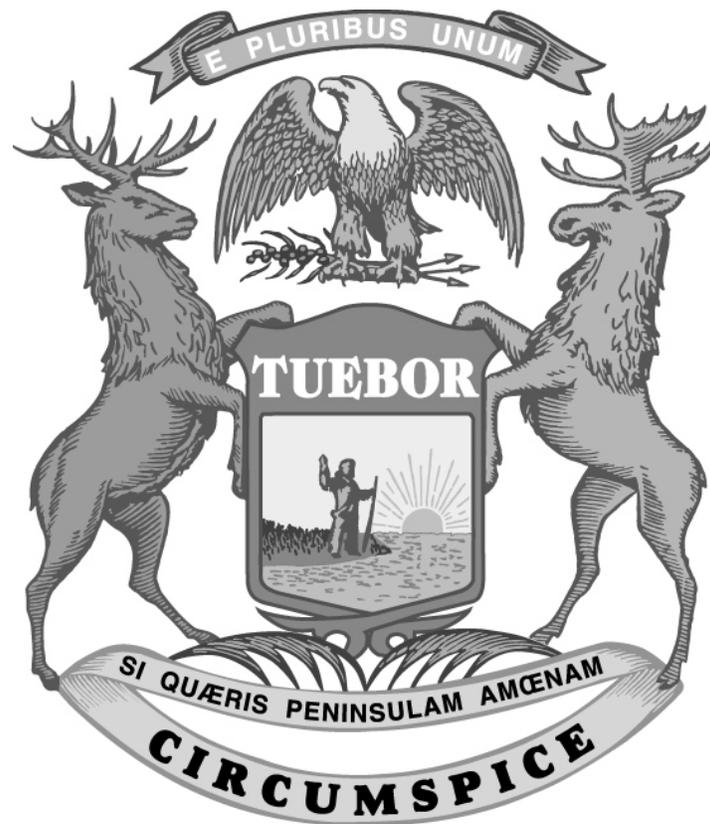


The Patient Protection and Affordable Care Act

Michigan's Strategic Plan



A report of the Health Insurance Reform Coordinating Council on
implementation of the Patient Protection and Affordable Care Act.
Presented to Governor Jennifer M. Granholm December 2, 2010.



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

December 2, 2010

The Honorable Jennifer M. Granholm
Governor of Michigan
P.O. Box 30013
Lansing, Michigan 48909

Dear Governor Granholm:

I am pleased to transmit Michigan's Strategic Plan to implement the Patient Protection and Affordable Care Act (ACA). The ACA is a voluminous and complex piece of legislation. It contains significant responsibilities for states. It also includes many provisions relating to the private sector and the federal government. This plan focuses only on the ACA provisions that require state action and implementation.

The plan describes the relevant provisions of the law, as well as, critical strategic issues and decision points. It also makes recommendations for structuring the decision making and implementation process.

I would like to thank the members of the Health Insurance Reform Coordinating Council for their leadership in implementing provisions of the law that took effect in 2010. I would also like to thank them for the significant time and expertise they devoted to the development of this plan.

Sincerely,


Janet Olszewski
Director





STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JOHN D. CHERRY, JR.
LT. GOVERNOR

EXECUTIVE ORDER
No. 2010 - 4

DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF ENERGY, LABOR, AND ECONOMIC GROWTH

IMPLEMENTATION OF THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, each principal department of state government is under the supervision of the Governor unless otherwise provided by the Constitution;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, the Governor is responsible to take care that the laws be faithfully executed;

WHEREAS, the Patient Protection and Affordable Care Act, Public Law 111-148, as amended, was duly enacted by the United States Congress and the President of the United States and is now the law of the land;

WHEREAS, Michigan residents and businesses will benefit from this new federal law through enhanced access to quality and affordable health care, critical insurance market reforms, and reductions in the cost of health care for Michigan families and job providers;

WHEREAS, enactment of the Patient Protection and Affordable Care Act reinforces the State of Michigan's longstanding commitment to improving the health of state residents by increasing citizen access to health care, reducing costs, and improving the quality of health care;

WHEREAS, a coordinated response by the executive branch of this state is necessary for the implementation of the Patient Protection and Affordable Care Act and to assure that this state takes appropriate further action to increase access, reduce costs, and improve the quality of health care in Michigan;

NOW THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. “Civil Service Commission” means the commission created under Section 5 of Article XI of the Michigan Constitution of 1963.

B. “Commissioner of Financial and Insurance Regulation” means the head of the Office of Financial and Insurance Regulation.

C. “Department of Community Health” or “Department” means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the Department of Community Health under Executive Order 1996-1, MCL 330.3101.

D. “Department of Human Services” means the principal department of state government created as the Department of Social Services under Section 450 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.550, renamed the Family Independence Agency under 1995 PA 223, MCL 400.1, and renamed the Department of Human Services under Executive Order 2004-38, MCL 400.226.

E. “Department of Technology, Management, and Budget” means the principal department of state government created as the Department of Management and Budget under Section 121 of The Management and Budget Act, 1984 PA 431, MCL 18.1121, and renamed under Executive Order 2009-55, MCL 18.441.

F. “Health Insurance Reform Coordinating Council” or “Council” means the council created within the Department of Community Health under Section II of this Order.

G. “Office of Financial and Insurance Regulation” means the office within the Department of Energy, Labor, and Economic Growth established by Executive Order 2000-4, MCL 445.2003, as the Office of Financial and Insurance Services and renamed the Office of Financial and Insurance Regulation under Executive Order 2008-2, MCL 445.2005.

H. “Office of the State Employer” means the autonomous office created within the Department of Management and Budget under Executive Order 1979-5, whose duties include, but are not limited to, those assigned by Executive Orders 1979-5, 1981-3, 1988-6, 2002-18, 2004-31, 2007-30, 2008-22, and 2009-55.

I. “Patient Protection and Affordable Care Act” or “Act” means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010.

J. "State Budget Director" means the individual appointed by the Governor under Section 321 of The Management and Budget Act, 1984 PA 431, MCL 18.1321.

K. "State Personnel Director" means the administrative and principal executive officer of the Civil Service Commission provided for under Section 5 of Article XI of the Michigan Constitution of 1963 and Section 204 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.304.

II. HEALTH INSURANCE REFORM COORDINATING COUNCIL

A. The Health Insurance Reform Coordinating Council is created as an advisory body within the Department of Community Health.

B. The Council shall consist of the following members:

1. The Director of the Department of Community Health.

2. The Director of the Department of Human Services, or his or her designee from within the Department of Human Services.

3. The Director of the Department of Technology, Management, and Budget, or his or her designee from within the Department of Technology, Management, and Budget.

4. The State Budget Director, or his or her designee from within the State Budget Office.

5. The State Personnel Director, or his or her designee from within the Civil Service Commission.

6. The Director of the Office of the State Employer, or his or her designee from within the Office of the State Employer.

7. The Commissioner of Financial and Insurance Regulation, or his or her designee from within the Office of Financial and Insurance Regulation.

8. The Director of the Medical Services Administration within the Department of Community Health.

C. The Director of the Department, or his or her designee, shall serve as the Chairperson of the Council. The Council shall elect a member of the Council to serve as Vice-Chairperson of the Council.

III. CHARGE TO THE COUNCIL

A. The Council shall act in an advisory capacity to the Governor and the Director of the Department of Community Health and shall do all of the following:

1. Conduct a comprehensive evaluation of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended, and the potential impact of the Act upon the health care system within this state to identify crucial decision points or state action items necessary to comply with the Act or to further enhance access to health care, reduce costs, and improve the quality of health care.

2. Identify and recommend mechanisms to assure a coordinated and efficient state response to implementation of the Act.

3. Engage with relevant stakeholders to assist in the development of recommendations for implementation of the Act.

4. Facilitate collaboration with appropriate federal agencies when necessary regarding the establishment of new rules, regulations, or mechanisms for implementation of the Act.

5. Develop recommendations for implementation of a health insurance exchange in this state.

6. Analyze the impact of the Act on state departments and agencies, including, but not limited to, budgetary implications of the Act for this state.

7. Identify federal grants, pilot programs, and other non-state funding sources to assist with implementation of the Act and other measures to further enhance access to health care, reduce costs, and to improve the quality of health care in this state.

8. Recommend executive action or legislation to effectively and efficiently implement the Act.

9. Submit to the Director of the Department and to the Governor a strategic plan for the effective and efficient implementation of the Act.

10. Perform other functions related to implementation of the Act as requested by the Director of the Department or the Governor.

B. The Council may establish advisory workgroups composed of Council members or others deemed necessary by the Council to assist the Council in performing its duties and responsibilities. Members may include, without limitation, doctors, nurses, health care professionals, patient advocates, representatives from health plans and health insurers, and others with expertise in

the private sector, organized labor, government agencies, and at institutions of higher education. The Council may adopt, reject, or modify any recommendations proposed by an advisory workgroup.

IV. OPERATIONS OF THE COUNCIL

A. The Council shall be staffed and assisted by personnel from the Department, subject to available funding. Any budgeting, procurement, or related management functions of the Council shall be performed under the direction and supervision of the Director of the Department.

B. The Council shall adopt procedures consistent with Michigan law and this Order governing its organization and operations.

C. A majority of the members of the Council serving constitutes a quorum for the transaction of the Council's business. The Council shall act by a majority vote of its serving members.

D. The Council shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Council.

E. The Council may, as appropriate, make inquiries, studies, investigations, hold hearings, and receive comments from the public. The Council may also consult with outside experts in order to perform its duties, including, but not limited to, experts in the private sector, organized labor, government agencies, and at institutions of higher education.

F. Members of the Council shall serve without compensation. Members of the Council may receive reimbursement for necessary travel and expenses consistent with relevant statutes and the rules and procedures of the Civil Service Commission and the Department of Technology, Management, and Budget, subject to available funding.

G. The Council may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Council and the performance of its duties as the Director of the Department deems advisable and necessary, in accordance with this Order, the relevant statutes, and the rules and procedures of the Civil Service Commission and the Department of Technology, Management, and Budget, subject to available funding.

H. The Council may accept donations of labor, services, or other things of value from any public or private agency or person.

