National Health Reform Update

Legislative Commission on Health Care Access

July 14, 2010

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Overview

- Majority of implementation details are still unknown - regulations have yet to be released.
- Impact of federal reform may be different in Minnesota as many of the reforms already exist. However, without additional detail it is difficult at this point to determine the level of change that may be required.
- Status of reform implementation under federal law:
  - Regulations and guidance issued to date
  - Provisions currently under discussion
  - Upcoming provisions
- Many of the regulations to date have been "interim final," meaning regulations are adopted and binding without prior public comment - federal agencies may invite post-adoption comments and incorporate in final readopted regulation.

Insurance Market: Regulations Issued

- **Insurance Changes Effective for Plan Years on or After September 23, 2010:**
  (Provisions apply to fully-insured and self-insured plans)
  - No lifetime benefit limits and "restricted" annual benefit limits on the "dollar value of essential benefits"
  - Dependent coverage to age 26
  - Coverage of preventive services and immunizations as recommended by the U.S. Preventive Services Taskforce, CDC, and HRSA without cost-sharing
  - No pre-existing condition exclusions for kids under age 19
  - No rescissions, except in cases of fraud or intentional misrepresentation

- **Minnesota Bulletin Issued June 17, 2010:**
  - Allows health plans to adopt interim endorsements to come into compliance with September 23, 2010 insurance changes
  - Adoption of endorsements is voluntary and will result in expedited review

Insurance Market: Implemented

- **Grandfathered Plans:**
  - Individuals and employers may keep the plan they currently have, but all health plans must comply with the provisions related to lifetime limits, rescissions, and dependent coverage. All employer plans must also comply with the provisions related to pre-ex for kids and "restricted" annual limits.
  - Grandfathered plans may make routine plan changes (e.g. inflation modifiers, adding new benefits, or voluntarily adopting new consumer protections).
  - Plans will lose grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.
  - Grandfathered plans must disclose to consumers that the plan is not subject to various rules and consumer protections under PPACA.

- **Early Retiree Reinsurance Program (ERRP):**
  - Program reimburses sponsors of participating employment-based plans for 80% of claims between $15,000 and $90,000 for early retirees.
  - $5 billion was appropriated for use till January 1, 2014 or until funds exhausted. HHS started accepting applications on June 29, 2010.

Insurance Market: Implemented

- **Web Portal:**
  - http://www.healthcare.gov was launched on July 1, 2010
  - Provides information to consumers to identify coverage options including individual and group plans, Medicare, Medicaid, CHIP, and high risk pools.
  - By October 2010, information on medical loss ratios (MLR), eligibility, availability, premium rates, and cost-sharing will also be available by plan.
  - The site is also structured to provide consumers with recommendations for preventive care and comparison information on provider quality.
  - May be precursor to federal exchange portal.

Insurance Market: Under Discussion

- **Medical Loss Ratio:**
  - In January 2011, 80% MLR for individual and small group, 85% MLR for large group
  - NAIC continues to work on definitions and methodologies for MLR calculation
  - Clinical to include "activities that improve health care quality." Much of NAIC discussion focused on definition of "quality."
- **Premium Rate Review:**
  - In January, annual process to start for premium rate review by states
  - Relationship to state rate review unclear; how are "unreasonable" rates defined and what are the potential sanctions.
  - NAIC still working on recommendations.

Insurance Market: Upcoming

- **Insurance Changes Effective January 1, 2014:**
  - Small group definition set at 1 to 100 employees. No federal definition yet of what counts as an employee. State may act on or before January 2016 to set the definition to size 1 to 50 employees.
  - Premium variation based on health status prohibited for individual and small group.
  - Rating variation for individual and small group limited to tobacco use (1.5:1), age (3:1), geography, and family composition. State to define geographic rating areas.
  - Wellness discounts allowed under HIPAA for group plans increased from 20% to 30% (HHS may increase to 50%). 10-state demonstration to apply wellness discounts to individual market.
  - Guarantee issue (and renewal) required for individual and small group plans during an open enrollment period.
  - Pre-existing condition exclusions prohibited for fully-insured and self-funded plans.
  - Annual limits prohibited for all fully-insured and self-insured plans.

Coverage Requirements & Assistance: Upcoming

- **Individual Coverage Requirement:**
  - Starting 2014, unless exempted, all must have coverage under a "Grandfathered" plan, public program, large employer plan, or at least a "Bronze" or "Young Invincible" plan.
  - Enforced via tax fines administered by IRS.
- **Benefit Requirements:**
  - By 2014, HHS is to establish a minimum benefit set ("Bronze" plan) for individuals and small employers. States may require additional benefits, but must cover the costs of these additional benefits for individuals eligible for Exchange subsidies.
  - Individuals and small employers have the choice of keeping their current plan ("Grandfathering") or choosing from four plan types (Bronze, Silver, Gold, Platinum). A "Young Invincible" plan will also be available.
- **Individual Coverage Assistance**:
  - Medicaid expansion to all non-elderly under 133% FPL in 2014, with no asset test.
  - Premium and cost-sharing subsidies for those not eligible for "affordable" employer coverage between 133% and 400% FPL buying in "Exchange" starting in 2014. States may use 95% of subsidy funds that would have been spent for individuals between 133% and 200% FPL without access to employer coverage to establish a "Basic Health Plan."

Coverage Requirements & Assistance: Upcoming

- **Employer Requirements:**
  - Starting in 2014, employers with 50+ "full-time" employees pay a penalty for employees getting Exchange subsidies (first 30 employees exempt).
  - Full-time employees defined as 30 or more hours per week. Both full-time and part-time employees are included in the calculation of determining if an employer is a "large employer"; however, part-time employees are not included in the penalty calculation.
- **Employer Assistance:**
  - Regulations have been issued for subsidies available in 2010 for employers not offering coverage with 25 or less "full-time" employees with $50,000 average wage. Subsidy limited to 35% of premiums. In 2014, subsidies available for up to 2 years for up to 50% of premiums.
- **State Waiver:**
  - In 2017, states may apply for 5 year waiver of federal requirements related to coverage requirements, benefit requirements, subsidies, and Exchanges.
  - State waiver must provide coverage that is at least as comprehensive and affordable, cover a comparable number of uninsured, and not increase federal funding.

Payment Reform & Care Coordination: Upcoming

- **CMS Innovation Center:** To be created in 2011 to test and expand Medicare and Medicaid payment models that reward value instead of volume, including state all-payer models and other proposals.
- **Medicaid and Medicare efforts, pilots and demonstrations, for example**:
  - Value-Based Purchasing for a variety of Medicare providers with percent of payment tied to quality (Development starting in 2011)
  - Medicare payment incentives/penalties to reduce hospital readmissions (2012)
  - Medicaid Bundled Payment Demonstration (8 states) (2012)
  - Medicare Bundled Payment Pilot (2013)
  - Medicare ACO Shared Savings Program (no later than 2012)
  - Pediatric ACO Demonstration (2012)

Quality Strategy: Upcoming

- **National Strategy:** HHS to develop a national strategy to improve health care quality.
  - A federal interagency workgroup is established in 2010 to coordinate and streamline quality activities and align public and private sector initiatives.
  - HHS to identify gaps in quality measurement and may award contracts for the development of quality measures. Stakeholder group to advise.
  - HHS to collect, aggregate, and publicly report data on quality and resource use.
  - Processes to be developed with stakeholders (including states) for the selection of quality measures to be used in federal programs.
  - HHS to develop and report on 10 quality measures for acute and chronic care and 10 measures on primary and preventive care for physicians and hospitals by 2012.

Medicaid Reform

- **Early Medicaid Expansion:**
  - Childless adults; under 65; up to 133% of FPG; 50% federal match
  - State early option available until 2014, when mandatory
  - New Medicaid category required
  - Legislatively authorized until January 15, 2011
- **Extended "Maintenance of Effort":**
  - States may not change eligibility standards, methodologies or procedures until 2014 for any Medicaid program
  - MOE for children in place until 2019
  - Sole exemption; parents above 133% after 2010 if state is projecting a deficit
  - No increase in local portion of non-federal share

Medicaid Reform

- **Loss of Rx Rebates**
- **Increased Federal Financing:**
  - 23 point increase (up to 88%) in CHIP funding from 2013 to 2019
  - 100% federal match for primary care rate increases for 2013, 2014
  - 90% federal match for health care home services (coordination fees) for 2 years beginning in 2011
- **Home and Community-Based Services:**
  - Creates incentives for providing home and community-based services, developing the Community First Choice Option
  - Directs CMS to remove barriers and promote the delivery of home and community-based services

MINNESOTA'S VISION
A Better State of Health

MINNESOTA MDH DEPARTMENT OF HEALTH

Health Reform Implementation Update
July 2010

GUIDING PRINCIPLES: Minnesota's 2008 health reform 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.

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.

- 41 grants have been awarded to community health boards throughout the state (several submitted joint applications) and tribal governments. These grants cover all of Minnesota's 87 counties and nine 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 and Measurement System.** MDH has contracted with a consortium led by MN Community Measurement (MNCM) to identify and develop recommended measures to be publicly reported by Minnesota physician clinics and hospitals. MNCM will also assist MDH in vetting proposed changes to a broader standardized set of quality measures for which health plans may require providers to submit data. The measure identification and development process is ongoing and includes opportunities for public input, both prior to and as part of an annual formal rulemaking process. The first quality rule was adopted in December 2009, and clinics and hospitals have begun submitting data on measures established in that rule. The Commissioner is required to annually review standardized quality measures, including the subset to be publicly reported. MNCM has submitted recommendations to MDH for changes to the 2010 administrative rule. The amended rule will be released on August 9, followed by a 30-day public comment period.
- **Provider Peer Grouping.** The peer grouping system will compare providers based on value (including both risk-adjusted quality and cost). The system will initially rely on existing quality measures and eventually incorporate other measures currently being developed, as well as de-identified health care claims data for information on price and resource utilization. A contract has been awarded to Mathematica Policy Research to implement the provider peer grouping system, for total care and up to six identified specific health conditions. Mathematica will also collaborate with Minnesota Community Measurement on quality reporting issues and the University of Minnesota to evaluate the project. Work on the project will build on the approach outlined by the Provider Peer Grouping Advisory Group last summer. Monthly conference calls to update stakeholders on the project are ongoing.

