SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Diane Loeffler, 59A
Representative Paul Thissen, 63A

85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

2010 Recommendations on Issues Related to Health Care Access in Minnesota

This report incorporates recommendations of the following working groups, adopted by the commission on December 15, 2010

Table of Contents

Health Insurance Exchange Working Group

Background

The Patient Protection and Affordable Care Act (PPACA) requires each state to establish an American health benefit exchange (exchange) to facilitate the purchase of qualified health plans and to provide for the establishment of a small business health option program (SHOP exchange) that will assist small employers and their employees to enroll in qualified health plans offered in the small employer market. The purpose of an exchange is to help consumers and small businesses shop for coverage in a way that permits easy comparison of available health plan options based on price, benefits, services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, exchanges should create more efficient and competitive markets for individuals and small businesses. Exchanges will also assist eligible individuals in receiving premium credits and cost sharing subsidies making coverage more affordable or in enrolling in other federal or state health care programs. By providing one stop shopping, an exchange will make purchasing health insurance more convenient and more accessible.

Each state must have a health benefit exchange operational by January 1, 2014, that meets all the exchange requirements of PPACA. By January 1, 2013, the Secretary is required to certify whether the state will have an operational exchange by this date. If the Secretary determines that the state will not meet this requirement, the federal government will establish and operate an exchange for the state, either directly or through an agreement with a nonprofit entity.

In order to begin planning the development of a health benefit exchange in compliance with ACA the Health Care Access Commission convened the Health Insurance Exchange Working Group and charged the group with identifying and exploring the options available to the state. The working group consisted of legislators and representatives of health care stakeholder groups, including health plans, health providers, medical centers, employers, brokers, the University of Minnesota, Center for the American Experiment, and Legal Aid. A list of the working group's membership is attached. During the past several months, eight meetings were convened. During these meetings, the working group concentrated on familiarizing its members with the issues associated with establishing a state exchange and began the groundwork necessary for the possible development of an exchange. A number of meetings were devoted to understanding the state's current health insurance market, including how coverage is obtained through the public health care programs and the commercial market, underwriting rules and regulations for the individual and small employer markets, reinsurance and risk adjustment options, and the current role of brokers in the procurement of commercial health coverage. The working group also began to identify and analyze the major decisions and tasks the state will need to address in order to comply with PPACA and establish a health insurance exchange by January 1, 2014.

While the working group has begun to lay the foundation necessary to begin making these decisions, there was a general acknowledgement by the group that its work over the past few months is just the beginning. The working group recognizes that there are a number of strategic policy decisions yet to be made and that the state cannot effectively make these decisions until the U.S. Department of Health and Human Services (HHS) and other federal agencies develop the necessary regulations and guidelines. It is anticipated that HHS will begin to issue regulations for public comment in early 2011 with additional regulations scheduled for publication later in 2011 and in 2012. Over the next three years HHS intends to publish a series of guidance documents to provide information to states as they begin the process of developing a health insurance exchange. However, the working group recognizes that it is necessary to begin the planning process now in order to completely understand the available options before strategic decisions have to be made. To begin this process, the working group has agreed on several general recommendations in order to establish a working framework for an operational and functioning state health insurance exchange.

Membership of Working Group

Legislative Members:

Senator Linda Berglin, Chair
Senator Julie Rosen, Chair
Senator Linda Scheid
Senator Mary Olson

Representative Paul Thissen, Chair
Representative Erin Murphy
Representative Steve Gottwalt
Representative Diane Loeffler
Representative Tom Huntley
Representative Mike Obermueller

Public Members:

Brian Rotty, Executive Director, Mayo Clinic Health Solutions
Cecilla Retelle, Manager, Education and Health Policy, Minnesota Chamber of Commerce
Cheryl Froland, Channel Management Executive, Blue Cross and Blue Shield of Minnesota
Dannette Coleman, Vice President of Public Policy and Government Relations, Medica
Dave Dzuik, Chief Financial Officer, HealthPartners
David Knutson, Co-Director, Center for Care Organization Research & Development, University of Minnesota
Debra Holmgren, President, Portico Healthnet
Greg Datillo, Legislative Chair, Minnesota Association of Health Underwriters
Jean Abraham, Assistant Professor, University of Minnesota, Division of Health Policy and Management
Jeanne Bailey, Chief Executive Officer, United Family Medicine
Lynn Blewett, Director, State Health Access Data Assistance Center
Maureen O'Connell, Advocacy Director, Legal Services Advocacy Project
Michael Allen, Chief Financial Officer, Winona Health
Peter Nelson, Policy Fellow, Center for the American Experiment
Phillip Cryan, Organizing Director, SEIU Health Care MN
Roger Kathol, President, Cartesian Solutions Inc.

Recommendations:

1. Establishment of a State Health Insurance Exchange

Under PPACA, an exchange must be available in each state by January 1, 2014. If a state chooses not to establish an exchange, a default exchange will be created by HHS. If a state chooses to establish a health insurance exchange, a state may elect to establish one exchange to provide both exchange and SHOP exchange services or may choose to establish separate exchanges. Furthermore, a state may choose to join with a number of other states to form a regional or interstate exchange, or it may choose to establish its own exchange, either as one statewide exchange or a number of subsidiary exchanges throughout the state, each serving a distinct geographic area.

The first issue discussed by the working group was whether the state should establish a health insurance exchange or instead allow the federal government to create a default exchange for the state. In considering this decision, the working group spent time evaluating whether the creation and control of a state exchange would be more beneficial for the state than ceding control to the federal government. The group recognized that if the

state chose to create its own exchange, it would have the opportunity to create an exchange that met the specific needs of Minnesota. The federal default exchange structure may, for example, use a "one size fits all" philosophy without regard to the needs of Minnesota or without recognizing the nuances of the health care markets in this state. The working group also recognized the importance of keeping the exchange under state control to ensure that there will be state coordination between the state's public health care programs and the subsidy programs that will be offered through the exchange. Furthermore, the group acknowledged that the state will continue to regulate insurers outside of the exchange. Since some insurers may offer products both inside and outside of the exchange, it may be easier and less confusing if the state maintained regulatory control over products offered in the exchange. Finally, there was support for the idea that the risk-adjustment and risk-pooling requirements within the exchange be based on the Minnesota insurance market. There was some concern that if the federal government set up a default exchange, the risk-adjustment and risk-pooling for the products offered in this exchange could be based on other state populations thereby creating higher premiums for the exchange products than would be the case if pooling was only based on Minnesota's markets.

Recommendation: Based upon the consideration of these issues, the working group recommends that the state proceed expeditiously, meeting all federal deadlines, to establish a state health insurance exchange rather than allow the federal government to manage the required exchange functions through a federal default exchange. The working group also recommends that the state establish a single statewide exchange to provide the required exchange services rather than join a regional exchange with neighboring states or establish a number of subsidiary exchanges throughout the state. Finally, the working group recommends that an actuarial assessment be completed in order to determine whether or not to establish a single risk pool for the individual and small employer market.

2. Exchange Entry Point for Eligibility and Enrollment

Under PPACA, the exchange is required to establish an enrollment system that: (1) ensures that applicants are screened for eligibility for all available health care subsidy programs, including the premium tax credits and cost-sharing subsidies available to qualified individuals through the exchange, Medicaid, CHIP, and other state public health care programs; and (2) enrolls individuals in public health care programs if determined eligible. This requires the coordination of efforts across available health care subsidy programs in order to create an efficient enrollment process and seamless transaction between the available health care programs.