I. Members of the Council shall refer all legal, legislative, and media contacts to the Department.

V. OFFICE OF FINANCIAL AND INSURANCE REGULATION

A. The Commissioner of Financial and Insurance Regulation shall establish within the Office of Financial and Insurance Regulation an Office of Health Insurance Consumer Assistance to do all of the following:

1. Coordinate with the Office of Financial and Insurance Regulation and with consumer assistance organizations the receipt and response to inquiries and complaints concerning health insurance coverage relating to federal health insurance requirements and related requirements under Michigan law.

2. Assist with the filing of complaints and appeals, including filing appeals with an internal appeal or grievance process of a group health plan or health insurance issuer and with the provision of information about any external appeal process.

3. Collect, track, and quantify problems and inquiries encountered by consumers.

4. Educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage.

5. Assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance.

6. Resolve problems with obtaining premium tax credits under Section 36B of the federal Internal Revenue Code of 1986.

7. Collect and report relevant data to the United States Secretary of Health and Human Services to the extent provided by federal law on the types of problems and inquiries encountered by consumers.

B. The Commissioner of Financial and Insurance Regulation shall designate an individual within the Office of Financial and Insurance Regulation to serve as the Michigan Health Insurance Consumer Assistance Ombudsman and to supervise and direct the Office of Health Insurance Consumer Assistance.

VI. MISCELLANEOUS

A. The Director of the Department of Community Health shall provide direction and supervision for the implementation of Sections II, III, and IV of this Order. The Commissioner of Financial and Insurance Regulation shall provide direction and supervision for implementation of Section V of this Order.

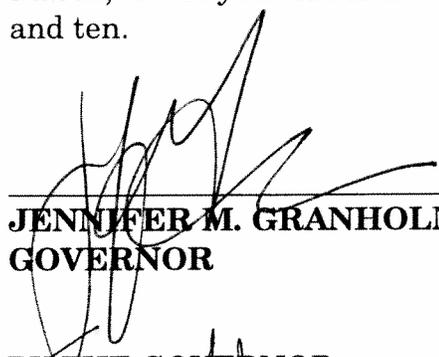
B. All departments, committees, commissioners, or officers of this state, or of any political subdivision of this state, shall give to the Health Insurance

Reform Coordinating Council or to any member or representative of the Council, any necessary assistance required by the Council or any member or representative of the Council, in the performance of the duties of the Council so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or review of the Council.

This Order is effective upon filing.

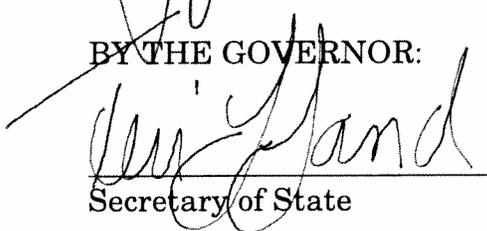


Given under my hand this 31st day of March, in the year of our Lord, two thousand and ten.



JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:



Secretary of State

FILED WITH SECRETARY OF STATE

ON 3/31/10 AT 10⁵⁰ AM

The Health Insurance Reform Coordinating Council

Ismael Ahmed	Department of Human Services
Sharon Bommarito	Office of the State Employer
Bob Emerson	State Budget Office
Steve Fitton	Department of Community Health
Janet Olszewski*	Department of Community Health
Kenneth Ross	Office of Financial and Insurance Regulation
Phil Stoddard	Department of Technology, Management, and Budget
Jan Winters	Department of Civil Service

* *Council Chairperson*

TABLE OF CONTENTS

I. INTRODUCTION	Page 1
II. BACKGROUND	Page 2
III. STAKEHOLDER INPUT	Page 3
IV. STATE BUDGET IMPLICATIONS	Page 4
V. RECOMMENDATIONS & CRITICAL DECISION POINTS	Page 5-8
A. State Infrastructure – Office of Health Care Reform and Health Care Reform Coordinating Council (p. 5)	
B. Health Insurance Exchanges (p. 5-6)	
C. Health Insurance Reform (p. 6-7)	
D. Michigan Medicaid (p. 7)	
E. Health Systems (p. 8)	
F. Stakeholder Input (p. 8)	
G. State Budget (p. 8)	
VI. KEY STRATEGIC ISSUES	Page 9-34
A. Health Insurance Exchanges (p. 9-12)	
B. Health Insurance Reform (p. 13-18)	
1. Health Insurance Coverage Reforms	
2. Consumer Protections	
3. Rating	
4. Employer and Personal Responsibilities	
C. Medicaid Program Changes (p. 18-24)	
1. Enrollment/Eligibility	
2. Long Term Care Systems Reform	
3. Medicaid System, Payment Reforms and Demonstration Opportunities	
4. Disproportionate share hospital payment reform	
D. Health System Changes (p. 25-28)	
1. Community Based Prevention and Wellness	
2. Primary Care Practice Transformation	
3. Health Care Workforce Expansion	
E. State Employer Impacts (p. 28-30)	
<i>Coverage of adult children to age 26</i>	
<i>Automatic enrollment in health coverage</i>	
<i>Excise Tax</i>	
<i>Retiree Reinsurance Program</i>	
<i>Additional Requirements</i>	
F. Services For The Aging (p. 30)	
G. System Connectivity (p. 30-34)	
1. Electronic Health Records	
2. Coordination between Michigan's Insurance Exchange and the Medicaid Program	
3. Administrative Simplification within Insurance Reform	
VII. ATTACHMENTS	
A. Operational Plan Grids	
1. Health Insurance Exchanges	
2. Health Insurance Reform	
3. Michigan Medicaid	
4. Health Systems	
B. State Budget Office Discussion on Budget Implications	
C. Resource Links	
D. Acronyms	

The Patient Protection and Affordable Care Act: Michigan's Strategic Plan

I. INTRODUCTION

On March 31, 2010, Governor Granholm signed Executive Order No. 2010 – 4, Implementation of the Patient Protection and Affordable Care Act (ACA), which created the Health Insurance Reform Coordinating Council as an advisory body within the Department of Community Health. The Council consists of the Director of the Department of Community Health, the Director of the Department of Human Services, the Director of the Department of Technology, Management, and Budget, the State Budget Director, the State Personnel Director, the Director of the Office of the State Employer, the Commissioner of Financial and Insurance Regulation, and the Director of the Medical Services Administration. Designees are permitted for most appointees. The Council is chaired by Janet Olszewski, Director of the Department of Community Health.

The Council was given ten charges relating to the Patient Protection and Affordable Care Act, Public Law 111-148. Among those charges was, “*Submit to the Director of the Department and to the Governor a strategic plan for the effective and efficient implementation of the Act.*” In its deliberations the Council determined that this charge would be completed in the fall of 2010. The plan represents guidance to Michigan's current and future state leadership as implementation of the various components of health care reform move forward.

This strategic plan is designed to identify key strategic issues that current and future state leadership will need to address as the ACA is implemented. It touches on the major topics contained in the Act:

- Health Insurance Exchanges
- Health Insurance Reform
- Medicaid Program Changes
- Health System Changes
- State Employer Impacts
- Medicare Changes Affecting Michigan's Medicare Beneficiaries
- System Connectivity

This plan is the product of the analysis and planning of the departments, bureaus and divisions within state government who have researched the Act, solicited initial stakeholder input, and *identified crucial decision points*, as directed by the Executive Order, some of which must be made very quickly to ensure an orderly and timely implementation of this historic law. It does not address all of the activity currently underway, nor does it describe in detail activities which have been completed, including grant opportunities which have been applied for, received or dismissed. While the information presented herein is not all encompassing, this plan does represent the Council's view of the significant activity which lies ahead for the state between 2011 and 2014.

II. BACKGROUND

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. This comprehensive health reform legislation, along with changes made to the new law by subsequent legislation, makes major changes to the nation's health care system. The new law seeks to expand coverage, improve health care delivery systems, and control health care costs. Key elements include:

- **An expansion of mandatory eligibility for Medicaid to 133% of the FPL** for all individuals, without regard to categorical eligibility. The current 133% FPL for a family of four is \$29,327 annual income..
- **Creation of health insurance exchanges** to allow individuals and small businesses to buy and retain health insurance coverage. Michigan may choose to establish and operate the exchange, or the federal government will operate the exchange if Michigan elects not to establish and operate the exchange.
- **Integration of Medicaid and MICHild insurance coverage eligibility determination systems** with eligibility determination for coverage through the health insurance exchange. While this responsibility rests with the exchange, there is a level of administrative flexibility allowed by the ACA and these options should be explored.
- **Consumer assistance** through a state health insurance ombudsman to provide information, facilitate enrollments, handle consumer complaints, and participate in appeals processes.
- **Requirements that large employers provide coverage or pay an assessment;** and incentives for small businesses to provide coverage to their employees.
- **Medicaid payment and system reform incentives** and pilots encouraging primary care, patient-centered medical homes, and global payments.
- Opportunities to **increase the number of comprehensive primary health care settings and the primary health care workforce.**
- Funding for states to **improve public health, disease prevention, and health care quality.**
- **An individual insurance mandate** that requires individuals and families to have insurance coverage or pay a tax penalty.

Michigan will need to carry out and monitor many of the changes to the health care system, especially the Medicaid expansion, new insurance market rules, health insurance ombudsman responsibilities, payment reforms, and service delivery/health care quality enhancements.

III. STAKEHOLDER INPUT

Stakeholder input is essential throughout the implementation of the ACA both at the state and federal level. The Michigan Department of Community Health Director, Office of Financial and Insurance Regulation Commissioner, and other members of the Health Insurance Reform Coordinating Council have presented to various stakeholder groups and received considerable stakeholder input during the initial stage of ACA implementation in Michigan. Through the Michigan Health Information Network (MiHIN) and the State Planning Project for the Uninsured, the state has demonstrated success in convening and organizing diverse stakeholders from across the state to work together to create recommendations and solutions for complex policy, technical, and business matters involving both integration and implementation issues.

There are two existing organizations in Michigan whose memberships comprise a large number of relevant stakeholders.