Carol Backstrom

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. Certification standards for health care homes were created through a stakeholder process. MDH and DHS have developed the payment methodology and a tool providers can use to categorize patients for payment. MDH held a series of regional workshops on certification throughout Minnesota in May and June, which about 500 people attended.
- **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 include diabetes, prediabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain and total knee replacement. The permanent rule relating to baskets of care became effective in March.

Supporting Activities

- **Consumer Engagement.** The law 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. A report to the Legislature is available on our website.
- **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 to the Legislature is available on our website.
- **Projecting health care costs and measuring savings.** MDH has published annual estimates for public and private health care spending, as well as 10-year projections for what health care spending would have been without Minnesota's health reforms. MDH is required by law to determine the difference between actual and projected spending and the percentage of estimated savings that are attributable to state-administered health care programs. This comparison did not yield savings for 2008, largely because many of the health reforms had not taken place. The report is available on our website.

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

High Risk Pools-Update

Legislative Commission on Health Care Access

July 14, 2010

Manny Munson-Regala
Deputy Commissioner
Minnesota Department of Commerce

Pre-Existing Condition Insurance Plan (PCIP)

- Started Taking Applications July 1, 2010.
- Run by HHS (along with U.S. Office of Personnel Management and the U.S. Department of Agriculture's National Finance Center).
- Primary administrator at HHS ran Maryland High Risk Pool.

PCIP (Cont.)

- Government Employees Health Association (GEHA) a national non-profit insurance association will be the plan administrator.
- Premium Rates and Benefit Design Still Being Set (Expected to come out July 15, 2010).
- Single Plan Design- No Deductible Choices.

PCIP (Cont.)

- According to OCIIO, applicants who are approved for enrollment by July 15th should get coverage starting August 1st, but this is looking more like September 1, 2010.
- Generally, a completed application received **on or before** the 15th of the month will go into effect on the first day of the next month.
- A completed application received **after** the 15th of the month will go into effect on the first day of the following month.

Source: http://www.healthcare.gov/law/about/provisions/pcip/faq/index.html#when

PCIP (Cont.)

- HHS has received around 350 applications as of July 6th (primarily Texas and Florida).
- Averaging 400 calls a day.
- Portal has ability to get applications for 30 states.
- HHS will have state specific data sometime in August.

Coordinating MCHA, PCIP and DHS

- Commerce, DHS and MCHA have reported data to HHS.
- Agency websites have been or will be updated to provide current information on PCIP, MCHA and public programs.
- MCHA website to provide link to PCIP & DHS sites.
- www.HealthCare.gov provides link to information on PCIP site, MCHA & Minnesota Health Care Programs.
- Medical Assistance and MinnesotaCare closing notices already contain information about the MCHA program, including a phone number. Efforts are underway to update.
- MCHA has a Resource list that includes info on coverage options in the private market and Minnesota Health Care Programs. Efforts are underway to update.
- Commerce and DHS have ongoing meetings/calls to discuss coordination.
- Meeting with MCHA, DHS and MCHA's TPA to discuss messaging.

PCIP Comparison to MCHA

	MCHA	PCIP
Eligibility:	Eligibility Requirements: • All enrollees must be residents of Minnesota. Applicants that can apply: • HIPAA eligible; • Health Care Tax Credit (HCTC) eligible; • > 65 and not eligible for Medicare; • Rejection from an agent or insurance carrier; or • Presumptive condition Special Populations: • Ryan White HIV/AIDS individuals through MN DHS • Medicare Eligible: > 65 or < 65 with disability	Eligible Individuals Must: • Be a citizen or national of or lawfully present in the US; • Not have been covered under creditable coverage (as defined in Section 2701 (c) (1) of the Public Health Service Act) for the previous 6 months before applying for coverage; • Have a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary (currently this can be satisfied by a denial letter from a carrier).
Benefits/Coverage:	Pre-existing Condition Limitation: 6 months *(Some statutory waivers)* Deductible Plans: $500; $1,000; $2,000; $5,000; $10,000: and HDHP Outpatient/Other Benefits: Member share is 20% after the deductible is met Individual Out of Pocket Limits: $3000 to $10,000 Lifetime Maximum Benefit: $5 million	Benefits/Coverage Must Have: • An actuarial value of at least 65 percent of total allowed costs; • An out-of-pocket limit no greater than the applicable amount for high-deductible health plans linked to health savings accounts or $5,950 per individual (IRS: 223 (c) (2) • No pre-existing condition exclusions.
Premiums:	• Premiums range between 101% and 125% of the weighted average for a comparable individual policy sold in 's commercial market • Rates are differentiated by 5 year age bands	Premiums Must: • Be established at 100% of the standard non-group rate • Not have age rating greater than 4 to 1 • Expected range is $100 to $900 a month.
Funding:	MCHA is currently funded through member premiums that were set at 123% of market rates in 2010 and by assessments on all insurers that sell health and accident insurance. MN premiums (2009): $122,038,917. MN incurred claims (2009): $241,370,823. MN Assessments (2009): $125,306,804.	Total Federal Funds: $5 Billion (Available: 7/1/10 – 1/1/14) States Allocation based on population similar to SCHIP Funding Formula. Can be reallocated by HHS.

MINNESOTA MDH DEPARTMENT OF HEALTH

MINNESOTA DEPARTMENT OF COMMERCE

LEGISLATIVE COMMISSION ON HEATH CARE ACCESS
Wednesday, July 14, 2010- 12:30 pm
State Capitol—Room 15

THE MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION'S CONTINUING ROLE –POST FEDERAL RISK POOL

- MCHA will continue to serve Minnesota residents who do not qualify for new federal risk pool (the Pre-existing Condition Health Plan) through December 31, 2013,

- Currently, MCHA has 27,137 members

- Who Eligible ? -- Minnesota residents who have pre-existing health conditions, do not have to be without health insurance for six months prior to application, and do not have to be American citizens,

- Premiums will still be above market rates for a comparable individual policy sold in MN,

- Six benefit plans will continue to be offered: $500, $1,000, $3,0000 (federally qualified High Deductible Health Plan), $5000, and $10,000 deductible plans; and a Basic Medicare Supplement plan,

- MCHA will continue to be funded by two sources: 1. Premium revenue that is above market rates—within range of 101% and 125% of average rate for individual policy sold in MN., and 2. Assessments on all companies that sell health insurance in MN. (self-insured companies and organizations cannot be assessed due to federal ERISA law),

- No eligible applicants will be turned away due to lack of program funding.

- MCHA will continue to offer disease management, case management, and multiple health and wellness programs to help members improve their health,

- MCHA will continue to join with the other 34 state high risk pools in seeking grant dollars from Congress to help offset plan losses and help the pool provide premium subsidy programs for low income members,

- MCHA will continue to urge the Minnesota Legislature to help make funding for MCHA more equitable by considering to broaden the funding base by, for example-- increasing Provider Tax (which applies to self-insured firms) or increasing cigarette, alcohol tax)

Lynn Gruchow
MCHA

SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Erin Murphy, 64A
Representative Paul Thissen, 63A

85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

COMMISSION WORKING GROUPS

1. Working groups will update the full Commission on their progress regularly.
2. Working groups will each submit recommendations on their respective topics for consideration by the full Commission.
3. The Commission Co-Chairs will appoint working group co-chairs and members through an application process.
4. Each working group will include a combination of legislators and private or non-profit sector advocates with expertise or interest in that area.
5. The Commission Co-Chairs will outline the scope for each working group and assign a deadline for final recommendations to be submitted to the Commission.
6. Working groups include:
    - Health Insurance Exchange
    - Payment Reform
    - Small Group Insurance Market
    - Work Force Shortage

HEALTH INSURANCE EXCHANGE

Scope: To investigate possible funding and options available to states for studying and operating exchanges.

- Determine how many exchanges are appropriate for Minnesota.
    a. Should we have one for small businesses and one for individuals?
    b. Should we have one for everyone?
- Decide who should operate the exchange
    a. State agency?
    b. Private/public non profit?
- Report on ways which ongoing operating costs could be paid
- Determine the scope of products
    a. Should we include all products or a limited scope?
    b. Should different products be available for different exchanges?
- Determine whether it is best to create our own exchange or participate with a multi state group
- Decide if plan subsidization is needed
    a. Should we do a coverage wrap around?
    b. Should we subsidize further than the Federal Government does?
- Assess the best time to start an exchange
    a. Should we start it before the mandated time of 2014?
    b. Are subsidies available to start earlier?
- Determine if other studies have information on exchanges that would be helpful

PAYMENT REFORM

Scope: To explore payment reform options for Minnesota.

- Investigate waivers or pilot programs for payment reform
- Determine what Minnesota can do beyond federal payment reform
- Explore whether the rule allowing for only one Medicaid pilot project per area will apply to this and if waivers are possible
- Decide whether the advanced primary care pilot or other pilots are best for Minnesota

WORK FORCE SHORTAGE

Scope: To thoroughly review issues and solutions for health care work force shortage in Minnesota.

- Identify current and anticipated health care workforce shortages, by both provider type and geography
- Evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce
- Study alternative incentives to develop, attract, and retain a highly skilled health care workforce and recommend whether to replace, enhance, or supplement current incentives with new ideas, including payment reform

Members:

- Two representatives from the Minnesota Council of Health Plans;
- Two representatives from the Minnesota Association of Health Underwriters;
- One representative from the Insurance Federation of Minnesota;
- One representative from the Minnesota Chamber of Commerce;
- One representative from the National Federation of Independent Businesses - Minnesota;
- Two representatives from employers whose businesses employ 50 employees or fewer;
- Two representatives from employers whose businesses employ between 51 and 75 full-time employees;
- Two representatives from employers whose businesses employ between 76 and 100 full-time employees;
- One representative from employees of businesses that employ 50 employees or fewer;
- One representative from employees of businesses that employ between 51 and 100 full-time employees;
- Two senators, including one member from the majority party and one member from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate;
- Two members of the house of representatives, including one member appointed by the speaker of the house and one member appointed by the minority leader
- The commissioner of commerce or the commissioner's designee.

