

State Health Financing and Politics

Fall 2016 (2 cr)

Thursdays 9:00 – 11:00 AM

Moos Health Sci Tower 2-116



The Honorable State Senator Tony Lourey, JD
(DFL) District 11

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Services Budget Division



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Course Overview

The purpose of this course is to provide students with an overview of the health programs financed and administered at the state level. Topics include the role of government in providing health care services, the role of state government in relation to federal financing and responsibilities; and the need for students interested in pursuing opportunities in state government. This course will teach the basic components of how and where US citizens obtain health insurance coverage, the state's main public health care programs, and trends in state financing and payment reform. We will also touch on the role of the executive branch and the state legislature in developing policy and passing state health care legislation.

Course Objectives

Upon completing this course students should be able to meet the following objectives:

- Describe the role states play in financing and administering health care coverage programs
- Describe fundamentals of public and private health care financing broadly and identify cost shifting between market segments.
- Understand the role politics and public opinion play in shaping health care programs and how to engage in the process to drive reform efforts
- Understand the importance and challenges of *implementation* of state health reforms, beyond the passage of policies into law
- Describe recent reform strategies for federal financing of public health coverage programs including the use of global budgets and Medicaid waivers for demonstration programs
- Identify recent trends and key components of the Affordable Care Act being implemented at the state level

Additional Course Support – Experts from the [State Health Access Data Assistance Center](#)

Reading Materials

There will be a variety of on-line readings. Some of the on-line readings are publicly accessible from any computer with a reliable Internet connection. Some of the on-line readings will require that you access the reading after logging onto the University of Minnesota system as a student (the latter will sometimes be true when accessing journal articles through the University of Minnesota library using the University's institutional subscription).

Assignments and Grading

Assignment	PERCENT OF GRADE	COMMENTS
Draft Paper 1	10%	Short opinion paper on current state health policy issue (3-5 pages). Students are free to choose their own topic, but sample topics will also be provided. <i>You can use your presentation topic for one of your paper topics.</i>
Review #1	5%	Peer review of one other student's draft paper #1
Final Paper 1	20%	Final draft of Project 1 incorporating comments and edits from students and faculty.
Draft Paper 2	10%	Short opinion paper on current state health policy issue (5-8 pages). Plus review and comment on another student's draft.
Review #2	5%	Peer review of one on student's draft paper #2
Final Paper 2	20%	Final draft of Project 2 incorporating comments and edits from students and faculty.
Student Presentation	20%	Student 8-10 minute PowerPoint presentation on Project 2 topic. There will be a short question and answer session at the end of each presentation. We will be scheduling two or three presentations each week during class for the final 6 weeks of the course.
Class Participation	10%	Students will be awarded points for completing the assigned reading and contributing a brief (1-2 paragraph) reflection on one of the weeks' readings posted to Moodle. An equal number of points assigned for responding to at least one other student's reflection. Also, see below for general class participation expectations.
Total	100%	

Class Participation You are expected to attend all class sessions, be attentive during class, ask questions if you do not understand something, and participate in class discussions. You are also expected to listen respectfully to other students, to the instructor, and to guest speakers. Your active participation helps with the learning process both for you and for others. The quality of your participation is more important than the quantity. Please feel free to experiment and take risks. “Wrong” answers can be just as instructive as “right” answers, and respectful debate is often a good way to develop familiarity with the material. There are many differences of opinion on the US health care system and it is critical that all views be respected. Class participation also includes the postings for the reading assignments each week – see specific assignment requirements.

Attendance is required as active participation of class is a key component of this class and contributes to the learning process. Please e-mail me prior to the class you will be missed if there is a medical emergency or other unavoidable circumstance that prevents you from attending class. If prior notice is not received this will be counted as an unexcused absence. You will be allowed 2 excused classes with no penalty; all other missed classes will be considered unexcused. 2 points will be deducted for each unexcused absence.

Assignments/Due Dates All assignments must be submitted to by **5 p.m.** on the stated due date. Late work will be penalized one grade notch (e.g., B to B-) for each day it is late. The weekend (Saturday and Sunday) counts as one day. If you anticipate having difficulty meeting due date deadline(s), you must make **prior** arrangements with the professor to be eligible for receiving full credit on your work. Students with disabilities are also encouraged to contact Disability Services to have a confidential discussion of their individual needs for accommodations (see below).

Grade Disputes If you wish to dispute the grade assigned to a paper or for class participation, you must do so *in writing*. You must include a specific rationale for why you believe you should have been graded differently or why the paper deserves a higher grade.

Grading Scale/System

The following grading scale is adapted from Teaching at the University of Minnesota: A Handbook for Faculty and Instructional Staff.

A	95 - 100	Represents achievement that is outstanding relative to the level necessary to meet course requirements
A-	90 – 94	
B+	85 – 89	
B	80 – 84	Represents achievement that is significantly above the level necessary to meet course requirements
B-	75 – 79	
C+	70 – 74	
C	65 – 69	Represents achievement that meets the course requirements in every respect
C-	60 – 64	
D+	55 – 59	

D	50 - 54 Represents achievement that is worthy of credit even though it fails to meet fully the course requirements	4
F	< 50 Represents failure and signifies that the work was either: (1) completed but at a level of achievement that is not worthy of credit; or (2) was not completed, and there was no agreement between the instructor and the student that the student would be awarded an “Incomplete.”	