Several options are available to the state in order to meet these enrollment requirements. First, the state could require the exchange to perform all eligibility determinations for exchange plans and Minnesota health care programs (MHCP). Second, it could require the exchange to perform exchange and MHCP eligibility determinations that come through the exchange and require the state and counties to perform exchange and MHCP eligibility determinations that come through their agencies. The third option is to require the exchange to perform determinations for the exchange plans and for MHCP that come through the exchange and have the state and counties only perform MHCP eligibility determinations for applications coming through their agencies.

Recommendation: The working group recommends that the state create an application process and a single entry point for all health care subsidy programs, including the premium credits and cost-sharing subsidies available through the exchange, Medicaid, CHIP, and other state public health care programs and that the exchange perform all eligibility determinations for exchange plans, as well as for the Minnesota health care programs. This would entail aligning eligibility rules, processes, systems and benefits to the extent possible; developing a secure, electronic data exchange interface to facilitate eligibility/subsidy determination; and obtaining technical and financial assistance in order to establish on-line eligibility determination and enrollment for individuals who will be eligible for premium tax credits, subsidies, and public health care programs. Counties would continue to be responsible for MHCP eligibility determination and enrollment for the elderly,

blind, and disabled. To the extent appropriate, the Department of Human Services enrollment activities for exchange eligible populations should be integrated with exchange enrollment activities.

3. Qualified Health Plans Participation in the Exchange

Under PPACA, HHS is required to establish minimum criteria that health plans will be required to meet in order to be certified as qualified health plans. A state may require health plans to meet additional criteria. Once these regulations are established, the exchanges are required to certify health plans that meet these criteria and make these plans available through the exchange. Only qualified health plans may be offered through the exchange. Within this general framework a state must make a number of policy choices regarding the structure of the exchange and exercising its regulatory authority over plan participation. For example, a state may maximize plan participation by minimizing certification requirements or it may use its certification authority to limit exchange participation to only high-value health plans.

While the state contemplates the available options as to how it structures its exchange and establishes its regulatory authority it is important for the state when making these decisions to establish requirements that will minimize the risk of adverse selection. Adverse selection will occur if a disproportionate number of individuals who are in poorer health and have high health expenses enroll in health plans through the exchange while healthier, lower cost individuals disproportionately enroll in health plans offered outside the exchange. If this occurs the cost of exchange health plans will be higher than the cost of health plans offered outside the exchange and the effectiveness and viability of the exchange will be in jeopardy.

PPACA contains several provisions to help guard against adverse selection. (i.e. premium credits available only in the exchange; uniform premium rate rules and benefit standards; temporary use of risk corridors and reinsurance; same premium for the same plan; risk adjustment and single risk pool requirements). It also provides states with flexibility in order to further limit the risk of adverse selection. For example, through the state's authority to regulate the individual and small group markets, the state can ensure that the rules for the insurance markets outside the exchange are consistent with the rules that apply inside the exchange. Furthermore, under PPACA health plans are not required to participate in the exchange and health plans offered outside the exchange do not have to meet the same standards as plans offered in the exchange. However, the state has the option to require all health plans who wish to offer products outside of the exchange to also offer coverage in the exchange and to offer the same products at the same price both inside and out. Another option for the state to consider is to merge the individual and small group markets over time increasing the chance of a more balanced risk pool and thereby reducing the risk of adverse selection occurring.

Recommendation: The working group recommends that the state should continue to explore regulatory options such as the ones described above or other market mechanisms to ensure a healthy marketplace and to encourage value based decision making by consumers and employers. Participating health plans should be encouraged to establish integrated health care delivery systems that use high-quality, low-cost providers and reward efficiency in coordination with health care reform efforts that are currently being implemented. Opportunities should also be provided to consumers and employers to share in savings when they choose high-quality value-based products and participate in measurable health and risk factor improvements. For example, incentives such as lower cost sharing requirements or premium rebates or offering additional benefits or services could be developed to encourage consumers to choose higher-quality, lower cost coverage and to make lifestyle decisions that will improve their health and reduce costs.

4. Application of Planning Grants

Beginning in 2010, HHS has made grants available to states to aid in the planning and the establishment of a state health insurance exchange. Grants will continue to be available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011 and the size of the

grants may be related to the number of milestones met. States that are not able to meet certain milestones by the spring of 2011 may apply for grants later in the year.

Recommendation: The working group recommends that the Minnesota Department of Health or other state agencies apply for state planning and implementation grants as soon as possible and for other grants consistent with these recommendations as they become available. One goal of these grants should to be to obtain funding that focuses on actuarial analysis assistance to permit the state to make an informed decision on whether to merge the individual and small group insurance markets. Another important focus for these grants should be to obtain technology support in order to establish an electronic verification and on-line eligibility system.

5. Continuation of a Working Group

Recommendation: The working group recommends the continuation of a health insurance exchange working group in order to continue to the develop key issues, to evaluate strategic options as they become available to the state, and ensure that the health insurance exchange that is established operates efficiently and effectively and focuses on improving the delivery of health coverage in this state. Membership of the working group should continue to be bipartisan and to represent a broad cross-section of stakeholders. This working group could continue to be organized by the Health Care Access Commission or as a task force established by the incoming administration but it is essential for the state to recognize the importance in continuing to provide time and resources for the strategic and operational planning of a statewide health insurance exchange.

Payment Reform Working Group

Background

The U.S. health care system is often criticized for providing care that is fragmented, and for paying many providers for this care under a fee-for-service system that rewards volume, rather than high quality care. This contributes to rapidly increasing health care costs and a system in which the quality of care does not always reflect the high level of expenditure.

In recognition of these concerns, the Minnesota Legislature in 2008 passed legislation that attempts to provide financial and other incentives for the provision of coordinated, high-quality care. These initiatives include provisions to certify health care homes and provide payment for care coordination, make quality incentive payments to providers, and allow consumers to compare providers based on the cost and quality of care (see Minn. Stat. chapter 62U). The 2010 Legislature directed the Commissioner of Human Services to implement a demonstration project to test alternative and innovative health care delivery models for Minnesota health care program enrollees, including accountable care organizations that provide services based upon a total cost of care or a risk-gain sharing payment arrangement (see Minn. Stat. § 256B.0755).

The federal Patient Protection and Affordable Care Act (PPACA) contains many provisions intended to encourage providers to coordinate the care provided to patients and to reward providers for providing care efficiently. One of these provisions establishes a shared savings program under Medicare for accountable care organizations. In addition, the Minnesota Department of Health and the Minnesota Department of Human Services were recently selected to participate in the federal Multi-Payer Advanced Primary Care Demonstration, to implement health care homes and care coordination payments for both Minnesota health care program enrollees and privately insured enrollees. Finally, many Minnesota health plans, health systems, and health care providers are conducting their own payment reform and care coordination initiatives to reward the provision of efficient, coordinated care and improve health care quality.

Given the interest in, and importance of, payment reform and care coordination initiatives at both the national level and in Minnesota, the Health Care Access Commission convened a Payment Reform Working Group. The membership of the working group consisted of legislators and representatives of various health care and consumer groups (see membership list below).

During the summer and fall of 2010, the working group held six meetings (August 18, September 8, September 27, October 14, October 27, and December 2). The meetings included presentations and discussion on: the status of state grant applications related to payment reform, payment reform and care coordination principles, and Minnesota public and private sector payment reform and care coordination initiatives, with a focus on the establishment of accountable care organizations.

The recommendations that follow grew out of the working group discussions of those topics. The goals of the recommendations are to: (1) encourage, and allow the state to facilitate, the many promising approaches to payment reform and care coordination that are being conducted by Minnesota health plans, health systems, and providers; (2) provide the state with an ongoing means of monitoring and evaluating the success of payment reform initiatives; and (3) apply promising initiatives to state health care programs, in order to improve patient care and to reduce the rate of increase in state health care spending.