Scope: To study and report on the options available to increase rate predictability and stability for groups of 100 or fewer employees.

- Analyze implementation options in expanding the small group definition to 100 employees
- Research underwriting concerns and rating requirements and the implications of change in small group market size on the entire health insurance market, and limitations on renewal, enrollment methodologies, and processes
- Study costs for employers, employees, brokers, and health plans
- Determine how to assist employers in understanding the implications of employers migrating from fully insured to self-insured and associated risks
- Create a uniform application form
- Research education and compliance issues related to the offering of Section 125 plans under Minnesota Statutes, section 62U.07
- Assure compliance with federal law, including expeditious implementation of federal health care reform requirements.

Health Care Spending & Projections

July 14, 2010

April Todd-Malmlov
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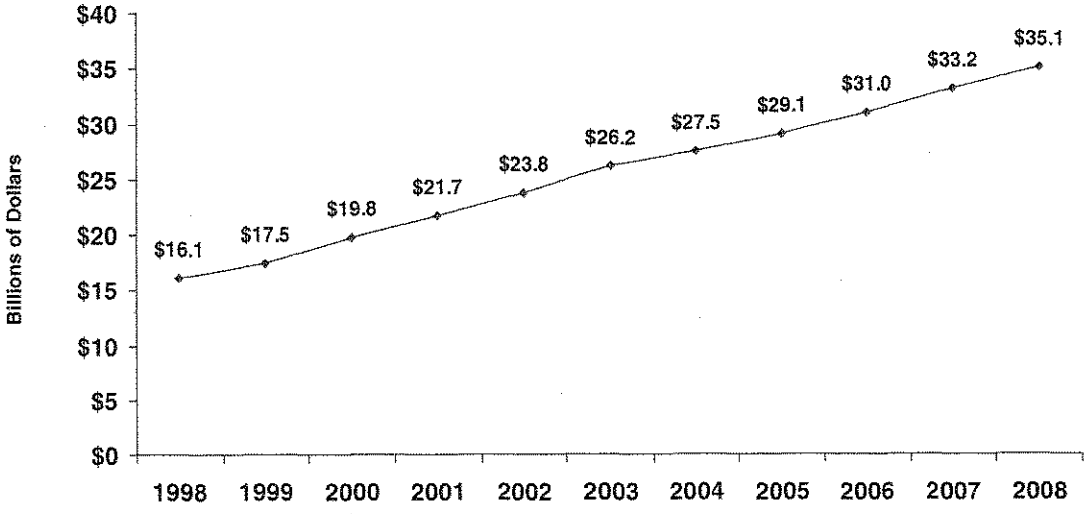
Legislative Requirements[1]

- Estimate *actual* health care spending for MN residents for the calendar year two years prior and obtain actuarial certification of the estimates
- Calculate annual *projected* health care spending for MN residents; establish a health care spending baseline that assumes the 2008 MN reforms were not implemented
- Determine the difference between estimated actual and projected health care spending
- If estimated actual spending is less than projected spending, calculate the portion of the difference attributable to state-administered programs.

[1] Minnesota Statutes, Section 62U.10

Ten Year Trend in Minnesota Health Care Spending



Source: MDH, Health Economics Program

Minnesota and U.S. Total Health Care Expenditure Growth

	2007		2008	
	MN	US	MN	US
Public Spending	8.0%	6.6%	8.2%	6.8%
Private Spending	6.5%	5.1%	4.0%	2.3%
Total Spending	7.1%	5.8%	5.7%	4.4%

Source: MDH, Health Economics Program

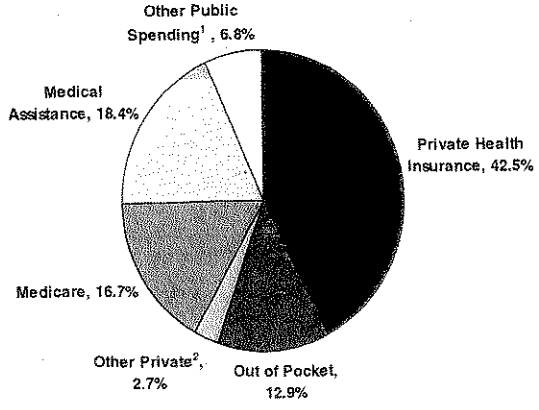
Minnesota and U.S. Per Capita Health Care Spending and Share of the Economy

	2004	2005	2006	2007	2008
Per Capita Spending:					
Minnesota	$5,409	$5,706	$6,029	$6,403	$6,720
U.S.	$5,916	$6,262	$6,616	$6,929	$7,166
Health Care Spending as a Share of the Economy:					
Minnesota	12.3%	12.5%	12.9%	13.2%	13.4%
U.S.	14.6%	14.7%	14.7%	14.8%	15.1%

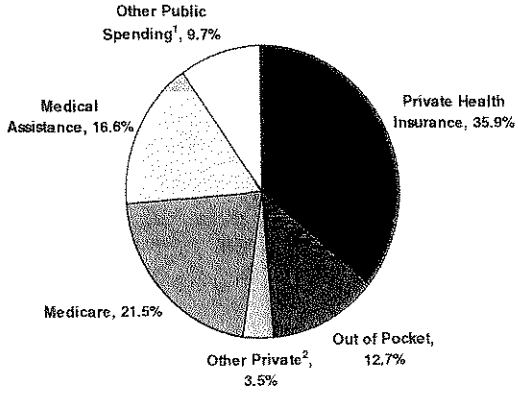
Source: MDH, Health Economics Program

Shares of Health Care Spending by Payer in 2008, Minnesota and U.S.

Minnesota



U.S.



Source: MDH, Health Economics Program

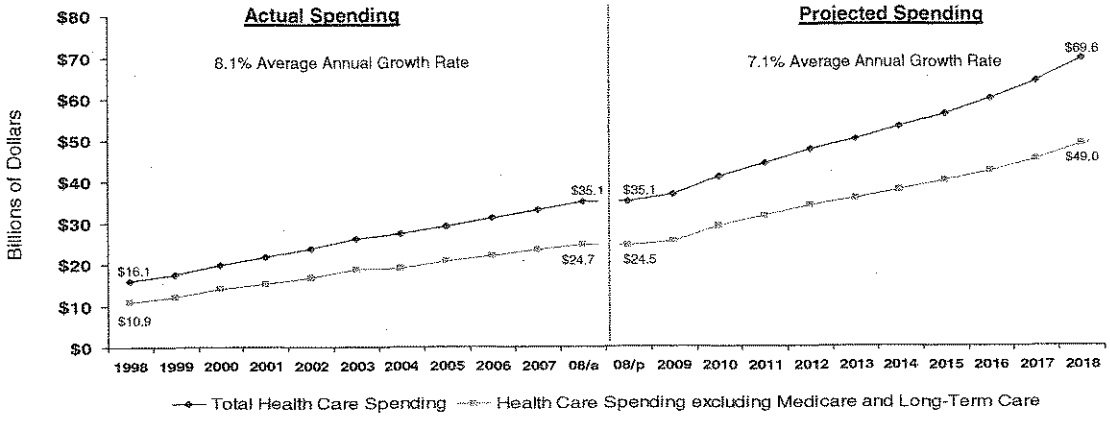
[1] Includes, among others, MinnesotaCare, General Assistance Medical Care, government workers' compensation, Veterans Affairs, and Minnesota Comprehensive Health Association

[2] Other major private payers include private workers' compensation and auto medical insurance

Projections of Health Care Spending

- Do not include the impact of the health care reforms enacted in 2008
- Projections are calculated for total health care spending and spending excluding Medicare and long-term care
- Methods are similar to those used by CMS to develop national health care spending projections
- Projections are derived from:
  - Econometric models of private health care spending
  - Public health care spending projections based on DHS forecasts and the CMS Actuary
- Projections are different from those published earlier:
  - Revisions to macroeconomic variables and methodology to reflect the anticipated effects of the economic recession and recovery
  - Changes to CMS price indices and methods
  - Updated MN-specific health spending estimates

Health Care Spending in Minnesota, 1998-2018



	Actual Spending	Projected Spending	Actual Less Projected	% Difference
Total Spending	$35,149.3	$35,085.5	$63.8	0.2%
Total Spending less Medicare and Long Term Care	$24,662.9	$24,494.3	$168.5	0.7%

Source: MDH, Health Economics Program

PPACA Grant and Demonstration Opportunities

James I. Golden, PhD
Director, Division of Health Policy
Minnesota Department of Health
July 14, 2010

General Grant Issues

- "Authorized" vs. "Authorized and Appropriated"
  - Programs created in authorizing legislation
  - Programs funded through annual appropriation bills
  - Direct/Mandatory funding, includes funding in the authorizing legislation.
- Approximately **70%** of grants and demonstration programs are **only authorized** and **not funded**.

General Grant Issues

- **FOA** – Funding Opportunity Announcement
  - Defines grant/demonstration funds available
    - Formula – competitive – demonstration – cooperative agreement
  - Identifies eligible applicants
  - Outlines application requirements
  - Describes obligations on successful applicants
    - Matching funds
    - Required partners
    - Maintenance of efforts
    - Prohibitions on participation in future grants/demonstration projects
- **Need to ensure** that funding opportunity is operationally feasible, financially viable, and consistent with existing Minnesota policy goals

MINNESOTA MDH DEPARTMENT of HEALTH

State Agency Activities

- Identify potential funding opportunities in statute
- Discuss opportunities with federal counterparts
- Work with national associations to provide advice and input to federal agencies
- Monitor FOAs
- Evaluate FOAs for fit with State efforts
- Apply when it makes sense

MINNESOTA MDH DEPARTMENT of HEALTH

HRSA Funding Opportunities

Provisions Authorized and Appropriated

NEW ACTIVITIES

ROLE OF PUBLIC PROGRAMS

- Section 2951 - Maternal, Infant, and Early Childhood Home Visiting Programs (FY2010)

PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

- Section 4002 - Prevention and Public Health Fund (FY2010):
  1. Healthy Weight Collaborative
  2. Public Health Training Centers
  3. Preventive Health Services - Infants, Children, Adolescents (SEE PPACA § 1001)
- Section 4101 - School-Based Health Centers (FY2010)

STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

- Section 10502 - Infrastructure to Expand Access to Care (FY2010)
- Section 5507 (a)(*b*) - New Demonstration Grant Program to develop Training & Certification Programs for Personal or Home Care Aids (FY2010)
- Section 10503 - Community Health Centers and National Health Service Corps Fund (FY2011)

REAUTHORIZED ACTIVITIES

- Section 5507(b) - Extension of Family -to- Family Health Information Centers (Out-Year)

MINNESOTA MDH DEPARTMENT of HEALTH

HRSA Funding Opportunities

Provisions Authorized Only

REAUTHORIZED ACTIVITIES

Improving Access to Innovative Medical Therapies

- Section 7101 - Expanded Participation in 340B Program (FY2010)
- Section 7102 - Improvements to 340B Program Integrity (FY2010)

Strengthening Quality, Affordable Health Care for All Americans

- Section 10412 - Automated Defibrillation in Adam's Memory Act (No specific date)
- Section 10501(m)(1) - Preventive Medicine and Public Health Training Grant Program (FY2010)
- Section 10501(n)(1) - NHSC Improvements (No specific date)

MINNESOTA MDH DEPARTMENT of HEALTH

HRSA Funding Opportunities

Provisions Authorized Only (cont.)

