INFORMATION BRIEF
Minnesota House of Representatives
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2008 Health Care Reform Act: Implementation Timelines

This information brief lists implementation timelines for the 2008 health care reform bill (S.F. 3780) that was signed into law as Minnesota Laws, chapter 358. The act contains a wide range of provisions related to health care access, public health, health care homes, provider quality, and payment reform, and requires these provisions to be implemented by various state agencies and private sector entities over a period of several years. Many of the provisions of the act reflect, or incorporate in modified form, the health care reform recommendations of the Legislative Commission on Health Care Access and the governor's Health Care Transformation Task Force.

Contents

Implementation Timelines by Area of Reform

This information brief lists implementation timelines for each of the following major areas of reform, along with brief descriptions of the provisions that are to be implemented:

A. Access/continuity of care

B. Health care homes/care coordination fees

C. Payment reform

   (1) Quality incentive payments

   (2) Provider peer groups

   (3) Baskets of care

D. Public health/other

E. Reports/monitoring (this category includes provisions that relate to the areas of reform listed previously)

This information brief also includes a table that lists implementation timelines for state agencies and private sector entities.

For more information on the provisions of the health care reform act, refer to the actual text of chapter 358 and to the House Research section-by-section act summary.

Note: The brackets that follow each provision indicate the location of the provision in the act and proposed statutory coding. An asterisk (*) indicates that a provision is effective on the date specified or upon federal approval, whichever is later.

A. Access/continuity of care

The health care reform act contains provisions that are intended to expand outreach for, and enrollment in, state health care programs. "State health care program" is defined in the act to mean the Medical Assistance (MA), MinnesotaCare, and General Assistance Medical Care (GAMC) programs. The provisions expand the availability of state health care program applications and renewal forms in foreign languages, allow for the exchange of eligibility information between state programs, make changes in a program that provides application assistance bonuses, and requires a study of methods to improve coordination between state health care and social service programs. The act also, over a two-year period, expands eligibility for MinnesotaCare, attempts to improve continuity of MinnesotaCare coverage by providing "grace months" of coverage, and establishes a new MinnesotaCare premium scale intended to make coverage more affordable.

Implementation: July 1, 2008

Sharing of eligibility information. The Department of Education (DOE) is required to enter into an agreement with the Department of Human Services (DHS) to share information on eligibility of children for the free and reduced lunch program and to identify children who may be eligible for MA or MinnesotaCare. Schools are required to provide DOE with eligibility information on each child eligible for the free and reduced lunch program, unless the child's parent or guardian elects not to have the information disclosed. [Art. 3, § 1/Minn. Stat. § 124D.1115]

Materials in foreign languages. DHS is required to make state health care program applications and renewal forms available on the web in the most common foreign languages. [Art. 3, § 2/Minn. Stat. § 256.01, subd. 27]

Application assistance bonus. Licensed insurance producers and school districts are eligible for the state health care program application assistance bonus for identifying and assisting potential state health care program enrollees in filling out and submitting applications. The amount of this bonus is increased from $20 to $25. [Art. 3, §§ 3 and 4/ Minn. Stat. § 256.962, subds. 5, 6]

School district outreach. School district outreach requirements are modified to require districts to provide families eligible for the free and reduced school lunch program with information on how to obtain an application for state health care programs (this replaces a requirement that districts provide the application). [Art. 3, § 4/ Minn. Stat. § 256.962, subd. 6]

Implementation: January 1, 2009

Renewal sites.* DHS must allow MinnesotaCare enrollees to renew eligibility at designated locations in the community, including community clinics and health care provider offices, if there is no change in circumstances. [Art. 3, § 8/ Minn. Stat. § 256L.05, subd. 3a]

Rolling month for renewals.* DHS must provide one additional month of eligibility, beyond the current eligibility period, to MinnesotaCare enrollees who fail to submit renewal forms and related documentation in a timely manner. [Art. 3, § 8/ Minn. Stat. § 256L.05, subd. 3a]

