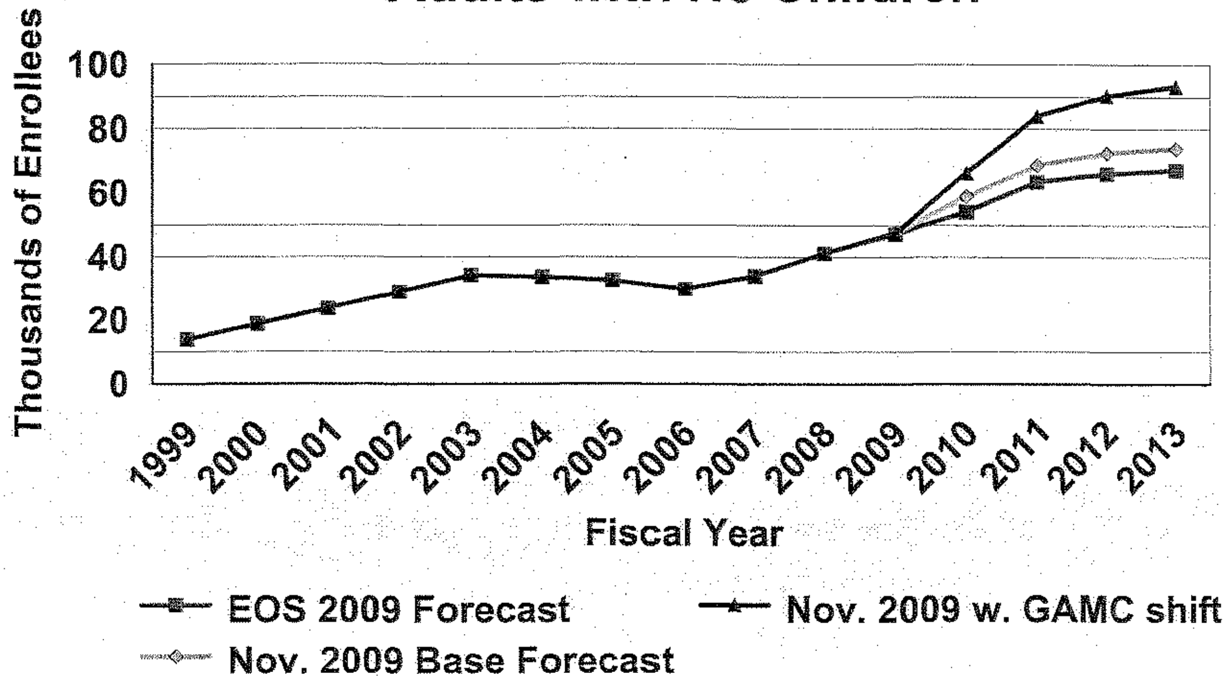
Adults without Children

The 2005 Legislature adopted a requirement to shift most GAMC-only enrollees to MinnesotaCare after their initial months of GAMC enrollment. This new policy took effect in September 2006 and is referred to as Transitional MinnesotaCare. Transitional MinnesotaCare enrollees receive six months of eligibility, of which on average two months of FFS coverage are funded by GAMC and four months of managed care coverage are covered by MinnesotaCare. (The term "Transitional MinnesotaCare" is used in this section for the months of MinnesotaCare coverage.) Certain "qualifiers" in the law exempt other GAMC recipients from enrollment in Transitional MinnesotaCare and permit them to remain in regular GAMC.

Excluding Transitional MinnesotaCare enrollment, average monthly enrollment of adults without children increased by 22% in FY 2009 as compared to the previous fiscal year. Noteworthy is that this increase appears to be driven by an increase in newly added enrollment each month with little change in monthly enrollment drops. This is consistent with the projected lagged effects of the challenging labor market on MinnesotaCare enrollment of adults without children. However, the economic impacts on enrollment appear to be greater than anticipated in the previous forecast. In addition to the economy, MinnesotaCare enrollment growth of adults can be at least partly attributed to additional enrollees who have remained on MinnesotaCare following six months in Transitional MinnesotaCare. (We refer to these enrollees as "graduates" of Transitional MinnesotaCare.) Also affecting enrollment growth is an increase in income eligibility for adults to 200% FPG effective January 2008 and to 250% FPG effective July 2009. Relative to the end of session forecast, base enrollment projections for adults without children (excluding Transitional MinnesotaCare) in the November forecast are about 8% higher in the current and about 10% higher in the next biennium. Due to the continued poor outlook for Minnesota's labor market, similar base enrollment increases are projected for Transitional MinnesotaCare HMO enrollees.