NEW ACTIVITIES

QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

- Section 1001 [PHS 2713(a)(3)] - Coverage of Preventive Health Services (FY2010)

ROLE OF PUBLIC PROGRAMS

- Section 2952 - Grants for Service to Individuals with a Postpartum Condition and their Families (No specific date)

IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

- Section 3508 - Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals (No specific date)

MINNESOTA MDH DEPARTMENT of HEALTH

HRSA Funding Opportunities

Provisions Authorized Only (cont.)

REAUTHORIZED ACTIVITIES

Improving the Quality and Efficiency of Health Care

- Section 3125 - Extension of and Revisions to Medicare Rural Hospital Flexibility Program (FY2010)
- Section 3510 - Patient Navigator Program (No specific date)
- Section 2505 - Trauma Care Centers and Service Availability (FY2010/2011)

Health Care Workforce

- Section 5101 - National Health Care Workforce Commission Medically Underserved Population (MUP) and Health Profession Shortage Areas (HPSA) Negotiated Rulemaking (FY2010)
- Section 5102 - State Health Care Workforce Development Grants (No specific date)
- Section 5103 - Health Care Workforce Assessment (FY2010)
- Section 5201 - Federally Supported Student Loan Funds (No specific date)
- Section 5202 - Nursing Student Loan Program (No specific date)
- Section 5204 - Pediatric Specialty Loan Repayment Program (No specific date)
- Section 5206 - Public Health Workforce Recruitment & Retention Program Grants for States and Local Programs (No specific date)
- Section 5207 - Funding for NHSC (No specific date)
- Section 5208 - Nurse-Managed Health Clinics (No specific date)
- Section 5301 - Training in Family Medicine, General Internal Medicine, General Pediatrics & Physician Assistantship (No specific date)
- Section 5302 - Training Opportunities for Direct Care Workers (No specific date)
- Section 5303 - Training in General, Pediatric, and Public Health Dentistry (No specific date)
- Section 5304 - Alternative Dental Health Care Provider Demonstration Project (FY2012)
- Section 5305 - Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education (No specific date)
- Section 5306 - Mental and Behavioral Health Education and Training Grants (No specific date)
- Section 5307 - Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training (No specific date)

MINNESOTA MDH DEPARTMENT of HEALTH

HRSA Funding Opportunities

Provisions Authorized Only (cont.)

HEALTH CARE WORKFORCE (cont.)

- Section 5308 - Advanced Nursing Education Grants (No specific date)
- Section 5309 - Nurse Education, Practice, and Retention Grants (No specific date)
- Section 5310 - Nurse Faculty Loan Repayment and Scholarship Program (No specific date)
- Section 5312 - Authorization of Appropriations for Parts B through D of Title VIII (No specific date)
- Section 5401 - Centers of Excellence (No specific date)
- Section 5402 - Health Professions Training for Diversity (No specific date)
- Section 5403 - Interdisciplinary, Community-Based Linkages (No specific date)
- Section 5404 - Nursing Workforce Diversity Grants (No specific date)
- Section 5508 - Increasing Teaching Capacity (No specific date)
- Section 5601 - Spending for Federally Qualified Health Centers (FQHCs) (FY2010)
- Section 5603 - Reauthorization of Wakefield Emergency Medical Services for Children Program (FY2010)

STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

- Section 10333 - Community-Based Collaborative Care Networks (No specific date)
- Section 1050(e) *[Sec 5316]* - Demonstration Grants for Family Nurse Practitioner Training Programs (No specific date)
- Section 1050(f) - Rural Physician Training Grants (FY2010)
- Section 10504 - Demonstration Project to Provide Access to Affordable Care (FY2010)
- Section 10606 - Extension of Medical Malpractice Coverage to Free Clinics (FY2010)

MINNESOTA MDH DEPARTMENT OF HEALTH

FFIS

SPECIAL ANALYSIS 10-02
Health Care Reform: Inventory of Funding Opportunities

May 24, 2010

Summary

The health care reform law includes a number of funding opportunities of interest to states. This analysis provides a listing of those programs along with key funding information. For some programs, the law includes both authorization and appropriations, thereby guaranteeing funding at the specified levels for the years cited in the law. The majority of programs, however, only receive an authorization in the law and will require funding through the appropriations process. As such, it is unclear if or when (and at what levels) these programs will be funded.

Background

In general, discretionary programs follow a two-step process to receive funding. A program is created or continued through enactment of authorizing legislation. This legislation also authorizes the maximum amount to be appropriated by either specifying an amount by fiscal year or allowing for "such sums as may be necessary." The program then may or may not be funded through inclusion in the annual appropriations bill. Almost all discretionary programs included in health care reform fall under the Labor/Health and Human Services (HHS)/Education appropriations bill.

Congress may bypass the two-step process by including funding for the program in the authorizing law. Such spending is referred to as direct or mandatory spending. Some direct spending is funded by permanent appropriations in the authorizing law. Other direct spending (appropriated entitlements such as Medicaid), is funded in appropriations acts, but the amount appropriated is controlled by the authorizing legislation.

Funding Opportunities

Table 1 provides a list of the funding opportunities contained in the health care reform law that may be of interest to states, including those going directly to state or local governments, or to entities within a state, such as institutes of higher education and health care facilities. The table displays, when specified in the law, the following information on each grant:

- Eligible Entities – A listing of entities eligible to directly apply for funds.
- Start Date – In some instances, the law mandates a start date for the program. For example, the Department of Health and Human Services (HHS) must establish the High-Risk Pool within 90 days after the law's enactment. In other instances, the law specifies the fiscal years for which funding is appropriated or authorized. Many of the programs begin in fiscal year (FY) 2010. However, it is unlikely that those programs requiring an appropriation will be funded in FY 2010, given that the end of the fiscal year is less than five months away and supplemental appropriations would be necessary.

JIM GOLDEN

- Direct Appropriation – Indicates if the program's appropriation is included in the law.

- Type of Grant – When specified in the law, the table indicates the type of grant (competitive, formula, demonstration, cooperative agreement). The table does not include selection criteria, which were specified for some of the programs.

- Matching/Maintenance of Effort (MOE) requirements – Indicates when a program requires the grantee to contribute a non-federal share or maintain spending at a certain level. Some of the programs include language to ensure that the funds supplement, not supplant, state funds.

- Discretionary Funding Per the Congressional Budget Office (CBO) – The law does not explicitly specify whether funding is mandatory or discretionary. CBO released a report that estimates the potential effects of health care reform on discretionary spending. Those programs included in the CBO report are highlighted on the table. In contrast, those programs that received a direct appropriation are considered mandatory programs.

- Funding Information – This provides additional details about the funding levels authorized and/or appropriated for the program.

Next Steps

More information on the programs is available in the health care reform law (P.L. 111-148 and P.L. 111-152). However, the program details (such as the timing, programmatic/financial requirements, and the specific funding distribution method) will not be known until the secretary of HHS issues program-specific guidance.

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Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Title I - Quality, Affordable Health Care:							
Health Insurance Consumer Information	State government or exchanges operating in states		Yes (Year 1)			X	$30 million in first year; future years - authorizes such sums as necessary
Premium Review Grants	State government	FY 2010	Yes	Formula			$250 million for FYs 2010-2014; No state should receive less than $1 million or more than $5 million annually
High Risk Pools	State government or non-profit private entity	No later than 90 days after enactment	Yes		MOE level - maintain spending at prior-year level		$5 billion total (for claims and administrative costs)
Wellness Program Demonstration	State government (up to 10)	No later than 7/1/14		Demo.			Cost neutral
Health Insurance Exchange - Planning and Establishment Grants	State government	No later than 3/23/11	Yes	Secretary discretion			Secretary of HHS determines amount; no grants awarded after January 1, 2015
Grants for Implementation of Appropriate Enrollment HIT	State and local government						
Title II - Role of Public Programs:							
Community First Choice Option	State government	FY 2011			Matching based on FMAP		Six percentage point increase in Medicaid FMAP
Money Follows the Person Rebalancing Demonstration (existing program)	State government	FY 2011	Yes	Demo.			$450 million annually for FYs 2011-2016
Aging and Disability Resource Centers (existing program)	State government and territories	FY 2010	Yes	Cooperative agreement	At least 5% of total cost		$10 million annually for FYs 2010-2014