Non-PHAP majors may elect the Pass/Fail Grading Option. PHAP majors must take the course for a letter grade. S/N option must complete all assignments and pass with a C- letter grade determined by total effort.

S Represents achievement that is satisfactory, which is equivalent to a C- or better unless specifically designated in writing by the instructor at a higher level of acceptable performance.

N Represents no credit and signifies that the work was not completed at a level of achievement and carries no grade points.

Additional University/School of Public Health Policy Statements

(a) Dropping a Course: Students may withdraw from a course through the second week of the semester without permission. After the second week, students will be required to obtain permission from their advisor and instructor (via email to the Student Services Center) and a W will remain on their transcript.

(b) Grade Change Notice: Students may change grading options without written permission as specified by the University and without penalty during the initial registration period or during the first two weeks of the semester. The grading option may not be changed after the second week of the term.

(c) Disability Policy: It is University policy to provide, on a flexible and individualized basis, reasonable accommodations to students who have documented disability conditions (e.g., physical, learning, psychiatric, vision, hearing, or systemic) that may affect their ability to participate in course activities or to meet course requirements. Students with disabilities are encouraged to contact Disability Services for a confidential discussion of their individual needs for accommodations. Disability Services is located in Suite 180 McNamara Alumni Center, 200 Oak Street. Staff can be reached by calling 612/626-1333 voice or TTY. The website <http://disserv3.stu.umn.edu/index2.html>.

(d) Incompletes: An incomplete grade (“I”) is permitted only in cases of exceptional circumstances and following consultation with the instructor. In such cases, an “I” grade will require a specific written contract with the instructor for timely completion of remaining assignments.

(e) Student Integrity: Scholastic dishonesty is a violation of the student conduct code and is defined as “any act that violates the rights of another student in academic work or that involves misrepresentation of your own work. Scholastic dishonesty includes (but is not limited to): cheating on assignments or examinations; plagiarizing, which means misrepresenting as your own work any part of work done by another; submitting the same paper, or substantially similar papers, to meet the requirements of more than one course without the approval and consent of all instructors involved; depriving another student of necessary course materials; or interfering with another student’s work.” Scholastic dishonesty in any portion of the academic work for a course shall be grounds for awarding a grade of “F” or “N” for the entire course. Please consult the student conduct code at: <http://www1.umn.edu/regents/policies/academic/StudentConduct.html>

Week 1

Course Overview/Introductions

9-8-16

Societal Values: State policies are intended to be a reflection of the values and perspectives of the state's population. Yet, the issues that are being discussed in the public arena are often presented through political lenses which can distort how those values are presented. The outcomes of the political process are often a reflection of the balance between the values of an individual's freedom, choice, and privacy and those of the larger society were issues of safety, well-being and an ordered society are of critical concern. The values and the weight of these values change over time and can often vary based on where you live – urban vs. rural, northern vs. southern regions. It's important to keep these values in mind as we study the role of state health financing and the role of politics at the state level.

Using Narrative to Shape Opinion: The use of data and information is critical to understanding the nature and extent of public problems and are often used to support or argue against key legislative proposals. However, the narrative that shapes the development and discussion of the issues may reflect the values or opinions of a small but vocal subset of society. We argue that the use of data and the ability to communicate clearly and effectively can help change (or better frame) the narrative of key issues being discussed in the political environment. Communication is critical to relaying information to the “people on the street” and to helping to move beyond political rhetoric to articulating policy choices and the impact of those decisions on people and the communities in which they live.

Often the narrative we hear about in the media or through legislative testimony is based on anecdotes or personal stories. People who come to the legislature with a personal interest in a topic – e.g. autism, treatment of breast cancer, funding for a particular service. These personal stories are powerful and can persuade the public as well as the legislators on the importance of the issue. But legislative decisions must take into account the broader societal context and work to balance these individual perspectives with societal costs with prospective benefits. This often requires analysis using existing data or assumptions to project future spending and impact. If we want legislators to do something different we need to get them to tell us to do something different and to use data not anecdotes to drive policy decisions. We need to change the narrative.

National Politics reflected at Local Level: It's also interesting to reflect on how the Presidential debate and national politics get reflected at the local level. The campaign of Presidential candidate Donald Trump is certainly unprecedented in its outspoken beliefs and values that is a reflection of certain segments of our society. But these impacts are occurring in often surprising and unpredictable ways. A recent editorial by Alexander Hertel-Fernandez and Theda Skocpol argue that despite Hillary Clinton's rise in the polls, the “Democrats are losing to Republicans at the state level, and badly.” The impact of Republican dominance in a polarized political process can have significant impact at the local level primarily in the areas of education,

transportation and of course, health care financing of public programs, state, county and city employee health plans, the financing of public programs for low income populations.

