2017 Innovation Waiver Progress Report

Health Care Administration

February 2015

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Minnesota Department of **Human Services**

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Minnesota Department of **Human Services**

Table of Contents

I. Executive summary

This progress report provides an overview and update from the Department of Human Services (DHS) regarding the state innovation waiver opportunities afforded under section 1332 of the Affordable Care Act (ACA) referred to in this document as the innovation waiver, available to states beginning January 1, 2017 or after. This progress report is required under Minnesota Statutes, section 256.01 subdivision 35.

This report provides an overview of what the innovation waiver allows and opportunities it affords to Minnesota to provide a more seamless consumer experience and meet the goals of improving patient experience and population health, and reducing costs, for the state's insurance affordability programs. As DHS and other state agencies (MNsure, MN.IT, Minnesota Department of Health and Commerce) continue to work and implement program changes and systems that support the state's new coverage landscape under the ACA; challenges and opportunities have been and will continue to be identified. This report discusses some possible solutions to those challenges at a high level, but is not intended to be exhaustive. These opportunities will require continued discussion with the Legislature, state agencies, advocates and other stakeholders to develop an innovation waiver plan and timeline. DHS anticipates this process starting in 2015.

II. Legislation

Laws of Minnesota, 2013, Chapter 108, Article 1, Section 3:

(e) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by January 15, 2015, on the progress of receiving a federal waiver and shall make recommendations on any legislative changes necessary to accomplish the project in this subdivision. Any implementation of the waiver that requires a state financial contribution to operate a health coverage program for Minnesotans with incomes between 200 and 275 percent of the federal poverty guidelines, shall be contingent on legislative action approving the contribution.

III. Introduction

Minnesota has a longstanding commitment to providing health care coverage to all low-income individuals as evidenced by continued strong bipartisan support for the MinnesotaCare program. Minnesota continues to modernize the coverage landscape and is the first state in the nation to receive approval for Basic Health Plan (BHP) funding for MinnesotaCare which transitioned from Medicaid funding to BHP authority and funding on January 1, 2015. This was a critical step in maintaining access to high quality health care for people who might otherwise struggle with out-of-pocket costs in the private market.

Minnesota has also embarked on new delivery systems, contracting and payment reforms that will help ensure a stable base on the continuation of coverage by reducing costs and focusing on outcomes. This includes encouraging system-wide innovations across payers with the Medicaid ACOs, Integrated Health Partnerships (IHPs), Medicare ACOs and private payer ACOs and Total Cost of Care models. Minnesota also has a federal State Innovation Model (SIM) grant to begin work on the infrastructure needed to support these new models.

The federal innovation waiver authority offers states some flexibility in the federal law in order to continue to improve quality and consumer experience. Coverage for lower-income individuals consists of multiple programs known as Insurance Affordability Programs (IAPs) (i.e., Medical Assistance (MA), MinnesotaCare and Advanced Premium Tax Credits (APTC), which are used to purchase Qualified Health Plan (QHP) products). These programs are administered by DHS, county and tribal agencies and MNsure, the Minnesota's health insurance marketplace. Changes in life situations can lead individuals and families moving in and out of different insurance affordability programs that have different eligibility criteria, costs, provider networks, administrative entities and procedures. The state has also made progress on driving delivery system and payment reform, but there is still significant room to scale up these promising pilot programs. Minnesota's uninsured rate is low; however thousands of people are still without coverage.

IV. Innovation Waiver

Beginning in 2017, states will have a new tool to improve the way care is accessed, delivered and paid for across the income spectrum. Section 1332 of the ACA makes available an innovation waiver that will allow states to waive many of the law's requirements and develop their own delivery and insurance systems, while receiving the federal subsidies that would otherwise have gone to the state's residents.

Section 1332 of the ACA allows states to waive core requirements of the ACA in order to experiment with alternative paths to achieving the ACA's goals. The section 1332 waivers can also be used in conjunction with existing waiver authorities such as section 1115 Medicaid waivers to align programs. Under Section 1332, states may propose modifications to the following elements of the ACA:

- **Health Plan Benefits**. States may change the requirements for Qualified Health Plans (QHP) and by extension, Basic Health Plan (BHP) requirements, including the definition of essential health benefits, limits on cost-sharing, rules for participating plans, and the metal levels.
- **Health Insurance Marketplaces**. States have the option to modify the Marketplace system. For example, states could waive specific requirements by extending access beyond currently eligible populations.
- **Premium Subsidies and Cost-Sharing Reductions.** States might modify the rules governing cost-sharing and premium subsidies. For example, states could smooth out steep increases and drop-offs in premiums that can occur between programs, tie subsidies to higher quality products, or change the income limits for subsidy eligibility.
- **Employer Mandate.** States could alter penalties for large employers who fail to offer coverage to their full-time employees.
- **Individual Mandate**. States may eliminate or modify the tax penalty for individuals who are required to enroll in coverage but do not do so.