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Medicaid Health Home for Enrollees with Chronic Conditions	State government	1/1/11			Matching based on FMAP		States will receive 90% FMAP for services for first eight quarters
Medicaid Health Home for Enrollees with Chronic Conditions: Planning Grants	State government	1/1/11			Matching based on FMAP		$25 million total
Medicaid Integrated Care Hospitalization Demonstration Program	State government (up to 8)	1/1/12		Demo.			Program through December 31, 2016; budget-neutrality requirement
Medicaid Global Payment System Demonstration Program	State government (up to 5)	FY 2010		Demo.		X	Authorization for such sums as necessary for FYs 2010-2012
Pediatric Accountable Care Organization Demonstration Program	State government	1/1/10		Demo.		X	Authorization for such sums as necessary from January 1, 2010 - December 31, 2016; budget saving requirement
Medicaid Emergency Psychiatric Demonstration Project	State government	FY 2011	Yes	Demo.			$75 million for FY 2011
Maternal, Infant, and Early Childhood Home Visitation Grant Program	State government, territories (non-profit if state doesn't apply or receive funds	FY 2010	Yes		Funds must supplement not supplant state funds		$100 million for FY 2010, $250 million for FY 2011, $350 million for FY 2012, $400 million for FY 2013, $400 million for FY 2014
Services to Individuals with a Postpartum Condition	Public or non-profit entity (including state and local government)	FY 2010				X	Authorizes $3 million in FY 2010 and such sums as necessary for FYs 2011 and 2012
Personal Responsibility Education Grant Program	State government (local organization if state doesn't apply)	FY 2010	Yes	Formula	Maintain FY 2009 spending level		$75 million annually for FYs 2010 - 2014

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Abstinence Education (restoration of funding for existing program)	State government	FY 2010	Yes	Formula			$50 million annually for FYs 2010-2014
Title III – Improving the Quality and Efficiency of Health Care:							
Hospital Value-Based Purchasing Program	Hospitals	FY 2013					Incentive payments made to hospitals for performance are paid for by a reduction in hospital payments
Hospital Value Purchasing Demonstration	Inpatient critical access hospitals and hospitals not eligible for purchasing program	No later than 3/23/12		Demo.			Three-year demonstration, subject to budget neutrality
Grants or Contracts for Quality Measure Development	Entity that meets specified criteria	FY 2010				X	Authorizes $75 million annually for FYs 2010-2014
Grants or Contracts for Collection of Data for Quality and Resource Use Measures	Entity that meets specified criteria	FY 2010			Matching requirement	X	Authorizes such sums as necessary for FYs 2010-2014
Rural Community Hospital Demonstration Program (one-year extension)	Expand participating states			Demo.		X	
Medicare Rural Hospital Flexibility Program (extension)	State government						Authorizes such sums as necessary for FYs 2011-2012 to be appropriated from the Federal Hospital Insurance Fund
Medicare Prescription Drug Program - Additional Funding for Outreach and Assistance for Low-Income Programs (existing program)	State health insurance programs, area agencies on aging, and aging and disability resource	FY 2009	Yes				Specifies additional funding amounts to be appropriated by entity for FYs 2009-2010 ($7.5 million in FY 2009 and $15 million in FY 2010 for health insurance and

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
	centers						agencies on aging; $5 million in FY 2009 and $10 million in FY 2010 for resource centers)
Quality Improvement Technical Assistance and Implementation Grants	Health care provider/org. and other specific entities				Matching		
Community Health Teams	State or state-designated entity						
Regionalized Systems for Emergency Care Responses	State government and state/local partnerships			Competitive	Matching (25% of total funds)	X	
Trauma Care Centers (3 grants)	Qualified public trauma centers	FY 2009			MOE requirement - secretary discretion	X	Authorizes $100 million for FY 2009; such sums as necessary for FYs 2010-2015
Trauma Service Availability	State government	FY 2010		Formula based on approp. level	Funds must supplement not supplant state funds	X	Authorizes $100 million annually for FYs 2010-2015
Demonstration Program to Integrate Quality Improvement and Safety Training into Clinical Education	Specified Institutes of Higher Education (IHEs)			Demo.	Matching		
Title IV - Prevention of Chronic Diseases and Improving Public Health:							
Prevention and Public Health Fund (to increase funding for certain programs authorized by Public Health Services Act)		FY 2010	Yes				$500 million for FY 2010, $750 million for FY 2011, $1 billion for FY 2012, $1.25 billion for FY 2013, $1.5 billion for FY 2014, and $2 billion for FY 2015 and thereafter
Education and Outreach Campaign Regarding Preventive Benefits	Priority funding for states and other entities					X	Authorizes such sums as necessary

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Grants for Establishment of School-Based Health Centers	School-based health center or sponsoring facility	FY 2010	Yes				$50 million annually for FYs 2010-2013
Grants for Operation of School-Based Health Centers	School-based health center or sponsoring facility	FY 2010			Matching (20% of grant); funds must supplement	X	Authorizes such sums as necessary for FYs 2010-2014
Research-Based Dental Disease Management	Community-based provider of dental services (including state or local health departments)					X	Authorizes such sums as necessary
Oral Health Infrastructure	State government and territories	FY 2010		Cooperative agreement		X	Authorizes such sums as necessary for FYs 2010-2014
Pregnancy Risk Assessment Monitoring System (mandated state report)	State government					X	Authorizes such sums as necessary
National Oral Health Surveillance System (to increase participation of states)	State government and territories	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2014
Improving Access to Preventive Services for Eligible Adults in Medicaid	State government	1/1/13			Matching based on FMAP		One percentage point increase in FMAP
Incentives for Prevention of Chronic Diseases in Medicaid	State government	No later than 1/1/11	Yes				$100 million for five-year period, beginning January 1, 2011
Community Transformation Grants	State and local government, and community-based organizations	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2014

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Healthy Aging, Living Well Pilot Project	State and local health departments	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2014
Demonstration Program to Improve Immunization Coverage	State government	FY 2010		Demo.		X	Authorizes such sums as necessary for FYs 2010-2014
Demonstration Project Concerning Individualized Wellness Plan	Community health centers (up to 10)			Cooperative agreement		X	Authorizes such sums as necessary
Epidemiology-Laboratory Capacity Grants	State and local health departments, and academic centers	FY 2010				X	Authorizes $190 million annually from FYs 2010-2013
Program for Education and Training in Pain Care	Health professions schools, hospices, and other private/public entities					X	Authorizes such sums as necessary for FYs 2010-2012
CHIP Obesity Demonstration Program (existing program)	Local government, health department or educational agency; community-based organization; other specified entities	FY 2010	Yes	Demo.			$25 million for FYs 2010-2014
Title V – Health Care Workforce:							
State Workforce Development Grants	State workforce investment boards	FY 2010		Competitive	Matching (planning - 15% of grant, implement - 25% of grant)	X	Planning grants: Authorizes $8 million for FY 2010 and such sums as necessary thereafter; implement grants: authorizes $150 million for FY 2010 and such sums as necessary thereafter

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
State and Regional Centers for Health Workforce Analysis	State, state workforce investment boards, and other specified entities	FY 2010				X	Authorizes $4.5 million annually from FYs 2010-2014; authorizes such sums as necessary for FYs 2010-2014 for longitudinal analysis
Grants to Nurse-Managed Health Clinics	Nurse-managed health clinics	FY 2010				X	Authorizes $50 million for FY 2010 and such sums as necessary from FYs 2011-2014
Primary Care Training and Enhancement	Hospitals, schools of medicine, public or private non-profit entities	FY 2010				X	Authorizes $125 million for FY 2010 and such sums as necessary for FYs 2011-2014
Training Opportunities for Direct Care Workers	IHEs	FY 2011				X	Authorizes $10 million for FYs 2011-2013
Training in General, Pediatric, and Public Health Dentistry	Hospitals, schools of dentistry, public or private non-profit entities	FY 2010				X	Authorizes $30 million for FY 2010 and such sums as necessary for FYs 2011-2015
Alternative Dental Health Care Providers Demonstration Project	IHEs, state or county public health clinics, and other specified entities					X	Authorizes such sums as necessary
Geriatric Workforce Development	Geriatric education centers	FY 2011			Funds must supplement not supplant federal, state, and local funds	X	Authorizes $10.8 million for FYs 2011-2014
Mental and Behavioral Health Education Training Grants	IHEs	FY 2010				X	Authorizes $35 million for FYs 2010-2013

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Nurse Retention Grants	Schools of nursing and health care facilities	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2012
Grants to Promote the Community Health Workforce	Public or non-profit private entities (including states and public health departments)	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2014
Demonstration Grants for Family Nurse Practitioner Training Program	Federally qualified health centers and nurse-managed health clinics	FY 2011					Authorizes such sums as necessary for FYs 2011-2014
Area Health Education Centers	Schools of medicine and schools of nursing	FY 2010			Matching requirement	X	Authorizes $125 million annually for FYs 2010-2014
Primary Care Extension Program - State Hubs	State government	FY 2011		Competitive		X	Authorizes $120 million annually for FYs 2011-2012 and such sums as necessary for FYs 2013-2014
Demonstration Project to Provide Low-Income Individuals with Opportunities to Address Health Professions Workforce Needs	State government, territories, IHEs, local workforce investment board, and others	FY 2010	Yes	Demo.			$80 million annually for FYs 2010-2012, $85 million for FYs 2013-2014
Demonstration Project to Develop Training and Certification Programs for Personal or Home Care Aides	State government (up to 6)	No later than 9/23/11	Yes	Demo.			$5 million annually for FYs 2010-2012
Teaching Health Centers Development Grants	Teaching health centers	FY 2010				X	Authorizes $25 million in FY 2010, $50 million annually in FYs 2011-2012, and such sums as necessary thereafter

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Payments to Teaching Health Centers that Offer Graduate Medical Education Programs	Teaching health centers	FY 2011	Yes	Formula		X	$230 million for FYs 2011-2015
Graduate Nurse Education Demonstration	Hospitals (up to 5)	FY 2012	Yes	Reimburses specified costs			$50 million annually for FYs 2012-2015
Federally Qualified Health Centers (existing program)		FY 2010				X	Authorizes specific funding for FYs 2010-2015, increases authorization from $2.9 billion in FY 2010 to $8.3 billion in FY 2015, with specified adjustments thereafter
Awards for Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings	Qualified community mental health programs	FY 2010				X	Authorizes $50 million for FY 2010 and such sums as necessary for FYs 2011-2014
Title VI – Transparency and Program Integrity:							
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities	State government	FY 2010	Yes		Matching requirement		Not to exceed $160 million for FYs 2010-2012
Establishment and Support of Elder Abuse, Neglect and Exploitation Forensic Centers	IHEs	FY 2011				X	Authorizes $4 million for FY 2011, $6 million for FY 2012, and $8 million annually for FYs 2013-2014
Enhancement of Long-Term Care Facilities	Long-term care facilities	FY 2011				X	Authorizes $20 million for FY 2011, $17.5 million for FY 2012, and $15 million annually for FYs 2013-2014