Membership of Working Group

Legislative Members:

Senator Tony Lourey, Co-Chair
Senator Rick Olseen
Senator David Senjem
Senator Linda Higgins
Senator Kathy Sheran

Representative Tom Huntley, Co-Chair
Representative Jim Abeler
Representative Julie Bunn
Representative Matt Dean
Representative Maria Ruud

Public Members:

Anne Edwards, Chair of Pediatrics, Park Nicollet Health Services
Charlie Fazio, Chief Medical Officer & Senior Vice President, Medica
Cindy Morrison, Vice President of Health Policy, Sanford Health
Daniel L. Svendsen, Executive Director, Generations Health Care Initiatives, Inc.
Don Jacobs, Chairman & Chief Executive Officer, Hennepin Faculty Associates
Douglas Wood, Chair, Division of Health Care Policy, Mayo Clinic
George Schoephoerster, Geriatrician, Geriatric Services of Minnesota
Heidi Holste, Associate State Director of Advocacy, AARP
James Wuellner, Vice President and Chief Financial Officer, St. Luke's Hospital of Duluth
Jim Przybilla, Chief Executive Officer, PrimeWest Health
Jonathan Watson, Director of Public Policy, Minnesota Association of Community Health Centers
Julie Sonier, Deputy Director, State Health Access Data Assistance Center, University of Minnesota
Lisa Fink, Staff Attorney, Legal Services Advocacy Project
Meg Hasbrouck, Vice President, Payer Relations and Contracting, Allina Hospitals and Clinics
Michael Scandrett, President LPaC Alliance, Minnesota Safety Net Coalition
Terry Carroll, Senior Vice President, Transformation and CIO, Fairview Health Services
Jim Reimann, Payer Relations Chair, Minnesota Medical Group Management Association
David Abelson, President and Chief Executive Officer, Park Nicollet Health Services

Recommendations

1. Develop Improved Methods of Risk Adjustment and Risk Assessment

Many payment reform initiatives require participating providers to bear some degree of financial risk, as an incentive to efficiently provide high-quality services. For example, payments to a provider for a defined set of services provided as needed to a patient may be fixed, or the level of aggregate payment to a provider may vary with whether the provider meets a target tied to service utilization. In these cases, providers with a patient base that is healthier than average (relative to other providers) will be more likely to benefit financially, since expenditures and service utilization for that patient base will be more likely to be lower than average. This can give providers and health plans and systems a financial incentive to seek healthy enrollees (“cherry-pick”), and a financial disincentive to establish programs that would serve and attract patients with high-cost health care conditions. In addition, small providers may be reluctant to participate in payment systems that involve risk

sharing, since any losses on patients with greater than average health care needs must be recouped over a smaller overall patient base.

Risk adjustment is one method of reducing the likelihood of providers being penalized for serving a greater-than-average proportion of patients with significant health care needs. Risk adjustment is the process of adjusting payments to health plans, health care providers, and other entities, to reflect differences in the risk characteristics of enrollees or patients. Risk adjustment can also be used to control for patient characteristics as part of measuring and comparing the cost and quality of care. Minnesota rules governing the statewide quality reporting and measurement system define risk adjustment in this context as "a process that adjusts the analysis of quality measurement by accounting for those patient-population characteristics that may independently affect results of a given measure and are not randomly distributed across all providers submitting quality measures. Risk adjustment characteristics include severity of illness, patient demographics, or payer mix" (Minnesota Rules, part 4654.0200, subpart 17).

Risk adjustment usually relies on a risk-assessment model to compare the risk characteristics of individuals or groups to a population average. These characteristics, which are typically obtained from enrollment or claims data, can include demographic factors such as age and gender, health status information, payor information, and information on medical condition and treatment. Risk assessment can be used to risk-adjust payments to health plans and providers when they are paid through capitation or some other non-fee-for-service payment method. Risk assessment can also be used to identify high-cost patients for purposes of disease management or care coordination, measure provider efficiency, and compare provider performance while controlling for patient health status and other relevant characteristics.

The working group discussed the limitations of current methods of risk assessment. Several working group members raised concerns about the fact that current methods do not generally incorporate factors such as race/ethnicity, language, or income/poverty that may influence health outcomes and health care utilization independently of other factors included in the models (e.g. age, gender, diagnoses).

Assessing the need for improvements to risk adjustment is a necessary and important step for implementing payment reform for two reasons. First, if providers do not trust the risk adjustment methods, many of them—especially small providers—will be reluctant to participate in payment reform initiatives. Second, inadequate risk adjustment could lead to financial incentives that penalize providers serving higher-risk populations and reward providers that serve lower-risk populations. This could ultimately reduce access to care for higher-risk populations.

Recommendation: The working group recommends that the state work with the private health care sector to assess the need for improvements in risk adjustment models, to develop the necessary data infrastructure (e.g. data collection on additional factors to be included in risk adjustment), and to develop and implement improved methods of risk adjustment. This process should result in a set of agreed upon standards for risk adjustment and risk assessment models. The standards could, for example, address issues such as: the demographic and health-related factors that should be included in a risk-assessment model; the extent to which health indicators should be based on diagnosis or treatment; and the extent to which a risk adjustment model should be prospective (based on health spending indicators from a previous period) or concurrent (based on health spending indicators from the current period).

The standards should, among other things, encourage smaller or specialized health care providers and health plans to participate in payment reform initiatives that require some risk-sharing. An appropriate risk adjustment method for these providers will likely require special features given the small patient base of these providers, since current risk assessment tools tend to do a better job of explaining variations in health care costs between larger patient populations, as opposed to smaller ones. An appropriate risk adjustment method for these

providers would also likely require including in the risk assessment model a wide range of variables, including non-clinical, socio-economic factors related to race, ethnicity, language, and poverty and homelessness.

2. Ensure the Full Participation of All Provider Types in Payment Reform

In order to have a significant effect statewide in reducing health care spending and improving the quality of care, payment reform, and care coordination initiatives must include participation by a wide range of providers, who in the aggregate serve a large and diverse patient population across all areas of the state, both rural and urban. Participation in payment reform initiatives should be feasible and attractive not only for large, urban group practices but also for solo-practitioners and other small (often rural) providers, safety net providers such as community clinics, and specialty providers that serve defined populations, such as those with specific health conditions or certain cultural, ethnic, or socio-economic groups.

These small, safety net, and specialty providers may not have the resources necessary to evaluate whether to participate in a payment reform initiative, negotiate successfully with health plans and health systems, and modify their organizational procedures and payment systems as necessary to allow them to participate in payment reform initiatives. The health information technology and electronic health record systems required to participate in payment reform initiatives may be unaffordable to these providers, and these providers may require technical assistance in selecting and maintaining these systems. Finally, these providers may only be able to accept limited financial risk as part of a payment reform initiative.

At the same time, many of these providers have experience in providing care to hard-to-serve populations using cost-effective and innovative payment and care delivery methods. This specialized expertise may be useful to health plans and large health care providers as they develop payment initiatives to serve low-income or culturally diverse or specialized populations.

Recommendation: The working group recommends that the state take steps to ensure that private sector payment reform initiatives, and those administered by the state for state health care program enrollees, are flexible in design and include a range of models, in order to incorporate the full range of health care providers and serve a diverse patient base. These steps could include, but are not limited to:

(1) encouraging and coordinating efforts to provide technical and financial assistance to small, safety net, and specialty providers, to allow them to evaluate and participate in payment reform initiatives;

(2) seeking any applicable federal grants that would support infrastructure development by small, safety net, and specialty providers, and assisting these providers in applying for relevant grants;

(3) providing a means of communicating best practices to all providers, including but not limited to those best practices used by small, safety net, and specialty providers to reach hard-to-serve populations;

(4) ensuring that financial risk arrangements do not preclude participation by small, safety net, and specialized providers; and

(5) ensuring that risk adjustment methods are appropriate for small, safety net, and specialized providers (see also recommendation 1).