Grace month for premium payment.* DHS must provide one additional month of coverage to MinnesotaCare enrollees who fail to pay MinnesotaCare premiums on time. With this change, disenrollment will be effective the first day of the calendar month following the month for which the premium is due, rather than the month the premium is due. Enrollees who are disenrolled for nonpayment and who reapply will not be required to pay the premium for the additional month. [Art. 3, § 9/ Minn. Stat. § 256L.06, subd. 3]

Implementation: January 15, 2009

Program coordination. DHS is required to report to the legislature on ways to improve coordination between state health care programs and social service programs. The report must include a review of options for the development of automated systems to identify persons served by social service programs who may be eligible for a state health care program. [Art. 3, § 12/ uncodified]

Implementation: July 1, 2009

Income limit increase. DHS is required to increase the MinnesotaCare income limit for adults without children from 200 to 250 percent of the federal poverty guidelines (FPG). (This replaces a scheduled increase to 215 percent of FPG that was to take effect on the same date.) [Art. 3, § 7/ Minn. Stat. § 256L.04, subd. 7]

New premium scale.* DHS must charge MinnesotaCare enrollees premiums using a new premium scale, under which the maximum percentage of gross monthly income that must be contributed is 8.0 percent at 275 percent of FPG. Under current law, the maximum premium is 9.8 percent of gross income.[1] The $4-monthly premium will still apply for children with family incomes that do not exceed 150 percent of FPG. [Art. 3, § 11/ Minn. Stat. § 256L.15, subd. 2]

Implementation: July 1, 2010

Income limit for parents.* DHS is required to increase the MinnesotaCare income limit for parents from $50,000 to $57,500. This is a "hard" income limit and applies even if household income does not exceed 275 percent of FPG for household size. [Art. 3, §§ 6, 10/ Minn. Stat. §§ 256L.04, subd. 1; 256L.07, subd. 1]

B. Health care homes/care coordination fees

The health care reform act requires the Commissioners of Health and Human Services to develop and implement certification standards[2] for health care homes, and to develop a payment system to provide health care homes with per-person care coordination fees. Health care homes are intended to provide coordinated care to patients, beginning first with patients with complex or chronic conditions. The act seeks, over a two-year period, to expand the use of health care homes and care coordination fees under state health care programs and in private sector health coverage.

[1] This maximum premium reflects an October 1, 2003, increase in MinnesotaCare premiums of 0.5 or 1.0 percentage points (depending on enrollee income). The 2007 Legislature eliminated this increase, effective upon federal approval, which had not been received as of July 1, 2008.

[2] In developing certification standards, the commissioners must consider existing standards developed by national independent accrediting and medical home organizations. The standards must also meet criteria specified in law, including but not limited to: providing consistent, ongoing contact with a personal clinician or team of clinical professionals; developing and maintaining comprehensive care plans for patients with complex or chronic conditions; focusing initially on patients who have or are at risk of developing chronic health conditions; and using information technology and systematic follow-up, including the use of patient registries.

Implementation: July 1, 2009

Certification of health care homes. DHS and the Minnesota Department of Health (MDH) are required to begin certification of health care homes, based upon standards developed by the commissioners. Personal clinicians (defined as physicians, physician assistants, advanced practice nurses) and primary care clinics may be certified as health care homes. Certification as a health care home is voluntary and must be renewed annually. [Art. 2, § 1/ Minn. Stat. § 256B.0751]

Health care home collaborative. DHS and MDH must establish a health care home collaborative to serve as a forum to allow health care homes and state agencies to exchange information related to quality improvement and best practices. Health care homes will be required to participate in the health care home collaborative. [Art. 2, § 1, subds. 3, 5/ Minn. Stat. § 256B.0751, subds. 3, 5]

Selection of health care homes. DHS must encourage state health care program enrollees with complex or chronic conditions to select a primary care clinic with clinicians who have been certified as health care homes. [Art. 2, § 1, subd. 7/ Minn. Stat. § 256B.0751, subd. 7]