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Grants to Enhance the provision of Adult Protective Services	State government and territories	FY 2011		Formula	Funds must supplement not supplant federal, state, and local resources	X	Authorizes $100 million annually for FYs 2011-2014
Adult Protective Services - State Demonstration Projects	State and local government	FY 2011				X	Authorizes $25 million annually for FYs 2011-2014
Grants to Support the Long-Term Care Ombudsman Program	Eligible entities with relevant experience	FY 2011				X	Authorizes $5 million in FY 2011, $7.5 million in FY 2012, and $10 million annually for FYs 2013-2014; training program - authorizes $10 million annually for FYs 2011-2014
Grants to State Survey Agencies	State agencies that perform surveys of nursing facilities	FY 2011				X	Authorizes $5 million annually for FYs 2011-2014
Title X – Strengthening Quality, Affordable Health Care for All Americans:							
State Balancing Incentives Program (Medicaid Home- and Community-Based Services)	State government	FY 2012			Maint. of eligibility req.		Increase in FMAP (2 or 5 percentage points); total cannot exceed $3 billion for the 10/1/11 - 9/30/15 period
CHIP Outreach and Enrollment (existing program)	State government		Yes				Extends program through FY 2015 and appropriates an additional $40 million
Pregnancy Assessment Fund	State government	FY 2010	Yes	Competitive			$25 million annually for FYs 2010-2019
Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards	State and local government, community health centers, hospitals, and others	FY 2010	Yes				$23 million for FYs 2010-2014; $20 million for each five year period thereafter

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law

Program Name	Eligible Entities	Start Date	Direct Approp.	Type of Grant	Matching and MOE Provisions	Discretionary $ Per CBO	Funding Information
Community-Based Collaborative Care Network Program	Network should include hospitals and federally qualified health centers	FY 2011				X	Authorizes such sums as necessary for FYs 2011-2015
National Centers of Excellence for Depression	IHEs	FY 2011		Competitive		X	Authorizes $100 million annually for FYs 2011-2014, $150 million annually for FYs 2016-2020
National Diabetes Prevention Program	State and local health departments and other specified entities	FY 2010				X	Authorizes such sums as necessary for FYs 2010-2014
Rural Physician Training Grants	Specified schools	FY 2010			MOE, funds must supplement	X	Authorizes $4 million annually for FYs 2010-2013
Preventive Medicine and Public Health Training Program	State and local health departments, and other specified entities	FY 2011				X	Authorizes $43 million for FY 2011 and such sums as necessary for FYs 2012-2015
Infrastructure to Expand Access to Care	Health care facilities	FY 2010	Yes				$100 million in FY 2010
Community Health Center Fund (to increase funding for existing community health center program)		FY 2011	Yes				$1 billion in FY 2011, $1.2 billion in FY 2012, $1.5 billion in FY 2013, $2.2 billion in FY 2014, and $3.6 billion in FY 2015; an additional $1.5 billion for FYs 2011-2015 for construction
Demonstration Project to Provide Access to Affordable Care	State-based, non-profit, public-private partnership	8/23/10		Demo.		X	Authorizes such sums as necessary

Table 1 - Inventory of Funding Opportunities in Health Care Reform Law							
Program Name	**Eligible Entities**	**Start Date**	**Direct Approp.**	**Type of Grant**	**Matching and MOE Provisions**	**Discretionary $ Per CBO**	**Funding Information**
State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation	State government	FY 2011		Demo.		X	Authorizes $50 million for FYs 2011-2015

PPACA Grant Opportunities Available as of July 9, 2010

Funding Opportunity	Eligibility	Expected #	Total
Affordable Care Act Medicare Beneficiary Outreach and Assistance Program Funding for Title VI Native American Programs	Current Title VI Native American Program Awardees	246	$246,000
Affordable Care Act (ACA) Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program	Native American tribal governments (Federally recognized); Native American tribal organizations (other than Federally recognized tribal governments)	15	$3,000,000
Health Profession Opportunity Grants for Tribes, Tribal Organizations or Tribal College or University	Native American tribal governments (Federally recognized); Tribal colleges or universities	3	$7,500,000
Primary Care Residency Expansion	Eligible applicants include public or nonprofit private hospitals, schools of medicine or osteopathic medicine, or a public or private nonprofit entity which the Secretary has determined is capable of carryout out such grants. To receive grant funds, an applicant or partner organization must be accredited as a residency training program in family medicine, general internal medicine, and/or general pediatrics by the Accreditation Council of Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA).	105	$168,000,000
ACA: Advanced Nursing Education Expansion Program	Eligible applicants are collegiate schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education that offer and have students enrolled in a primary care nurse practitioner program and/or an accredited nurse-midwifery program.	40	$30,000,000
Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals	State governments; Public and State controlled institutions of higher education; Native American tribal governments (Federally recognized); Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education; Nonprofits that do not have a 501(c)(3) status with the IRS, other than institutions of higher education; Private institutions of higher education	17	$51,000,000

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PPACA Grant Opportunities Available as of July 9, 2010

Funding Opportunity	Eligibility	Expected #	Total
Affordable Care Act (ACA) Nursing Assistant and Home Health Aide Program	State-approved community colleges or community-based training programs	10	$2,500,000
Affordable Care Act: Personal and Home Care Aide State Training Program	Applicants that are capable of carrying out the legislative purpose of preparing individuals to become personal and home care aides	6	$750,000
Strengthening the Aging Network: An Opportunity for Training and Evaluation	State governments; County governments; City or township governments; Public and State controlled institutions of higher education; Native American tribal governments (Federally recognized); Native American tribal organizations (other than Federally recognized tribal governments); Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education	1	$500,000
ACA: Expansion of Physician Assistant Training Program	Eligible entities are public or private academically affiliated physician assistant training programs that have as their objective the education of individuals who, upon completion of their studies in the program, will be qualified to provide primary care medical services with the supervision of a physician.	40	$32,000,000
Affordable Care Act (ACA) Nurse Managed Health Clinics	Nurse-practice arrangements managed by advanced practice nurses, which provide primary care or wellness services to underserved or vulnerable populations, and have an association with a school, college, university, or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.	10	$15,000,000
Affordable Care Act (ACA) School-Based Health Centers Capital Program	A school-based health center or a sponsoring facility of a school-based health center	1000	$50,000,000
Affordable Care Act: State Health Care Workforce Planning Grants	State Workforce Investment Board	30	$2,000,000
Affordable Care Act: State Health Care Workforce Implementation Grants	State Workforce Investment Board that received a planning grant	1	$3,000,000

PPACA Grant Opportunities Available as of July 9, 2010			
Funding Opportunity	**Eligibility**	**Expected #**	**Total**
Nationwide Program for National and State Background Checks for Direct Patient Access Employees of Long Term Care Facilities and Providers	States	54	$140,000,000
FY10 Support for Pregnant and Parenting Teens and Women FOA	State governments; Native American tribal governments (Federally recognized)	25	$2,000,000
Strengthening Public Health Infrastructure for Improved Health Outcomes	Eligible applicants include all 50 states, Washington, D.C., 9 large local health departments supporting cities with populations of 1 million or more inhabitants (Chicago, Illinois; Dallas, Texas; Houston Texas; Los Angeles, California; New York City, New York; Philadelphia, Pennsylvania; Phoenix, Arizona; San Antonio, Texas; San Diego, California), 5 U.S. Territories, 3 U.S. Affiliated Pacific Islands and up to 7 federally-recognized tribes with an established public health department structure (or their equivalent) that provide public health services to their tribal members, or bona fide agents of any of the eligible entities.	85	$212,500,000
Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program	State Governments	56	$90,000,000
"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)	State Governments	51	$51,000,000

Medicare Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Minnesota's Application

Minnesota's Health Care Home model of medical home development and implementation is seen as a national model for the redesign of the delivery system focusing first on primary care. The Minnesota HCH program relies on vigorous certification, complexity adjusted payments, and Triple Aim results. Significant program development and implementation steps are occurring including certification of practices, state plan amendment approval for the payment methodology for Medicaid fee for service recipients. Approximately 500 primary care providers are in the process of certification with more expected. Payments are available beginning July 2010 for services for FFS and managed care Medicaid and MinnesotaCare.

The MAPCP Demonstration is an opportunity for fee-for-service Medicare beneficiaries to join state-led multi-payer medical home efforts already underway. The demonstration was created by executive order in the fall of 2009. The solicitation was issued in June, and applications are due August 17th. The demonstration period is 3 years.

- The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) are jointly applying on behalf of our state. The agencies have convened a stakeholder advisory group of Medicare and health care home content experts to provide guidance on key strategic issues for the application.

- Minnesota appears to be strongly positioned to compete for the demonstration due to the design of its Health Care Home initiative, which includes a statewide provider certification process, a collaboratively-developed multi-payer payment methodology, and system of outcomes measurement with a fiscal expectation of budget neutrality. The addition of care coordination payments for the majority of Medicare enrollees would be a crucial step toward the "critical mass" of payment reform needed for broad-scale transformation of the delivery system. Medicare participation would also make it significantly easier for health care homes to develop in the rural parts of Minnesota.

- Despite the strength of Minnesota's position compared with other states, stakeholders have a few areas of concern related to the solicitation:

    - The Center for Medicare and Medicaid Services (CMS) has stated that only one demonstration may be running in a geographic area. MDH and DHS intend to propose statewide implementation, and are providing unequivocal feedback to CMS about the need for health reform goals to take precedence over impractical research designs. CMS has offered some assurances that MAPCP will not conflict with the Medicare Shared Savings (ACO) program or initiatives led by the newly-created Center for Medicare and Medicaid Innovation.

    - The solicitation states that CMS does not expect per-member per-month (PMPM) payments to practices to exceed $10. The rationale for this amount is not associated with the actual work required. Minnesota's health care home payment methodology pays higher amounts (based on valuation of the expected work

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required) for more complex patients who require more care coordination time and effort.

- CMS wants Medicare to join efforts that have significant participation of both public and private payers. CMS expects at least 50% of the state's market share in the program. Because the participation of large self-insured employers governed by ERISA in the health care home initiative is voluntary, it is challenging to firmly demonstrate to CMS the level of interest from these employers at this stage of the initiative.

