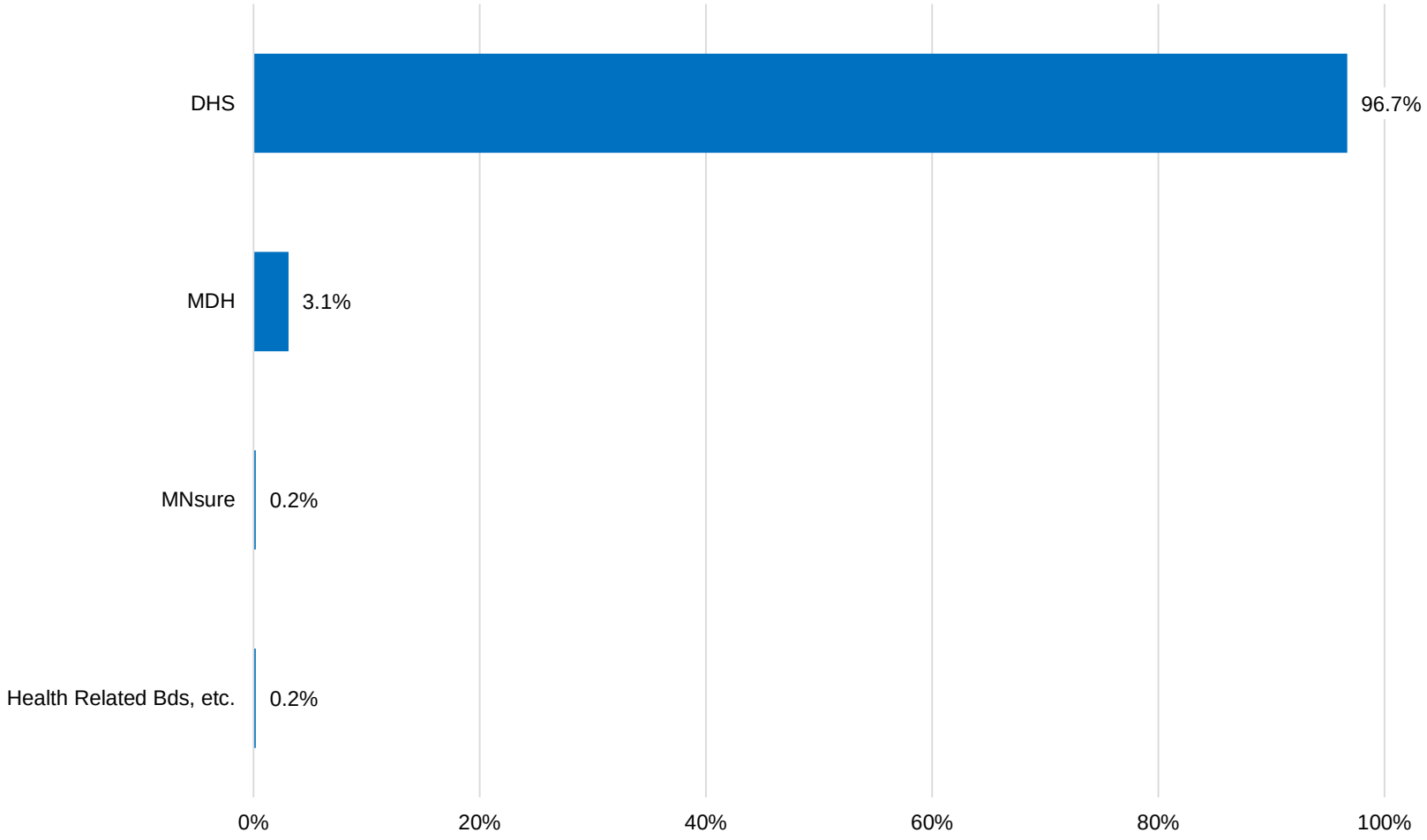
Health Finance and Policy

OVERVIEW OF COMMITTEE JURISDICTION

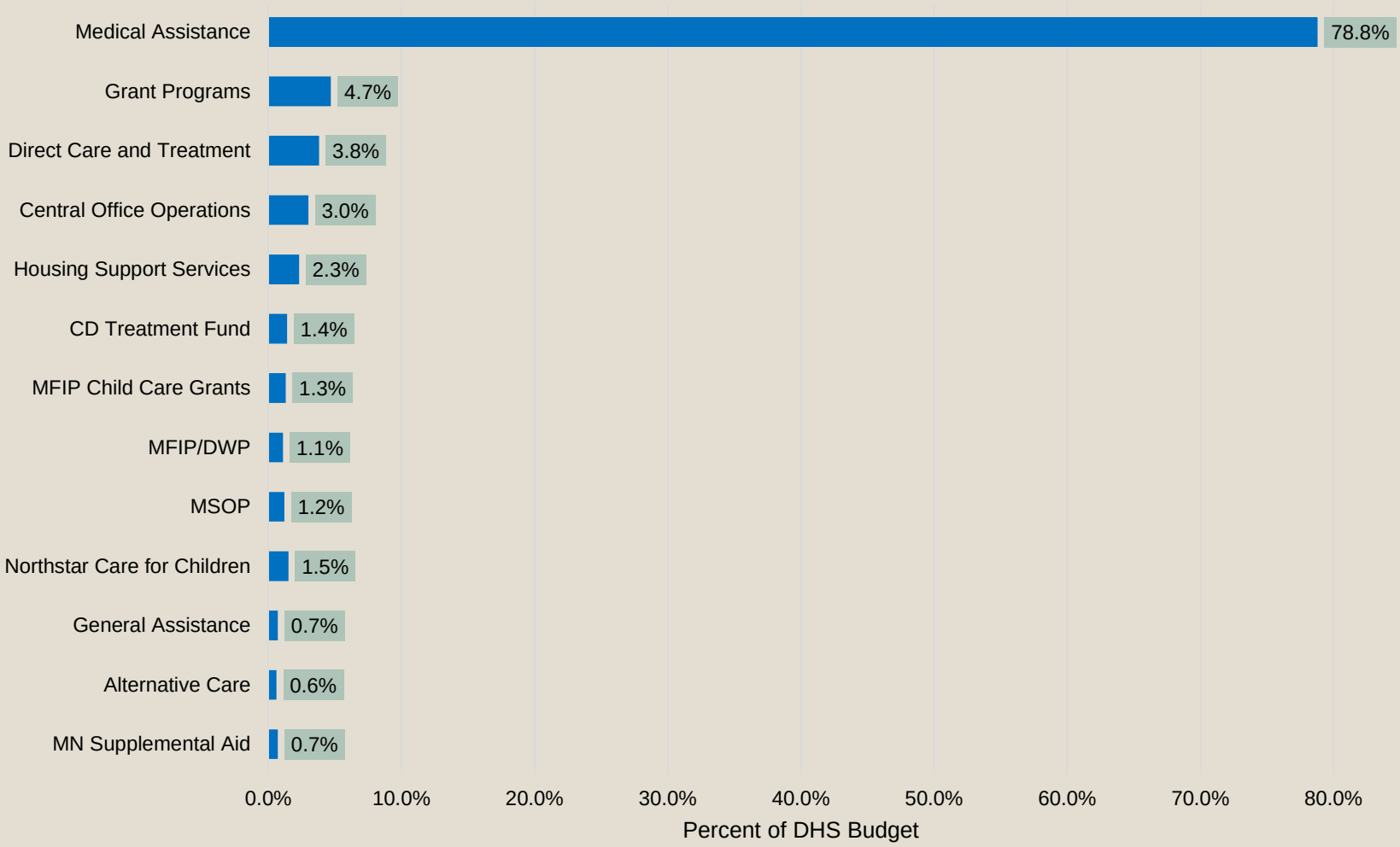
JANUARY 2021

Health and Human Services All Funds Expenditures
Base FY 2022-23 = $46.375 billion



Source: Data from FY 2022-23 Agency Base Budget Books.

Department of Human Services Budget Program Base FY 2022-23
DHS State General Fund Expenditures: $16.398 Billion



Source: House Research and House Fiscal Analysis. Data from November 2020 Forecast.

Subsidized Health Care

Overview of Subsidized Coverage

- **In Minnesota, persons with low to middle incomes can obtain subsidized health coverage through three main programs:**
- **MA**, the state's Medicaid program, is administered by the state within broad federal guidelines.
- **MinnesotaCare** operates as a Basic Health Program under the Affordable Care Act (ACA).
- **MNsure subsidies** -- premium tax credits and cost-sharing reductions for purchasing qualified health plans through the state's health insurance exchange.

Subsidized Health Care

Continuum of Subsidized Coverage

- The programs provide a rough continuum of coverage for Minnesotans with low to middle incomes (up to 400% of the federal poverty guidelines -- FPG).
- Adults without children/parents and caretakers:
  - MA (0% to 133% FPG);
  - MinnesotaCare (over 133% to 200% FPG); and
  - MNsure tax credits (over 200% to 400% FPG).
- Covered services and enrollee costs will vary across the continuum.

Medical Assistance

Overview

- MA is a jointly funded, federal-state program that pays for health care services provided to eligible low-income individuals.
- MA is the state's Medicaid program. Laws governing MA are found mainly in Chapter 256B of statute.