Implementation: January 1, 2010

Care coordination payment system. DHS, in coordination with MDH, must complete development of a payment system to provide health care homes with per-person care coordination fees for the provision of care coordination services and managing or employing care coordinators. Care coordination fees must vary by "thresholds of complexity," with the highest payments paid for individuals requiring the most intensive care coordination. In developing criteria for payments, DHS is to consider the additional time and resources needed by patients with limited English language skills, cultural differences, or other barriers to care. DHS may develop a phase-in schedule and provide payments first for individuals who have, or are at risk of developing, complex or chronic health conditions. [Art. 2, § 3/ Minn. Stat. § 256B.0753]

Provider network inclusion. Health plan companies must include health care homes in their provider networks. [Art. 4, § 6/ Minn. Stat. § 62U.03]

Implementation: July 1, 2010

DHS implementation.* DHS is required to begin paying care coordination fees to health care homes serving state health care program enrollees under fee-for-service, managed care, and county-based purchasing. DHS may make recommendations to the legislature for reallocating costs within the health care system, if initial savings from implementation of health care homes are not sufficient to implement care coordination fees in a cost-neutral manner. [Art. 2, § 3/ Minn. Stat. § 256B.0753]

Health plan company implementation. Health plan companies must pay a care coordination fee for their members who enroll in certified health care homes. Payment conditions and terms for the care coordination fee must be consistent with the system developed by DHS. [Art. 4, § 6/ Minn. Stat. § 62U.03]

DOF implementation. The Department of Finance (DOF) must implement care coordination fees for State Employee Group Insurance Program (SEGIP) participants and may reallocate payments within the health care system to ensure cost-neutral implementation. [Art. 4, § 6/ Minn. Stat. § 62U.03]

C. Payment reform

The health care reform act contains numerous provisions intended to bring about health care payment reform and greater transparency in health care prices and quality. These provisions require the Commissioner of Health to: (1) develop a payment system that provides quality incentive payments to providers; (2) develop a payment reform plan that includes the establishment of provider peer groups based on comparisons of provider risk-adjusted cost of care and quality of care; and (3) define baskets of care[3] for which health care providers would establish package prices. These payment systems and reforms are to be developed and incorporated in state health care programs and in private sector health coverage over a two-and-one-half year period.

(1) Quality incentive payments

Implementation: July 1, 2009

Quality incentive payment system. MDH must complete development of a system for quality incentive payments for providers. Payments will be in addition to existing payment levels, and based upon a comparison of provider performance against specified targets. The targets must be based on and consistent with a standard set of quality measures developed by MDH. The quality incentive system must include measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other conditions as designated by MDH. MDH may contract with a nonprofit entity or consortium to develop standardized quality measures and the quality incentive payment system, and to collect and report information on provider quality of care. [Art. 4, § 5/ Minn. Stat. § 62U.02]

Implementation: January 1, 2010

Data submission. Physician clinics and hospitals must submit to MDH or a designee, standardized electronic information on outcomes

[3] The act defines a "basket of care" as "a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient." [Minn. Stat. § 62U.01, subd. 2]

and processes associated with patient care and other measures designated by MDH. [Art. 4, § 5, subd. 3/ Minn. Stat. § 62U.02, subd. 3]

Standard quality measures. Health plan companies must use standardized quality measures developed by MDH, and must not require providers to use and report health plan company-specific measures. [Art. 4, § 5, subd. 5/ Minn. Stat. § 62U.02, subd. 5]

Implementation: July 1, 2010

DHS implementation. DHS must implement quality incentive payments as established by MDH, for enrollees in state health care programs. [Art. 2, § 4, subd. 1/ Minn. Stat. § 256B.0754, subd. 1]

MDH standards. MDH must establish standards for measuring health outcomes, establish a system for risk-adjusting quality measures, and begin issuing annual public reports on provider quality. [Art. 4, § 5, subd. 3/ Minn. Stat. § 62U.02, subd. 3]

DOF implementation. DOF must implement the quality incentive payment system for SEGIP participants. [Art. 4, § 5, subd. 5/ Minn. Stat. § 62U.02, subd. 5]