In addition to base enrollment changes, the November forecast recognizes an enrollment shift from GAMC due to the Governor's veto of GAMC funding during the 2009 legislative session. This enrollment shift is expected to begin March 2010. All current regular GAMC enrollees (those with a qualifier) will be enrolled in Transitional MinnesotaCare for the remainder of their six-month GAMC eligibility period. At that time, their eligibility for regular MinnesotaCare will be reviewed. Also beginning March 2010 new applicants who would have been approved for GAMC will be enrolled in Transitional MinnesotaCare instead.

The shift of enrollment from GAMC is expected to increase Transitional MinnesotaCare enrollment by about 70% and MinnesotaCare adults without children enrollment by about 7% in this biennium and about 20% in the next biennium. Since the GAMC enrollees who are shifting to MinnesotaCare are in general more expensive than current MinnesotaCare enrollees and GAMC managed care rates much higher than Transitional MinnesotaCare rates, the relative cost of the shift is greater than the relative enrollment effect. The GAMC shift is projected to increase base Transitional MinnesotaCare costs by about 150% and MinnesotaCare adults without children costs by about 20% in the current biennium and about 44% in the next biennium.



Apart from the enrollment shift from GAMC, managed care rates for MinnesotaCare adults without children will be considerably higher for CY 2010 than expected in the previous forecast. The new rates reflect actual health plan experience in CY 2008 and revised trend assumptions. In general, the upward movement of rates appears to be the result of sicker people entering MinnesotaCare from GAMC by way of Transitional MinnesotaCare. (The following sections address what the change in rates would be, if not for the expected shift of enrollment of regular GAMC enrollees after GAMC coverage ends. The anticipated costs of the additional GAMC population will result in substantial added rate increases.)

HMO rates effective January 2010 for Transitional MinnesotaCare enrollees would be about 28% higher than CY 2009 rates. This is a direct reflection of higher costs experienced by the health plans for Transitional MinnesotaCare enrollees. Allowing for the 7.5% increase anticipated in the previous forecast, this represents an increase of about 21% in expected costs.

HMO rates effective January 2010 for MinnesotaCare adults without children (excluding Transitional MinnesotaCare enrollees) would be about 19% higher than CY 2009 rates. Rate increases of 7.5% were anticipated in the CY 2010 rates, which would put the new rates about 11.5% higher than anticipated; but other adjustments reflecting actual experience in CY 2009 put the net increase in average costs at about 16%.

Average monthly premium revenue for MinnesotaCare adults without children was slightly higher than anticipated during the first few months of FY 2010. This results in small cost savings due to slightly higher projected premium revenue of about 1% in both the current and the next biennium.

Finally, the same legislative issue of the managed care withhold as mentioned above applies to the MinnesotaCare adults without children also.

Projecting the Shift of GAMC Recipients to MinnesotaCare

The effect of the end of GAMC coverage on MinnesotaCare enrollment has been projected by monthly cohorts. The cohorts of those who have months of GAMC eligibility remaining when GAMC coverage ends were distinguished from cohorts of new applicants. Those with remaining months of eligibility were assumed to be transferred to Transitional MinnesotaCare for varying numbers of months depending on their remaining GAMC eligibility. New applicants were assumed to get an average of 3.5 months of Transitional MinnesotaCare coverage.

Each cohort, at the end of its Transitional MinnesotaCare coverage was assumed to be reviewed for regular MinnesotaCare eligibility. Based on experience with the current Transitional MinnesotaCare group, 25% of those coming to the end of Transitional MinnesotaCare were assumed to transition to regular MinnesotaCare. Of these, about 67% were assumed to remain on MinnesotaCare after their first 12-month eligibility review (month 13 of regular MinnesotaCare) and 41% to remain after their second 12-month eligibility review (month 25 of regular MinnesotaCare).