- Medicaid programs vary across states—each state adopts its own operating and administrative standards, but must remain within the parameters of federal Medicaid law.

Medical Assistance

Administration

- County agencies administer MA, under the supervision of DHS, and also determine eligibility for persons who are elderly, blind, or have disabilities using MAXIS, the state's legacy system.
- The Minnesota eligibility technology system (METS) is used by DHS and the counties to determine eligibility for families and children, and adults without children.

Medical Assistance

Care Delivery

DHS uses two systems to deliver services to MA enrollees:

- Under the fee-for-service system, enrollees can see any MA participating provider; DHS reimburses providers using fee schedules established by the agency; reimbursement reflects the volume of services.

- DHS also contracts with managed care and county-based purchasing plans, and provides these plans with a monthly capitation payment for each enrollee. Under managed care, enrollees are normally limited to seeing providers in a plan's network.

Medical Assistance

Eligibility – Overview

Main eligibility criteria:

- Belong to an eligible group
- Meet income and any applicable asset limits
- Be a US citizen, or a legal noncitizen who meets certain criteria

MA also provides up to three months of retroactive coverage from the time of application, if the person would have been eligible in those months

Medical Assistance

Eligibility – Major Groups Eligible

- MA coverage is available for all major groups of individuals: children, parents and caretakers, pregnant women, elderly, persons with disabilities, and adults without children.
- Adults without children with incomes up to 133% of FPG have been covered since January 1, 2014, under the ACA expansion option.