- **The Medical Care Advisory Council (MCAC)** has worked closely with the Michigan Department of Community Health (MDCH) for a number of years, providing advice on policy issues related to Medicaid. Additionally, the Council is actively involved with the issues of access to care, quality of care, and service delivery for Medicaid programs. Members of the Council represent the Michigan League for Human Services, Michigan Health and Hospital Association, Michigan State Medical Society, Michigan Osteopathic Association, Greater Detroit Area Health Council, American Association of Retired Persons, and many other important stakeholders.
- **The Michigan Health Insurance Access Advisory Council (MHIAC)** is a nonprofit, non-partisan organization committed to improving the health status of Michigan residents, controlling health care costs for individuals, employers, and the State, and maximizing the efficiency of health care expenditures. Council members represent the Small Business Association of Michigan, Economic Alliance for Michigan, Michigan Chamber of Commerce, Blue Cross Blue Shield of Michigan, Michigan AFL-CIO, Michigan Association of Health Plans, Michigan Universal Healthcare Access Network, and many others representing business, consumers, and health care providers.

The State has already received stakeholder input from these two organizations, and will continue to rely upon these organizations for ongoing stakeholder involvement: Medicaid provider liaison meetings will provide additional opportunity for stakeholder input.

Other stakeholders include the Michigan Legislature, municipal leaders, local public health departments, trade associations, insurers, businesses and employers, and representatives from the health care delivery and provider community. Within the executive branch of state government, principle stakeholders include the Michigan Department of Community Health (MDCH), the Office of Financial and Insurance Regulation (OFIR) within the Department of Energy, Labor, and Economic Growth (DELEG), and the Department of Human Services (DHS). As implementation of the ACA moves forward, the state will make a concerted effort to receive input from all stakeholders. Michigan has a long history of collaboration between governmental and non-governmental stakeholders for the development and improvement of state programs and policy.

IV. STATE BUDGET IMPLICATIONS

The ACA provides considerable federal funding opportunities to support state efforts to address provisions in the legislation. Michigan has already received funding to assist with the planning and development of competitive health insurance marketplaces through a health insurance exchange, to enhance consumer protections and assistance, to support home visitation services, and improve local and state capacity to perform effective public health prevention programs.

Many of the provisions of the ACA require further federal clarification and guidance before Michigan can fully assess the budget implications of these provisions; the state will bear some costs associated with ACA implementation. For instance, Michigan will incur additional budgetary costs from administrative spending to absorb the Medicaid population expansion and integrate the Medicaid program with the exchange. State funds will be required as matching funds for newly eligible individuals beginning in 2017. There will also be strong pressure for the Medicaid program to pay primary care physicians at rates equal to Medicare after 2014, a substantial increase above current Medicaid rates, requiring additional state match. Primary care physician Medicaid payment rates will be equal to Medicare rates in 2013 and 2014, with the increase cost covered solely with federal funds. The provision of more Medicaid services through Federally Qualified Health Centers (FQHCs) will result in higher reimbursement for these services than the capitated reimbursement model used for Medicaid managed care services provided at non-FQHC sites, although this increase might be offset by savings generated through early and comprehensive primary care delivered by the FQHCs.

In principle, the offset to increased costs described for FQHCs extends to the ACA and Medicaid more broadly. The anticipated direct increases in state costs through increased enrollees in Medicaid, while relatively modest compared to the substantial federal funding that will be provided, should be countered by ACA payment reforms and other health delivery system reforms that reduce the overall costs.

See Attachment B for a State Budget Office discussion on significant state budget decisions and impacts that will occur as a result of the implementation of the ACA.

V. RECOMMENDATIONS AND CRITICAL DECISION POINTS

A. **State Infrastructure – Office of Health Care Reform and Health Care Reform Coordinating Council:**

- i. Michigan needs to decide whether and how state government operations will be restructured to implement federal health care reform more effectively. One option is to establish an Office of Health Care Reform to coordinate state government activities and perhaps consolidate existing functions. Several states have created offices of health care reform and others are in the process of establishing similar offices.
- ii. If an office is established, determinations need to be made regarding placement of this office within the existing governmental structure, resource identification for this office, the roles and responsibilities of this office and the role delineation with DELEG Office of Financial and Insurance Regulation, MDCH, and DHS. It is recommended that this coordinating office be placed within the Governor's Office. There is precedent for the establishment of such an office, as one was established during the Engler Administration under Executive Directive 1993-2.
- iii. Michigan needs to develop and then implement a structured communication strategy and public education effort to inform citizens about federal health reform, as well as Michigan's actions and planned future actions being taken in compliance with the new law. State agency responsibilities will need to be assigned in light of the state structures developed to implement reform.
- iv. The long-term role of the Health Care Reform Coordinating Council needs to be articulated in light of the state structures developed to implement reform. It is recommended that the Health Care Reform Coordinating Council continue as an advisory council for the Office of Health Care Reform. Consideration should be given to the involvement of non-governmental stakeholders with the Council.

B. **Health Insurance Exchanges**

- i. Michigan must decide whether to create and operate a health insurance exchange, participate in a regional health insurance exchange with other states, or to opt for a federally created and operated health insurance exchange. This decision should be made with attention paid to state costs as well as the benefits that attend the state. The ACA requires that the health insurance exchange be self sustaining.
- ii. If a state run exchange is established, Michigan must decide if separate exchanges will be created and run for individuals and for small businesses. This decision should be made with consideration to the particular structure of Michigan's current small business insurance markets.
- iii. If a state run exchange is established, Michigan must decide the administrative structure of the exchange, including governance and organizational placement within or outside of state government.

- iv. If a state run exchange is established, Michigan must decide how the exchange's costs will be supported, whether from fees charged to insurance carriers (self supported), state administered funds (GF, Medicaid, combination), or a combination of sources.
- v. If a state run exchange is established, an evaluation of the impact of the funding options should be carried out before decisions are finalized. Of particular importance will be the value placed on the relationship that fees to insurance carriers will have on premiums since insurance carriers' administrative costs are expected to be passed along to the insured through the overall structure of premiums.
- vi. Coordination between the Medicaid program and the health insurance exchange will need to be addressed. Michigan needs to examine its systems to determine the best configuration to meet the functionality required by the ACA. In particular, Michigan must consider the interface between existing eligibility systems (Bridges/MARS) and the new eligibility systems that will be created by the health insurance exchange. The state will also need to decide whether eligibility for premium subsidies will be determined by the health insurance exchange, or if this determination will be integrated with existing Medicaid eligibility systems. These decisions have not been finalized and will benefit from the analysis that is currently under way, supported by the recently received health insurance exchange planning grant.
- vii. Michigan needs to decide whether to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL, who would otherwise be eligible to receive premium subsidies in the exchange. The ACA permits states to create a Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the health insurance exchange. Instead, the subsidies associated with those in the Basic Health Plan would accrue to the state.
- viii. Once the decision is made whether to create and operate a state-based health insurance exchange, participate in a regional health insurance exchange with other states, or opt for a federally created and operated health insurance exchange, state law must be passed that codifies this decision.

C. Health Insurance Reform

- i. A thorough review of Michigan's current health insurance code should be undertaken with an eye toward any conflicts, or omissions between the elements of the ACA and Michigan statute.
- ii. Legislation should be enacted to address any inconsistencies or omissions uncovered from a review of the new law and Michigan statute.

- iii. Michigan must consider new Administrative Rules or legislative changes to the Insurance Code and the Nonprofit Health Care Corporation Reform Act in order to provide Michigan's Office of Financial and Insurance Regulation (OFIR) with sufficient flexible authority to enforce federal law.
- iv. Michigan must consider legislative changes to the Insurance Code and the Nonprofit Health Care Corporation Reform Act to revise the current definition of small employer group from 2-50 employees to the federal mark of 1-100 employees.

D. Michigan Medicaid

- i. Michigan must decide whether it will become an "early adopter" of the Medicaid program expansion, taking into view the number of individuals that would become eligible, the immediate cost of such an expansion, the long term cost of such an expansion, and the ability of the state to fund the program expansion. Michigan should juxtapose these costs against the estimated benefits -- increased wellness and the concomitant health care cost avoidance.
- ii. The Centers for Medicare and Medicaid Services (CMS) is making it clear to states they expect an eligibility system, coverage options, and delivery system choices that are seamless and transparent to the consumer and that promote continuity in consumer/physician relationships. Therefore, Michigan must consider this guidance while recognizing the need to maintain ease of eligibility determination for safety net programs as Medicaid moves towards closer integration with private insurance as required by the ACA.
- iii. Michigan must evaluate the current health care delivery system's ability to absorb the estimated 400,000 newly insured Medicaid individuals, evaluate the estimated costs of strengthening that system and consider potential funding sources, if needed, to include both facilities and medical/health care workforce components.
- iv. Michigan needs to assess the cost and benefits of adopting the Long Term Care system reform options available through the ACA. Michigan Medicaid has a legacy of pursuing quality, consumer choice and cost effectiveness in its long term care programs. The ACA provides opportunity to further develop and emphasize home and community based care options for program beneficiaries. Long term care and services provided to populations with special needs should be included in the health insurance exchange discussions, given that the health insurance exchange could transform long term care.
- v. Michigan should be at the forefront of working with HHS to pursue opportunities through the ACA that will allow for innovative payment and system reforms for Medicaid's dual eligible beneficiaries.
- vi. Michigan needs to evaluate the State's readiness in pursuing Medicaid grant and demonstration projects available through the ACA.

E. Health Systems

- i. Michigan and the state's health system should be aggressive in pursuing demonstration projects, grant opportunities, and other aspects of the ACA to augment existing resources and increase effectiveness.

F. Stakeholder Input

- i. As described earlier, Michigan has received considerable stakeholder input through the initial stage of ACA implementation. However, Michigan will need to develop a formalized process for stakeholder participation, and define the role and scope of stakeholder involvement. A range of options for involving stakeholders will need to be considered, including the utilization of existing organizations, public and provider forums, formal workgroups, public comment, and the well-defined Medicaid policy input structure.

G. State Budget

- i. Several provisions in the ACA will have state budget implications, and the attached operational grid (Attachment A) and State Budget Office discussion (Attachment B) identify many of these provisions. Michigan should perform a cost analysis as appropriate for these provisions in order to inform implementation decisions. In most instances, additional information is needed from the federal government in order to begin these analyses.