Public Service: Finally, we would like to make a pitch for the importance and significance of public service. State and county employees play an increasingly important role in the policy process including developing and analyzing state legislative proposals; forecasting and simulating state budget and program decisions; designing and implementing new innovative programs to serve those in need; and assessing and regulating industries to protect the health and well-being of the citizens of your state. The primary value for working in state government is the valued stewardship of public funds – to maximize the impact of state-funded program, effectively and efficiently target scarce resources, to provide the best data and analysis required for decision making, and to value each and every person with dignity and respect.

Connecting American Values with Health Reform.

@2009 The Hastings Center. Garrison, NY.

http://www.thehastingscenter.org/wp-content/uploads/Connecting_American_Values1.pdf

Policy and Politics.

Hertel-Fernandez, Alexander and Theda Skocpol. VOX August 3, 2016.

<http://www.vox.com/2016/8/3/12368070/democrats-losing-state-level>

Week 2

Overview of State Regulatory Authority

9-15-16

The 10th Amendment: The constitution gives the states its independent authority to raise revenue (through taxes and fees) and to make spending allocation decisions. It outlines how the state and federal governments are independent and sovereign each designed to conduct different duties and functions. The intergovernmental relationship between the two branches of government has changed over time from one of “cooperative federalism,” of the 1960s, to Ronald Regan’s “New Federalism” with more duties delegated to states limiting the federal government to functions of national interests. “Regulatory federalism” refers to ways in which the federal government provides incentives or penalties through funding mechanisms for states to act in certain ways. The relationship between the federal and state levels of government are critical in the understanding of state policy – both in terms of financing of health care programs but also in term of regulatory jurisdiction. Key federal laws are of particular importance to states in terms of their regulatory and taxing functions, ERISA, HIPAA, and EMTALA. Each uses a law passed by the Congress to define federal and state authority and jurisdiction, to incent or require certain activities at the state and local level, and to use its funding authority (Medicare) to mandate service provision by providers.

Employment Retirement Income Security Act-ERISA: Employers play a significant role in the provision of health insurance coverage in the U.S. providing an estimated 55.4% (2014) of all

coverage in the U.S.¹ The role of employer sponsored insurance (ESI) has been voluntary in nature with early incentives during significant economic constraints to provide health benefits in lieu of wage increases in labor negotiations. A key regulatory function of the states is the regulation of private health insurance that is sold in the individual, small group or large group markets outside of ERISA. These insurance products are sold within state boundaries and are regulated as such. Many companies that have multi-state presence will choose to self-insure their health care benefits. Because these benefits are not technically insurance (as defined as a transfer of risk through an actuarially derived premium), these products are not regulated by the state but are regulated as an employee benefit through the federal ERISA (Employment Retirement Income Security Act). These plans function very similarly to regulated insurance products but any losses are paid for out of companies' reserves. Many local health plans serve as third-party administrators, paying claims and overseeing quality and access but again, there is no transfer of risk and health plans are paid for the services provided. The implications of this law are that states cannot regulate or tax neither self-insured plans nor require employers to provide health insurance coverage. A recent court ruling in Vermont under ERISA, also claimed that states cannot require self-insured plans to submit data as part of state efforts to develop All Payer Claims Data Systems (APCDs).

State Note: *The state of Hawaii is the only state that received a federal waiver from ERISA and has its own state employer mandate for employee working 20 hours or more per week. Hawaii's Prepaid Health Care Act (PHCA) was enacted in June 1974, just three months before the Employee Retirement Income Security Act (ERISA) was signed into law. In 1983, Congress granted the state of Hawaii a specific ERISA waiver.² This waiver is often cited as the reason for Hawaii's high health insurance coverage rates. In 2014, private sector coverage by ESI in Hawaii was 64.4% compared to the national average of 57.8%.³*

HIPAA: There has been some precedence of the federal government passing laws that include both the self-insured and fully insurance market. The first of these provisions was included in the HIPAA law of 1996 (Public Law 104-191). In response to the failed Clinton health reform efforts of the early 1990s, the Congress passed HIPAA with sweeping privacy, administrative simplification and access provisions. HIPAA is largely under-valued as a significant piece of health reform legislation. In this legislation was requirement that (1) states must make available a guaranteed issue product for anyone leaving group coverage – either fully insured or self-insured-most states in the past used their high risk pool to meet this requirement, and (2) mandated benefits for all plans include a minimum 48 hour hospital stay for mother of newborn (96 hours for a cesarean); requires post-mastectomy coverage for breast reconstruction, prosthesis, and any physical complications; and includes mental health parity provisions for employers with 50 or more employees.⁴

EMTALA: The Emergency Medical Treatment and Labor Act were passed in 1986 to ensure access to needed emergency care regardless of immigration status or ability to pay. Some people refer to this as part of the U.S. universal coverage policy. As part of Medicare's Hospitals "Conditions of Participation", hospitals with emergency departments must provide a medical screening examination (MSE) and patients must be stabilized and treated for an emergency medical condition, including active labor and deliver. This law was initially referred to as the

"anti-dumping" law as it was intended to prevent hospitals from transferring uninsured or patients to public hospitals, something that was happening so that community hospitals could avoid uncompensated care. Significant fines are levied for hospitals and physicians who violate this law. ⁵

Readings

Executive Summary: Medical Expenditure Panel Survey Insurance Component Chartbook, 2014. Rockville, MD: Agency for Healthcare Research and Quality: August 2015. AHRQ Publication No. 14(15)-0053-EF. https://meps.ahrq.gov/data_stats/MEPSICChartbook.pdf

How We Got to Now: A Brief History of Employer-Sponsored Healthcare.