Medical Assistance

Eligibility – COVID-19

- MA coverage is available for uninsured individuals for testing and diagnosis of COVID-19
- No income or asset requirements; individuals must be MN residents and US citizens or otherwise lawfully present
- 100% federal match and no copayments or deductibles
- Coverage applies for the duration of the federal public health emergency

Medical Assistance

Eligibility – Income Limits

MA income limits vary by eligibility group and are set as a percentage of the federal poverty guidelines (FPG)

- Children under age 2: 283% FPG ($61,467 household of three)
- Children 2 through 18: 275% FPG ($59,730 household of three)
- Parents and caretakers, children 19 through 20: 133% FPG ($28,887 household of three)
- Pregnant women: 278% FPG ($60,381 household of three)
- Aged, blind, disabled: 100% FPG ($12,768 household of one)
- Adults without children: 133% FPG ($16,970 household of one)

Medical Assistance

Eligibility – Income Methodology

- In determining income eligibility, the MA program excludes or disregards various types of income.
- The ACA requires states to use modified adjusted gross income (MAGI) for parents, children, pregnant women, and adults without children.
- Minnesota's existing income methodology (based on the federal Supplemental Security Income program) continues to apply to the elderly, disabled, and certain other groups.

Medical Assistance

Eligibility – Spenddown

Individuals with income above the program income limit can qualify by "spending down"—by incurring medical bills in amounts equal to or greater than the amount of income in excess of the following spenddown limits:

- 133% FPG for families and children
- 81% FPG for aged, blind, and disabled (100% effective July 1, 2022)

No spendddown option for adults without children

Medical Assistance

Eligibility – Asset Standards

Some enrollees must meet asset standards:

- Parents and caretakers on a spenddown: $10,000 for one and $20,000 for two or more in assets that are not excluded
- Elderly, blind, disabled: $3,000 for one/$6,000 for two or more in assets that are not excluded

No asset limit for pregnant women, children, parents and caretakers not on a spenddown, and adults without children (ACA compliance).

Medical Assistance

Covered Services

- MA covers all federally-mandated and most optional health care services.
- The MA benefit set tends to be comprehensive, compared to private sector coverage (e.g., MA usually covers a wider range of long-term care services).

Medical Assistance

Enrollee Cost-sharing

- Cost-sharing under federal law must be "nominal" for most enrollees and total monthly cost-sharing cannot exceed 5% of income for persons with incomes at or below 100% of FPG.
- MA does not charge enrollee premiums. Certain services are subject to copayments and fee-for-service enrollees are subject to a family deductible.
- Children and pregnant women, and certain American Indians and Alaska natives, are among the groups exempt from cost-sharing.

Medical Assistance

Financing

- MA is financed jointly by the state and federal government. Federal government provides a 50% match towards the cost of MA services; state general fund pays remaining 50% (there is a county-share for specified services).
- The federal Children's Health Insurance Program (CHIP) provides an enhanced match of 65% towards the cost of certain services.
- For newly eligible persons under the ACA Medicaid expansion (in MN, these are adults without children), 90% federal match.

Medical Assistance

Financing – COVID-19

- Federal Families First Coronavirus Response Act provides a 6.2 percentage point increase to each state's regular federal MA match
- Effective January 1, 2020, through the last day of the calendar quarter in which the federal public health emergency ends
- Maintenance of effort requirement tied to receipt of this federal funding

Medical Assistance

Managed Care -- Enrollment

- A majority of MA enrollees receive covered services through HMOs and county-based purchasing plans.
  - MA managed care enrollment (July 2020): 941,818
  - MA enrollees (July 2020): 1,119,244
- Families and children, adults without children, and the elderly are required to enroll in managed care.
- Persons with disabilities may opt-out and remain in the fee-for-service system.

Medical Assistance

Managed Care – Services and Payment

- Each plan must provide or arrange for most MA covered services, including up to 180 days of nursing facility services, and elderly waiver services.
- DHS pays each plan a capitation rate that varies with enrollee characteristics but otherwise is fixed – unlike fee-for-service, plan reimbursement does not increase as more services are provided.
- DHS withholds a portion of the capitation rate; some of this withhold is returned pending the plan meeting specified performance targets.
- Each plan determines its own provider network and sets its own provider payment rates.

Medical Assistance

Managed Care -- Procurement

- Since 2012, competitive bidding has been used in the metro-area counties to set rates for families and children and adults without children. 2016 enrollment reflects the results of the first statewide competitive bidding for this group.
- Rates for persons who are elderly or have disabilities are set through negotiation on an aggregate (not plan-specific) basis, based upon claims experience, trends in utilization, and other factors.
- DHS future plans for plan procurement are as follows:

  RFP issued in January 2021 to serve families and children in the metro area in 2022

  RFP issued in October 2021 to serve elderly and persons with disabilities in 2023

  RFP issued in January 2022 to serve families and children in Greater MN in 2023

Medical Assistance

Integrated Health Partnership Demonstration

- The IHP demonstration is a health care provider direct contracting program – DHS contracts with health care provider organizations (called integrated health partnerships) to provide services to MA and MinnesotaCare enrollees. The program operates in both the fee-for-service and managed care systems.

- The program uses a value-based payment model under which all IHPs receive population-based payments for care coordination. The larger, more integrated IHPs are paid under a risk/gain-sharing arrangement, under which the IHP shares in savings and losses relative to their total costs for a defined set of services, for enrollees who are attributed to the IHP.

- As of July 2020, 25 IHPs provided services to 428,664 state program enrollees (MA and MinnesotaCare).