VI. KEY STRATEGIC ISSUES

This section of the strategic plan provides additional detail, background, and information on the key strategic issues that current and future state leadership will need to address as the ACA is implemented. It touches on the major topics contained in the Act:

- A. Health Insurance Exchanges
- B. Health Insurance Reform
- C. Medicaid Program Changes
- D. Health System Changes
- E. State Employer Impacts
- F. Medicare Changes Affecting Michigan's Medicare Beneficiaries
- G. System Connectivity

Included in this discussion is a description of key issues, alternatives to addressing the issue, and as applicable information on federal guidance and/or funding opportunities. This information is the product of the analysis and planning of the departments, bureaus and divisions within state government who have researched the Act and *identified crucial decision points*, as directed by the Executive Order, some of which must be made very quickly to ensure an orderly and timely implementation of this historic law. It does not address all of the activity currently underway, nor does it describe in detail activities which have been completed, including grant opportunities which have been applied for, received or dismissed. The attached operational grids (Attachment A) provide even further detail on these key issues.

A. Health Insurance Exchanges

A key component to the Patient Protection and Affordable Care Act (ACA) is the establishment of health insurance exchanges. A health insurance exchange will create an organized marketplace for the purchase of health insurance, facilitating cost-efficient competition among insurers while affording new mechanisms for regulating insurance products and assuring consumer protections. Health insurance exchanges are expected to play a key role in making health insurance more readily available to segments of the population that currently struggle to obtain insurance coverage.

States must decide whether to create their own exchange, participate in a regional/multi-state exchange, or allow the federal government to operate an exchange for the state. Within an exchange, issuers will offer health benefit plans to individuals and small businesses, as well as premium subsidy and public program eligibility determinations. Such a marketplace will allow consumers to become actively engaged in the process of program eligibility, enrollment, and choice. With the expansion of Medicaid, an individual mandate for health insurance coverage, and other regulatory changes in the insurance market, the landscape of coverage for health services will vastly change. Program integration will be necessary to assure insurance coverage programs will not be fragmented and disjointed for consumers of health insurance in Michigan.

The ACA also stipulates that within each state or region there either be two separate exchanges – one for individuals and one for small businesses, or one consolidated exchange covering both individuals and small businesses. The small business exchange will give small business owners and their employees a one-stop shopping place for health coverage, allowing individuals and business owners to see what different plans offer at various cost thresholds, presented in an easy-to-understand format. Participation in the small business exchange is optional for small businesses, and will initially be limited to employers with fewer than 100 employees. Until 2016, states have the discretion to further limit participating employers to those with fewer than 50 employees. Beginning in 2017 however, the ACA requires states to define a small employer as one with up to 100 employees, so those employers may participate in the exchange.

If Michigan decides to operate a state exchange, the exchange must be established and fully operational by January 1, 2014. Decisions about the exchange will have to be made in 2011, along with required state legislative action, in order for new enrollment systems to be built, new entities/agencies to be created or existing entities/agencies to retool, and to ensure that the state is in compliance with federal laws and regulations. If the state does not opt to create an exchange, including a small business exchange, the federal government will provide one on behalf of the state. Therefore, a critical part of planning the exchange is to determine if Michigan will administer its own exchange, participate in a regional exchange, or if it wants the federal government to run the exchange.

If Michigan administers its own exchange, it should be in a better position to coordinate eligibility determination with Medicaid and MICHild, in addition to using the exchange as a tool for achieving its consumer and regulatory objectives. For example, Michigan would have the ability to define standardized benefit packages for the state’s insurance marketplace. In addition, as the state’s largest purchaser of health insurance, for the Medicaid program and state employee/retiree health coverage, state government would be able to better integrate the transition of coverage between these plans and the other types of coverage provided through the exchange.

If the federal government administers the exchange for Michigan, Michigan could lose control of its ability to determine its policy priorities. At this point there is insufficient information to be able to describe how the federal government would operate an exchange for Michigan. Nevertheless, it is quite plausible that the entity operating the exchange would be from outside the state, the federal government and its contractors will decide how consumer complaints will be resolved, integration with eligibility determination for Medicaid and MICHild could be more difficult, and the federal government would likely have more control over issues that affect budget decisions involving Medicaid and MICHild. It should be noted that the federal government is encouraging states to operate state exchanges or join together to form regional exchanges.

- ❖ If Michigan administers its own exchange, it should be in a better position to coordinate eligibility determination with Medicaid and MICHild, in addition to using the exchange as a tool for achieving its consumer and regulatory objectives.
- ❖ If the federal government administers the exchange for Michigan, Michigan could lose control of its ability to determine its policy priorities.
- ❖ Administering a state exchange does carry some financial risk as it must be self-sustaining by 2015.

Administering a state exchange does carry some financial risk as it must be self-sustaining by 2015. Renewable federal funding will be awarded to states by the U.S. Department of Health and Human Services (HHS) to support state exchanges until 2015. These funds will support start-up costs and initial operating expenses of the exchange. The ACA does give the state the authority to identify new financial resources to support the operation of the exchange beyond 2015. Michigan should assess costs and savings projections focusing on *new* costs, savings, and revenues to the state if there is a state exchange, compared to what the state costs will be without establishment of a state exchange.

Legislation establishing the state exchange would need to be enacted. If Michigan opts to establish a state exchange, decisions must be made with respect to the organizational location of the exchange: whether the exchange will be within an existing state agency, a newly structured

- ❖ States are permitted to operate multiple exchanges on a regional basis, provided that each exchange serves a defined geographic region.
- ❖ Larger states and those with diverse geographic characteristics – such as Michigan – may benefit from offering exchanges tailored to specific regional districts.
- ❖ Establishment of additional exchanges does entail greater administrative complexities.

state agency, a quasi-public authority, or a nonprofit entity. Each choice has risks and rewards; as such, a thorough analysis of all options needs to be conducted relative to the most efficient and appropriate entity in which to house the exchange. This analysis will be completed in the context of the “State Planning and Establishment Grants for the Affordable Care Act’s Exchanges” grant described below.

States are permitted to operate multiple exchanges on a regional basis, provided that each exchange serves a defined geographic region. Larger states and those with diverse geographic characteristics – such as Michigan – may benefit from offering exchanges tailored to specific regional districts. However, the establishment of additional exchanges entails greater administrative complexities. In addition, states may form compacts, or alliances, that allow all insurers to sell products in

participating states. This is an acceptable option only if the coverage is as comprehensive and affordable as it would be in a state exchange.

The ACA permits states to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies to purchase health insurance through the exchange. A state can create a coverage plan and receive the federal subsidies that would otherwise subsidize the exchange-offered insurance premium. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits under a premium cap. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the exchanges. Instead, the subsidies associated with those in the Basic Health Plan would accrue to the state.

The Secretary of HHS will issue regulations setting standards for meeting the requirements with respect to the establishment and operation of a state exchange; offering of qualified health plans through the exchange; establishment of reinsurance and risk adjustment programs; and other requirements as the Secretary determines appropriate.

The Michigan Department of Community Health has received a “State Planning and Establishment Grants for the Affordable Care Act’s Exchanges” grant. This 12-month planning grant will support Michigan’s effort to address the following items:

- To operate a state exchange or participate in a federal or regional exchange
- To combine or choose separate individual and small business exchanges
- The overall management approach for the exchange(s)
- State agency roles within the exchange
- If the exchange will have an independent governing Board or not
- The extent to which the exchange will be allowed to operate outside of State government
- Assure transparency of the exchange
- The capabilities of Michigan’s current information technologies and what new systems must be developed so that federal and private sector systems will integrate with State systems within the exchange
- Criteria to select health plans
- The intersection between public, subsidized, and commercial coverage
- How Medicaid, MIChild, and other public programs will coordinate with or function within the exchange
- Whether the state will create a “basic health plan” to be offered within the exchange

If the planning process recommends creation of a state exchange, the planning grant will be used to complete a business operations assessment and plan. It is anticipated that business operations would be multi-faceted with the expansion of Medicaid, guaranteed issue of health plans, on-site public program eligibility determinations, and other various issues.

Also during the planning phase, considerable time and effort will go into determining which laws, administrative rules, orders, and other authoritative documents will have to be amended, revised, eliminated, or created due to the requirements of the ACA, specifically as they relate to the exchange. There are many changes in Medicaid and insurance that will warrant administrative and legislative changes. It is crucial that thorough legal analyses be performed to identify where regulatory and policy action is needed to ensure that Michigan's exchange is in compliance with federal law.

The success of the exchange in linking consumers to health insurance products will depend on its interoperability. The capability for data matching must be established to allow for eligibility determinations, verification processes, information dissemination, enrollment, and status changes to ascertain the appropriate program in which the consumer should enroll. Michigan will need to devote considerable energy during the planning phase for development of real-time interoperability. Methods of tracking and coordinating newly eligible individuals will need to be developed, as well as evaluation tools to measure the success of the exchange and methods for making the information available to the public.

B. Health Insurance Reform

The ACA has made sweeping changes to many aspects of the health insurance industry. The ACA affects health insurance coverage, consumer protections, rating standards, and employer responsibilities. Some insurance reforms took effect upon enactment; others took effect at the six month mark of the effective date of the ACA on September 23, 2010; more reforms are effective in subsequent years – primarily on January 1, 2014.

A full legal analysis must be completed to review statutes, rules, bulletins, and other documents to ensure that Michigan's edicts are harmonious with federal law and to determine what changes must be drafted to accomplish congruence. New Administrative Rules or legislative changes to the Insurance Code and the Nonprofit Healthcare Corporation Reform Act must be considered in order to provide Michigan's Office of Financial and Insurance Regulation (OFIR) with sufficient flexible authority to enforce federal law.

The effect of the ACA's changes to the health insurance industry are expected to result in a market that covers more individuals, spreads risk more broadly, and reforms payment mechanisms to contain future health care spending.

1. Health Insurance Coverage Reforms

The ACA fundamentally alters some long-standing health insurance practices, including denial of coverage based on pre-existing conditions, strict annual and lifetime benefit limits, and increasing cost-sharing requirements. As the health issuers in Michigan adopt these new guidelines, OFIR must work in tandem with the industry to provide timely, accurate information to consumers and ensure issuer compliance with the constructs of the ACA.