Section 1332 impacts the federal funding for the insurance affordability programs through a QHP. Waivers to the Medicaid program must be requested through section 1115 and Title XIX of the Social Security Act. When a state implements a BHP, it may adopt a mixture of QHP and Medicaid requirements. Waiving BHP rules may require waivers under both section 1332 and section 1115.

Section 1332 could involve a request for federal funding commitment that varies by population—Medicaid, BHP, and premium tax credits. For example, although the BHP statute and rule limit state payments to 95% of tax credits for the second lowest silver plan, enrollees with income above 200% of poverty are not eligible for BHP and therefore the federal funding would not necessarily be limited in the same way.

To qualify for an innovation waiver, the state must establish that its reform plan would provide coverage that:

- Is at least as comprehensive as ACA coverage,
- Is at least as affordable as ACA coverage,
- Covers at least as many residents as the ACA would have covered, and
- Will not increase the federal deficit.

By promoting changes that create a stable platform for improvements in payment and delivery reform, a stand-alone or combined (section 1332 with a Medicaid waiver) waiver proposal will assist in reducing federal expenditures as well as promoting a better consumer experience, reduce disruption in coverage, and increase administrative simplicity. These goals are consistent with the requirements for both Medicaid and Innovation waivers.

As major purchasers of health care, both Minnesota and the Centers for Medicare & Medicaid Services (CMS) have an interest in realizing efficiencies through delivery reform. Subsidizing health care up to 400% of poverty has already succeeded in increasing the number of people with insurance. The ACA has also resulted in significant progress in simplifying and streamlining the eligibility factors across the affordability programs. However, some differences remain and those differences result in complexity that may create confusion for individuals and impede quality and access to care.

V. Opportunities for Creating a Seamless Coverage Experience

Many families experience fluctuations in income during the year. As individuals and families move between programs, relationships with trusted providers and care delivery should not be disrupted. In addition, payers and providers should be working towards the same goals of quality and efficiency regardless of product or program. Federal waivers can be leveraged to create consistency and align regulatory requirements across the insurance affordability programs. Different sources of funding can also be consolidated to support continuity of care, reduce gaps in coverage, and help smooth the transitions between programs. This will provide a solid base for alignment of efforts across payers to improve health and patient experience and to lower costs.

We have identified three overarching areas of focus to address the identified issues:

1. **Align the affordability programs eligibility and enrollment requirements:** Use section 1332 and section 1115 waiver authorities to align eligibility and enrollment requirements across insurance affordability programs to provide a stable platform to increase momentum of health care payment and delivery reform. Reduce sharp differences in out-of-pocket costs as people move from one affordability program to another by creating one standardized sliding scale.

2. **Create multi-payer alignment in payment and delivery reform across affordability programs:** Realign incentives so that providers are working towards the same goals of quality and efficiency across the insurance affordability programs. This may include creating aligned payment methodologies across payers and products that hold provider organizations accountable for performance on health outcomes, implementation of integrated care models, community coordination and partnerships, and creating system efficiencies and cost-effective alternatives.

3. **Align coverage and contracting requirements:** There are a range of options that could align or require continuity of care and management of members experience moving among affordability programs.

Minnesota's MA, MinnesotaCare and Advanced Premium Tax Credits (APTC) operate under different federal rules, which sometimes introduce unnecessary complexity.

Under the current system, people whose income increases slightly face significant differences in cost and coverage between MA, MinnesotaCare and APTC. Benefit and network differences between programs make integration of provider incentives across programs difficult. In addition, gaps in coverage and consumers who move in and out of these programs will reduce the number of people able to meaningfully participate in payment reform models that do not span the current insurance affordability programs. Aligning eligibility and enrollment requirements across programs would improve consumer experiences and reduce coverage disruption.

Federal waivers could be used to create a more unified and seamless continuum of coverage for Minnesotans from zero to 400% of the federal poverty level.

- **Reduce barriers to coverage related to cost**
  Reducing the abrupt changes in premiums and cost-sharing for consumers across affordability programs would provide a better consumer experience, encourage them to stay insured and lessen the likelihood of choosing to discontinue care. For example, introducing gradual increases in cost-sharing for higher income enrollees could create a smoother transition from public programs to QHP cost-sharing levels. This strategy could potentially free up funding for other priorities such as financial support for premiums and cost-sharing for individuals who are near the lower limits for premium tax credits.