Medical Assistance

Spending and Enrollment

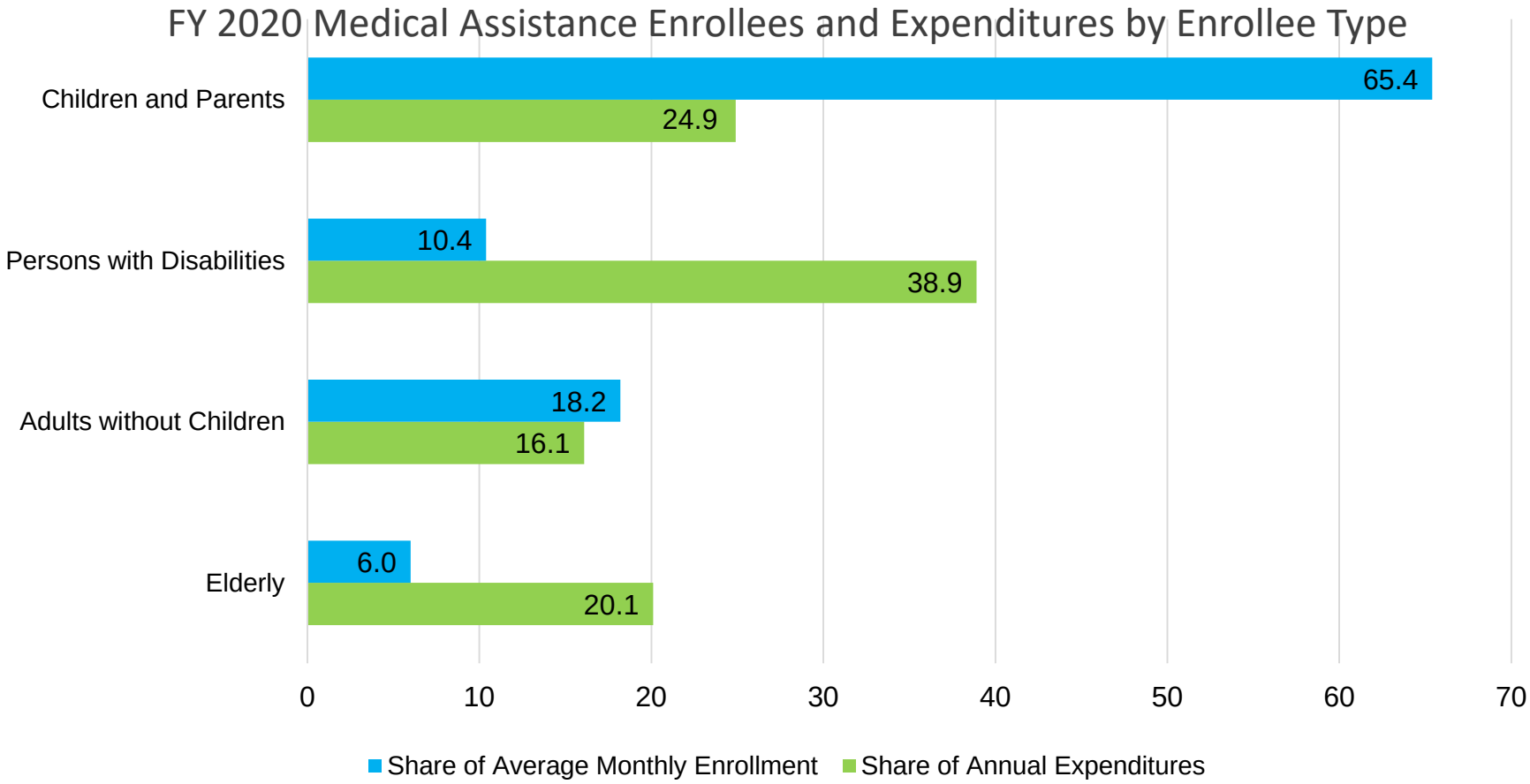
MA spending FY 2020

- Total: $13.371 billion
- Federal: $7.817 billion
- State $4.710 billion

MA enrollment FY 2020

- 1,078,321 average monthly enrollees

MA Enrollees and Expenditures



Source: House Research. Data provided by DHS.

MinnesotaCare

Overview

- MinnesotaCare is a jointly-funded, federal-state program that provides subsidized health coverage mainly to parents and caretakers and adults without children.
- Established by the legislature in 1992 as part of broader health care access legislation. MinnesotaCare laws are codified in Chapter 256L of Minnesota Statutes.
- Has operated as a basic health program under the ACA beginning January 1, 2015.

MinnesotaCare

Administration

- Program is administered by the state through the DHS central office.
- DHS contracts with managed care and county-based purchasing plans to provide services to enrollees.
- The Minnesota Eligibility Technology System (METS)—the system developed under MNsure—is used to determine enrollee eligibility.

MinnesotaCare

Eligibility -- Overview

- Meet income limits
- No asset limit
- Meet requirements related to lack of access to health insurance, and not be MA eligible
- Be a Minnesota resident
- Be a citizen or legal noncitizen

MinnesotaCare

Income Limits

- Eligibility is limited to persons with incomes greater than 133% but not exceeding 200% of FPG (the income limit for the basic health program under the ACA).
- Exceptions to income floor for certain groups and legal noncitizens.
- Those 133% FPG and under – MA coverage.
- Those with incomes greater than 200% FPG – may receive subsidized coverage through MNsure.

MinnesotaCare

No Asset Limit

Since January 1, 2014, there has been no asset limit for MinnesotaCare (ACA compliance for a basic health program).