- Minnesota statute calls for payments for privately insured Minnesotans to be made in a "manner consistent with" that developed by the DHS. As the program has developed clarity about the extent of payment consistency for privately insured citizens is lacking. These relationships are negotiated independently. The CMS MPAPC requirement of consistency of payment is explicit thought the extent is unclear.

Minnesota Department of **Human Services**

Minnesota's State Health Access Program (SHAP)

In 2009, the Minnesota Department of Human Services (DHS) received a State Health Access Program (SHAP) grant from the federal government to help uninsured Minnesotans get health care through local access to care programs.

DHS distributes SHAP funding through grants to community agencies, for programs providing affordable health care coverage, with an emphasis on preventive and primary care, to people ineligible for public programs and unable to afford private insurance.

Federal Funding Purpose and Amounts

The State Health Access Program awards grants to states, to help them expand access to affordable healthcare coverage for people who are uninsured. The grant is administered by the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services. The SHAP grant period is September 1, 2009 through August 31, 2014.

The total approved budget for Minnesota in **year one is $5.6 million** ($4.6 million federal and $928,355 non-federal). The total possible amount for all five years is $35.3 million. In order to access funds for the remaining four years, Minnesota must meet milestones set forth in the grant proposal, accomplish legislative changes and spend federal funds as budgeted. DHS will need to re-apply for funding each year.

Minnesota's SHAP Activity Objectives

Minnesota's State Health Access Program has three objectives:

Objective 1: Increase access to affordable health care coverage through the expansion of local access to care programs and to achieve partial statewide coverage for the uninsured; including many who are self-employed or working in small businesses, at-risk adults or populations of color.

Objective 2: Create a statewide regulatory administrative and fiscal framework to identify and disseminate best practices for expanding coverage. This framework will provide sustainability by granting funds to create replication models throughout the state.

Objective 3: Develop and streamline enrollment and administrative infrastructure for public health care programs. Tools will be created to accelerate eligibility determination including online application and electronic verification. These tools will be used by community partners to ensure that uninsured Minnesotans are enrolled into the correct program that efficiently uses limited state and community dollars.

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Minnesota's Expected Outcomes

1. Expanded affordable coverage options to partially fill public-private coverage gap
2. Reduced disparities in access to health care coverage through simplified enrollment and targeted outreach and training
3. Increased enrollment of eligible individuals into Minnesota Health Care Programs (MHCP)
4. Administrative efficiencies for MHCP and multi-share programs through the use of common technology tools

External Partners

1. Grant Partners
    a. **Portico Healthnet,** serves low-income uninsured individuals and families in Dakota, Hennepin, Ramsey and Washington counties
    b. **HealthShare** of Duluth, is expanding its employer-based multi-share program to include people in St. Louis, Carlton, Cook, Lake, Itasca, Koochiching and Aitkin counties
    c. **Values Health (PrimeWest Health)** is developing and implementing an employer-based multi-share program to serve Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse counties
    d. **SHADAC**, the State Health Access Data Assistance Center at the University of Minnesota School of Public Health will conduct program evaluation

In the first two years of the SHAP grant, DHS will contract with Portico HealthNet, HealthShare and Values Health to operate local access to care programs serving the twenty-four county area noted above. In the third year of the grant, new partners will be invited to propose new local access to care programs in other areas of the state for SHAP funding. Ultimately, the SHAP grant will promote statewide coverage for persons currently uninsured through multiple local access to care programs, which serve populations that are geographically and demographically diverse.

Local access to care programs are not considered health insurance, but do offer access to affordable health care to people not eligible for Minnesota Health Care Programs and unable to purchase private insurance products. The three existing models have their own eligibility guidelines and benefit sets, which are specific to the communities that they serve.

2. Advisory Committee

   The committee makes suggestions on direction and goals, advise on needed partners to complete work and connect the work of the grant to new communities around Minnesota

   The committee includes a broad group of stakeholders including, but not limited to – Department of Health, Department of Commerce, Counties, Minnesota Hospital Association, and Minnesota Safety Net Coalition

Progress to Date

1. In year one, $2,957,626 (64 percent) of the grant funds were distributed to partner agencies with $1,684,150 (36 percent) remaining with DHS. After the first year, DHS will use 11 percent of the total grant award with 89 percent going to partner agencies in years two through five.

2. Total enrollment as of June 1, 2010 (Portico HealthNet and HealthShare): 629 persons

3. Total employers (HealthShare only): 36 employers

4. Services are expanding in the new year, starting September 1, 2010:

   a. HealthShare will serve an additional three counties in Northern Minnesota (Itasca, Aitkin and Koochiching)

   b. Services will begin at Values Health (PrimeWest), probably rolling out first in Alexandria and Bemidji. Values Health is finalizing agreements with Douglas County Hospital in Alexandria, with 26 physician clinics, and with pharmacies and behavioral health programs. Eventually, Values Health will serve in each of the 13 counties served by PrimeWest.

   c. In 2011, overall LACP project enrollment is expected to increase by 2,400 enrollees, thereby increasing total enrollment to 3,200 persons after the second year of the grant

5. Contract negotiations are underway for the development of an online application for health care, cash, food support, and child care assistance to improve the efficiency of health care and financial assistance eligibility operations. Online application development should be underway by the end of the summer.

6. During the first year, DHS initiated a project focused on development of an enterprise electronic verification system that will utilize existing state databases to improve the efficiency of health care and financial assistance eligibility operations for clients as well as county and state workers.

For More Information

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Health Insurance Exchanges

Legislative Commission on Health Care Access

July 14, 2010

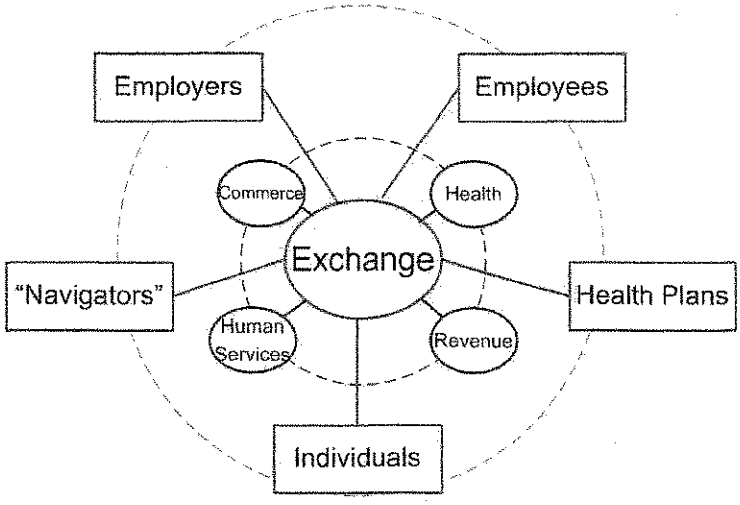
April Todd-Malmlov
State Health Economist
Director, Health Economics Program
Minnesota Department of Health

Overview

- What is an Exchange?
- Goals of an Exchange
- Components of an Exchange
- Questions and decision points to date
- Implementation details for 2014 still unknown
  - NAIC has yet to have first meeting on recommendations for Exchange rules
  - HHS has not released any guidance or information on release of planning/implementation funds
  - Additional questions and decision points will likely arise after discussions with NAIC and HHS
  - Many questions and decision points are dependent on other questions and decision points

What is an Exchange?

What is an Exchange?: An organized competitive marketplace (one stop shop) to facilitate the comparison, choice, and purchase of health insurance coverage for individual consumers.



Goals of an Exchange

- **Primary Goal:** To foster a more competitive marketplace with greater incentives for health plans to compete on cost and quality. To address some of the barriers to competition in the market:
  - **Imperfect Information:** Prices/cost and quality information not easily available. Exchange creates simplicity of "one stop shop" and transparency of comparison information on price/cost, quality, network/providers, benefits, etc.
  - **Lack of Consumer Engagement:** Consumers not responsible for insurance choice or cost. In Exchange, individuals and employees responsible for choice from among multiple health plans and products, and price differential from individual subsidy or employer defined contribution.
  - **Lack of Mobility and Portability:** Many consumers not free to change or maintain plan (employer choice). Exchange allows consumers to change or maintain plans and keep tax benefits of employer-based coverage.
  - **Lack of Many Buyers and Sellers:** Most insurance markets have few sellers. Exchange reduces some of the barriers to entry for new health plans. Exchange offers large pool of accessible enrollees without requiring the upfront costs and time associated with marketing, sales, and enrollment functions.

Exchange Components & Questions

- **Functions:**
  - Operate toll-free telephone hotline and website for customer service
  - Establish "Navigator" program to fund eligible entities to provide information, assist with enrollment, and address questions and grievances for health plans in Exchange
  - Certify health plans for participation in Exchange
  - Provide comparative information for health plans in Exchange, including ratings for price, quality, and enrollee satisfaction
  - Determine eligibility and facilitate enrollment for Medicaid, subsidies, and private plans
  - Grant certifications for individuals exempt from the individual coverage requirement and transfer to IRS/HHS information on those eligible for subsidies, exempt from coverage requirement, and no longer enrolled in coverage
  - Use an electronic interchange to share information with state and federal agencies
- **Questions:**
  - Are there additional functions the Exchange should perform?
  - Should some of these functions be performed by state agencies or other organizations?
  - Requirements for "Navigator" program (eligible entities, responsibilities, compensation)? (HHS yet to establish standards for Navigators)

Exchange Components & Questions

- **Eligibility:** The following groups are eligible to participate:
  - Individuals without access to "affordable" employer-based coverage
  - Individuals may not participate if they are eligible for a state "Basic Health Plan"
  - Small groups (may be defined as 50 or 100 employees)
  - Large groups may be allowed to participate in 2017
  - Exchange must also determine eligibility for Medicaid and tax subsidies
- **Questions:**
  - Should the definition of small group be 50 or 100 employees?
  - Should large groups be eligible? If yes, should there be an upper limit on group size eligibility?
  - Should there be participation requirements for employers in the Exchange (share of employees participating, employer contribution, limits in range of products employees can select)?
  - Should Minnesota establish a "Basic Health Plan"? What should happen to MinnesotaCare?