(2) Provider peer groups

Implementation: July 1, 2009

Encounter data. All health plan companies and third-party administrators shall submit encounter data to a private entity designated by MDH, beginning on this date and every six months thereafter. Encounter data is claims data related to the utilization of health care services by, and the provision of health care services to, individual patients. This information is to be used to develop provider peer groups based on cost and quality of care. [Art. 4, § 7, subd. 4/ Minn. Stat. § 62U.04, subd. 4]

Data on contracted prices. All health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by MDH, beginning on this date and annually on January 1 thereafter. This information is to be used to develop provider peer groups based on cost and quality of care. [Art. 4, § 7, subd. 5/ Minn. Stat. § 62U.04, subd. 5]

Implementation: January 1, 2010

Payment reform plan. MDH must complete development of a payment reform plan. The plan must:

- create price transparency; encourage provider innovation and collaboration and cost-effective, high-quality care delivery;
- reduce administrative burdens on providers and health plans associated with submitting and processing claims; and

- provide comparative information to consumers on variations in health care cost and quality across providers. [Art. 4, § 7, subd. 1/ Minn. Stat. § 62U.04, subd. 1]

Implementation: June 1, 2010

Relative cost of care and peer groups. MDH is required to develop a uniform method of calculating a provider's relative cost of care, defined as a measure of health care spending (including resource use and unit prices) and relative quality of care. MDH is also required to develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care for a provider's practice overall, and for specific conditions determined by MDH. While no completion date is specified for these duties, they would need to be completed by MDH prior to the June 1, 2010, date for providing information to providers on cost of care, resource use, quality, and the results of peer grouping. [Art. 4, § 7, subds. 2 and 3/ Minn. Stat. § 62U.04, subds. 2 and 3]

Information to providers. MDH shall provide information to providers on their cost of care, resource use, quality of care, and results of provider peer grouping in comparison to an appropriate peer group. Providers must be given 21 days to review the data for accuracy and an opportunity to submit comments. [Art. 4, § 7, subd. 3/ Minn. Stat. § 62U.04, subd. 3]

Implementation: September 1, 2010

Publishing of provider information. MDH shall publish information on provider cost, quality, and results of peer grouping, on a risk-adjusted basis, at least annually. [Art. 4, § 7, subd. 3/ Minn. Stat. § 62U.04, subd. 3]

Implementation: January 1, 2011

DHS implementation. DHS must use the information and methods developed under provider peer grouping to establish a payment system that: (1) rewards high-quality, low-cost providers; (2) creates incentives for enrollees to receive care from high-quality, low-cost providers; and (3) fosters collaboration among providers to reduce cost-shifting. [Art. 2, § 4, subd. 2/ Minn. Stat. § 256B.0754, subd. 2]

DOF implementation. DOF must use the information and methods developed under provider peer grouping to strengthen incentives for SEGIP participants to use high-quality, low-cost providers. [Art. 4, § 7, subd. 9/ Minn. Stat. § 62U.04, subd. 9]

Implementation by political subdivisions. All political subdivisions that offer employee health benefits must offer plans that differentiate providers based on cost and quality and provide incentives for members to use better performing providers. [Art 4, § 7, subd. 9/ Minn. Stat. § 62U.04, subd. 9]

Health plan company implementation. All health plan companies shall use the information and methods of provider peer grouping to

develop products that encourage consumers to use high-quality, low-cost providers. [Art. 4, § 7, subd. 9/ Minn. Stat. § 62U.04, subd. 9]

Health plan offering. All health plan companies that offer health plans in the individual or small employer markets must offer at least one health plan that uses provider peer grouping to establish financial incentives for consumers to choose higher-quality, lower-cost providers. [Art. 4, § 7, subd. 9/ Minn. Stat. § 62U.04, subd. 9]

(3) Baskets of care

Implementation: July 1, 2009

Definition for baskets of care. MDH shall establish uniform definitions for baskets of care, beginning with at least seven baskets of care. In selecting baskets, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression, and shall consider the prevalence of the health conditions, the cost of treatment, and the potential for innovations to reduce cost and improve quality. MDH shall convene one or more work groups to assist in establishing the definitions. [Art. 4, § 8, subd. 1/ Minn. Stat. § 62U.05, subd. 1]