MinnesotaCare

Requirements Related to Lack of Insurance (Insurance Barriers)

- Since January 1, 2014, persons must not have minimum essential coverage.
- Since January 1, 2014, persons must not have access to subsidized coverage that is affordable (not more than 9.83% income for 2021) and provides minimum value (coverage at least 60% of medical expenses on average).

MinnesotaCare

Not MA Eligible

- Since January 1, 2014, persons eligible for MA have not been eligible for MinnesotaCare (prior to this date, enrollees could choose either program if they were eligible).
- This has had the effect of shifting most children and pregnant women from MinnesotaCare to MA since the MA income limits for these groups are higher.

MinnesotaCare

Covered Services

- The program has several benefit sets. Pregnant women and children have access to a broader range of services—nearly all MA benefits—than adults who are not pregnant.
- Parents and adults without children are eligible for most MA services.
- These benefits meet the ACA requirement that a basic health program provide at least the essential health benefits.

MinnesotaCare

Premiums

- MinnesotaCare enrollees age 21 and older pay per-person premiums based on a sliding scale; children are exempt.
- Persons with incomes below 35% of FPG pay no premiums. American Indians and Alaska natives are exempt.

MinnesotaCare

Cost-sharing

- Various copayment and coinsurance requirements apply; pregnant women and children and American Indians and Alaska natives are exempt.
- Cost-sharing was increased effective January 1, 2016. DHS is required to adjust copayments, coinsurance, and deductibles to maintain the actuarial value at 94 percent.

MinnesotaCare

Financing

- As a basic health program, the state receives from the federal government 95% of the value of premium tax credits and a portion of the value of cost-sharing reductions that would otherwise have been provided through MNsure.
- The state share is funded by a 1.8% tax on the gross revenues of health care providers and a 1% tax on nonprofit health plan premiums; money from these taxes is deposited into the Health Care Access Fund.
- The 2019 Legislature repealed a January 1, 2020, sunset for the provider tax, but reduced the rate from 2.0% to 1.8%.

MinnesotaCare

Spending and Enrollment FY 2020

Total: $452.6 million

State: $26.2 million

Federal: $395.6 million

Enrollee premiums and drug rebates: $30.8 million

Average monthly enrollees: 77,832

Health Care – MNsure Health Insurance Exchange

- MNsure was established as the state-run exchange by the 2013 Legislature. MNsure laws are codified in Minnesota Statutes, chapter 62V.
- The exchange assists individuals and families in selecting and purchasing health coverage, and also determines eligibility for premium tax credits and cost-sharing reductions.
- The exchange is also the common entry point for individuals to apply for health coverage from the private sector and from Medicaid and other public health care programs.

MNsure Subsidies

Overview

- Federal government provides premium tax credits and insurers under the ACA are required to provide cost-sharing reductions for persons with low to moderate incomes who purchase coverage through MNsure, the state's health insurance exchange.
- The Centers for Medicare and Medicaid Services (CMS) has not reimbursed health insurers for the cost of cost-sharing reduction since October 2017.

MNsure Subsidies

Eligibility

- Meet general requirements for exchange coverage (citizen or legal noncitizen, not incarcerated).
- Income must be greater than 200% but not exceed 400% FPG (not exceed 250% for cost-sharing reductions).
- Not covered by Medicaid, Medicare, MinnesotaCare, employer coverage (unless coverage is unaffordable or provides less than 60% actuarial value), or other specified coverage.

MNsure Subsidies

Essential Health Benefits

- Exchange plans must cover essential health benefits as defined by the ACA.
- The ACA requires essential health benefits to be similar to a typical employer health plan. The ACA requires the following categories to be covered: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness and chronic disease management, and pediatric services (including oral and vision care).

MNsure Subsidies

Premiums and Premium Tax Credits

- Enrollee is responsible for premiums of the policy chosen through the exchange, but may be eligible for premium tax credits.
- Premium tax credits: limit premium payments to a specified percentage of income, based on the cost of the second lowest cost silver plan. For 2021, premium tax credits limit enrollee premium costs to 6.52% of income (for persons with income just over 200% FPG) to 9.83% of income (at 400% FPG).

MNsure Subsidies

Cost-sharing Subsidies

- Health insurers are required to provide cost-sharing subsidies to persons with incomes not exceeding 250% FPG, purchasing plans at the silver level only—these increase the plan's actuarial value from 70% to 73% (sometimes achieved by reducing a plan's annual out-of-pocket limit).
- Insurers had been reimbursed by the federal government for the cost of providing cost-sharing reductions. The federal government decided in October 2017 to terminate these payments.

MNsure Subsidies

Financing

Federal government pays all of the cost of premium tax credits.

MNsure enrollees received an estimated $220.2 million in premium tax credits for 2019 (Kaiser Foundation).

Average monthly tax credit by household: $422/month (as of November 2020)

Regulation of Health Occupations

Health-Related Professional Regulation

- Minnesota statutes provide that no occupation may be regulated by the state unless its regulation is required for the safety and well-being of Minnesotans.
- Health-related occupations are regulated by either MDH or one of the 17 health-related licensing boards. The state regulates at least 56 health-related occupations.
- Some health-related licensing boards regulate a single occupation, while others, like the Board of Medical Practice, regulate a range of related occupations.