3. Facilitate Transparency and Coordination

Many payment reform initiatives require increased transparency—i.e. greater sharing of price and quality information between health care providers, and with consumers. Effective implementation of payment reform initiatives may also require health care providers and health plans to work together to coordinate care using

uniform procedures. State and federal data privacy, antitrust, and fraud and abuse laws may limit the extent to which information can be shared, and the ability of providers to work together to establish uniform procedures for care coordination. These laws may also hinder efforts to allow consumers to choose providers or health care systems based on comparisons of cost and quality.

The PPACA, in order to promote the development of Medicare accountable care organizations, provides federal agencies with waiver authority related to fraud and abuse laws, and also gives those agencies the authority to designate new regulatory exceptions and safe harbors.

Recommendation: The working group recommends that:

(1) the state assist efforts by the private health sector to cooperatively develop uniform procedures and standards for payment reform initiatives, by convening groups of patients rights and consumer protection organizations, health care providers, and health plans when some form of state protection from antitrust laws is necessary;

(2) state agencies assist provider groups and health plans interested in developing payment reform initiatives, by issuing timely decisions or issuing advisory opinions, after input from consumers, and when necessary, assisting providers and plans in obtaining clarification from the federal government;

(3) the state monitor the extent to which data privacy and anti-fraud laws hinder the implementation of payment reform, and when necessary recommend appropriate changes in state and federal laws and any necessary federal waivers; and

(4) the Minnesota Department of Health, in consultation with the Department of Human Services and providers and plans, develop improved patient reported outcome measures that can be used to measure delivery system performance and the effectiveness of payment reform initiatives.

4. Design and Implement Payment Reform in the Broader Context of Societal Determinants of Health

While much of the discussion of payment reform focuses on the actual provision of and payment for health care services, other factors also have a significant impact on population health outcomes. For example, the county health rankings model assigns weights to the various health factors that influence health outcomes. The model assigns a weight of 20 percent to clinical care, with the remaining 80 percent assigned to three sets of non-clinical factors—health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent). [Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, County Health Rankings: 2010 Minnesota, http://www.countyhealthrankings.org/minnesota]

Since the ultimate goal of the health care system is good health and positive health outcomes, payment reform initiatives should be developed in the context of these broader societal determinants of health, and in coordination with the public health system.

Recommendation: The working group recommends that payment reform initiatives for enrollees of state health care programs:

(1) incorporate preventive services;

(2) provide incentives for patients to adopt and maintain healthy lifestyles;

(3) take into account racial, ethnic, and cultural factors;

(4) respect patient preferences and decision-making; and

(5) use measures of population health status as well as individual health status, including the health status of specific racial, ethnic, and low-income populations, when evaluating effectiveness.

The working group also recommends that the state encourage private sector payment reform initiatives to satisfy these criteria.

5. Continue the State's Focus on Payment Reform and Cost Containment

The development and implementation of payment reform initiatives is an ongoing process. Many payment reform models have only recently been implemented and have not been fully evaluated. Given the potential impact of payment reform on health care costs and quality, the state should maintain a means of reviewing the progress of payment reform, evaluating the effectiveness of payment reform initiatives in lowering health care costs, and providing a forum for discussing relevant issues with stakeholders.

Recommendation: The working group recommends that the state continue to focus on payment reform and cost containment, whether through a working group of the Health Care Access Commission, a commission appointed by the governor (perhaps similar to the Governor's Health Care Transformation Task Force of 2007), or by another means. Membership in the working group should continue to be bipartisan and represent a broad cross-section of stakeholders.

In addition to focusing on the recommendations listed in this report, the working group or other entity may also want to consider:

(1) promoting and further developing the health care payment and quality reforms authorized by the 2008 Legislature, e.g. by continuing to transition payment reform from bundled payments and shared savings approaches to total cost of care models;

(2) continuing to promote the development of health care homes, in both private and public sector programs, and monitoring health care home initiatives such as the Multi-Payer Advanced Primary Care Practice Demonstration for which participation by Minnesota was recently approved;

(3) monitoring the development of ACOs in Minnesota, including the health care delivery systems demonstration project authorized under Minnesota Statutes, section 256B.0755, and based upon this monitoring, determining whether state regulation of ACOs is necessary;

(4) evaluating the effectiveness of private sector payment reform models and payment reform initiatives authorized by the PPACA, and whether successful initiatives should be incorporated into state health care programs;

(5) evaluating what an appropriate definition and level of reimbursement should be for total cost of care and other cost-sharing arrangements, in order to both evaluate the effectiveness of payment reform and obtain a baseline for assessing ongoing provider concerns about the adequacy of reimbursement. In defining total cost of care, the working group should consider not just medical costs incurred by a provider for the provision of patient services but also the impact on costs (cost-shifting) for other providers, payers, government entities, and nonprofit organizations; and

(6) promoting state collaboration with the newly established Center for Medicare and Medicaid Innovation, through communicating effective strategies to the center and seeking any necessary federal approval for state payment reform initiatives.

Work Force Shortage Working Group

The Work Force Shortage Working Group was charged with reviewing issues and solutions for health care work force shortages in Minnesota by focusing on the following:

I. Identifying current and anticipated health care workforce shortages, both by provider type and geography;
II. Evaluating the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce; and
III. Studying alternative incentives to develop, attract and retain a highly skilled health care workforce and recommend whether to replace, enhance, or supplement current incentives with new ideas, including payment reform.

The working group consisted of a diverse group of 24 people, including six legislative members, 18 public members, and legislative staff.[1] It met six times between September 23 and December 8. While the time was far too short, the engagement and enthusiasm of the members was remarkable.

I. Current and Anticipated Health Care Workforce shortages, by provider type and geography.

There is broad agreement that Minnesota faces severe workforce shortages in a number of professions, geographic areas and for certain populations, and that the shortages will continue to worsen. These shortages will impact the ability of Minnesotans to access appropriate health care and will also impact Minnesota's economy.

The health care industry is a major Minnesota employer, with about 344,000 public and private sector jobs, or 13.4 percent of total state employment for 2009. According to the Minnesota Department of Employment and Economic Development (DEED), over 103,000 new jobs will be created and additional thousands of replacement health care workers (including those in the social assistance sector) will be needed between 2009 and 2019. In 2009, the professions with the highest job vacancy rates were psychiatrists, occupational therapy assistants, occupation therapists, and physical therapy assistants. The largest numbers of vacancies in 2009 were for health aides, nursing aides, orderlies and attendants, and registered nurses.[2]

According to the state Office of Geographic and Demographic Analysis, between 2005 and 2035, the population over age 65 will grow by 125 percent, or almost 770,000 people. By 2035 the proportion of the population 65 or older will go from about 12 to 22 percent.[3] This older population will likely need more health care services. At the same time, many Baby Boomers will be retiring from jobs in health care, which will create many vacancies and greatly increase the demand for health care providers.

In addition to an aging workforce and a growing senior population, practice choices of medical students, students of other health professions, and new providers contribute to workforce shortages in rural and inner-city areas, particularly in primary care specialties. The working group identified the following:

- Practice related factors, such as lack of familiarity with a geographic area, lack of professional support, and limited availability of collaborative relationships.

[1] A list of working group members may be found in Appendix A.
[2] Minnesota Department of Employment and Economic Development, "An Overview of the Health Care Industry in Minnesota," June, 2010.
[3] Minnesota Office of Administration, State Demographic Center; http://www.demography.state.mn.us/projections.html.