The ACA requires issuers to provide all enrollees with a package of preventive care benefits with no cost-sharing requirements, effective for the new plan year that begins after September 23, 2010. Pre-existing condition limitations and coverage denials are no longer permitted for individuals under the age of 19. Other coverage reforms taking effect in 2010 include the prohibition of issuers to place lifetime limits on essential benefits and restriction of annual benefit limits.

❖ By 2014 coverage reforms including a prohibition on the imposition of pre-existing condition limitations or denial of coverage to adults based on their health status must be reflected in health policies and certificates of insurance.

By 2014 coverage reforms including a prohibition on the imposition of pre-existing condition limitations or denial of coverage to adults based on their health status must be reflected in health policies and certificates of insurance. Excessive waiting periods, longer than 90 days, will be prohibited in group coverage plans. All plans must include an essential benefits package containing specific benefits, cost sharing limits, and actuarial values. Additionally, beginning January 1, 2014, Medicaid eligibility will be expanded to include all adults under age 65 up to 133% percent of the Federal Poverty Level (FPL) and the exchange will offer private health insurance to other individuals with a federal subsidy/tax credit for those who make under 400% FPL.

The ACA provides financial assistance to low income individuals and families who purchase health insurance through exchanges. Families and individuals with family incomes between 133% up to 400% FPL will be eligible for a subsidy or a tax credit to help reduce the cost of their insurance (effective in 2014). Generally, people who are offered coverage through their employer are not eligible for this credit. The amount of the tax credit will be 2% to 9.5% of income, dependent upon the cost of the premium relative to family income, based on the cost of a plan with an actuarial value of 70%.

Cost-sharing subsidies will also be available for lower income people with high out of pocket costs at the point of service. The ACA sets a maximum out of pocket limit and adjusts the amount downward according to income levels ranging from 100% to 400% of the FPL.

Issuers have a responsibility to their existing and potential customers to offer products that are in compliance with the requirements of the ACA. It is incumbent upon the state and issuers to make current information available to consumers. Issuers and OFIR will work cooperatively in getting health coverage products to the market in a timely, direct, and efficient manner.

Health insurance coverage forms, including coverage offered by commercial insurers, health maintenance organizations, or Blue Cross Blue Shield of Michigan, must be filed for approval with OFIR. Issuers must either file new policies and certificates or amendatory endorsements to bring their policies and certificates into compliance with the coverage reforms in the ACA.

Federal guidance is currently available, offered through frequent communication between HHS, NAIC, and OFIR. The Secretary of HHS has issued regulations relative to lifetime benefit limits and is reviewing the definitions of restrictive annual limits, permissible annual limits, medical loss ratio, and health status. The Secretary will define essential health benefits and determine the scope of benefits covered under a “typical employer plan” as a standard to be applied to individual plans, in addition to issuing regulations regarding employer contributions to Health Savings Accounts as applicable to individual plans and variations of their actuarial value.

Currently, OFIR’s State Electronic Rate and Form Filing (SERFF) system allows forms to be submitted, reviewed, and finalized in a timely manner. New products that are ACA compliant will be filed and approved through this system to insure their timely availability. Insurance products have been required to be filed exclusively through SERFF since 2008.

OFIR will continue to review policies and certificates for compliance with federal and state law. Provisions within the coverage guidelines that are not in compliance will be rejected and prohibited from use in Michigan. Formal action will be taken against issuers that display a pattern of non-compliance, as identified by OFIR's Consumer Services Division using substantiated complaint data.

2. Consumer Protections

Consumer protections against practices such as rescission – or retroactive health insurance cancellation – are an important cornerstone of the ACA. These safeguards are intended to increase access to care through better coverage, more transparency, and protection against denial based on health status. Further, consumers will be given more consumer assistance through a health insurance ombudsman authorized within the ACA to provide information, facilitate enrollments, handle consumer complaints, and participate in appeals processes.

These immediate protections include prohibiting issuers from rescinding coverage, except in very limited circumstances in which a 30-day notice of cancellation is required. Dependent children are defined as children up to age 26, and the ACA has established a temporary insurance plan for people with pre-existing conditions. This plan is being administered in Michigan by Physicians Health Plan (PHP) of Michigan, Inc. The ACA has also guaranteed the patient's right to an appeals process under both insured and self-insured plans, complementing Michigan's current statutory language.

The ACA encourages consumer choice with the preservation of the right to maintain existing coverage, otherwise referred to as “grandfathered” coverage. While the consumer's choice of providers is permitted, insurer's have a limited ability to impose prior authorization requirements when certain providers are chosen.

Here again the ACA requires states to provide consumer assistance and information programs through the health insurance ombudsman. The ACA also provides state consumer services with the ability to discuss cases and trade evidence with the federal government, formerly prohibited for self-insured health plan complaints.

Beginning in 2014, all applicants for health insurance must be guaranteed coverage, which cannot be canceled by the issuer unless the insured commits fraud or fails to pay the premium. Issuers may not discriminate based on a person's receipt of subsidies or by salary level. An issuer may not discriminate against any provider operating within their scope of practice or against an insured person that is involved in a clinical trial.

- ❖ Beginning in 2014, all applicants for health insurance must be guaranteed coverage, which cannot be canceled by the issuer unless the insured commits fraud or fails to pay the premium.
- ❖ Insurers may not discriminate based on a person's receipt of subsidies or by salary level.
- ❖ An issuer may not discriminate against any provider operating within their scope of practice or against an insured person that is involved in a clinical trial.

Executive Order 2010-4 designates the establishment of a Michigan Health Insurance Ombudsman within OFIR. This Ombudsman is required by ACA. Michigan has received a federal grant which, among other things, will support this position. Michigan's designated health insurance ombudsman will respond to consumer complaints about violations of various consumer protections as well as participate in appeals review under the Patients' Right to External Review, as defined in statute.

3. Rating

The ACA makes important changes to the rating requirements for health benefit products. In addition to modifying the rating requirements, the ACA initiates various issuer assessment and reinsurance programs, to offset the expected increase in claim costs to carriers. The ACA requires Michigan to develop and implement a risk adjustment methodology to be applied to plans in the individual and small group markets, exempting the grandfathered health plans. The number of changes prompted by the ACA is not large, but the changes will have significant impact on the health benefit industry.

The ACA has introduced new medical loss ratio standards, requiring insurers to pay no less than 80% and 85% of premiums received on health care services in the individual/small group market and the large employer market, respectively. If insurers do not meet these loss ratio requirements, they must issue premium rebates to consumers beginning in January 2011.

Medical loss ratio is the ratio of the total costs paid out in claims plus adjustment expenses divided by total earned premiums. In the health insurance industry, medical loss ratio's typically run between 60% and 110%. The ACA has introduced new medical loss ratio standards, requiring issuers to pay no less than 80% and 85% of premiums received on health care services in the individual/small group market and the large employer market, respectively. If issuers do not meet these loss ratio requirements, they must issue premium rebates to consumers beginning in January 2011. The rating reforms apply uniformly to issuers as well as group health plans. Besides standardizing allowable MLR's, the ACA ensures consumers get value for their dollars with an annual review of unreasonable premium increases.

The Secretary of HHS will work with the National Association of Insurance Commissioners to establish permissible age rating bands. The Secretary will also establish federal standards for the definition of "high-risk individuals" as well as a formula for reinsurance and assessment payment amounts, which nationally will total \$25 billion over three years (2014 – 2016). In addition to assessment and reinsurance amounts, the Secretary will establish risk corridors for health plans whose costs exceed 103% of total premiums. Michigan has applied for, and received, one million dollars from "Grants to States for Health Insurance Premium Review-Cycle I" program for this endeavor.

Michigan will use these grant funds to consult with actuaries to analyze and review health insurance rate filings, develop procedures for a new rate review program, perform a feasibility study on retrieving information from rate filings, and post the information to a new State website. Additionally, Michigan will review other states' methodologies for guidance on rate transparency and develop strategies for a public portal that will offer information to the public in a user-friendly manner.

4. Employer and Personal Responsibilities

The ACA contains provisions for individual and employer mandates for insurance coverage beginning in 2014. The ACA places detailed requirements on all employers. The ACA requires automatic enrollment for employees of large employers, defined as 200 or more employees. After 2017, states may allow large employers to enroll employees in health coverage through the state exchange. The employer must also inform employees of coverage options. Through the ACA, the Internal Revenue Code has been amended related to cafeteria plans as well as employer-related taxes. Generally, plans provided through the exchange will not be an eligible benefit under employer-sponsored cafeteria plans.

Employer offered health plans must include one of four options of the essential health benefits package. This package includes: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

The Act requires an employer with at least 50 full-time employees that does not offer coverage and has at least one full-time employee receiving a premium assistance tax credit to make a payment of \$2,000 per full-time employee, although the first 30 full-time employees are exempt from the penalty calculation. If the employer offers coverage but has at least one full-time employee receiving the premium assistance tax credit, the employer will pay the lesser of \$3,000 for each of those employees receiving the tax credit or \$2,000 for each of their full-time employees, not including the first 30 workers. The ACA requires states to define the small employer group market as an employer having 1 to 100 employees by 2016. Since Michigan currently defines the small employer group market as 2 - 50 employees, legislative changes to the insurance code must be considered.

There are additional reporting requirement for employers. Employers must report to HHS whether they offer insurance coverage to full-time employees (and their dependents) and whether the coverage meets the minimum essential coverage, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories, and the employer's share of the total allowed costs of benefits provided under the plan. The HHS Secretary will be issuing guidance on how to determine an employee's hours of service, as well as how to determine coverage for employees who are salaried, not hourly. The HHS Secretary will also provide guidance on employer reporting requirements.

For the individual and small group markets, the Secretary will define the essential health benefits, which must be equal in scope to the benefits of a typical employer plan. All individuals, with some limited exception, will be required to obtain health insurance. Those who elect against having insurance will be required to pay a yearly financial penalty.