Implementation: December 31, 2009

Quality measurements. MDH shall establish quality measurements for defined baskets of care. MDH may contract with a health care quality improvement organization to make recommendations about the use of existing measures or establishing new measures. [Art. 4, § 8, subd. 3/ Minn. Stat. § 62U.05, subd. 3]

Implementation: January 1, 2010

Package prices. Health care providers may establish package prices for baskets of care defined by MDH. No provider that has established a package price shall vary the payment amount the provider accepts as full payment. This requirement applies only to services provided to Minnesota residents or nonresidents who obtain coverage through a Minnesota employer. The requirement does not apply to services paid for by Medicare, state health care programs, workers' compensation, or no-fault auto insurance. Providers also may provide charity care or care for a reduced price due to financial hardship or the patient being a relative or friend. [Art. 4, § 8, subd. 2/ Minn. Stat. § 62U.05, subd. 2]

Implementation: July 1, 2010

Information on baskets of care. MDH or a designee shall publish comparative price and quality information on baskets of care in a manner that is easily accessible and understandable to the public. [Art. 4, § 8, subd. 3/ Minn. Stat. § 62U.05, subd. 3]

D. Public health improvement/other provisions

The health care reform act includes provisions that require the Commissioner of Health to implement a statewide health improvement program, though which communities will receive grants to fund local public health initiatives. The act also includes provisions relating to adoption of health information technology, including electronic health record certification and implementation of electronic prescribing capacities. Also, the act requires certain employers to offer Section 125 plans to allow their employees to purchase health insurance with pretax dollars, and requires that certain health insurance plans offered to state employees include high-deductible options.

Implementation: July 1, 2008

Certification of electronic health records. Effective on this date, in order to meet the 2015 mandate for interoperable electronic health records, certain hospitals and clinical practice settings must implement interoperable electronic health record systems certified by the Certification Commission for Healthcare Information Technology (CCHIT). This requirement only applies to providers whose practice settings are covered by CCHIT certifications. [Art. 4, § 2/ Minn. Stat. § 62J.495, subd. 3]

Implementation: April 1, 2009

Section 125 opt-out forms. The Commissioner of Commerce shall create a check-box form for employers to opt out of the Section 125 plan requirements. The form must contain a check box indicating the employer is choosing to opt out and a check box indicating that the employer certifies they have received education and information on the advantages of Section 125 plans. The Commissioner of Commerce shall make the form available through the Department of Commerce web site. [Art. 4, § 10/ Minn. Stat. § 62U.07, subd. 2]

Implementation: July 1, 2009

Statewide health improvement grants. MDH is required to begin providing competitive statewide health improvement program (SHIP) grants to community health boards and tribal communities. The grants are to assist grantees in convening, coordinating, and implementing strategies targeted at reducing obesity, overweight, and tobacco use. This provision includes requirements for grantee activities and a local 10-percent match. [Art. 1, sec. 1/ Minn. Stat. § 145.986]

Section 125 plans. All employers with 11 or more current full-time equivalent employees in Minnesota must establish and maintain a Section 125 plan to allow their employees to purchase individual or employer-based coverage with pretax dollars. Employers are exempt from this requirement if they: (1) offer group health coverage to employees; (2) self-insure for health benefits; (3) have no employees eligible to participate in a Section 125 plan; or (4) opt out of the requirement by sending a check-box form to the Commissioner of Commerce, certifying that the employer has received education and

information on the advantages of a Section 125 plan. The Department of Employment and Economic Development (DEED) shall award grants of $350 to eligible small employers to cover costs related to establishing Section 125 plans.[4] [Art. 4, § 10/ Minn. Stat. § 62U.07]

Implementation: January 1, 2010

High-deductible health plan option. Health coverage offered to state employees covered under the commissioner's plan and managerial plan must include a high-deductible health plan option. [Art. 4, § 1/ Minn. Stat. § 43A.23, subd. 1]