J Rook David P Griffin Group. <http://www.griffinbenefits.com/employeebenefitsblog/history-of-employer-sponsored-healthcare>

The Labor Department and Liberty Mutual v. Gobeille,

Bagley, Nicolaos. The incidental Economist, January 6, 2016 at 8:00 am.

<http://theincidentaleconomist.com/wordpress/the-labor-department-and-liberty-mutual-v-gobeille/>

Strategies for Health System Innovation after Gobeille v Liberty Mutual Insurance Company.

Bland SE, Crowley JS, Gostin LO. *JAMA*. Published online June 30, 2016.

<http://jama.jamanetwork.com/article.aspx?articleid=2532230>

Other Readings/Resources

EBRI - Employee Benefit Research Institute

<https://www.ebri.org/>

Medical Expenditure Panel Survey – Insurance Employer Component

https://meps.ahrq.gov/survey_comp/Insurance.jsp

Georgetown University Policy Institute: Center on Health Insurance Reforms

<https://chir.georgetown.edu/>

Week 3

Role of State and Special Populations

9-22-16

Unfortunately, there is no federal constitutional right to health care in the U.S. Yet, most state and local constitutions delineate the authority and obligation of state and local governments to provide medical care for the poor. Not surprisingly there is variation in how these obligations are described and what benefits are covered.

Elizabethan Poor Laws: Much of the history of care for the poor came about in the early days of the country, during colonial times, and the reliance on previous experience with the

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Elizabethan poor laws. Care of the indigent and poor were the responsibility of the town and localities with a focus on maintaining social order (vagrancy, begging and taking care of district inhabitants only) and not necessarily on alleviating suffering. These laws recognized the “deserving” poor – typically women, children, the blind, disabled and aged and the “undeserving poor” those who should be able to get a job and fend for themselves (able bodied men). The role of Christianity and care for the poor by the church-state was also still prevalent during this period but the role of the city-state started to emerge as communities and number of poor continued to grow. The view was that poverty was caused by immorality and laziness – with some of these views remaining even today. The history is important to understand the role of County public hospitals and their role in charity care. There are still indigent care funds at the county level that are used to care for the poor without any connection to the state or to the federal Medicaid program.⁶

Immigrant Status: There are many barriers to obtaining public health coverage for immigrants. Federal Medicaid rules specifically bar undocumented immigrants from obtaining Medicaid or CHIP and for those who arrive with the required documentation there is a waiting period of 5 years (the Five-Year Ban) for eligibility. There are many specific optional programs that states can avail themselves of including specific programs to treat TB, Medicaid; coverage for pregnant mothers and newborns through the Immigrant Children’s Health Improvement Act of 2009; and transitional emergency Medicaid services.⁷

<http://www.chlpi.org/wp-content/uploads/2014/01/Issue-Brief-June-2015-The-Medicaid-Tuberculosis-Option.pdf>

State Note: *The state of New York is the only state in the country that includes language in its constitution that requires the state to provide medical care to all regardless of immigration status. Public program coverage for the undocumented typically is paid for with state only funds. In addition, at least three states have All-Kids Coverage programs that include health insurance coverage for children regardless of immigration status. These include the state of Washington and Illinois and several counties in California including Los Angeles and San Francisco Counties. Pennsylvania has a cover-all-kids program but does not include coverage for undocumented children.*

Washington State (includes undocumented kids):

http://www.childrensalliance.org/sites/default/files/cover_all_children_summary.pdf

Illinois All Kids program (includes undocumented)

<http://ccf.georgetown.edu/ccf-resources/cover-all-kids-pennsylvanias-state-wide-campaign-to-expand-eligibility/>

<http://www.commonwealthfund.org/publications/newsletters/states-in-action/2006/mar/march-2006/snapshots--short-takes-on-promising-programs/illinois--universal-coverage-for-children>

Health Kids program in San Francisco

<http://www.sfhf.org/visitors/healthy-kids/>

Readings

Health care for the poor: For whom, what care, and whose responsibility?

Swartz, Katherine. Focus Vol. 26, No. 2, Fall 2009

<http://www.irp.wisc.edu/publications/focus/pdfs/foc2621.pdf>

The Deserving Poor, the Family, and the U.S. Welfare System.