C. Medicaid Program Changes

The ACA moves Medicaid from being a safety net program to a position of being an integral part of the system of health insurance coverage for citizens of Michigan and the United States. The ACA will lead to numerous changes to the Michigan Medicaid program, including an unprecedented expansion of Medicaid eligibility and the need for the seamless integration of Medicaid eligibility with the exchange. The ACA also enables Michigan to pursue innovative payment and systems reform opportunities in long term care and Medicaid reimbursement and services in other program areas as well. The ACA also changes the Disproportionate Share Hospital payments. These focal points within the ACA will provide opportunities for increased federal match, support creation of efficiencies within the system, and will help address fraud and abuse, creating opportunity for improvement and recognition of best practices in the delivery of care for Medicaid beneficiaries. These changes and opportunities that the ACA provides for Medicaid will play an integral role in Michigan's health system as a whole.

Given the ACA provisions for federal funding of the Medicaid expansion population, Michigan does not expect to incur significant expense for this group until at least 2017. Michigan will have to undertake significant staff and technology activity to plan for the expansion, to develop the operational elements for the new eligibility standards, and to effect the required coordination and integration with the health insurance exchange. While Michigan will absorb some additional costs for these activities, there is significant federal funding available to support this work.

1. Enrollment/Eligibility

To be eligible for Medicaid coverage today individuals must be in a covered category, such as the disabled, children, or pregnant women, and meet the financial eligibility requirements. The ACA changes Medicaid eligibility from a mostly categorical program to an income-based eligibility program that ensures coverage for low-income individuals and the aged and disabled. Michigan can expect enrollment of up to 400,000 new beneficiaries beginning in 2014. In addition, up to 50,000 additional individuals currently eligible but not enrolled could enter the Medicaid program as a result of the coverage mandate. Enrollment and eligibility determination will place an additional burden on current resources and providing flexibility in completing these functions will need to be considered.

ACA expands mandatory eligibility for Medicaid to 133% of the FPL for all individuals, without regard to categorical eligibility. The current 133% FPL for a family of four is \$29,327 annual income. ACA permits states to expand Medicaid to this new group as an "early adopter" beginning April 1, 2010 without enhanced federal match. The increased-match begins January 1, 2014.

In addition to expanding eligibility, the ACA also mandates a new method beginning in 2014 for determining the income amount for Medicaid eligibility, called Modified Adjusted Gross Income (MAGI). MAGI includes a broad definition of income and will establish higher

income levels for eligibility, streamlined budgeting, and enhanced federal reimbursement. In addition to this significant change in eligibility determination, states must also establish an "equivalent income test" to make sure that no individuals lose eligibility due to the transition to MAGI.

The new and expanded Medicaid eligibility groups have certain inherent process, procedure, and fiscal impacts. Significant systems changes are required, including new or revised eligibility systems for the new, and possibly existing, populations, which will require interaction with the existing programs. The ACA also permits the Medicaid program to enter into agreements with state exchanges to permit the state agency to conduct eligibility determinations for premium subsidies. This will require systems interaction with the health insurance exchange. Additionally, a state decision whether or not to offer a Basic Health Plan rather than offering premium subsidies through the health insurance exchange will have to be considered.

The different programs and expanded eligibility opportunities all have different funding opportunities and responsibilities. The expansion to newly eligible (133% FPL) program, for one, provides significant federal funding as follows:

- For newly eligible individuals: 100% Federal Financial Participation (FFP) beginning in 2014, through 2016; 95% FFP in 2017; 94% FFP in 2018; 93% FFP in 2019; and 90% FFP in perpetuity starting in 2020.
- For individuals eligible before the ACA, but not enrolled, Michigan will receive the regular FMAP rate.
- CMS has proposed a federal rule allowing an enhanced administrative match of 90% FFP until January 2015 for streamlining and upgrading Medicaid eligibility systems. A 75% FFP has been proposed for eligibility system changes past 2015.

For all new and expanded programs, the Department has begun consultations and planning in conjunction with HHS. The state should continue planning, discussing, and educating its staff and key stakeholders. Such work will permit stakeholders and the state to develop concrete plans for implementation and determination on development of alternative systems and programs to effectuate the ACA's required changes. Because of the necessary proximity to the exchange, the state's Medical Services Administration should continue to be a key decision maker in the exchange planning and development process.

As it relates to optional changes to Medicaid, including the early adoption of newly eligible individuals and the level of integration of Medicaid and the health insurance exchange, policymakers must decide the appropriate next step by determining available resources, resource priority, program alternatives, and program cost. The department will need to submit all required state plan amendments to comply with federal laws and regulations.

2. Long Term Care Systems Reform

The ACA emphasizes the need for a strong primary care system which is community based, shifting appropriate services from inpatient to outpatient settings. Long term care is an appropriate area of health care to look for alternatives in a community based setting. The ACA requires HHS to promulgate regulations that support flexible, consumer oriented home and community based services funded by Medicaid and other sources. The ACA changes to the Social Security Act (SSA) include the ability to offer all services that could be offered under a home and community based services waiver; extension of eligibility to 300% of Supplemental Security Income (SSI) if the need for an institutional level of care is met; and other expansions. Additionally, the ACA modifies some provisions of the Deficit Reduction Act, including elimination of the MIChoice waiver enrollment cap and expansion of the state Medicaid benefits package.

The ACA seeks to provide incentives to encourage long term care in a home or community based setting outside of traditional institutional settings, when appropriate. Currently, Michigan's Medicaid program transitions qualifying individuals from nursing homes to home and community based services. These additional opportunities would supplement those existing efforts.

There is a clear focus within the ACA on increasing the availability of age and culturally appropriate services to individuals within the long term care system. This becomes significant for the services provided to populations with special needs, whose health care services most often have been institutionally based, and at a higher cost than the services which are home based or community based. The ACA seeks to provide incentives to encourage long term care in a home or community based setting outside of traditional institutional settings, when appropriate. Currently, Michigan's Medicaid program transitions qualifying individuals from nursing homes to home and community based services. These additional opportunities would supplement those existing efforts.

One such prospect is the State Balancing Incentive Payments Program. This program aims to increase availability of home and community based services (HCBS) in states currently spending less than 50% of their long-term care budgets on non-institutional care. If a state's spending on non-institutional services was less than 25% in 2009, as is the case in Michigan, and a target of 25% is reached by 2015, FMAP will be increased by five percentage points for eligible payments.

To qualify for this FMAP incentive, Michigan must apply to participate in the program. The application must include a budget that provides, in detail, how the state will make structural changes to its system during the incentive period that ends in 2015. Services that would qualify for the incentive include HCBS provided through waivers, home health services, personal care services, and Programs of All-inclusive Care for the Elderly (PACE). For some services to qualify for this incentive, eligibility must be expanded for beneficiaries up to 300% of SSI.

States must agree to the following within six months of application for program participation:

- Create a no wrong door/single point of entry
- Develop a conflict-free case management system
- Develop and implement a standardized assessment for determining eligibility for institutional and non-institutional services

This opportunity holds limited potential for Michigan in the short term as the state is unable to meet the qualifying criteria related to the development of a single point of entry and a conflict-free case management system within six months. The goals of this program, however, are consistent with the state's long term goals and it may be advantageous to use this as an opportunity to move forward. Further, given these requirements could be integrated with the health insurance exchange, long term care services provided to individuals should also be included in the exchange planning discussions.

Michigan's Office of Services to the Aging (OSA) has been involved over the past two years with efforts moving toward a single point of entry model for aging services, including the establishment of a State Aging and Disability Resource Center (ADRC) Partnership. Involving many partners across State government and interested agencies and facilities, the ADRC structure is intended to provide seamless access to supports and services for older adults and persons with disabilities across the state. ADRCs should meet the single point requirement for the State Balancing Incentive Payments Program. The target date for ADRC completion is 2014, and OSA should provide updates and guidance within the health insurance exchange planning discussion, considering the exchange could also transform long term care. Changing Michigan's current system to the conflict-free case management system required will be difficult as the state currently has multiple case managers involved with beneficiaries (DHS, Mental Health, Medicaid Health Plans, Waiver Agents, etc.).

In addition to the FMAP enhancement made available under ACA for home and community based services, the ACA provides an additional six FMAP percentage points for attendant care services and supports. Community First Choice is a current optional Medicaid program in Michigan that provides community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Community First Choice could be used as a basis for Michigan to qualify for this program if the state can satisfy the following requirements:

- Develop and implement the state plan amendment in conjunction with a Development and Implementation Council that includes a majority of members with disabilities, elderly persons and their representatives.
- Provide consumer-directed HCBS attendant services on a statewide basis without regard to the person's disability, age, or the services and supports needed.

- Maintain the level of expenditures for services provided to persons with disabilities or elderly individuals in the first year of operation.
- Establish and maintain a comprehensive quality assurance system for community-based attendant services.
- Collect and report information determined by the HHS Secretary for the purposes of approving this state plan amendment, providing federal oversight and conducting an evaluation.

Additional mechanisms to encourage transition from institutionally based care to community or home based care are detailed in the ACA. One such provision is extension of the Money Follows the Person Rebalancing Demonstration Program, originally scheduled to end in 2011, but now active until 2016. The program aims to support uninterrupted care as individuals shift to community or home-based services, in addition to removing barriers in state Medicaid plans that may hinder transition. Michigan currently has a Money Follows the Person grant that has been recognized nationally for successfully developing transition services as an integral part of the state's long-term care system. Grant resources have been instrumental in addressing needs such as housing, outreach, and staff training. Another program created by the ACA is the Community Living Assistance Services and Supports (CLASS) Act. The CLASS Act establishes a nationwide, optional insurance program through which individuals may purchase community-based services in lieu of institutional care. The ACA also provides grant opportunities to assist State Long Term Ombudsmen in providing follow-up services to individuals who will transition from nursing facilities to licensed residential services.

Currently Michigan provides some home and community based services to all qualifying beneficiaries under the Medicaid state plan. These state plan personal care services are commonly known in Michigan as Home Help. Additional services, however, are provided under 1915 (c) home and community based service (HCBS) waiver authority that allow the state to limit spending, as well as the number of beneficiaries served by the waiver programs. A decision to move services currently available only through HCBS waivers to the state plan could result in increased costs to the state for those particular items. However, these costs could potentially be offset by savings achieved through systems change, specifically the difference between providing more care in the community versus an institutional setting. The department must perform analysis of potential utilization and costs, taking into consideration the additional FMAP available for five years.