Implementation: January 1, 2011

E-prescribing program. Providers, group purchasers, prescribers, and dispensers must implement an electronic prescribing program that adheres to certain criteria established under the electronic prescription drug program. [Art. 4, § 3/ Minn. Stat. § 62J.497]

E. Reports/monitoring

The health care reform act requires the Commissioners of Health and Human Services to report to the legislature on the implementation of health care homes and payment reform, and to evaluate the health care home model three and five years after implementation. The act requires the Commissioner of Health to report to the legislature biennially on the state health improvement plan. The act also requires the Commissioner of Health to report to the legislature recommendations on an essential benefit and other specified topics related to health care reform, and also requires the commissioner to convene a Health Care Reform Review Council and specified work groups.

Implementation: December 15, 2008

Long-term care employee health insurance. DHS must report to the legislature recommendations for a rate increase to long-term care employers for the purchase of employee health insurance in the private market. This provision would apply to persons employed by nursing facilities, intermediate care facilities for persons with developmental disabilities (ICFs/MR), and community-based long-term care providers. [Art. 3, § 13/uncodified]

Implementation: January 15, 2009

Workforce shortage study. MDH is required to make recommendations to the legislature on changes in health professional licensure and regulation necessary to ensure full utilization of advanced practice nurses, physician assistants, and other licensed health care professionals in the health care home and primary care

[4] The omnibus tax bill (Laws 2008, ch. 366, art. 17, § 4) provides tax credits to certain small employers that establish Section 125 plans. A June 24, 2008 letter from House and Senate leadership to the governor states that the legislature intends, early in the 2009 session, to "repeal that provision retroactive to the date of its original enactment, and . . . replace it with a credit for health insurance premiums paid by previously uninsured individuals with limited household incomes."

delivery system. [Art. 2, § 5/uncodified]

Implementation progress report. MDH shall submit to the Legislative Commission on Health Care Access, beginning on this date, periodic progress reports on the implementation of payment reform and health care homes. [Art. 4, § 9, subd. 2/ Minn. Stat. § 62U.06, subd. 2]

Health Care Reform Review Council convened. MDH must convene the first meeting of the Health Care Reform Review Council by this date. The council is to review the progress of implementation of payment reform and health care homes, and must meet at least quarterly. [Art. 4, § 12/ Minn. Stat. § 62U.09]

Health care affordability proposal. MDH shall present to the legislature a health care affordability proposal for persons with access to employer-subsidized health coverage with gross family incomes up to 300 percent of FPG. [Art. 4, § 14/uncodified]

Community benefit standards. This act requires the Commissioner of Health to make recommendations to the legislature on community benefit standards to be required of nonprofit health plan companies doing business in the state. Though the act does not specify a date on which the recommendations are due, MDH anticipates reporting its recommendation by this date. [Art. 5, § 4, subd. 3/uncodified]

Implementation: October 15, 2009

Essential benefit set. A work group convened by MDH shall submit to that agency an initial essential benefit set. The benefit set must include coverage for a broad range of services, be based on evidence that the services are clinically effective and cost-effective, and provide lower enrollee cost-sharing for services determined to be cost-effective. [Art. 4, § 11/ Minn. Stat. § 62U.08]

Implementation: December 15, 2009

Health care home implementation and evaluation. DHS and MDH must report to the legislature on the implementation and administration of health care homes for state health care program enrollees, beginning December 15, 2009, and each December 15 thereafter. [Art. 2, § 2, subd. 1/ Minn. Stat. § 256B.0752, subd. 1]

Note: DHS and MDH are also to provide the legislature with comprehensive evaluations of the health care home model, three and five years after implementation. [Art. 2, § 2, subd. 2/ Minn. Stat. § 256B.0752, subd. 2]

Implementation: January 1, 2010

Consumer engagement. A work group convened by MDH must recommend to MDH and the legislature strategies for consumer engagement related to health care costs and quality. [Art. 4, § 7, subd. 7/ Minn. Stat. § 62U.04, subd. 7]