- Financial factors, including the high cost of professional education, high debt loads, and relatively lower salaries in primary care specialties and health care shortage areas.

- Lifestyle factors, including desire for work-life balance and fewer or more predictable work and on-call hours; and community opportunities for education, support, recreation and culture.

The Minnesota Department of Health (MDH) developed a similar analysis of future workforce shortages. The analysis concentrated on licensed primary care providers, including physicians, nurses, and physician assistants. It concluded that Minnesota's rapidly aging population will create a sharp increase in age-related health care needs, which will increase the demand for health care services just as significant numbers of health care providers are retiring. The MDH report notes that Minnesota's educational system has seen some increases in class size for health professionals but is not increasing the production of health professionals rapidly enough to keep pace with demand. A preliminary estimate of the effects of federal health care reform predicts that the supply of new providers trained under federal workforce initiatives may be sufficient to care for those newly eligible under federal reform, but it will not reduce future underlying workforce shortages.[4]

The MDH designates health professional shortage areas (HPSA) for dental care, primary care and mental health providers using criteria established by the federal government. Currently, there are both urban and rural HPSAs for dental and primary care. There are also rural HPSAs for mental health care providers. Although there are no designated HPSAs for providers of mental health care in urban areas, the working group noted there are serious unmet mental health needs in urban areas, too. For example, there is a significant need for child psychiatrists all over the state.

The shortage of nurses is complex because nurses practice at different levels (i.e. advanced practice nurses, RNs, and LPNs) and in many different practice settings. In some parts of the Twin Cities metropolitan area, nurses have a difficult time finding jobs, while nurse shortages exist in many rural areas. Disparities can be found among professional settings too, regardless of geographic area. For example, hospitals generally do not have trouble staffing nurse positions, while long-term care nursing facilities struggle to fill vacant positions and retain staff.

The working group identified the following areas that are especially burdened by current and projected workforce shortages and are in urgent need of attention to ensure patient access to care: (1) long-term care facilities are understaffed and experience high turnover due, in large part, to the inability to offer competitive wages because of low reimbursement rates; (2) rural areas of the state are unable to attract and retain providers to serve large areas, which affects patients' access to care and places additional burden on urban facilities; and (3) there is an acute need for more mental health care providers across the state.

II. Incentives currently available to develop, attract, and retain a highly skilled health care workforce.

The working group heard presentations from several current programs working to develop, attract, and retain a highly skilled health care workforce. While these are not "incentives," as set forth in the charge to the working group, they illustrate successful approaches to building capacity in Minnesota's health care system. Additionally, there was consensus among the working group members that Medical Education and Research Costs (MERC) funding is vital to efforts to provide needed clinical training to health care professionals.

AHEC – The Area Health Education Centers is a national initiative that receives federal funding. The Minnesota AHEC program was established in 2002 and is a collaboration among the University of Minnesota Academic Health Center's six health professions schools, a statewide program office, and rural and urban regional centers,

[4] Minnesota Department of Health, Office of Rural Health and Primary Care, information presented and provided to the Work Force Shortage working group, 2010.

all administered through the University of Minnesota. Minnesota's AHEC programs include initiatives to: build the state's health care workforce pipeline through programs for students in kindergarten through high school; provide support to health professional students working in rural and urban underserved communities; and provide support and information to health care professionals and underserved communities.[5]

HealthForce MN – HealthForce Minnesota is a virtual collaborative network housed at Winona State University and administered through Minnesota State Colleges and Universities (MnSCU). It is funded with state dollars as one of four Centers of Excellence in Minnesota. It is a collaborative partnership of education, industry, and community that was created to increase the number and expand the diversity of health care workers; to integrate health science education practice and research; and to build capacity for education and industry to collaborate to enhance patient care.[6]

TCCP – The Clinical Coordination Project increases the capacity of clinical education programs to provide clinical experiences to students. It acts as a bridge between clinical sites and health care education programs to schedule clinical time more efficiently and effectively so that current capacity needs are met while simultaneously planning for future capacity needs. TCCP began as a pilot in 2006 and was funded by MnSCU. It is currently funded by MnSCU and federal Department of Labor grants, but future funding is uncertain. A 2009 evaluation reported a 75 percent decrease in time spent scheduling, planning, and tracking clinical experiences, as well as an increased ability to provide and secure clinical space.

MERC – The Medical Education and Research Costs fund was established to help offset lost patient care revenue for teaching facilities and to help ensure continued excellence of health care research in the state.[7] Though funding sources have changed since its establishment, MERC is currently funded by cigarette tax revenues, a carve-out of medical education funds from the Prepaid Medical Assistance Program/Prepaid General Assistance Medical Care Program, and federal Medicaid matching funds obtained by the Department of Human Services.

MERC funding has been an important incentive and support to the training of health care professionals. More than 500 training sites receive MERC funds for all provider types across the state, and more than three thousand trainees benefit annually from this funding. Training health professionals is a four to ten year commitment.

Loan Forgiveness – MDH testified that their studies show the state's current loan forgiveness programs are effective, in that they are a factor in participants' decisions on where to practice. Applications for participation in these loan forgiveness programs outstrip the available funding, which indicates unmet demand for these incentives.

III. Recommendations

The Work Force Shortage Working Group makes the following recommendations to the Commission on Health Care Access:

Recommendation 1: *Establish a consistent source of direct funding for training health care professionals in primary care.*

The working group identified barriers that limit capacity growth for the primary care workforce, including dentistry, mental health and long-term care. The primary barrier to training health care providers is access to clinical instructors and training sites. Clinical instructors must be able to train students without being expected

[5] Minnesota Area Health Education Center Network, http://www.mnahec.umn.edu.
[6] HealthForce Minnesota, http://www.healthforceminnesota.org.
[7] Minnesota Statutes, §§ 62J.691-62J.693.

to absorb financial harm to their practice. Without funding dedicated for this purpose, providers will be less and less willing to take on additional time and financial pressures in order to provide on-site training.

Additionally, in order to meet current capacity needs by scheduling clinical training more efficiently and effectively, the work of TCCP, described above, must be appropriately funded. The modest funding required for this program is not certain in the near future.

A strong consensus exists in the working group that MERC funding must be preserved at least at its current level in order to meet Minnesota's pressing need to train health care professionals. An adequate and stable funding stream dedicated to the education of health care professionals is critical to meeting Minnesota's health care workforce needs.

Recommendation 2: Support and reinforce multidisciplinary team-based settings to better utilize the training and skills of all providers and to serve patients more effectively.

The working group believes that the health care of the future will be delivered not so much by individual practitioners but by health care teams. These teams will consist of practitioners from a variety of disciplines, and even in different locations, who will collaborate to provide effective, efficient, and affordable care to patients. The team approach to health care will require training in team settings so that practitioners learn to work with and rely upon colleagues in a variety of disciplines.

The working group recommends utilizing collaborative practice settings to make the best use of the skills and training of each of the health care disciplines. Improved utilization of providers' training and skills in team-based settings will build capacity of the current workforce across disciplines and care settings. Rural practices will especially benefit from providers working within multidisciplinary collaborations and utilizing innovations such as telemedicine, which would allow access to specialists at the point of care.

Dedicated training funds are critical to training health care professionals in multidisciplinary team-based settings. Training funds should be made available to certified health care homes.

The working group considered some proposals to expand or clarify the scope of practice of advance practice nurses and other health care professionals. While such changes may impact the future availability of some services in areas of shortage, the proposals are controversial and could not be fully vetted in the short time available to this working group.

Recommendation 3: Increase funding to expand loan repayment programs, pursue every opportunity to obtain federal funding, and support higher education institutions in applying for federal funding.