The following table shows the projected increase in MinnesotaCare enrollment as a percentage of projected GAMC enrollment and as a percentage of projected GAMC managed care enrollment:

	Average Added MinnesotaCare Enrollment	**% of GAMC with Qualifier Total Enrollment**	**% of GAMC with Qualifier Man. Care Enrollment**
FY 2010 (4 months)	21,913	73.1%	98.1%
FY 2011	15,274	50.9%	68.3%
FY 2012	17,702	59.1%	79.3%
FY 2013	19,226	64.4%	86.5%

Proportions are relatively large for four months of FY 2010 because of the automatic shift of current GAMC enrollees when GAMC coverage ends. Proportions fall off somewhat in FY 2011 as the effect of the initial automatic shift declines. Then they rise in the next biennium based on the projected survival of earlier cohorts in regular MinnesotaCare.

Health Care Access Fund Solvency Issues
November 2009 Forecast

(in millions)

	FY 2010	FY 2011	FY 2012	FY 2013
Projected Balance/(Shortfall)	**$166**	**$0**	**($371)**	**~~($839)~~** 468 (George Hoffman)
Added MinnesotaCare Expenditures in Forecast				
Due to GAMC Line-item Veto	$68	$185	$239	$281
Due to other factors	$53	$88	$74	$90
Total	**$121**	**$273**	**$313**	**$371**
Assumed General Fund Impact per M.S. 16A.724				
No Transfer from Health Care Access Fund to General Fund	$0	($48)	($48)	($48)
Transfer from General Fund to Health Care Access Fund	$0	($110)	$0	$0
Total	**$0**	**($159)**	**($48)**	**($48)**
Projected Balance/(Shortfall) Without Line-item Veto	**$235**	**$96**	**($36)**	**($223)**

Prepared by Minnesota Management & Budget, December 16, 2009

Kristin Dybdal

Created by House Health Care and Human Services Finance Committee

Estimated Disenrollment in MinnesotaCare in FY 2012/2013 under Minnesota Statutes § 256L.02, subd. 3(b) (2009)
(all figures are thousands of dollars)

	FY 2012	FY 2013
Projected Health Care Access Fund Deficits:	($371,109)	(~~$839~~,140) 468
Forecasted cost of childless adults:		
Adults with No Children (excl. Limited Benefit Set and Transitional MnCare)	$565,699	$648,968
Transitional MnCare	$187,699	$199,197
TOTALS:	**$753,398**	**$848,165**
Childless adults -monthly average enrollees	90,299	93,165
Adults with No Children (excl. Limited Benefit Set and Transitional MnCare)	71,454	74,340
Transitional MnCare	18,845	18,825
Per person per year childless adults costs	$8,343	$9,104
# of people disenrolled due to deficits:	***44,481***	***92,173***
(as a percent of total childless adults)	***49.3%***	***98.9%***

George Hoffman

Source: DHS Budgets and Forecasts, November 2009

Health Reform Implementation Update
December 2009

GUIDING PRINCIPLES: The unique, comprehensive package seeks to create meaningful, transformative health reform based on the Institute for Healthcare Improvement's Triple Aim. The goals of the Triple Aim are to *simultaneously*:

- Improve the health of the population;
- Improve the patient/consumer experience; and
- Improve the affordability of health care.

Unprecedented collaboration among public and private partners – including consumers, patients, providers and payers – is critical to achieving these goals.

POPULATION HEALTH

While all of the reforms strive to improve the health of all Minnesotans, an integral part of the health reform law is the public health component, the Statewide Health Improvement Program (SHIP). The goal of SHIP is to help Minnesotans live longer, healthier lives by reducing the burden of chronic disease. SHIP will use effective, evidence-based strategies to create changes in policies, environments and systems to support healthy behaviors that reduce tobacco use and obesity, the leading preventable causes of illness and death.

- 40 grants have been awarded to community health boards throughout the state (several submitted joint applications) and tribal governments. These grants cover 87 out of Minnesota's 87 counties and eight of 11 tribal governments.
- Grantees are required to create community action plans, assemble community leadership teams, establish partnerships, and implement and evaluate interventions in order to make progress toward a set of process and performance measures.

MARKET TRANSPARENCY & ENHANCED INFORMATION

These reforms aim to improve the transparency of health care quality, cost and value in Minnesota, and to provide better information so that consumers, providers, purchasers and policymakers can make more informed decisions about health care. The goal of this transparency is to promote quality improvement, better management of chronic disease and more efficient resource use.