3. Medicaid System, Payment Reforms and Demonstration Opportunities

The ACA initiates several payment reform initiatives and demonstrations through Medicaid, in addition to the increase in FMAP for the newly eligible population. The ACA lays the groundwork for the development of creative state pilot and demonstration projects to address the integration of care and payment reform for Medicaid dual eligibles (the elderly and disabled Medicaid beneficiaries simultaneously enrolled in Medicare.) Additionally, two of the new Medicaid payment options included in the ACA are practice transformation initiatives that can support payment reform and the concept of bundling payment structures. These payment reforms and demonstration opportunities are intended to provide a foundation of financial stability as health care reform moves forward.

The dual eligible population represents 13% of total Medicaid enrollment, but drive 36% of total Medicaid spending. The disproportionate impact that this population has on the Medicaid budget reiterates the need for the structural and financial integration of Medicaid and Medicare in order to achieve better health outcomes for beneficiaries and cost savings for the state. The ACA recognizes the integral role that Medicaid plays in financing a substantial portion of the costs for this vulnerable and costly group. The legislation creates two new federal offices: 1) the Center for Medicaid and Medicare Innovation tasked with testing new payment methods and health care delivery systems that reduce cost and improve the quality of care delivered under Medicaid and Medicare and 2) the Federal Coordinated Health Care Office, tasked with the goal of more effectively streamlining access and coordinating coverage for dual eligibles. These two offices will work with states as they pursue demonstration programs focused around integrated care models and innovations on special needs plans for their dual eligible populations.

❖ The ACA directs the Secretary of HHS to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary:

The ACA provides incentives for states to implement patient centered medical homes as well as accountable care organizations. These delivery models can provide services at reduced costs principally by focusing on practice efficiencies and enhanced attention to quality. To encourage practitioners to participate in these primary care models, the ACA provides a 10% Medicare payment bonus for up to five years to primary care practitioners who deliver service in health professional shortage areas. Additionally, primary care practitioners who deliver primary care services to Medicaid enrollees in 2013 and 2014 will receive payments at 100% of Medicare payment levels for similar services; the federal government will bear the

1. With respect to an episode of care that includes a hospitalization;
2. For concurrent physician services provided during a hospitalization.

full cost of this increased reimbursement in 2013 and 2014. These incentives align with the ACA's support of accountable care organizations, patient centered medical home practices, and federally qualified health center (FQHC) expansion efforts. The ACA includes provisions for the significant expansion of FQHCs across the country.

States will likely incur additional costs from some of these policies. For example, there will be strong pressure for state Medicaid programs to pay primary care physicians at rates equal to Medicare (a substantial increase above current Medicaid rates) after 2014, requiring additional state match. Also, the state Medicaid program reimburses FQHCs for Medicaid services based on a prospective payment system methodology, per federal guidelines. The provision of more Medicaid services through FQHCs will result in higher reimbursement for these services than the capitated reimbursement model used for Medicaid managed care services provided at non-FQHC sites, although this increase might be offset by savings generated through early and comprehensive primary care delivered by the FQHCs.

The ACA directs the Secretary of HHS to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: 1) with respect to an episode of care that includes a hospitalization; and 2) for concurrent physician services provided during a hospitalization. The demonstration will be conducted in up to eight states. A state may target particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular regions of the state.

The movement to bundled payment structures within the next several years is expected to become a standard. Currently in Michigan, a significant amount of work will be required to set up a functional bundled payment structure. If handled under the fee for service payment model, systems adjustments to CHAMPS would need to be made to accommodate bundled payments. Similar adjustments would likewise have to be made by Medicaid health plans, given they serve about two-thirds of all beneficiaries. This undertaking will be worthwhile in that it promises to better align payments with the goals of better care at reduced costs. Nevertheless, accomplishing this will require significant investments in staff and IT systems resources.

4. Disproportionate Share Hospital payment reform

The Medicaid Disproportionate Share Hospital (DSH) payments are intended to compensate hospitals for their uncompensated care expenses. Currently the total amount, nationwide, allocated for this program is approximately \$11.7 billion. The ACA, anticipating a substantial reduction in the number of uninsured and a concomitant decline in expenses for their care, includes a scheduled national reduction in Medicaid DSH payments beginning in 2014. The national reductions range from \$600 million in 2014 to a high of \$5.6 billion in 2019.

These are federal amounts and do not include the state matching funds necessary to draw down the federal dollars. Currently by statute, Michigan receives about 2.3% or \$269 million of the \$11.7 billion in total Medicaid DSH funding. It is estimated that the ACA action will reduce available funding by 4% in 2014 to over 40% in 2019. The SBO estimated impact on Michigan is found in Attachment B. These reductions are expected to be balanced by increases in patients with insurance provided through the ACA. The statute requires the Secretary to develop a methodology to distribute the DSH reductions that imposes the largest reduction in DSH (up to 50%) for states with the lowest percentage of uninsured, so the final impact on Michigan is uncertain.

The Medicaid DSH allotment directly benefits high volume Medicaid hospitals in the state as well as county health plans. County health plans are community based programs that provide an ambulatory health benefit in 72 of Michigan's 83 counties. Michigan must work to assure that DSH resources continue to be allocated on the basis of accurate Medicaid and uncompensated care rates for providers. Reductions in the key years (FY 2018-2020) will need to be structured in a way that is not directly harmful to the state's bottom line. The state will need to monitor CMS for potential action, although no action is anticipated prior to 2013.

D. Health System Changes

The ACA recognizes that extending coverage to the uninsured is not the only reform necessary to improve the health of the U.S. population or to make the care delivery system more effective. It is widely recognized that this country has an excellent sickness care system built around the delivery of care in episodic fashion. However, 75% or more of all health care spending is directed at the treatment of the effects of chronic disease. To “bend the cost curve” requires investments in prevention of chronic diseases on a community and individual level, and the retooling of the care delivery system to include much more robust primary care delivery that focuses on prevention and early management of chronic diseases to reduce cost, both human and financial.

Michigan’s health care delivery system is a complex network of closely related providers, facilities, and payers, representing large and small institutions as well as individual providers and provider groups. The ACA requires Michigan to undertake fundamental changes to virtually every aspect of our health care system. As discussed earlier, access to health care will be enhanced through coverage expansions and health insurance exchanges. Health insurance subsidies for individuals and employers will be available. As part of the strategy to lower health care costs, the ACA also provides considerable opportunities to strengthen public health infrastructure, transform primary care practice, and enhance health care workforce. State government will be involved in many of the system change initiatives.

1. Community Based Prevention and Wellness

The ACA will support a number of new initiatives designed to promote healthy living, provide health education, and expand community-based health improvement activities. The ACA establishes a Prevention and Public Health Fund to boost funding for prevention and public health; increases access to clinical preventive services under Medicare and Medicaid; and funds research on optimizing the delivery of public health services. It also creates a federal interagency council to promote healthy policies and prepare a national prevention and health promotion strategy. Funding also is provided for maternal and child health services, including abstinence education and a new home visitation program.

Michigan and the state’s health system should be aggressive in pursuing demonstration projects, grant opportunities, and other aspects of the ACA to augment existing resources and increase effectiveness. Several grant opportunities to enhance public health infrastructure, promote wellness, and prevent disease are anticipated. These opportunities can support efforts to integrate public health and primary care, improve health outcomes and reduce health care costs, prepare the safety net for the anticipated enrollment increases in public and private health insurance plans, ensure that populations that remain without insurance coverage obtain needed health care services, integrate behavioral health and primary care services.

The State of Michigan has applied for or partnered on a number of ACA grant opportunities already and expects to monitor future funding opportunities and apply for grant programs that are consistent with state priorities.

2. Primary Care Practice Transformation

The ACA puts into place mechanisms to transform primary care practice. Considerable efforts are already underway in Michigan around transformation of primary care practices to patient-centered medical homes (PCMH) as a means to improve population health and reduce or slow the growth of health care costs. Payment systems are beginning to change to incentivize quality and effectiveness rather than utilization; consumers are becoming engaged in self-management of their health and chronic conditions, and programming is in place to increase the number of primary health care professionals. Michigan currently has the largest number of designated Patient Centered Medical Home (PCMH) practices in the nation. The PCMH provides comprehensive, coordinated, efficient, pro-active, whole-person, evidence-based care to each patient in their practice panel through the use of health professional teams, health information technology, evidence-based clinical guidelines, and improved access to community resources. Community-based teams of health professionals from numerous disciplines (e.g., nurses, nutritionists, pharmacists, health educators, social workers, behavioral health workers) can enable these practices to provide coordinated, whole-person care to their patients, and help these practices achieve designation as a PCMH without having to employ these professionals directly.

As of January 1, 2011, Medicare will begin to cover an annual wellness visit that provides a personalized prevention plan and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle health risks and promote wellness (e.g., weight smoking cessation, fall Medicaid, as of January 1, improve access to eligible adults via

Michigan currently has the largest number of designated Patient Centered Medical Home (PCMH) practices in the nation.

management, or interventions to reduce self-management and loss, physical activity, prevention, nutrition). 2013, will be permitted to preventive services for enhanced FMAP funding.

HHS has recently grants for states (or multi-primary care extension year planning grants or 6-grants.) The purpose of with a county or local entity that shall serve as the Primary Care Extension Agency to assist providers to develop Patient-Centered Medical Homes, and to create primary care learning communities to share Best Practices and the research findings for evidence-based practice. The Extension Agencies can provide support for community health teams, can assist with continuous performance improvement, can collaborate with local health departments and others to identify community health priorities, and can participate in efforts to address the social determinants of health and eliminate health disparities.

announced competitive states) to establish program state hubs (2-year implementation such a hub is to contract

The Michigan Primary Care Consortium (MPCC), a collaborative private/public partnership, seeks to resolve the system level barriers that are impeding the efficient delivery of effective primary care. The focus within the ACA on patient centered medical homes is

consistent with the strategic initiatives of the MPCC. The groundwork established by the MPCC encouraging the establishment of patient centered medical homes should position Michigan to fully benefit from the numerous opportunities in the ACA regarding re-design of primary care at the practice level. In fact, Michigan was recently selected as one of eight states to participate in a Centers for Medicare and Medicaid Services (CMS) demonstration project that is intended to improve the efficiency and effectiveness of health care, strengthen the patient and primary care physician relationship, and reduce health care costs.