  The state could also chose to address the issue of affordable coverage and eligibility for premium tax credits for families with employer-sponsored insurance where the affordability test applies only to single coverage for the employee but not dependent coverage for the employee's family making the family members ineligible for premium tax credits.

- **Reduce barriers to coverage related to risk and perceived risk by applying BHP Tax reconciliation rules in the marketplace**
  Some people might avoid purchasing coverage in the marketplace because of the financial risk and uncertainty associated with the tax reconciliation process. Minnesota could explore the feasibility and cost of using waiver authorities to allow the state to shield consumers from this. For example, if Minnesota administered coverage for the affordability programs together, perhaps a standardized Income Reconciliation Factor could be applied across the MinnesotaCare and tax credit programs in a manner similar to one applied to MinnesotaCare in 2015.

- **Align eligibility rules and enrollment timelines.**
  Federal waiver authorities could also be leveraged to align eligibility rules and enrollment procedures across programs. This has the potential to significantly reduce members moving in and out of the insurance affordability programs and increase administrative efficiency. Stable coverage will support member relationships with providers, allowing time for innovations and best practices to impact health outcomes. For example:

  Use a Single Income Measure Across Programs – Using a single method for counting income supports continuity of coverage. MA currently determines financial eligibility based on point in time income, while MinnesotaCare and APTC are determined based on projected annual income for the current tax year. Using a single standard supports continuity of coverage and predictability of costs.

  Adopt Consistent Household Rules Across Programs – Using the same rules to define a household across programs would result in same Federal Poverty Level (FPL) result regardless of the program, which reduces confusion for families.

Align Income Exclusions Across Programs –Using standard exclusions across programs reduces complexity and consumer uncertainty.

Adopt a Single Definition of American Indian – Using a single definition of American Indian to reduce consumer confusion and increase equitable treatment across programs.

Adopt a Consistent Enrollment Date – Currently MA, MinnesotaCare and APTC have different enrollment dates for determinations made on the same day.

Adopt Post-Eligibility Verification of Income Across Programs – For programs other than MA, applicants are enrolled in coverage and then allowed a reasonable opportunity to verify any sources of income that could not be verified when the application was submitted.

- **Improve health outcomes and program sustainability by expanding outcome-based purchasing and contracting strategies across insurance affordability programs**

Once the affordability programs are aligned, reductions in administrative complexity and members moving in and out of programs will support the state in continuing to advance its goals and build on the foundation and momentum of the reforms already started including the Integrated Health Partnership (IHP) program and other delivery system reforms fostered by the investments of the State Innovation Model (SIM) grant. This means moving more populations to outcome-based purchasing strategies to serve MA, MinnesotaCare and APTC members across health care payers. This includes changing the contracting and financial arrangements to ensure a broader participation of entities and basing those arrangements on improving the care and experience of members as well as holding down costs to ensure sustainability of the program and meet federal budget requirements under an innovation waiver.

The state could bring these emerging models up to scale while also focusing on areas of the state where there is less penetration of accountable care organizations and model. This will allow the state and other payers to expand innovative delivery models and more directly influence the changes needed at the delivery system and community level. Changes to foster this expansion include:

Base payment on performance. A greater portion of the payment for providing care to members should be based on performance that results in:

- Improved health outcomes
- Implementation of integrated care models
- Community coordination and partnership
- Reduction in disparities
- Creation of system efficiencies
- Implementation of cost-effective alternatives

New payment arrangements should take into consideration services that are not traditional medical benefits but that contribute to improved health outcomes and other factors that impact a person's health and quality of life.

Align requirements across payers. Align network adequacy, quality incentives and other requirements across payers to facilitate formation of ACOs who serve members across multiple affordability programs.

VI. Conclusion

In summary, the logical next steps in continuing to improve health outcomes, consumer satisfaction and to contain costs include strategies to create consistent rules across the affordability programs and to continue development of purchasing reforms. Creating consistency in program rules will help reduce gaps in coverage, lessen administrative complexity and improve the consumer experience. Alignment of the affordability programs will support the state in continuing to advance its goals and build on the foundation and momentum of important payment and delivery reforms already underway. Any new waiver should also consider this important component of continuing to expand the state's payment and delivery system transformation efforts to ensure that Minnesota can sustain the quality health care coverage it provides to its residents.

VII. Appendix

Add appendices to a report to show interesting material that reinforce the report, such as a list of committee members and their affiliations, detailed survey instruments, supporting information and data.

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