- **Statewide Quality Reporting System.** MDH has contracted with a consortium led by MN Community Measurement (MNCM) to develop recommendations for a set of standard quality measures and a set of quality measures for public reporting. The measures development process included public input, including a 30-day comment period after the proposed rule was published in September. MDH anticipates the adoption of a final rule in December.
- **Provider Peer Grouping.** The peer grouping system will compare providers based on value (including both quality and risk-adjusted cost), offering more comprehensive information for consumers, providers, health plans and employers. The system will use the quality measures currently used and those under development, as well as de-identified encounter data. An advisory group whose charge was to make recommendations to the Commissioner of Health on how to appropriately compare providers has written a final report on the methodology. The report is available on our Web site, and MDH has solicited public comments on it. MDH has issued a request for proposals to implement the provider peer grouping system; the deadline for responses is December 23.

Care Redesign & Payment Reform

The law incorporates models that will change the way we deliver and pay for health care, with the goal of improving quality, reducing costs and promoting more consumer engagement in health care choices.

- **Health Care Homes.** A health care home is a redesign of primary care, allowing providers, patients and families to work in partnership to improve health and quality of life. Health care homes aim to improve the patient experience by centering care around the patient and family, improving access to care, and coordinating care between providers and community resources. Health care homes also represent one type of payment reform because providers will be reimbursed for care coordination and recertified based on outcomes. The proposed rule for certification of health care homes was adopted by the Commissioner of Health in November and will become effective when it is published in the State Register. The certification process has begun, and MDH has received 19 letters of intent to apply for certification. MDH and DHS are in the process of developing the payment methodology and have solicited public comments on the proposed methodology. Two educational conferences have been done with further development of the learning collaborative in process.
- **Baskets of Care.** Baskets of care will bundle services together in order to encourage providers, payers and consumers to think differently about episodes of care by packaging related services together in a way that supports high-quality, lower-cost care. Baskets pull together health care services that are currently paid for separately, but are usually combined to deliver a full diagnostic or treatment procedure for a patient. The initial eight baskets will include diabetes, prediabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain and total knee replacement. A proposed rule for baskets of care was published on December 7, and the 30-day comment period will end on January 5.

Other Initiatives

- **Consumer Engagement.** The legislation requires that MDH develop strategies to engage consumers around the issues of cost and quality in health care. MDH has been embedding discussions and awareness about these issues throughout the health reform efforts. MDH is exploring what incentives are needed to get consumers to act themselves or advocate for health system changes.
- **E-health.** MDH and the e-Health Advisory Committee are working to ensure that all health care providers have interoperable health records by 2015. This effort is supported by an estimated $600-800 million in Medicare and Medicaid incentive payments for meaningful use of electronic health records. MDH and DHS are actively working through state and Federal efforts to help providers meet health information exchange and quality reporting requirements for the incentive payments.
- **Administrative simplification.** Health care payers and providers are now required to conduct eligibility verifications, claims and remittance advice transactions electronically using a standard format and content. Implementing these standards is expected to save the health care delivery system $60 million annually. MDH and the Minnesota AUC are currently working on developing standard transactions guides for new Federal requirements and to achieve further administrative simplification.
- **Essential benefit set.** A work group met this fall to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. Challenges associated with designing the essential benefit set include tradeoffs between comprehensiveness of benefits and affordability, and designing mechanisms to encourage greater use of effective health care services and less use of ineffective or low-value services. The work group's report is due to the Legislature on January 15.
- **Projecting health care costs and measuring savings.** In June 2009, MDH produced baseline health care spending projections through 2018. In June 2010 MDH will begin publishing annual estimates for public and private health care spending. As required by law, MDH will determine the difference between actual and projected spending and the percentage of estimated savings that are attributable to state-administered health care programs.

For more information: www.health.state.mn.us/healthreform

SHIP: The Statewide Health Improvement Program

The goal of the Statewide Health Improvement Program (SHIP) is to help Minnesotans live longer, healthier, better lives by preventing risk factors that lead to chronic disease.