Uniform claims review process. A work group convened by MDH must make recommendations to the commissioner on reducing claims

and adjudication costs of health care providers and health plan companies, through uniform payment methods and uniform provider prices. [Art. 4, § 13/uncodified]

Implementation: January 15, 2010

Statewide health improvement program. MDH must submit the first biennial report on SHIP to the legislature. These reports are due January 15 of every other year. The first report must include recommendations for a sustainable source of funding. [Art. 1, sec. 1, subd. 5/ Minn. Stat. § 145.986, subd. 5]

Essential benefit set. MDH shall report the recommendations of the essential benefit set work group to specified legislative committee chairs. [Art. 4, § 11/ Minn. Stat. § 62U.08]

Implementation: January 1, 2011

Health plan company products MDH shall report to the governor and legislature recommendations to encourage health plan companies to promote products that encourage the use of high-quality, low-cost providers. [Art. 4, § 7, subd. 9/ Minn. Stat. § 62U.04, subd. 9]

Implementation: January 15, 2011

Statewide health improvement program. MDH must report recommendations to the legislature as to whether any SHIP funds should be distributed based on health disparities demonstrated in the populations served. [Art. 1, sec. 1, subd. 1/ Minn. Stat. § 145.986, subd. 1]

Implementation Timelines for State Agencies and Other Entities

Note: The letter in brackets that follows each provision refers to the health care reform topic under which the provision is listed in the more detailed narrative timeline that precedes this table. These topics are designated as follows:

[A] = Access/continuity of care

[B] = Health care homes/care coordination payments

[C1] = Payment reform – quality incentive payments

[C2] = Payment reform – provider peer groups

[C3] = Payment reform – baskets of care

[D] = Public health/other

[E] = Reports/monitoring

An asterisk (*) indicates that a provision is effective on the date specified or upon federal approval, whichever is later.

For more information on the provisions in this table, please refer to the narrative timeline, the language of the health care reform act, or the House Research section-by-section summary of that act.

Implementation Timeline for State Agencies and Other Entities

Date	Department of Health	Department of Human Services	Other State Agencies	Health Plans/Third Party Administrators	Health Care Providers/Employers
7/1/2008		Make state health care program forms available on the Internet in common foreign languages [A] Licensed insurance producers and school districts eligible for outreach bonus; bonus amount increased [A] School district outreach requirements modified [A]	DOE to share information with DHS to identify children who may be eligible for MA or MinnesotaCare [A]		Interoperable electronic health records standards set for use in practice settings are covered by CCHIT certifications [D]
12/15/2008		Report to legislature recommendations for rate increase to long-term care employers for employee health insurance [E]			
1/1/2009		* MnCare enrollees may renew eligibility at community locations [A] * MnCare enrollees who fail to submit renewal forms on time receive one additional month of eligibility [A] * MnCare enrollees who fail to pay premiums receive one additional month of coverage [A]			
1/15/2009	In consultation with health licensing boards and professional associations, complete workforce shortage study and report to the legislature [E]	Report to legislature on improving coordination between health care and social service programs [A]			

Date	Department of Health	Department of Human Services	Other State Agencies	Health Plans/Third Party Administrators	Health Care Providers/Employers
	By this date, MDH anticipates making recommendations to the legislature on community benefit standards to be required by nonprofit health plans [E] Submit to the Health Care Access Commission the first periodic progress report on implementation of payment reform and health care homes [E] Convene first meeting of the Health Care Reform Review Council [E] Present to legislature a health care affordability proposal for persons with access to employer-subsidized coverage [E]				
4/1/2009			Commerce Dept. to create employer opt-out form for Section 125 plan requirement [D]		
7/1/2009	Begin providing competitive SHIP grants to community health boards and tribal communities [D] With DHS, develop and implement standards for certification of health care homes [B]	Encourage state health care program enrollees with complex or chronic conditions to select a health care home. [B] With MDH, develop and implement standards for certification of health care homes [B]	DEED to award grants to certain small employers that establish Section 125 plans [D]	On this date and every six months thereafter, submit encounter data to an entity designated by MDH [C2] On this date and every January 1 thereafter, submit data on contracted prices to an entity designated by MDH [C2]	Employers with 11 or more employees must establish and maintain a Section 125 plan unless the employer meets an exception specified in statute [D]

