



Minnesota Department of **Human Services**

Fast Facts: 2011 Legislative Session

Changes for state health care programs

The 2011 Minnesota Legislature made a number of changes in how health care is purchased and delivered. These are the key changes are effective July 21, 2011, unless noted.

Managed care and provider payment reform

- Builds competitive price bidding into managed care contracts for health care services and provides for payment reductions and limits on future rate increases to bring down future costs.
- Establishes incentives for quality and efficiency with performance targets. For managed care, these are reducing emergency room use, and hospital admissions and readmissions; for fee-for-service, it is hospital readmissions.
- Requires people with disabilities who are eligible for Medical Assistance (MA) to enroll in managed care plans for basic health services with the choice to opt out effective Jan. 1, 2012.
- Requires additional financial reporting by managed care plans.
- Maintains flexibility to contract with providers that are developing more efficient delivery systems and move to a system that pays for outcomes rather than just services.

Eligibility

- Maintains early expansion of MA, Minnesota's Medicaid program, for low-income adults without children; captures federal funding for low-income adults without children receiving MinnesotaCare.
- Creates the Healthy Minnesota Contribution Program with a monthly state contribution for adults without children in MinnesotaCare who have income above 200 percent of poverty to purchase private health coverage.
- Moves certain noncitizens who do not qualify for federally funded health care programs from MA to MinnesotaCare.
- Repeals two provisions that did not receive federal approval and were not implemented. (They were intended to provide two extra months of MA coverage and automatic MinnesotaCare coverage for certain children ineligible because of excess family income and a MinnesotaCare premium grace month for enrollees who fail to timely pay their premiums and a renewal "rolling" month for enrollees who failed to timely submit renewal forms.)

Policy, payment and program efficiencies

- Creates an incentive program for hospitals to develop policies and quality programs to eliminate elective induction of labor before 39 weeks gestation; requires hospitals to report to DHS all births covered by MA and MinnesotaCare. This is effective Jan. 1, 2012.
- Requires electronic prior authorization systems for health care providers effective March 1, 2012.
- Ends coverage for specialized maintenance therapy (SMT) effective Jan. 1, 2012, for managed care; requires authorization for services.
- Modifies the pharmacy reimbursement rate methodology to replace use of the average wholesale price (AWP) with the wholesale acquisition cost (WAC) effective Sept 1, 2011.

- Maintains the current Child and Teen Checkup screening rate.
- Authorizes payment to new dental services provider types for MA to accurately reimburse new mid-level dental providers effective Sept. 1, 2011.
- Clarifies eligibility for the Critical Access Dental (CAD) program; reduces the CAD add-on payment for MinnesotaCare to the same level as that for MA.
- Requires certain spouses of people who receive MA for long-term care services or Alternative Care to pay a monthly fee toward the cost of care.
- Enhances fraud detection and payment recovery tools, requires contracts with private vendors.

Electronic health records and eligibility system improvements

- Establishes an electronic health records (EHR) incentive program; provides state funds to administer federal EHR incentive program providing \$180 million for health care providers that meet certain criteria for use of EHR.
- Provides state matching funds to leverage federal funding to develop and implement a streamlined system for determining eligibility for publicly funded health care programs.

Payments

- Repeals hospital rebasing, steps in phasing in a cost-based formula for reimbursing hospitals, are canceled to save the state money in future years, effective Jan. 1, 2013.
- Reduces inpatient hospital rates by 10 percent Sept. 1, 2011, through June 30, 2015, with lower reductions for reducing readmissions.
- Reduces nonemergency transportation rates by 4.5 percent, effective Sept. 1, 2011 for fee-for-service, effective Jan. 1, 2012, for managed care.
- Reduces fee-for-service payments to physicians and for professional services by 3 percent, Sept. 1, 2011, through June 30, 2013.
- Reduces fee-for-service dental service payments Sept. 1, 2011, through June 30, 2013.
- Reduces fee-for-service payments for basic care services Sept. 1, 2011, through June 30, 2013; outpatient hospital services are reduced 5 percent and other services by 3 percent.
- Suspends incentive payments to managed care plans for expanding preventative services effective July 1, 2011, to June 30, 2013.
- Maintains funding for medical education and research costs (MERC) through the transfer of MA managed care payments at a reduced level. A total of almost \$24 million per year in state and federal funding will be available in FY 2012-13, and \$37 million per year in FY 2014-15.

Related information

- DHS end-of-session fact sheets, http://www.dhs.state.mn.us/id_000101
- DHS fact sheet, Minnesota Health Care Programs, <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-4932-ENG>

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