SHIP is an integral component of an overall health care reform initiative passed during the 2008 Legislative session. Minnesota's health reforms aim to simultaneously improve the health of Minnesotans, enhance the patient experience and contain the spiraling costs of health care in our state.

Why do we need SHIP?

Tobacco use and exposure and obesity are leading causes of chronic disease[i].

- In Minnesota, 38 percent of adults are classified as overweight based on Body Mass Index (BMI), and 25 percent of adults are classified as obese.
- Only 24 percent of adults consume five or more fruits and vegetables per day.
- Only 51 percent of adults get 30 or more minutes of moderate physical activity five days per week.
- 18 percent of adults are current smokers.

The result is that many Minnesotans live with chronic diseases:

- 23,500 new cases of cancer were identified in 2006.
- In 2006 139,000 Minnesotans were diagnosed with coronary heart disease or angina, and 71,000 Minnesotans had a stroke.
- 322,000 Minnesotans had diabetes, and more than one million Minnesotans had prediabetes in 2005. These conditions increase the risk of heart disease, blindness, renal failure, amputations and death.
- 11 percent of Minnesotans either have asthma or have had it in the past.

How will SHIP help?

SHIP addresses the top three preventable causes of illness and death in the U.S. by:

- Reducing the percentage of Minnesotans who use or are exposed to tobacco.
- Reducing the percentage of Minnesotans who are obese or overweight through better nutrition and increased physical activity.

What makes SHIP different from other prevention programs?

Some prevention programs focus on individual behavior change. Behavior change from programmatic efforts can be difficult to sustain beyond the life of the program or the individual's involvement in the program. But behavior change can be maintained if the environment supports it. SHIP aims to create sustainable, systemic changes that make it easier for Minnesotans to choose healthy behaviors.

SHIP grants are awarded to community health boards and tribal governments across Minnesota. Grantees will work in their communities to employ evidence-based strategies to make policy, systems and environmental change in four settings:

- Schools
- Communities
- Worksites
- Health Care Systems

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Comment line: 651-201-5530
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Web: www.health.state.mn.us/healthreform

What are policy, systems and environmental changes?

SHIP focuses on broad, behind-the-scenes changes that make it easier for people to incorporate healthy behaviors into their daily lives.

- Policy interventions include changes in laws and regulations, such as restricting smoking in public buildings and providing time off during work hours for physical activity.
- Systems interventions create change in organizations and institutions, such as a school district implementing food preparation options or offering more time in physical education in all schools in the district.
- Environmental interventions include decisions about land use, zoning and community design, such as ensuring that neighborhoods have access to healthy foods and there are ample opportunities for activities such as walking and biking.

How do risk factors relate to health care costs?

Studies prove that risk factors such as tobacco use, obesity and physical inactivity increase health care costs.

A HealthPartners study of over 5,000 adult enrollees in 1995-1996 found that[ii]:

- Each additional unit of BMI increased medical charges by nearly 2 percent.
- A history of tobacco use was associated with 26 percent higher medical charges.
- Each additional day of physical activity per week reduced medical charges by almost 5 percent.

A national study found that 27 percent of health care charges for adults over age 40 are associated with people being physically inactive, overweight and/or obese[iii].

Per capita private health insurance spending for obese adults was $1,272 higher than that for normal weight adults in 2002[iv].

How will we know if SHIP is effective?

The changes implemented through SHIP will require considerable time and effort, so large-scale, population-based changes in health behaviors will take time to emerge.

Nonetheless, evaluation and effective outcomes are an essential component of SHIP. Both the Minnesota Department of Health and individual SHIP grantees will measure outcomes of the program. Measurements will provide information about:

- Health care costs
- Risk factors of tobacco use/exposure and obesity and related chronic disease
- Individual health behaviors linked to tobacco use/exposure and obesity
- Policy, systems and environmental changes that are proven to reduce tobacco use/exposure and obesity
- Activities that move local communities toward those changes

References

[i] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/BRFSS/

[ii] Pronk NP, Goodman MJ, O'Connor PJ, Martinson BC. Relationship between modifiable health risks and short-term health care charges. JAMA. 1999 Dec 15; 282(23):2235-9.

[iii] Anderson DR, Whitmer RW, Goetzel RZ, Ozminkowski RJ, Dunn RL, Wasserman J, Serxner S. The relationship between modifiable health risks and group-level health care expenditures. Am J Health Promot. 2000 Sep-Oct; 15(1):45-52.