Moffitt, R *Demography* (2015) 52: 729. <http://link.springer.com/article/10.1007/s13524-015-0395-0>

Fifty Years Later: From a War on Poverty to a War on the Poor

Anna Maria Santiago. *Social Problems* Feb 2015, 62 (1) 2-14;

English poor laws: Historical precedents of tax-supported relief for the poor.

Hansan, J.E. (2011). <http://socialwelfare.library.vcu.edu/programs/poor-laws/>

Additional Readings/Resources

Who Shall Live? Health, Economics and Social Choice.

Fuchs, Victor R. @World Scientific (2011)

Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law.

Thomas Kelley. *Fordham Law Review. Issue 6 - May 2005*

http://heinonline.org/HOL/Page?handle=hein.journals/flr73&div=92&g_sent=1&collection=journals

Week 4

Medicaid/CHIP

9-29-16

Medicaid and the Children's Health Insurance Program (CHIP) are the key public health insurance programs administered at the state level under federal minimum standards and administrative rules. Medicaid is considered an entitlement program and is funded through federal matching assistance payments to state Medicaid program spending. The matching payments vary from a minimum of 50% match in Minnesota to a high of XX in Tennessee. FMAP is based on the state's average wage and is intended to provide more federal financial assistance to lower-wage states.

CHIP also is financed through an "[enhanced FMAP](#)" payment that ranges from 88% base in states like Minnesota, California, Maryland, and Massachusetts to a high of 100% in states like Alabama, Arkansas, Kentucky and Mississippi. CHIP, however, is not an entitlement program but is funded through a federal allocation that is distributed across states using FMAP payments. CHIP financing is based on a set global allotment and could result in states setting up queues to stay within their budget allocation. Queues are not allowed in the Medicaid program – all those

who are income eligible are “entitled” to receive services. The FMAP has been used over time to not only fund core programs but also to incent states to develop and implement specific programs and initiatives based on federal administrative priorities.

There is considerable variation in the structure of Medicaid/CHIP across states. The outcomes are based on local culture, beliefs, and how state residents perceive the role of government. These values are reflected in the type of benefits provided (mandatory vs optional benefits), expansion of Medicaid under the ACA and the use of waivers and state plan amendments to achieve state-specific goals.

Medicaid at 50 — From Welfare Program to Nation’s Largest Health Insurer.

Iglehart, John K. and Benjamin D. Sommers. *New England Journal of Medicine* (2015). 372:2152-2159, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1500791>

Context and Overview of Medicaid/CHIP.

MacPAC, Chapter 1. MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/Context_and_Overview_of_Medicaid_and_CHIP.pdf

Trends in State Medicaid Programs: Looking Back and Looking Ahead. Snyder, Laura and Robin Rudowitz. Issue Brief. June 2016, Kaiser Commission on Medicaid and the Uninsured. <http://files.kff.org/attachment/Issue-Brief-Trends-in-State-Medicaid-Programs>

Medicaid: A Primer. Kaiser Family Foundation. 2013

<https://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>

Additional Reading/Reference

Overview of the Medicaid Program. CMS, [Medicaid.gov](http://www.Medicaid.gov)

<https://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html>

Overview of the Children’s Health Insurance Program. CMS, [Medicaid.gov](http://www.Medicaid.gov)

<https://www.medicaid.gov/chip/chip-program-information.html>

Week 5

How to measure and pay for value

10-6-16

Many states have moved from paying providers on a fee-for-service basis to managed care contracts either through PPO or HMO type of models. For states with managed care markets, many are moving back to provider specific contracts through CCOs (Oregon) or IHPs (Minnesota) and other ACO type of payment arrangements. These models reflect years of demonstrations in payment models that work to align incentives so that the financial incentives

reward the right care at the right time. “Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.” (Porter 2010).

Many of these new models of care require providers to have better and more real-time data to reflect past health care use, to identify those with high-cost/chronic conditions and to set benchmarks for quality improvement. Public data collection and reporting has become complex and controversial in some states. For example, in Minnesota we have an industry-sponsored data quality reporting system as well as a state-sponsored quality initiative. What entity should be responsible for cost and quality reporting? Who should pay for this reporting? How does the state hold providers and health systems accountable? Should the state be concerned about public programs only or health care overall? How are these decisions made?

Readings

What is value in health care

Porter, Michael E. N Engl J Med 2010; 363:2477-2481
<http://www.nejm.org/doi/ref/10.1056/NEJMp1011024#t=references>

Paying for value in Medicaid: A synthesis of Advanced Payment Models in Four States. SHADAC report to the MAPAC. February 2014

https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_Visits_Final-Report-Feb-2014.pdf

Measuring Health Care Quality: Overview of Quality Measures.

Families USA. Issue Brief 2014.

http://familiesusa.org/sites/default/files/product_documents/HSI%20Quality%20Measurement_Brief_final_web.pdf

Oregon's Health System Transformation.

Oregon Health Authority. 2014 Final Report.