Exchange Components & Questions

- **Health Plan Participation/Certification:** HHS to establish minimum criteria for plan participation in an Exchange to include requirements for:
  - Marketing
  - Network adequacy
  - Accreditation on local clinical quality measures, patient experience, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and patient information systems
  - Implementation of a quality improvement strategy
  - Utilization of a standard format for comparing health plan options
  - Utilization of a uniform enrollment form/process
  - Health plan offering of at least 1 "silver" and 1 "gold" plan
- **Questions:**
  - Are there additional requirements that should be required of health plans to participate?
  - Should all plans be required to participate, should plan participation be voluntary, or should plans be required to compete/bid to participate?
  - Should the number of products offered be limited or unlimited?
  - Should benefit structure variability within actuarial value levels be limited or unlimited?

Exchange Components & Questions

- **Market Rules:**
  - Benefit and rating rules apply to all individual and small group plans inside and outside an Exchange, but some regulatory/certification rules apply only to Exchange plans (i.e. marketing, network adequacy)
  - A 10-state demonstration project starts in 2014 that allows wellness discounts currently permitted for group plans to be applied to the individual market for premiums and cost-sharing inside and outside an Exchange
  - Health plans that offer the same plans inside and outside an Exchange must charge the same premiums inside and outside an Exchange
- **Questions:**
  - Should the same regulatory/certification rules (for network adequacy and marketing for example) apply to plans sold inside and outside an Exchange?
  - Should Minnesota seek to participate in the 10-state demonstration project to allow wellness discounts for premiums and cost-sharing for the individual market?
  - Should health plans be required to offer the same product plans inside and outside the Exchange? If yes, what should the definition of the same be?

Exchange Components & Questions

- **Risk Sharing:**
  - Reinsurance program from 2014-2016 to reallocate funding to individual market plans inside and outside Exchange with high risk individuals. Funded by fully and self insured plans. State to choose reinsurer (may be high risk pool). NAIC to establish model regulations.
  - HHS in consultation with states to establish criteria and methods for risk adjustment for individual and small group plans inside and outside Exchange.
  - Individual market plans inside and outside Exchange are in same risk pool. Small group plans inside and outside Exchange are in same risk pool.
  - States may merge their individual and small group markets.
- **Questions:**
  - Who should be the reinsurance entity? How is national pool of funds used in states?
  - How much flexibility will the state have in establishing a risk adjustment mechanism? What should be considered to incent health plans to want to manage care for higher risk populations?
  - What are the specifics of risk pooling? What are the issues to consider regarding risk selection/segmentation between health plan products?
  - Should the individual and small group markets be merged?

Exchange Components & Questions

- **Governance, Structure, and Financing:**
  - May be operated by a government agency, non-profit entity established by the state, or the federal government on behalf of a state
  - May be structured as a separate or combined Exchange for individuals and small groups, multiple subsidiary Exchanges each serving a distinct geographic area, or a regional Exchange including multiple states
  - Within 1 year of enactment, HHS to award funding to states for Exchange start-up, but federal funding can not be used for ongoing operations
  - A state may require additional benefits for the essential benefit set, but the state must cover the costs of these additional benefits for individuals getting Exchange subsidies
- **Questions:**
  - How should the Exchange be operated?
  - How should the Exchange be structured?
  - How should on-going Exchange operations be funded?
  - Should additional benefits be required for the essential benefit set? If yes, how should the cost of additional benefits for those receiving Exchange subsidies be funded?

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2010 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Temporary High-Risk Pool Program	Monitor federal guidance and State application and participation	July 1, 2010
Early Retiree Reinsurance Program	Monitor federal guidance and State application and participation	July 1, 2010
Web Portal for Consumer Health Information	Monitor federal implementation	July 1, 2010 for phase I; October 2010 for phase II
Grant Opportunities: ▪ Maternal, Infant and Early Childhood Home Visiting Program *(announced)* ▪ Health Insurance Rate Review *(announced)* ▪ Health Insurance Consumer Assistance	Monitor federal guidance Review criteria and recommend priorities Monitor State applications and participation	FY 10 Home visiting grant and rate review grant announced—initial applications due during July 2010
Insurance Market Changes: ▪ Dependent Coverage up to age 26 ▪ Prohibitions on coverage limits and exclusions ▪ Limits on policy rescissions ▪ Coverage Required for Preventive Services ▪ Health plans Required to Report Medical Loss Ratio ▪ "Grandfathered" plans may be excluded from certain requirements	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning September 23, 2010
Medicaid Provisions: ▪ State option to implement expansion to non-categorical adults with incomes up to 133% of FPL at State's regular FMAP rate (no enhanced FMAP until 2014) ▪ Maintenance of effort requirement regarding eligibility changes unless State meets hardship exemption—certification on or after 12/31/10 ▪ Changes to prescription drug rebates	Monitor federal guidance Determine State policy on options for coverage Enact statutory changes needed to implement policies Authorize State funding if necessary	▪ Beginning FY 10 unless specified otherwise below ▪ Option permitted beginning April 2010 ▪ State may apply for waiver from MOE on or after 12/31/10 (available from Jan.1, 2011 to Jan. 1, 2014)

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TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2010 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
▪ Coverage of tobacco cessation services for pregnant women *(October 2010)*		
Small business tax credit	Monitor impact	2010 tax year

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2011 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Medicaid provisions: ▪ Prohibit payments to States for Medicaid services for health care acquired conditions ▪ Options for community-based long-term care services, medical homes for individuals with chronic conditions, wellness and prevention of chronic disease	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes needed to implement policies Authorize State funding if necessary	▪ July 1, 2011 ▪ Funding available October 2011 for CBLTC option; January 2011 for medical homes and wellness and prevention
Grants available for medical liability demonstration projects/tort reform	Review criteria and recommend priorities Monitor State applications and participation	Available FY 2011
Grants available for planning establishment of state-based exchanges	Monitor federal guidance Determine State role in operation of exchange Determine governance and structure for exchange	Available by March 2011
Insurance market reforms: ▪ Health plans must issue rebates if medical loss ratio requirements not met (80% for individual and small group; 85% for large group)	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning January 1, 2011
National voluntary long-term care insurance program created (CLASS)	Monitor impact on public programs and existing long-term care insurance laws	Effective January 1, 2011

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2012-2013 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
	2012	
Medicaid provisions: ▪ Demonstration projects for bundled payments *(limited to 5 states)* ▪ Pediatric accountable care organizations ▪ Emergency care treatment for adults with mental illness	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes if necessary Authorize State funding if necessary	Funding available beginning January 1, 2012 except emergency care demo project funding made available in October 2011
	2013	
Exchange —State must notify federal government by January 1, 2013 of decision to operate exchange	Monitor federal guidance Determine State role in operation of exchange Determine governance and structure for exchange Monitor State application for planning grants and participation Enact statutory authorization for exchange Authorize State funding if necessary	Notification by State before December 31, 2012; State law/authorization must be in place
Medicaid provisions: ▪ 1% increase in FMAP for coverage of preventive services and immunizations without cost-sharing ▪ Increases payments for primary care services for 2013 and 2014 with 100% federal funds	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes if necessary Authorize State funding if necessary	Beginning January 1, 2013

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:

Key Provisions Affecting State Programs and State Law

2012-2013 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Insurance market reforms: ▪ Creation of nonprofit insurance companies in States (COOP) permitted ▪ Administrative simplification measures for insurance companies implemented (eligibility and claims handling)	Monitor federal guidance Review existing law and enact statutory changes if necessary	▪ COOP effective January 1, 2013 ▪ Rules to be adopted by July 1, 2011; effective date for plans beginning January 1, 2013

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2014 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Individual mandate to obtain health insurance	Monitor federal guidance Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Employer mandate to offer coverage to employees	Monitor federal guidance Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Exchange established for individuals and small employers with 100 or fewer employees; Subsidies made available for eligible individuals and families with incomes between 133% FPL and 400% FPL	Maintain oversight over exchange operation Make statutory changes to address Dirigo assessment as necessary	Effective January 1, 2014
State option to establish Basic Health Plan for uninsured individuals with incomes between 133% FPL and 200% FPL otherwise eligible for premium subsidy through exchange	Monitor federal guidance Determine State policy on options for coverage Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Insurance Market Reforms: ▪ Guaranteed issue and renewal ▪ Rating changes ▪ Lifetime limits and preexisting condition exclusions prohibited ▪ Limits on out-of-pocket costs, deductibles and waiting periods ▪ National essential benefits package ▪ Option to merge individual and small group market ▪ Temporary reinsurance program for high-risk individuals in individual market	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning January 1, 2014
State grant opportunity to permit financial rewards for cost of coverage for participating in wellness programs in individual market; standards to be developed	Review criteria and recommend priorities Monitor State applications and participation	By July 1, 2014 (10 states)

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:

Key Provisions Affecting State Programs and State Law

2014 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Medicaid Provisions: ▪ Expands Medicaid to all non-Medicare eligible adults under age 65 with incomes up to 133% FPL; enhanced FMAP for new eligibles ▪ Coordination of eligibility and enrollment for Medicaid, CHIP and exchange ▪ Reduces DSH allotments	Monitor federal guidance Determine State policy Enact statutory changes as necessary Authorize State funding if necessary	Effective January 1, 2014

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2015 -2018 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
	2015	
Annual Medicaid enrollment reporting	Monitor State response	Beginning January 1, 2015
Changes in CHIP funding; CHIP-eligible children may get tax credits to obtain coverage through exchange	Monitor federal guidance Determine State policy Enact statutory changes as necessary	Beginning FY 2016
Exchange must be self-supported; assessments and user fees permitted	Maintain oversight of exchange Enact statutory changes if necessary	Beginning January 1, 2015
	2016	
States may form health care choice compacts to allow insurance plans from out-of-state insurers	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Rules adopted no later than July 1, 2013 Effective January 1, 2016
	2017	
Reduction in enhanced FMAP for Medicaid begins	Monitor federal guidance Determine State policy Enact statutory changes as necessary	Beginning FY 2017
State exchange can allow participation from large employers (more than 100 employees)	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Beginning January 1, 2017
States may apply for waiver to operate alternative program for coverage	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Rules adopted within 180 days of enactment (9/23/10) Effective January 1, 2017