[iv] Thorpe, KE. Factors accounting for the rise in health-care spending in the United States: the role of rising disease prevalence and treatment intensity. Public Health. 2006 Nov; 120(11):1002-7.

Statewide Health Improvement Program (SHIP) Update: December 1, 2008

In 2008, SHIP was signed into law as an integral public health component of the Minnesota Health Reform Initiative. Under the auspices of SHIP, communities and tribes across Minnesota will implement policy, systems, and environmental changes aimed at reducing obesity and tobacco use, which will in turn reduce the statewide burden of chronic disease and decrease health care costs. In Fiscal Years 2010 and 2011, $47 million will be awarded through competitive grants to Community Health Boards (CHBs) and tribal governments beginning July 1, 2009.

SHIP Development Structure

- The SHIP Executive Team oversees all relevant activities. Six Work Groups report to the SHIP Executive Team: Request for Proposals (RFP) Development Work Group, Intervention Work Group, Evaluation and Data Collection Work Group, Technical Assistance Work Group, Communications Work Group, and Chronic Disease Integration Work Group. MDH staff, representatives from Local Public Health organizations and tribal governments also participates in most of the Work Groups (with the exception of the RFP Work Group, due to conflict of interest issues).
- A State Community Health Services Advisory Committee (SCHSAC) SHIP Ad Hoc Work Group convenes in December to provide additional local level input.
- Other external partners in the state offer input as needed and have been meeting regularly with staff from MDH including numerous non-profits, HMO's and institutes of higher learning. Some of the work being done by the Executive Team and these Work Groups is outlined below.

Structure for Awarding and Receiving SHIP Grants Funding

- Funding methodology has been determined for competitive grant awards, this information will be communicated to potential grantees on December 1, 2008.
- Funding will be awarded in two phases: Phase I – Planning and Assessment Phase, and Phase II – Implementation Phase.
    - CHBs and tribal governments awarded funds for Phase I may remain in Phase I for up to nine months.
    - CHBs and tribal governments will need to show evidence of readiness to move into Phase II.
    - If an applicant has completed sufficient planning and assessment prior to initial application, funding will be awarded for Phase II.
    - Criteria for receiving funding for Phase I or Phase II is being developed, and the application for funding will rely in part on a system that CHBs are already using, the Community Health Assessment and Action Planning (CHAAP) system.
    - SHIP-relevant assessment will be added to this existing system.

- The first was a webcast on November 24, 2008. The webcast was designed to outline the meaning of "policy, systems, and environmental change" and provide examples about how this work might be done in communities and tribes in Minnesota. Donna Nichols, M.S. Ed., C.H.E.S., a nationally-recognized expert in this topic, as well as the principal health promotion policy and partnership manager for Directors of Health Promotion and Education (DHPE), was the keynote speaker at this webcast.
- The second opportunity will be a videoconference on January 21, 2009 designed to assist applicants in writing a comprehensive, cohesive, and effective grant application.
- The third opportunity will be an in-person conference in the Twin Cities in March 2009 to help applicants think through the first steps in implementing policy, systems, and environmental change in their own communities and tribes. Planning for the second two technical assistance opportunities is underway, and planning for post-award technical assistance has also begun.

SHIP Timeline

- Applications for funding will be released in February 2009;
- Applications will be due in May 2009;
- Initial funds will be awarded on July 1, 2009.

MINNESOTA'S VISION | HCH Health Care Homes
A Better State of Health

December 2009

Legislation

2007: Minnesota passed first "medical home" legislation, called "provider directed care coordination," for patients with complex illness in the Medicaid fee-for-service population. More information is online at www.dhs.state.mn.us/primarycarecoordination .

The Governor's Health Care Transformation Taskforce and Legislature's Health Care Access Commission both endorse medical homes.

2008: Health care reform legislation requires development of "health care homes" for all Medicaid, SCHIP, state employees and privately insured Minnesotans (statute 256B.0751 and 62U.03).