Regulation of Health Occupations

Health Licensing Boards

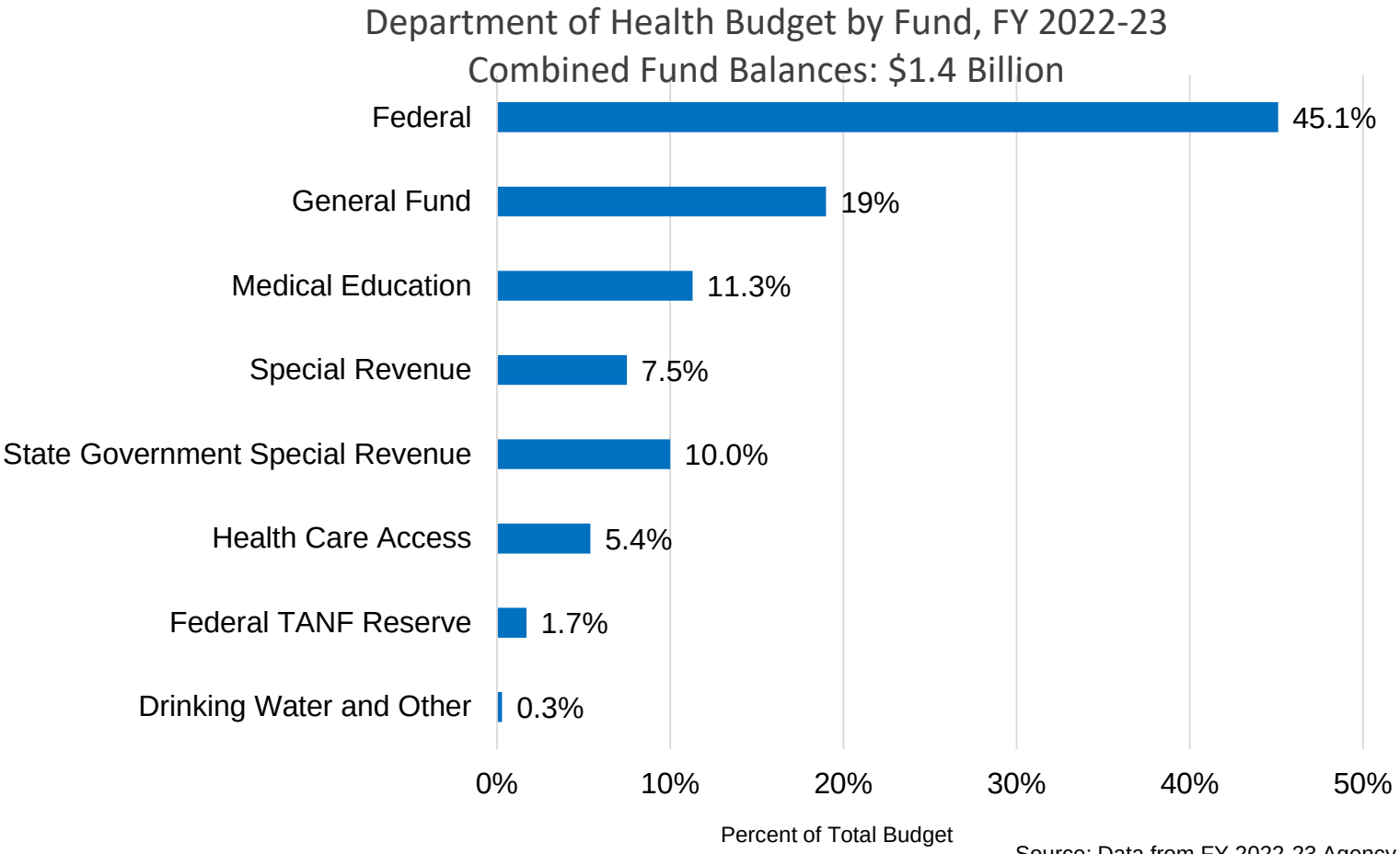
- Board of Behavioral Health and Therapy
- Board of Chiropractic Examiners
- Board of Dentistry
- Board of Dietetics and Nutrition Practice
- Emergency Medical Services Regulatory Board
- Board of Marriage and Family Therapy
- Board of Medical Practice
  - Physicians and surgeons
  - Acupuncturists
  - Athletic trainers
  - Genetic counselors
  - Naturopathic doctors
  - Traditional midwives
  - Respiratory therapists
  - Physician assistants
- Board of Nursing
- Board of Executives for Long Term Services and Supports
- Board of Occupational Therapy
- Board of Optometry
- Board of Pharmacy
- Board of Physical Therapy
- Board of Podiatric Medicine
- Board of Psychology
- Board of Social Work
- Board of Veterinary Medicine

Regulation of Health Occupations

MDH Regulated Occupations

Allied Health Professionals	Environmental Health Professionals	Unlicensed Complementary & Alternative Health Care Practitioners
Speech-language pathologists	Lead workers	Culturally traditional healing practices
Audiologists	Asbestos workers	Aroma therapy
Body art technicians	Environmental health specialists/sanitarians	Meditation
Mortuary science practitioners	Food managers	Massage therapy
Doulas	Water supply system operators	Mind-body healing practices
Nursing assistants	Wells and borings contractors	Acupressure
Hearing instrument dispensers	Pool operators	

Health Department Programs and Activities



Source: Data from FY 2022-23 Agency Base Budget Books.

Health Department Programs and Activities

Three broad categories of activities:

- Public Health
- Health Care Regulation
- Health Care Reform

Health Department Programs and Activities

Public Health: activities to protect and promote the health of people and communities by preventing people from becoming sick or injured, promoting wellness, tracking disease outbreaks, educating people about health risks, and compiling health statistics.