<http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf>

Additional Readings/Resources

MNHealthScores.org Quick Reference

http://mncm.org/wp-content/uploads/2013/04/MNHS-Measure-Quick-Reference_2016.pdf

The Minnesota Statewide Quality Reporting and Measurement Systems (SQRMS) Denise McCabe, June 27, 2013

<http://www.health.state.mn.us/healthreform/measurement/sqrms062712overview.pdf>

Week 6

Payment Reform Continued, ACOs, and ACHs

10-13-16

This session will provide an overview of state-initiated payment reform models and other initiatives to improve state contracting to get the best value for the tax-supported health purchasing efforts. We will look at Minnesota's competitive bidding process and outcomes; global budgeting (Oregon global waiver); states that have developed coordinated Health Care Authorities to pool purchasing and contracting across Medicaid and other agencies including state employee health plans (Oregon, Maryland and new initiative by Connecticut). And federally funded State Innovation Model initiatives that provide funding to engage communities, health systems, providers and others around population health goals for a defined population. We will discuss the role of the health care system in addressing upstream risks or social determinants of health.

Accountable Health Communities Model.

CMS.gov <https://innovation.cms.gov/initiatives/AHCM>

Accountable Health Communities: Insights from State Health Reform Initiatives.

Janet M. Corrigan and Elliott S. Fisher. The Dartmouth Institute for Health Policy & Clinical Practice. November 2014. <http://tdi.dartmouth.edu/images/uploads/AccountHealthComm-WhPaperFinal.pdf>

State Levers to Advance Accountable Communities for Health.

NASHP May 2016. <http://nashp.org/wp-content/uploads/2016/05/ACH-Brief-with-Appendix.pdf>

Accountable Health Communities And Expanding Our Definition Of Health Care

Health Affairs Blog. March 2016

<http://healthaffairs.org/blog/2016/03/02/accountable-health-communities-and-expanding-our-definition-of-health-care/>

Accountable care for the poor and underserved: Minnesota's Hennepin Health model.

Blewett, Lynn A and Ross Owen. [Am J Public Health](#). 2015 Apr;105(4):622-4.

Week 7

Tour of the Capitol meet w/Governor and/or Legislative leaders

10-20-16

Week 8

State Legislative Process

10-27-16

In this session we will examine who is responsible for assumptions about policy proposals. With so many different views on the costs, benefits and functioning of a proposal, which makes the forecast assumptions is critical and varies by state. We will review materials prepared by the National Conference of State Legislators for a MN Finance Committee hearing on how various states approach this task. There are of course pros and cons to each option and many limiting factors of current budgeting processes in every version.

We will discuss key actors, interest groups and associations involved in crafting policy. We will explore who legislators listen to and why as well as how effective evidence, experts and data are at changing a narrative and making the case for a change. Through this conversation, we will consider how and when innovation can happen, what are the necessary factors and coalitions to move a piece of legislation as well as how much a state can really do in a policy area with such a pervasive federal framework.

There are three key branches of government in the legislative process: administrative agencies including the politically appointed agency head and core staff that stay through consecutive administrations (2) the Governor's office, legislative and agency liaisons, chief of staff, Lieutenant governor, (3) the two houses of the legislature, the House and the Senate.

Most states have a Department of Budget or Finance that works with agencies to produce their budgets, provides analysis of specific reforms or budget reduction strategies and develops revenue and forecast assumptions for policy proposals. We have included several documents from the National Council of State Legislators (NCSL) that provide detail on each state's approach to management and budget activities. The various approaches are critical to understanding the forecasting and budget decisions that can tip the balance of power. Having general knowledge of these various activities and specific knowledge of how this structure works in the state where you would like to work, will help you be an effective steward of state spending

A bill for an act relating to health care; eliminating repeal of the tax on hospitals and health care providers Senate File 2552 (With A-6 Amendment and Combined Fiscal Note)
https://www.revisor.mn.gov/bills/text.php?number=SF2552&session=ls89&session_year=2016&session_number=0&version=latest&format=pdf

Health Care Financing Task Force Final Recommendations

(Recommendations Sections Pp10-32 and Appendix F, Millikan Modeling document Pp55-59 only)

http://mn.gov/dhs/assets/final-materials-final-report_01-28-2016_tcm1053-165972.pdf

NCSL Presentation on Joint Budget Targets in states around the country (see Moodle)

Week 8

State Budget and Health Care

11-03-16

State legislators must pass a balanced budget every two years. And unlike the federal government, states do not borrow to meet their spending obligations. The legislature along with the Governor must balance many important and competing interests, limited resources, and partisan debates. The state budget process is where much of state health policy is made as allocation decisions impact the approach and type of programs that are funded. It is critical to understand the state's role in managing and budgeting state resources including who decides on the assumptions that are used to estimate cost, take up and other functions of legislative or program proposals.

States generally raise revenue through income tax, sales tax, cigarette taxes, fees and assessments. Much of the revenue is placed in the "General Fund" that is used to fund its primary programs - K12, HigherEd, Transportation, and Health and Human Services. Other related intergovernmental transfers are revenue generating mechanisms.