The Minnesota approach to health care homes

The Health Care Home is a transformative change in the delivery of primary care. The design principles for health care home in Minnesota focus broadly on the continuum of "health" and incorporate expectations for engagement of the patient, family and community. Fundamentally, health care home is a change in the patient-provider relationship augmented by financial structures and measurement of results. Expectations for transformative change must be sufficient to achieve these results. Among these expectations are:

- **Patient- and family-centered care**
- **Quality improvement teams**
- **Learning collaborative**
- **Financial structures**
- **Recertification**

Steps in Health Care Home program development

Foundational components

- Outcomes recommendations
- Capacity assessment – clinic and public
- Patient/family/consumer council
- Resource and Education Committee

Program components

- Certification criteria
- Certification and recertification process

www.health.state.mn.us/healthreform

- Payment methodology
- Learning collaborative
- Outcome measurement

Progress to date and upcoming activities

Program components

Health care home criteria

- Recommendations for health care home certification standards were presented to the Commissioners of Health and Human Services in early February. There are five standards with measureable criteria that support each standard. The major categories for standards include:
    - Access / communication
    - Patient tracking and registry functions
    - Care coordination
    - Care plans
    - Performance reporting and quality improvement.
- The Commissioner of Health, Dr. Sanne Magnan, adopted the rule by order and on November 25, 2009, the Administrative Law Judge Eric L. Lipman signed an order that the proposed rules were adopted in compliance with the procedural requirements

Certification and recertification process
Process workgroup is developing tools and processes to include in the initial certification site visits. Recertification requires the demonstration of progress towards Health Care Home outcomes.

Initial steps in the verification process with consistent language in the form of standards and criteria in the HCH rule for certification that all types of clinics, in all areas of the State have been developed. The HCH certification process design, an online web-based program, is under development and as of December 4, 2009, MDH has received thirty-two (32) requests for access to submit a letter of intent, and eighteen (19) submitted letters of intent from various clinics, clinicians, and health systems across the State.

Payment methodology

Legislative requirement for Care Coordination Payment

256B.0753

- DHS and MDH develop a system of per-person care coordination payments to certified HCHs by January 1, 2010
- Fees vary by thresholds of patient complexity

- Agencies consider feasibility of including non-medical complexity information
- Implemented for all public program enrollees by July 1, 2010

62U.03

- Health plans include HCHs in their provider networks by January 1, 2010 and make care coordination payments by July 1, 2010
- Payment conditions and terms shall be developed "in a manner that is consistent with" the system under 256B.0753

A payment methodology steering committee has met over the second half of 2009. Payment methodology is due to be completed by January 2010. The statute requires stratification of care coordination payments by medical and "non medical" complexity. Stratification will identify patients with chronic conditions requiring care coordination because of the severity, likelihood to be persistent or recur, or need for specialty care.

Payment methodology subgroups include:

- Clinic and health plan processes for health care home payment
- Patient risk stratification and payment architecture
- Consumer/patient payment considerations.

Payment principles:

- Care coordination payment will reflect the patient's medical complexity, and will evolve toward reflecting complexity in care coordination needs such as limited English-language skills, social detreminants, and other barriers to health care.
- Providers will prospectively self-identify patients eligible for care coordination payments, using a common method across payers that includes information on medical and non-medical complexity.
- Care coordination services will be coded consistently across practices and payers, fostering uniformity in definitions of the duration of service, level of patient complexity, etc.
- Gate keeping (limiting services via primary care solely as a cost containment mechanism) is inconsistent with the health care home model. However, health care home providers will be accountable for outcomes related to health, patient experience, and cost.
- Improvement in outcomes related to health, patient experience, and cost as commonly agreed-upon will be required for continued certification as a health care home

- Payment methodology will be collaboratively refined and will evolve over time.

Learning collaborative

- Wilder research has completed a contract to report on learning collaborative research and implementation models.
http://www.health.state.mn.us/healthreform/homes/collaborative/index.html

Outcome measures

The Health Care Homes Outcomes Measurement Advisory Workgroup began meeting in August 2009. The purpose of this workgroup is to recommend a decision-making process for measuring health care home improvement in the areas of patient health, patient experience and cost-effectiveness. An Outcomes Measurement Technical Advisory Team will review individual measures for recommendation to the Advisory Group. Individual measures will be consistent with the recommendations of the ICSI HCH outcomes report.

National considerations

CMS announced this fall the development of an Advanced Primary Care (medical home) demonstration program for Medicare.