Consensus exists among members that loan repayment programs are effective tools to draw providers into practice in underserved geographic areas. Expanding these programs by increasing funding and making it available to more professions would be beneficial. Student loan repayment for faculty in health care programs is also needed. Numerous opportunities for additional workforce funding are available under the Patient Protection and Affordable Care Act (PPACA); these should be pursued.[8]

Recommendation 4: The State should establish one statewide council to establish, promote and monitor a statewide plan for addressing health care workforce issues.

One ongoing council with a comprehensive and multidisciplinary membership (including, but not limited to, representatives of public health; all levels of dentistry; pharmacy; long-term care; all levels of nursing and state

[8] See Appendix B.

agencies) should be established under the auspices of the state to bring these groups together to establish, promote, and monitor a statewide plan for addressing health care workforce issues.

Multiple groups are working on health care workforce issues in Minnesota, including, but not limited to the following: working groups at the University of Minnesota; the Governor's Workforce Development Committee (GWDC); and HealthForce MN's Healthcare Education-Industry Partnership (HEIP). The HEIP council has been meeting for 14 years and consists of health care industry leaders, education leaders, labor representatives and state government representatives. The working group agrees that the HEIP council provides valuable information and collaboration, and recommends that the statewide council work with existing groups and broaden participation.

The working group has identified health care workforce issues that are complex and, in some cases, continuous. The following issues should be among those addressed by the statewide council:

(1) Development of competency-based guidelines to address clinical training experience necessary for mental health practitioners and others to ensure eligibility for reimbursement of their services.

(2) Consider whether modifications to state practice regulations would be helpful or appropriate in order to expand access to rural and other underserved populations. For example, development in cooperation with MMA and MNA of compromised recommendations to the legislature regarding independent practitioner status and prescription authority for advanced practice registered nurses; the recommendations must use the *Consensus Model of APRN Regulations* as a baseline and consider clarifying the definition of "collaborative management" as it pertains to patient care and APRN oversight.

(3) Better utilization and compensation for mental health care providers working within an integrated care approach.

(4) The need for additional funding through MERC or other resources to expand clinical training sites.

(5) The use of simulation centers and other technology-based resources to expand clinical training opportunities.

(6) These and all issues considered by the council should be examined on a continuous basis to ensure adequate patient access to safe, effective, and affordable services.

APPENDIX A

WORK FORCE SHORTAGE

Legislative Members:

Senator Ann Lynch, Chair
Senator Sharon Erickson-Ropes
Senator David Tomassoni

Representative Tina Liebling, Chair
Representative Patti Fritz
Representative Jeff Hayden

Public Members:

Ann C.F. Olson, Associate Professor & Certified Nurse Practitioner, Winona State University-Rochester Health Services
Bruce Nelson, Chief Executive Officer, ARRM
Deb Tauer, President, Minnesota Licensed Practical Nurses Association
Heather Bidinger, Founding PA Program Director, St. Catherine University
Jon Marchand, Programs Administrator, Greater Minnesota Family Services
Laura Beeth, System Director Talent Acquisition, Fairview Health Services
Linda Slattengren, Past President, Minnesota Nurses Association
Macaran Baird, Professor and Head of Family Medicine and Community Health, University of Minnesota Medical School
Mary Alice Mowry, Director, Pathways to Employment & Manager of Disability Services, DHS
Mary L. Chesney, Director, Doctor of Nursing Practice Program, University of Minnesota School of Nursing
Mary Rosenthal, Director, Health Care Reform, SEIU Health Care MN
Meghan M. Goldammer, Health Policy Analyst, Sanford Health Plan
Phil Kibort, Vice President of Medical Affairs and Chief Medical Officer, Children's Hospitals and Clinics
Randy Rice, Physician & Partner, Gateway Family Health Clinic
Robert Lohr, Medical Director, Mayo Health System
Sheila Riggs, Chair, Department of Primary Dental Care, University of Minnesota School of Dentistry
Shelley Vogt, RN, BSN, PHN, Sound Objective Solutions LLC & Good Samaritan Society
Trisha Stark, Director of Professional Affairs, Minnesota Psychological Association
Troy Taubenheim, Executive Director, Metro Minnesota Council on Graduate Medical Education

Staff:
Senate Counsel and Research: David Giel
House Research: Emily Cleveland
Tasha Truskolaski, Laura Herman

APPENDIX B

The working group supports the recommendation to leverage every opportunity available to support higher education institutions by seeking federal funding. In an effort to understand the new and existing federal funding for available workforce development, the working group asked the following institutions to complete a document that would indicate available and received grants under the Patient Protection and Affordable Care Act (PPACA):

- University of Minnesota
- Minnesota Department of Health (MDH)
- Minnesota Department of Human Services (DHS)
- Department of Employment and Economic Development (DEED)
- Minnesota State Colleges and Universities (MnSCU)
- Minnesota private colleges

The group received information from DEED, MDH, The College of St. Scholastica, and MnSCU. DHS confirmed that they do not have the ability to apply for such grants given their designation. The University of Minnesota is working on a submission in a format requested by the working group.

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization: **Governor's Workforce Development Council (DEED)** Contact Person: Bryan Lindsley, 651-259-7572, bryan.lindsley@state.mn.us

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
The State Health Care Workforce Development **Planning Grant** is authorized under Section 5102 of the Affordable Care Act (P.L. 111-148)	(A) - $149,599 (R) - $149,599	The program authorizes funds for states to **plan** activities leading to health care workforce development strategies at the State and local levels. These activities are expected to lead to a 10 percent to 25 percent increase in the primary care health workforce over a ten year period, and applicants will be expected to address how the activities will lead to the expected increases in health workforce.	One-time planning grant	Requirement to provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other federal, state, local, or private sources to carry out the activities.	9/30/2010 through 9/29/2011	Minnesota was eligible to apply for a Planning Grant **or** an Implementation Grant (see below). Because Minnesota did not already have a comprehensive plan, and because 30 planning grants and only one implementation grant were to be awarded nationally, Minnesota chose to apply for the planning grant. The Department of Employment and Economic Development is the fiscal agent for the grant. HealthForce Minnesota will be providing project management for the grant. It is unknown at this time if there will be additional federal funds available for implementation at this time.

The State Health Care Workforce Development **Implementation Grant** is authorized under Section 5102 of the Affordable Care Act (P.L. 111-148)	(NAF) - 3,000,000	The program authorizes funds for states to **implement** activities leading to health care workforce development strategies at the state and local levels. These activities are expected to lead to a 10 percent to 25 percent increase in the primary care health workforce over a ten year period, and applicants will be expected to address how the activities will lead to the expected increases in health workforce.	One-time implementation grant	Requirement to provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other federal, state, local, or private sources to carry out such activities.	9/30/2010 through 9/29/2012	Minnesota was eligible to apply for a Planning Grant (see above) **or** an Implementation Grant. Because Minnesota did not already have a comprehensive plan, and because 30 planning grants and only one implementation grant were to be awarded nationally, Minnesota chose not to apply for the implementation grant.
2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known						

3. Funding Under Other Federal Programs Available to This Organization						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known						
4. Funding Under Other Federal Program Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known.						

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization **Minnesota Department of Health** Contact Person Barb Juelich, 651-201-3947, barb.juelich@state.mn.us

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None. MDH is not eligible for any direct PPACA workforce-related funding.						