Health Care Regulation

Health Care Reform

Public Health

Public health is a partnership between MDH, community health boards, tribal governments, and other organizations.

All areas of the state are covered by a community health board or tribal government.

Public Health

Health Protection

- Environmental Health Programs
  - Indoor Air Quality
  - Drinking Water Protection
  - Food, Pools, and Lodging Establishments
  - Well Management
- Infectious Disease Epidemiology, Prevention, and Control
  - Foodborne illnesses
  - Immunizations
  - Emerging infectious diseases
  - Health care associated infections
  - STDs, HIV, tuberculosis
- Public Health Laboratory

Health Improvement

- Child and Family Health
  - Maternal and child health
  - Children and youth with special health needs
  - Family home visiting
- Health Promotion and Chronic Disease
  - Cancer control
  - Heart disease, stroke, diabetes, and asthma
  - Injury and violence prevention
- Community Health
- Emergency Preparedness, Health Equity, Health Statistics

Public Health

Health Protection

Environmental Health Programs

- Safe Indoor Environments
  - Indoor air quality, including Clean Indoor Air Act
  - Lead testing and abatement, asbestos abatement, and radon mitigation
- Drinking Water
  - Drinking water protection programs
  - Well management
- Food Safety
- Radiation Safety

Public Health

Health Protection

- Infectious Disease Epidemiology, Prevention, and Control
  - Foodborne, waterborne, and zoonotic disease outbreaks
  - Immunizations
  - STDs, HIV, and TB
  - Collecting data on and investigating infectious diseases
- Public Health Response Contingency Account
- Health Care Response Fund

Public Health

Health Protection

Public Health Laboratory

- Analysis of environmental samples to detect public health hazards
- Testing human samples for infectious disease agents to detect disease outbreaks
- Reference and confirmation testing of human specimens, and conducts tests not available in other settings
- Newborn screening program:
  - Tests newborn infants for 61 disorders of metabolism, hormones, the immune system, blood, breathing, digestion, hearing, and the heart
  - State law governs the retention, destruction, and use of blood spots and test results

Public Health

Health Protection: COVID-19 Response Activities

COVID-19 testing

Collection and reporting of data on COVID-19 cases

Contact tracing and case investigations

Vaccines: including guidance on phased allocation, registration and training of vaccine providers, reporting data on vaccine administration

Messaging, public education, and community outreach

Guidance documents for the public, for specific settings and specific occupations, and for implementation of executive orders

Activities to prevent and address COVID-19 in long-term care settings

Distribution of state and federal grants

Temporary changes to MDH programs and activities

Public Health

Health Improvement

- Child & Family Health
  - Maternal and Child Health
  - Home Visiting
  - WIC and Commodity Supplemental Food Program
  - Children and Youth with Special Health Needs

Public Health

Health Improvement

- Health Promotion and Chronic Disease Prevention
  - Center for Health Promotion
  - Cancer control programs
  - Injury and violence prevention activities
  - Chronic disease
- Community Health
  - Emergency preparedness and response
  - Health equity
  - Office of Statewide Health Improvement Initiatives

Public Health

Vital Records System

- MDH operates Office of Vital Records under supervision of State Registrar
- Statewide system of vital records, including records on births, deaths, and marriages
- Requirements exist for who must file vital records, when they must be filed, and amendments to vital records

Health Department Programs and Activities

Public Health

Health Care Regulation: includes regulation of certain health occupations, managed care systems, health facilities, and home care providers; adverse health event reporting; investigating complaints regarding care provided in health care facilities; and administering the medical cannabis program

Health Reform

Health Care Regulation

Regulation of Health/Public Health Occupations

Allied Health Professionals	Environmental Health Professionals	Unlicensed Complementary & Alternative Health Care Practitioners
Speech-language pathologists	Lead workers	Culturally traditional healing practices
Audiologists	Asbestos workers	Aroma therapy
Body art technicians	Environmental health specialists/sanitarians	Meditation
Mortuary science practitioners	Food managers	Massage therapy
Doulas	Water supply system operators	Mind-body healing practices
Nursing assistants	Wells and borings contractors	Acupressure
Hearing instrument dispensers	Pool operators	

Health Care Regulation

Regulation of Health Facilities and Providers

Regulates health facilities such as hospitals, nursing homes, boarding care homes, supervised living facilities, housing with services establishments, hospices, birth centers, and assisted living facilities (beginning August 2021).

Licenses home care providers and conducts periodic surveys of these providers.

Administers the essential community provider designation program.

Office of Health Facility Complaints

Health Care Regulation

Regulation of Health Facilities and Providers

Licensure of assisted living facilities, effective August 1, 2021

- Two facility categories: assisted living facility and assisted living facility with dementia care
- Facility is responsible for all housing and service-related matters and will obtain a single license to provide both housing and services