Several states including Minnesota have a provider assessment. In Minnesota there is a 2% assessment on all non-public revenue and a 1% premium tax on health insurers that are "earmarked" to a special Health Care Access Fund to pay for access to care and other health related programs. In Minnesota, legislation was passed to sunset the provider tax by the end of 2019. There are heated debates on the need to reinstate the provider tax, change it substantially in terms of rate and purpose or continue on the path for full elimination.

States also fund their state employee health plan out its general revenue reserves. There are states referred to as "Federal Maximizing States" for their expertise in finding ways to generate federal revenue used to "match" state expenditures under the Medicaid, CHIP or other program or through intergovernmental transfers.

Medicaid is the largest single state expenditure cross all programs. In 2015, on average, states spend 19.3% of General Fund expenditures on Medicaid and 27.4% of total state spending from all funds (including federal match, federal grants, Health Care Access Funds and other fund categories) and represents the single largest state expenditure. There has been significant concern about the continued increase in state Medicaid spending with the expansion of Medicaid under the Affordable Care Act. In FY15, with expanded enrollment, Medicaid spending increased by 16.3% across all states with state funds growing by 6% and federal by 23.1% (NASBO 2016 Fiscal Survey of States). These growth rates are projected to slow to 2.1% in FY17.

Readings

Where the General Fund Dollars Go? Where the General Fund Dollars Come From?
2016-17 Biennium and 2017-18 Biennium projections

https://mn.gov/mmb/assets/2016-fba-eos-pie-charts_tcm1059-246939.pdf

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General Fund Spending Major Area (FY 1990-2017)

https://mn.gov/mmb/assets/General-Fund-Spending-by-major-area_tcm1059-127661.pdf

Health Care Access Fund Projections

https://mn.gov/mmb/assets/hcaf-final-report-jan-2014_tcm1059-127828.pdf

State budget battles gut healthcare for the most vulnerable

<http://www.modernhealthcare.com/article/20160423/MAGAZINE/304239988>

DHS Forecast Narrative 2013

https://mn.gov/dhs/assets/November-2013-Expenditure-Forecast_tcm1053-166430.pdf

Additional Readings/References

State Expenditure Report (FY2013-2015). National Association of State Budget Officers. Washington, DC. <http://www.nasbo.org/publications-data/state-expenditure-report>

Fiscal Survey of States, Fall 2015, National Association of State Budget Officers. Washington, DC <http://www.nasbo.org/publications-data/fiscal-survey-states/fiscal-survey-states-fall-2015>

Week 10**Overview of the Affordable Care Act and the Role of the State
11-10-16**

In this class we will continue the discussion about how a piece of legislation can pass by reviewing the case made for the ACA on the national level in 2010 and what role was left for the states. We will get an overview of the key insurance and access provisions required of states and how various states approached compliance (or didn't). We will discuss the Supreme Courts involvement and how that shaped the implementation of the ACA. In reviewing the options left to states, we will discuss different approaches to Health Insurance Exchanges (HIX) as well as the different Federal and State options for financing.

The United States Health System in Transition.

John E. McDonough (2015)

Health Systems & Reform, 1:1, 39-51. <http://dx.doi.org/10.4161/23288604.2014.969121>

State Options To Control Health Care Costs And Improve Quality.

Health Affairs Blog. April 28, 2016. Emanuel, Zeke, Joshua Sharfstein, Topher Spiro and Meghan O'Toole. <http://healthaffairs.org/blog/2016/04/28/state-options-to-control-health-care-costs-and-improve-quality/>

Two States on the Path to the Basic Health Program.

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Sonya Schwartz. Georgetown University Health Policy Institute. April 2, 2014.
<http://ccf.georgetown.edu/all/two-states-on-the-path-to-the-basic-health-program-2/>

Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance.

Benjamin D. Sommers, Robert J. Blendon, John Orav, and Arnold M. Epstein Journal of the American Medical Association. Original Investigation | August 08, 2016.
<http://archinte.jamanetwork.com/article.aspx?articleid=2542420>

Week 11

Data Modeling, Forecasting, Micro Simulation Models

11-17-16

In this class we will do a case study on the forecasting of Minnesota's implementation of the ACA using the Gruber, Gorman Micro Simulation estimates and evaluating what we got right, and what we got wrong. From this we will consider the continued value of MSM into the future vs. alternative methodologies for forecasting. We will consider what data sources are available and needs as well as how experts and academia can engage to help use data and evidence to drive good policy and budgeting practice. Finally, we will have a brief introduction to the Return on Investment trend and Minnesota's recent adoption of the Results First tool.