2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
Primary Care Residency Expansion Program, HRSA/HHS CFDA 93.510 Awarded to Hennepin County Medical Center	(R) - $1,918,827	Increase the number of residents trained in general pediatrics, general internal medicine, and family medicine.	Two additional residency slots added each year.	Unknown	2010-2015	

3. Funding Under Other Federal Programs Available to This Organization						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
National Health Service Corps State Loan Repayment Program CFDA 93.165	(A) - $100,000 (R) - $100,000	Improve access to primary care by helping underserved communities recruit and retain primary care medical, mental health, and dental providers. Eligible providers include: family practice, internal medicine, pediatric and OB/GYN physicians; nurse practitioners; physician's assistants; certified nurse midwives; psychiatrists; clinical psychologists; licensed independent clinical social workers; licensed professional counselors; psychiatric nurse specialists; marriage and family therapists; dentists; and dental hygienists who serve the targeted populations living in Health Professional Shortage Areas (HPSA).	Five per year. Providers serve a two-year commitment.	One to one state match required	9/1/2010–8/31/2011 Renewed annually	

Grants to States to Support Oral Health Workforce Activities CFDA 93.236	(A) - $994,542 (R) - $994,542	(1.) Improving infrastructure to support dental hygienists and dentists practicing with collaborative agreement. (2.) Collaborating with the University of Minnesota School of Dentistry to develop an Early Decision Program for Rural Dentistry Track for first year college students. (3.) Ensuring that young people across the state are exposed to dental careers via the development of the "Careers in Oral Health Inter-active Website" in cooperation and coordination with the University of Minnesota's Academic Health Center (AHC). (4.) Expanding the externship program of the pediatric dentist residency training program at Rice Memorial Hospital located in Willmar, Minnesota. (5.) Promoting, developing and implementing school prevention dental (sealant) programs in federally qualified dental health professional shortage areas and other underserved and rural areas of the state.	(1.) 25-30 hygienists and dentists trained; increasing the capacity of these providers. (2.) Two current students in early decision track, total of three by the end of the grant. (3.)Website estimated completion date: 12/31/2010 (4.) 11 dental residents participating through the end of the grant. (5.) Training for up to 25 dental hygienists and ten "mini grant" recipients.	40 percent state match required.	10/1/2010 - 9/30/2011. Grant expected to continue through 8/31/12.	Symposium, for 50 dental educators planned in 2012.

		(6.) Collect and analyze data on Minnesota's Oral Health Workforce. (7.) Dental Therapist and Advanced Dental Therapist Teaching Laboratory funding at a community dental clinic (8.) To improve primary care prevention infrastructure through upgrades to aging fluoridation equipment in the state. (9.) Public Health Nurses Primary Caries Prevention Project.	(7.) Supporting training of approx. 20 new midlevel providers in next two years. (8.) Prevention/population health project (9.) 20 Public Health Nurse agencies			
4. Funding Under Other Federal Program Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization: **The College of St. Scholastica** Contact Person: Marty Witrak, Ph.D., R.N., FAAN

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
CFDA No. 93.513 Affordable Care Act - Advanced Nursing Education Expansion (ANEE)	(A) - $1,330,560 (R)	Rural Advanced Nursing Education Expansion (Rural ANEE) Collaboration	56 new nurse practitioners will graduate within a five-year time frame	None	September 30, 2010	This grant will provide substantial financial assistance to RNs, thus allowing them to pursue nurse practitioner certification.
						In response to the acknowledged role that nurse practitioners play in delivering high value care, this project involves a unique collaboration between the College of St. Scholastica, National Rural Health Resource Center (NRHRC), and Essentia Health to increase the number of rural nurse practitioners.

2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

3. Funding Under Other Federal Programs Available to This Organization						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
Information Technology Professionals in Health Care: Program of Assistance for University-Based Training grants, funded under section 3016 of the Public Health Service Act, as added by the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5	(R) - $1,547,750	*UP-HI: University Partnerships for Health Informatics Training* is a private-public partnership that builds on the strengths of existing HIT programs to increase the number of Minnesota graduates entering careers as: Clinical/Public Health Leaders; Health Information Management and Exchange Specialists; Health Information Privacy and Security Specialists; Research and Development Specialists; Programmers and Software Engineers; and Health Information Technology Sub-Specialists.	12 nursing informatics certificates, five master's degrees in health information management/health information exchange, and 60 graduate certificates in HIM/HIE. The time for completion of the masters degrees is two years from this fall and the certificates in HIM/HIE will be completed in 1-1.5 years, depending on start date. The nursing informatics certificate completion date will be approximately one year from the start date of January 2011.	None	September 1, 2010	This public-private partnership between the University of Minnesota (Minneapolis and Crookston campuses) and the College of St. Scholastica represents a high level of resource-sharing that will positively affect healthcare and workforce development. The key variables that stimulate students to pursue these degrees and certificates are the tuition and stipend packages. Qualified and interested students are now able to pursue the education needed to manage the HIT challenges and enhancements in healthcare. The need for and desirability of these programs is evident in the fact that most of the slots, intended for a three-year time frame, will be filled in the first year of offering.
						The majority of these programs will be delivered online and are therefore accessible to urban, rural and other students for whom travel is difficult.

American Recovery and Reinvestment Act of 2009, Title XIII - Health Information Technology, Subtitle B—Incentives for the Use of Health Information Technology, Section 3012, Health Information Technology Implementation Assistance Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program	(R) - $19 million plus (R) - $1.4 million small and rural hospital supplement	*REACH: Regional Extension Assistance Center for Health Information Technology* will help healthcare providers improve the quality and value of care they deliver through adopting and meaningfully using health information technology (HIT). The project focuses on rural and small urban practices for medically underserved patients and areas.	10-15 new HIT field staff positions, two to four years Opportunities for internships for other federally funded programs	10 percent in years 1-2 90 percent in years 3-4	2/8/2010 9/2010 (hospital supplement)	Key Health Alliance (KHA)—Stratis Health, National Rural Health Resource Center, and the College of St. Scholastica are partners, with Stratis serving as the lead organization. This project is an example of partnerships across public and private organizations as well as between non-profits with complementary missions.
4. Funding Under Other Federal Program Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

Minnesota State Colleges and Universities

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), PL 111-148. The law puts into place comprehensive health insurance reforms that will hold insurance companies more accountable and will lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.[9] With the understanding that increasing coverage will result in an increasing demand for appropriately trained healthcare professionals, the PPACA provided for regulatory changes and additional funding to increase supply and improve distribution of healthcare workers. These funding opportunities have a strong focus on primary care provided by physicians, physician assistants, and advanced nurse practitioners; access to healthcare services through community health centers; and direct financial support for practitioners through loan forgiveness, traineeships, and National Health Service Corps expansions.

A review of www.grants.gov results in a range of grant opportunities representative of the scope of the PPACA and its goals. To illustrate this, a handful of the opportunities are included in the table below. The highlighted rows indicate MnSCU applications/partnerships submitted.