Health Care Regulation

Regulation of Health Carriers

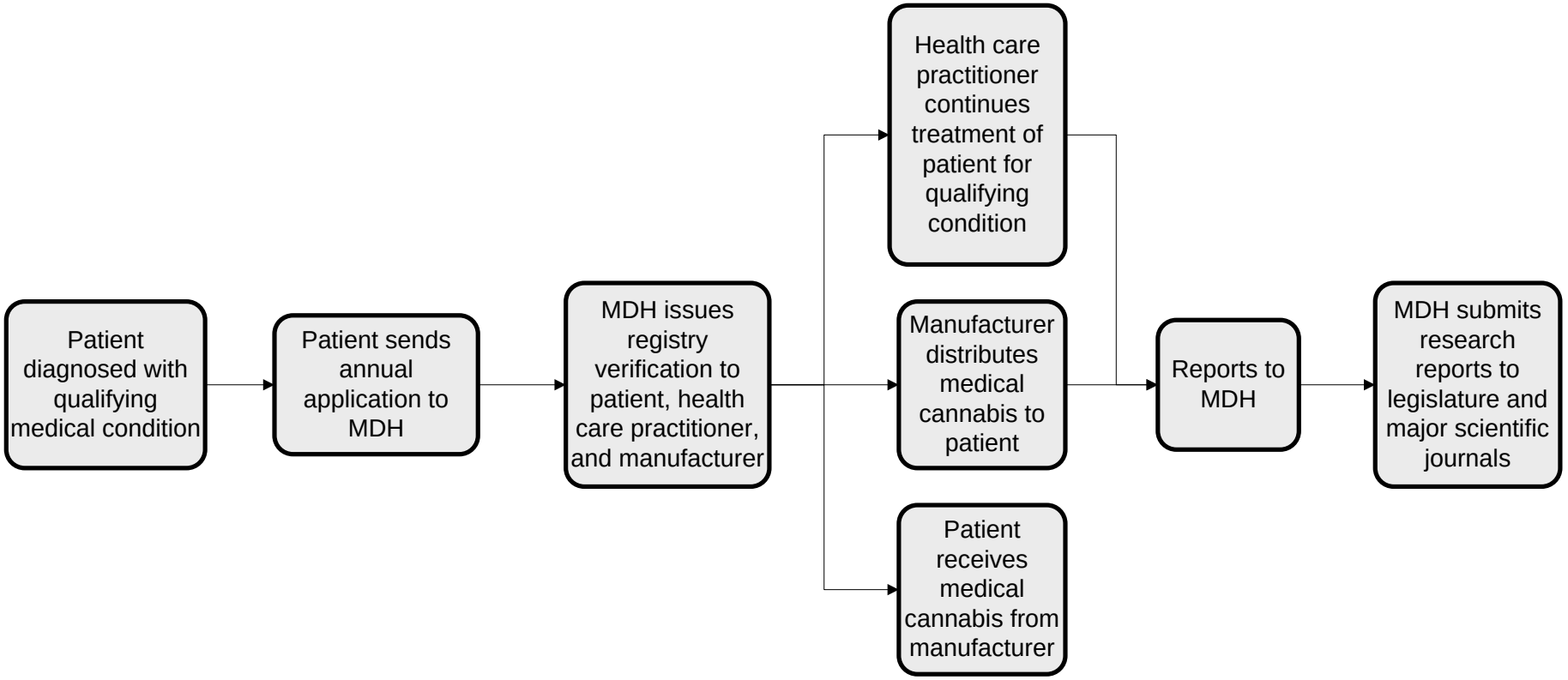
Licenses health maintenance organizations (HMOs) and regulates their fully insured health plans

Regulates county-based purchasing organizations

Ensures provider network adequacy of HMO networks and the networks of health carriers regulated by the Department of Commerce

Health Care Regulation

Medical Cannabis Program: General Design



Health Care Regulation

Medical Cannabis Program: Patient Access

Qualifying medical conditions

- Cancer*
- Glaucoma
- HIV/AIDS
- Tourette's syndrome
- ALS
- Seizures
- Severe and persistent muscle spasms
- Inflammatory bowel disease
- Terminal illness with a life expectancy of under one year*
  - Intractable pain
  - Alzheimer's disease
  - Post-traumatic stress disorder
  - Autism spectrum disorder
  - Obstructive sleep apnea
  - Alzheimer's disease
  - Chronic pain
  - Sickle cell disease, chronic motor/vocal tic disorder (8/1/21)

Health Department Programs and Activities

Public Health

Health Care Regulation

Health Care Reform: initiatives and programs to improve patient care, improve population health, and reduce health care costs.

- Health care workforce development programs
- Initiatives to improve access and efficiency using technology
- Initiatives to ensure value in health care spending

Health Care Reform

Health Care Workforce Development Programs

Loan Forgiveness Program

Clinical or Residency Training Grant Programs

Medical Education and Research Costs (MERC) Program

Home and Community-Based Services Employee Scholarship Program

International Medical Graduates Assistance Program

Health Care Reform

Initiatives to Improve Access and Efficiency Using Technology

- Electronic health records: commissioner must maintain standards used by electronic health records systems for sharing data across systems
- Electronic prescription drug program: electronic prescription drug program must be used for all prescriptions, and drug prior authorization requests must be submitted electronically
- Health information exchange: system for transmitting health information between providers and provider organizations must comply with uniform standards for interoperability

Health Care Reform

Initiatives to Ensure Value in Health Care Spending

Health Care Homes: clinics certified by MDH and provide coordination of primary care and other services, care coordinators, and care plans for patients with complex or chronic conditions. MA provides payment to these clinics for care coordination.

Statewide Quality Reporting and Measurement System (SQRMS): standardized set of quality measures for health care providers.

Health Care Reform

Initiatives to Ensure Value in Health Care Spending

All-Payer Claims Database (MN APCD): database of health care claims data on Minnesota residents

- Data is submitted by health plan companies, third-party administrators, and pharmacy benefits managers that cover Minnesota residents and paid claims over a certain amount in the previous calendar year. MDH also obtains Medicare and MA claims data.
- Enrollment data, encounter data, and pricing data are submitted.
- Allowable uses of the data are specified in statute.

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MN HOUSE RESEARCH

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