Intention is for Medicare to join existing state-led multi-payer medical home initiatives, with a focus on:

- Substantial support from primary care physicians
- Rigorous standards for practice qualification
- Integration of community resources
- Prospective assurance of budget neutrality

Application is due out early in 2010. Minnesota is uniquely positioned and intends to apply.

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2008 Health Care Reform
ARTICLE 3: INCREASING ACCESS; CONTINUITY OF CARE

Section 1. **FREE AND REDUCED SCHOOL LUNCH PROGRAM DATA SHARING.** Data exchange of students receiving free and reduced lunch program

- Working with the Minnesota Department of Education (MDE) to exchange data.

Sec. 2. **Subd. 27. Application and renewal forms.** Designates that DHS shall make state health care program application and renewals available on the department's website in the most common foreign languages

- Completed, the form in the most common foreign languages is available on the DHS website.

Sec. 3. **Subd. 5. Incentive program**. Increases application assistance bonus from $20 to $25

- Successfully implemented the Minnesota Community Application Assistance (MNCAA) program.

Sec. 4. **Subd. 6. School districts.** Lessens outreach requirements for school districts. Also clarifies that school districts are eligible for the application assistance bonus.

- This is the responsibility of MDE. DHS has worked with MDE to exchange information and Health Care information has been posted on their website.

Sec. 5. **Subd. 2c. ~~Extended coverage for~~ Seamless coverage for MinnesotaCare eligible children**. Additional 2 months of coverage for children who become ineligible for Medical Assistance due to excess income.

- The change has been requested in a waiver amendment submitted to CMS as part of the 2009 amendment package sent September 30th, 2009.

Sec. 6. **Subdivision 1. Families with children**. Increases the $50,000 income limit for parents to $57,500

- The change has been requested in a waiver amendment submitted to CMS as part of the 2009 amendment package sent September 30th, 2009.

Sec. 7. **Subd. 7. Single adults and households with no children**. Increases the MinnesotaCare income limit for adults without children from 200% to 250% of FPG

- Implemented July 1, 2009.

Sec. 8. **Subd. 3a. Renewal of eligibility.** Designates that enrollees who experience no change in circumstances, may renew eligibility at designated locations including community clinics and health care providers' offices. Also allows MinnesotaCare enrollees who fail to submit renewal forms to remain eligible for an additional month before being disenrolled. The enrollee remains responsible for the MinnesotaCare premium for the rolling month.

- The change has been requested in a waiver amendment submitted to CMS as part of the 2009 amendment package sent September 30th, 2009.

Sec. 9. **Subd. 3. Commissioner's duties and payment.** Nonpayment of premiums will result in disenrollment effective the first day of the calendar month following the month the premium was due. The commissioner shall waive premiums for coverage to persons disenrolled for nonpayment who reapply under 256L.05, subd. 3b.

- The change has been requested in a waiver amendment submitted to CMS as part of the 2009 amendment package sent September 30th, 2009.

Billi Jo Zielinski DHS

Sec. 10. **Subdivision 1. General requirements.** Effective 1/1/09 or upon federal approval, eliminates the MinnesotaCare requirement that enrollees who have "no other health coverage" for 4 months prior to pay their premium will be disenrolled the month following the month the premium is due. Currently, they are disenrolled the month the premium is due application and renewal. Makes conforming changes to increase the MinnesotaCare income limits to 250 % FPG.

- The change has been requested in a waiver amendment submitted to CMS as part of the 2009 amendment package sent September 30th, 2009.

Sec. 11. **Subd. 2. Sliding fee scale; monthly gross individual or family income.** Provides that MinnesotaCare enrollees must pay premiums based on an affordability scale. The affordability scale is established for individuals and families with gross incomes of 300% of the FPG or less. Children in families with income at or below 150% FPG shall pay a premium of $4.

- Implemented July 1, 2009.

Sec. 12. **<u>AUTOMATION AND COORDINATION FOR STATE HEALTH CARE PROGRAMS.</u>** DHS must report to the legislature on ways to improve coordination between MHCP and social service programs such as WIC and food stamps.

- The report was completed on time.

Sec. 13 **<u>LONG-TERM CARE WORKER HEALTH COVERAGE STUDY.</u>**
A study and report to the legislature with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market.

- Report complete.