Name/Description	CFDA	#	$	Close Date	Agency	Notes
Health Benefit Exchanges	93.525	51	$51,000,000	7/29/10	Consumer Info. and Insurance Oversight	Governor to appoint one applicant per state
Medicaid Rebalancing (HCBS; 'money follows the person')	93.791	20	$22,500,000	1/7/11	CMS	One applicant per state
Infrastructure to Expand Access to Care	93.502	1	$100,000,000	10/4/10	HRSA	Public education with dental and medical school
Enhance public health programs through building epidemiology, laboratory, and health information systems capacity	93.521	58	$35,900,000	8/27/10	CDC	MN is one of the 58 eligible applicants
New Community Health Centers	93.527	350	$250,000,000	11/17/10	HRSA	
Consumer Assistance Program	93.519	56	$29,000,000	9/10/10	Consumer Info. and Insurance Oversight	
Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals	93.093	17	$51,000,000	8/5/10	Admin. for Children & Families	MN applied as a single applicant; HealthForce partner
Health Profession Opportunity Grants for Tribes, Tribal Organizations or Tribal College or University	93.093	3	$7,500,000	8/3/10	Admin. for Children & Families	Eligible: Tribes, Tribal orgs., Universities; participants: TANF and low-income
Nursing Assistant and Home Health Aide Program	93.503	10	$2,500,000	7/22/10	HRSA	RCTC applied with SE Tech and MnWest

[9] www.healthcare.gov

Name/Description	CFDA	#	$	Close Date	Agency	Notes
Maternal, Infant, and Early Childhood Home Visiting Program	93.505	56	$90,000,000	8/18/10	HRSA	Governor determines single applicant
Primary Care Residency Expansion Program	93.510	105	$168,000,000	7/19/10	HRSA	Accredited residency programs
Expansion of Physician Assistant Training Program	93.514	40	$32,000,000	7/19/10	HRSA	Physician Assistant programs
Advanced Nurse Education Expansion	93.513	40	$30,000,000	7/19/10	HRSA	Stipends for students; Metro, MSU Mankato, MSU Moorhead, & WSU
State healthcare workforce development implementation	93.509	1	$3,000,000	7/19/10	HRSA	MN applied for the planning grant
State healthcare workforce development planning	93.509	30	$2,000,000	7/19/10	HRSA	MN applied through GWDC; HealthForce & MnSCU as partners

In March 2010, the National Conference of State Legislatures released a report entitled "Summary of the Health Workforce Provisions in the Patient Protection and Affordable Care Act: H.R. 3590." This report listed workforce-specific grants which were identified in the PPACA. A summary table of these grants, including an update on release date and known MnSCU applications is shown below. As shown, many of the grants have not yet been released and many are not applicable to MnSCU.

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
Allied Health Workforce Recruitment and Retention	Unknown			Grants for eligible individuals Authorizes $60M in FY10	No	
Training Opportunities for Direct Care Workers	Unknown			Grants for accredited educational provider with partnership with long-term care Authorizes $10M for FY2011-2013	Unknown	
Federally Qualified Health Centers	8/25/10	350+	$1,277	Funds for community health centers Authorizes $2,988,821,592 in FY10; more in subsequent years	No	
Community Health Workforce	Unknown			Supporting CHWs Authorizes appropriations as necessary	Unknown	
School-Based Health Clinic-Capital	6/30/10	1,000	$50	Must operate a SBHC	No	
School-Based Health Clinic-Operations	Unknown			Must be an SBHC Authorizes appropriations as necessary	No	
Training in General, Pediatric, and Public Health Dentistry 1) Support and development of training programs 2) Faculty loan repayment	4/28/10	60	$20	Released in conjunction with ARRA funds and tagged as ARRA funding Primary focus on dentistry	Yes	Yes-Normandale applied under this group of grants
Alternative Dental Healthcare Providers Demonstration	Unknown			Up to 15 grants; $4M for five years; authorizes appropriations as necessary Geared toward underserved and rural communities and includes dental therapists, advance practice, independent, and supervised dental hygienists and others	Likely	
US Public Health Sciences Track	Unknown			Tuition and stipends for service as Commissioned Corps Officers	Unlikely	
Commissioned Corp and Ready Reserve Corps	Unknown			Establishes Commissioned Corps and Ready Reserve Corps	NA	
Workforce Diversity				Amends criteria for nursing workforce diversity grants already offered	NA	
Centers of Excellence				Reauthorizes Authorizations appropriations of $50M for	Unlikely	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
				FY2010-2015 Requires minority enrollment thresholds be met to apply		
Health Professions Training for Diversity				Authorizes changes in loan repayment and increases scholarship funding for disadvantaged students who commit to working medically underserved areas and loan repayments for fellowships	NA	
Interdisciplinary Training				Amends program Authorizes funds as necessary	NA	
Co-locating Primary and Specialty Care in CB Mental Health Settings	Not yet released		$50	Community mental health programs are eligible	No	
National Health Care Workforce Commission	N/A	N/A	N/A	Being formed; Mark Schoenbaum and Laura Beeth have applied to be on the commission; appointments made by 9/30/10	NA	
National Center for Workforce Assessment State and Regional Centers Longitudinal Evaluation	Est. 9/30 Est. 9/30 Unknown		$1 $4.5 Unknown		Unknown	
Demonstration Projects to address health professions workforce needs	6/21/10 6/17/10	17 6	$51 $5	Health Professions Opportunities for TANF and Low-Income Individuals – GWDC applied with MnSCU partnership Personal and Home Care Aide State Training Program	No	DHS applied w/MnSCU partnership
Continuing Educational Support for professionals in underserved communities	Unknown			Outreach and support for continuing education for isolated, rural providers Authorizes $5M for FY2010-2014	Unknown	
Area Health Education Centers	4/26/10	26	$11.2	Amended program Eligible entities are academic health centers Unclear if new funds have been appropriated	No	
Nurse Retention	Unknown			May be included in the nursing grants below Appear to be either changes in, or additions to, existing annual HRSA grant funds which various MnSCU institutions apply for	Likely	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
State Health Care Workforce Planning	6/17/10	20	$3	GWDC applied with MnSCU as partner	No	GWDC; HealthForce Minnesota to operationalize if funded
State Health Care Workforce Implementation	6/17/10	1	$3	MN chose to apply for planning grant with hopes of securing implementation grant in the future	No	
Mental and Behavioral Health Education and Training	Unknown			Recruitment and support of students education in social work, psychology, and child and adolescent health	Yes	
Pediatric Specialty Loan Repayment	Unknown			Loan repayment	No	
Public Health Service Act Nursing Programs	Unknown			Authorizes funding for Public Health Service Act nursing	Unlikely	
Nurse Faculty Loan	Unknown			Raises limits on existing program which requires education institution to provide 1/9 cash match; program funds approximately 20 awards per year	Yes	
Advanced Nursing Education	NA			Amends existing program to include midwifery MnSCU institutions often apply for this annual grant round	Yes	Metro, Mankato, Moorhead and WSU were funded
Geriatric Education	Unknown			Extends program through FY2014 Existing program	Yes	
Nursing Student Loan	NA			Raises limits on student loan amounts	NA	
Nurse Managed Health Centers	6/17/10	10	$15	For nurse-managed clinics	Yes	No; no nurse-managed clinics in MnSCU
Medical Residency Training	NA			Modifies IME and DGME	No	
Distribution of Additional Residency Positions	NA			Redistributes unfilled residency slots	No	
Pediatric Specialty Loan Repayment	Unknown			For pediatric specialists	No	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
Primary Care Residency 6/17/10	Unknown 6/17/10	 105	 $168	Support new or expanded primary care residency programs at teaching health centers Authorizes $25,000,000 in FY2010 $80,000 per resident	No No	
Primary Care Extension Program	Unknown			Establishes extension program to support primary care providers Requires state Medicaid program, sate health dept., and health professions schools	Unknown	
Natl Health Service Corps	NA			Funds for the NHSC	NA	
Primary Care Student Loan	NA			Student loans for primary care physicians	NA	
Primary Care Training and Enhancement	4/26/10	Un-clear	Unclear	For broad enhancements in primary care education	No	
Capacity Building in Primary Care	Unknown			Preference for physician training	Not Likely	
Public Health Workforce Loan Repayment	NA			Authorizes $195,000,000 for FY2010	NA	
Fellowship Training in Public Health	NA			CDC fellowships	NA	
Geriatric Education Center	Unknown			Variety of geriatric education initiatives Requires physician training	No	
Geriatric Career Incentive	Unknown			Partners with Geriatric Education Center	Unknown	
Geriatric Academic Career Awards	4/14/10	72	$5	Medical School Faculty are eligible to apply	No	