The Impact of the ACA and Exchange on Minnesota: Updated Estimates

<https://mn.gov/mnsure-stat/assets/Report-GruberGormanUpdate-2013-02-28.pdf>

Economics Struggles to Cope With Reality. Noah Smith

<http://www.bloomberg.com/view/articles/2016-06-10/economics-struggles-to-cope-with-reality>

APCD Report to the legislature

<http://www.health.state.mn.us/healthreform/allpayer/APCDwkgrpFinalRpt2015Jan.pdf>

PEW Charitable Trust: A Guide to Evidence Based Budget Development

<http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/07/a-guide-to-evidence-based-budget-development>

Report Card on State Price Transparency Laws — July 2016

<http://www.catalyzepaymentreform.org/images/documents/2016%20Price%20Transparency%20Report%20Card.pdf>

Additional Readings/Resources

Predicting the Effects of the Affordable Care Act: A Comparative Analysis of Health Policy Micro simulation Models. Abraham, Jean. RWJF State Health Reform Assistance Network. <http://statenetwork.org/wp-content/uploads/2014/11/State-Network-SHADAC-Predicting-the-Effects-of-the-ACA1.pdf>

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Week 12
Thanksgiving Weekend
11-24-16

Week 13
Politics and Policy
12-1-16

To this point we've primarily covered policy and debate in the legislative context. Now we turn to why politics really matters and how it plays out in the real world. We are after all a representative democracy, and politicians will never get too far out ahead, or too far behind what the electorate is telling them. We need to use data, research and evidence to drive public opinion in order to have policy makers really pay attention. This can be incredibly challenging in a changing landscape of how the public is informed, but also has some promise for effective approaches. We will also put into context how health care is large segment of the U.S. GDP with many vested interests with misaligned incentives in current U.S. health care system. In this environment, changing the narrative is particularly difficult as each vested interest is also working on their own narrative about the value they bring to the public.

MN HealthBasics Commentary by Dave Durenberger

<http://mnhealthbasics.com/perspectives/minnesotas-health-opportunity/>

Huffington Post Commentary by Brian Rooney

<http://www.huffingtonpost.com/brian-rooney/the-healthcare-confusion- b 8933114.html>

The Economist Blog: Politics of Obamacare Decision, Expect More Shouting

<http://www.economist.com/blogs/democracyinamerica/2015/06/politics-obamacare-decision>

Journal Sentinel Commentary: Lillian Thomas

<http://archive.jsonline.com/news/health/7-factors-that-help-make-us-health-care-system-expensive-inefficient-b99284928z1-262899131.html>

Week 14
The Future of Health Care System and Role of the State
12-8-16

At this point in time we will know the results of the Presidential election, which parties control the two houses of Congress and the results of the state elections. The next steps of reform will be dictated, in part, on the political dynamics at the state and national level. The tension between

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the two parties will continue but at hand is how much states can do to refine ongoing health reform strategies. The 1332 waivers give states new opportunities to move ahead with state indicatives. Yet their rules and guidelines are complex and only a few states have moved forward.

Given the continued cost of health care, the rise of prescription drug prices and medical technology, there will continue to be a focus on value-based purchasing, quality measurement and financial incentives. For some states, there will be continued efforts to streamline public coverage programs, simplify enrollment and develop more efficient state operations. A focus will be on value, using public dollars wisely, and demonstrating the impact of reform with data and evaluation of program outcomes.

Readings

United States Health Care Reform Progress to Date and Next Steps

Barack Obama. *JAMA*. 2016;316(5):525-532. doi:10.1001/jama.2016.9797.

<http://jama.jamanetwork.com/article.aspx?articleid=2533698>

The Partisan Divide on Health Care. Journal of the American Medical Association.

Larry Levitt. July 27, 2016. <https://newsatjama.jama.com/2016/07/27/jama-forum-the-partisan-divide-on-health-care/>

**Wednesday
Dec 14 – Last Day of Fall
Semester Classes**

References

¹ US Census Bureau. Health Insurance Coverage in the U.S. 2014. September 16, 2015. Report #P60-253. <http://www.census.gov/library/publications/2015/demo/p60-253.html>

² Bruce Shutan. “An Island unto ERISA Waivers.” Plansponsor Magazine. July 2008. <http://www.plansponsor.com/MagazineArticle.aspx?id=4294990300&magazine=429499014>

³ Medical Expenditure Panel Survey Insurance Component Chartbook, 2014. Rockville, MD: Agency for Healthcare Research and Quality: August 2015. AHRQ Publication No. 14(15)-0053-EF. https://meps.ahrq.gov/data_stats/MEPSICChartbook.pdf

⁴ M.T. Donahoe and Associates. HEALTH INSURANCE PORTABILITY, PRIVACY AND OTHER RIGHTS (HIPPA) <http://www.mtda.com/Documents/Compliance/compliance-11.HTM>

⁵ American College of Emergency Physicians. “EMTALA” New Room. Fact Sheets. <https://www.acep.org/news-media-top-banner/emtala/>

⁶ Dowell, Michael A. State and Local Government Legal Responsibilities to Provide Medical Care for the Poor. *Journal of Law and Health* 3 J.L. & Health (1988-1989). http://heinonline.org/HOL/Page?handle=hein.journals/jlah3&div=6&g_sent=1&collection=journals

⁷ Ku, Leighton and Mariellen Jewers. Health Care for Immigrant Families: Current Policies and Issues. June 2013. National Center on Immigrant Integration Policy. <file:///C:/Users/blewe001/Downloads/COI-HealthCare.pdf>