Date	Department of Health	Department of Human Services	Other State Agencies	Health Plans/Third Party Administrators	Health Care Providers/Employers
	With DHS, establish a health care home collaborative [B] Develop system of quality incentive payments for providers [C1] Define at least 7 baskets of care [C3]	With MDH, establish a health care home collaborative [B] MnCare income limit for adults without children increases from 200 to 250% FPG [A] * MnCare enrollees pay premiums based on the new premium scale [A]			
10/15/2009	MDH to convene work group to submit recommendations on the design of a health care benefit set [E]				
12/15/2009	With DHS, on this date and every December 15 thereafter, report to legislature on implementation and administration of health care homes [E]	With MDH, on this date and every December 15 thereafter, report to legislature on implementation and administration of health care homes [E]			
12/31/2009	Establish quality measurements for defined baskets of care [C3]				
1/1/2010	MDH work group must report to MDH and legislature on strategies for increasing consumer engagement [E] MDH working group to make recommendations on reducing claims adjudication costs of health care providers and health plan companies [E]	In coordination with MDH, complete development of a payment system for care coordination in health care homes [B]	DOF: health coverage offered under the commissioner and managerial plans must include a high-deductible option [D]	Health plans must include health care homes in their provider networks [B] Health plans must use quality measures developed by MDH. [C1]	Clinics and hospitals to submit to MDH standard electronic information on patient care outcomes [C1] Providers may establish package prices for baskets of care. [C3]

Date	Department of Health	Department of Human Services	Other State Agencies	Health Plans/Third Party Administrators	Health Care Providers/Employers
	Complete development of a payment reform plan [C2]				
1/15/2010	Submit first report on SHIP to the legislature (reports due January 15 of every other year); the first must include recommendations for a sustainable funding source [E] Report the essential benefit set working group's recommendations to the specified legislative committee chairs [E]				
6/1/2010	Beginning this date, give providers information on cost, resource use, quality, and peer grouping. [C2] By this date, develop a uniform method of calculating a provider's relative cost of care, and a peer grouping system for providers based on a combined measure. While no due date is given, this would need to be completed by this date to provide information to providers. [C2]				
7/1/2010	Establish standards for measuring health outcomes, establish a system for risk-adjusting quality measures, and begin issuing public reports on provider quality [C1]	*Begin paying care coordination fees to health care homes [B]	DOF to implement care coordination fees for SEGIP enrollees [B]	Health plans must pay care coordination fees for their members enrolled in health care homes [B]	

Date	Department of Health	Department of Human Services	Other State Agencies	Health Plans/Third Party Administrators	Health Care Providers/Employers
	Begin publishing comparative price and quality information on baskets of care [C3]	Implement quality incentive payments for enrollees in state health care programs [C1] *MnCare income limit for parents is increased from $50,000 to $57,500 [A]	DOF to implement the quality incentive payment system for SEGIP participants [C1]		
9/1/2010	Begin publishing information on provider costs, quality, and peer group; provide information at least annually [C2]				
1/1/2011	Report to legislature and governor recommendations for encouraging health plans to promote the use of high-quality, low-cost providers [E]	Use the information and methods developed under provider peer grouping to establish a payment system [C2]	DOF to use information and methods developed under provider peer grouping to strengthen incentives for SEGIP enrollees to use high-quality, low-cost providers [C2]	Health plans must use provider peer grouping to develop products to encourage use of high-quality, low-cost providers [C2] Health plans that offer plans in the individual or small market must offer at least one health plan that uses provider peer grouping [C2] Health plans and TPAs must use e-prescribing to transmit prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or provider [D]	Health care providers must use e-prescribing to transmit prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or payer [D] All political subdivisions that offer employee health benefits must offer plans that differentiate providers based on cost and quality and provide incentives for using better performing providers [C2]
1/15/2011	Make recommendations to legislature on whether SHIP funds should be distributed based on health disparities [E]				