The ACA establishes a demonstration project that allows qualified pediatric providers to be recognized as Accountable Care Organizations by Medicaid. The pediatric ACOs that meet performance guidelines and provide services at a lower cost would share in these savings. Michigan is interested in pursuing this demonstration project, and further guidance is anticipated in 2011.

The ACA has funding available for state agencies to create multi-disciplinary community health teams that will bridge between public health agencies and primary care practices for disease prevention, population management, patient self-management, linkages to community health and social service resources, safe transitions between settings and/or health care providers (e.g., from hospital to home or from pediatrics to adult practitioners), case management including medication management, and other services for at-risk patients and/or socially complex adults, children and families. The Michigan Department of Community Health will continue to monitor funding opportunities and apply for programs that are consistent with state priorities.

3. Health Care Workforce Expansion

The ACA includes numerous provisions to increase the public health and health care workforce, including the primary care workforce. It amends and expands many of the existing health workforce programs authorized under the Public Health Service Act (PHSA); creates a Public Health Services Track to train health care professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response; and encourages the training of more primary care physicians through changes to the Medicare graduate medical education (GME) payments to teaching hospitals. The new law also establishes a national commission to study projected health workforce needs.

The increase in persons covered by insurance as a result of the ACA coupled with incentives to provide more health care in an ambulatory, community-based setting increases the demand for a larger health care and primary care workforce. Many of the provisions of the ACA deal directly with the education and training of such a workforce. Additionally federal programs like the National Health Service Corp assume an important role in the expansion of this workforce.

The Michigan Department of Community Health, through the State Primary Care Office (PCO), administers several primary care workforce programs which address provider training and the recruitment and retention of providers. These programs include the SEARCH program – Student/Resident Experiences and Rotations in Community Health, State Loan Repayment Program, Conrad 30 J-1 Visa Waiver Program, and site development along with program promotion for the National Health Service Corps. In addition, the PCO partners with Wayne

State University School of Medicine on the Michigan Area Health Education Center Program, with the Michigan Center for Rural Health on the Rural Recruitment and Retention Network (3RNet), and with the Michigan Primary Care Association for the recruitment and retention of providers and administrative staff at Michigan's Federally Qualified Health Centers (FQHCs). MDCH also maintains an informational website designed to gather, review, and disseminate information on healthcare workforce related issues.

In recognition of the numerous challenges associated with meeting the demand for health care professionals working in primary care fields the Michigan Primary Care Consortium has committed to completing a primary care workforce state plan that reflects the existing workforce, recognizes current work patterns and mobility, and projects future needs based on the patient-centered medical home model. In putting forth such a plan it is the expectation of the Consortium that a collaborative public/private partnership is the most appropriate method for addressing the anticipated demands for and upon the primary care workforce.

The Michigan Department of Energy, Labor & Economic Growth, in partnership with the Michigan Department of Community Health, applied for a Healthcare Workforce Planning Grant, funded under the ACA. Although Michigan was not awarded this grant, an opportunity to apply for these funds again is expected in 2011. Additional federal funding opportunities are also expected to expand and enhance the health care workforce, including funding for community health workers and patient navigators. By leveraging available federal funds, Michigan can help to invest in the growing health care employment sector.

E. State Employer Impacts

With over 50,000 classified employees, Michigan state government represents one of the largest employers in the state. Health care coverage options available to eligible state employees include a State Health Plan (SHP) PPO and thirteen HMO options, depending upon an employee's home location. About 56% of state employees are enrolled in the SHP PPO with the remaining 44% enrolled in HMOs. In addition, the State provides health coverage under retiree plans to approximately 47,000 retirees and their dependents.

Based upon the ACA and clarifying regulations, the State of Michigan, as an employer, has "grandfathered" health plans, "non-grandfathered" plans, and "retiree-only" plans. Grandfathered plans are those plans in existence when the ACA became law on March 23, 2010. These plans are those that cover employees hired before April 1, 2010. Non-grandfathered plans are those that were not in existence on March 23, 2010. "Retiree-only" plans are those plans that cover fewer than two participants who are current employees. The State of Michigan retiree plan is a "retiree-only" plan.

Based on the State of Michigan's health coverage options, several new mandates apply to State Government as an employer. Mandates and implementation decisions vary based on whether a plan is "grandfathered" or if the plan is "retiree-only". These mandates include:

Coverage of adult children to age 26

For the plan year that began October, 2010, employees may now enroll adult children up to age 26 without regard to residency (physical custody) and dependency (dependent on the employee for at least 50% of support) requirements to determine eligibility. This provision will not be implemented for the State's "retiree-only plans" per the June 14th Interim Final Rules that announced the HHS's interpretation that Congress did not intend for this provision to apply to retiree-only governmental plans.

Automatic enrollment in health coverage

Beginning in January 2014, large employers must offer a group health plan and must automatically enroll all employees into health coverage. Employees will need to opt out of coverage, whereas currently they need to opt in. As a result, the State of Michigan will need to enroll the non-career employees who typically work less than 90 days and are currently not eligible for health benefits. The automatic enrollment of all employees and the new mandatory coverage for non-career employees will mean increased costs to the State in premiums and administrative expenses, although the extent of these additional costs is not yet known. A large employer like the State of Michigan will be penalized if an employee applies for a federal subsidy to purchase health care through the health insurance exchange.

Excise Tax

Beginning in 2018, a 40% excise tax on plan administrators will be applied if health coverage costs more than \$10,200 for single coverage (\$11,850 for early retiree single) and \$27,500 for family coverage (\$30,950 for early retiree family). Currently, single coverage for an active employee in the SHP is \$6,376 and \$17,598 for family coverage. Given that many provisions in the ACA are meant to reduce or slow the growth of health care costs, the state will most likely not be subject to the excise tax provision in the future. However, the state should continue to monitor the costs of its coverage as the impact of the excise tax provision on the State of Michigan is uncertain.

Retiree Reinsurance Program

The ACA provides \$5 billion in financial assistance to the nation's employers to help maintain coverage for retirees age 55 and older who are not yet eligible for Medicare. Reimbursements from the fund are on a first-come, first-served basis with the program scheduled to end when funds are exhausted. The State of Michigan has applied, and been approved, for this financial assistance program. The reimbursement for the state's retiree-only plan is estimated at \$33 million annually.

Additional Requirements

Effective October 3, 2010, plan benefits must exclude lifetime limits and eliminate annual limits which are "restrictive" as determined by HHS. Lifetime limits have been lifted from state plans as well as annual limits on essential services from the "non-grandfathered" plans.

Effective October 3, 2010, co-pays and deductibles cannot apply to *evidence-based* preventive services. The state has reviewed federal guidelines and determined that only a few additional preventive services must be added to the state's current preventive care benefit.

Additional administrative issues include uniform explanation of coverage documents (effective 3/23/2012), new federal reporting requirements (effective 1/1/2014), new group health plan appeal procedures (effective TBD by HHS), required electronic transaction standards (effective 12/31/2013), employer notification requirements to employees (effective 1/1/2014), and imposition of a self-insured health plan fee (effective 10/1/2012).

F. Services for the Aging

While the Medicare program is a federally administered program, many aspects and funding are part of the programs in Medicaid, and often Medicaid funding decisions are driven by federal financial and payment decisions made for the Medicare program. The ACA seeks to encourage the integration of Medicaid and Medicare services to the aging population where appropriate. Many of the provisions contained within the ACA are intended to reduce Medicare program costs by nearly \$400 billion over the next decade through a combination of payment adjustments and increasing efficiencies in the delivery of health services. Since Medicaid funding for services to the elderly and disabled populations approach 70% of Michigan's Medicaid budget, attention to these provisions is warranted.

The ACA contains grant funding opportunities to develop fully functioning ADRCs. (See earlier discussion on Long Term Care Services and Payment Reform.) The ACA also provides access to a non-competitive grant to support efforts to find and assist with enrollment of those potentially eligible seniors not currently enrolled in Medicare Part D. Many of these people, with limited incomes, are not connected to communities, disability or aging services and may not be aware of Part D or the Medicare Savings Program which can cover their Medicare Part B deductible with federal Medicaid funds.

G. System Connectivity

Many of the opportunities presented through this strategic plan are influenced by information technology and system connectivity. The scope and impact of the ACA involves systems currently in place, requirements to be developed, and new component linkages yet to be realized. In Michigan there are initiatives now underway which will be critically linked to the state and regional health information technology (HIT) infrastructure being developed across the state's health care system. These "cross walks" fall into three broad categories. They are singled out here for their strategic significance with respect to other parts of this plan.

- Electronic Health Records, Health Information Technology, and Michigan Health Information Network
- Medicaid - Insurance Exchange Interaction
- Administrative Simplification within Health Insurance Reform

1. Electronic Health Records

The American Reinvestment and Recovery Act of 2009 (ARRA) created a significant opportunity to develop and use Electronic Health Records (EHR) and to develop health information exchanges (HIE). The ACA now builds on these initiatives through a number of provisions regarding health information technology (HIT) that address many of the challenges facing electronic health information exchange. The ARRA also provided incentives for developing innovative new methods to reimburse expenses for quality care, coordinate that care, evaluate overall quality of the care, and a significant expansion of the administrative simplification requirements under HIPAA (Health Insurance Portability and Accountability Act).

HIT provisions embodied in the ACA can be categorized into two distinct groups: 1) Provisions that attempt to improve the quality of healthcare by increasing quality data collected; 2) Provisions that set new operating rules and standards that will directly or indirectly control the use and innovation of HIT.

The ARRA's Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs begin in 2011. These incentive programs are designed to support providers in this period of HIT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care. The Centers for Medicare and Medicaid Services (CMS) are administering the Medicare incentive. Each state is administering the Medicaid EHR program. Michigan Medicaid is administering the EHR incentive program for Michigan's eligible providers. CMS has indicated it will wait until ACA programs are implemented before developing EHR adoption standards, and the ACA administrative simplification provisions aimed at health plans and health plan clearinghouses will help shape EHR standards.

- ❖ The ARRA's Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.
- ❖ The programs begin in 2011.
- ❖ They are designed to support providers in this period of HIT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

The Michigan Health Information Network (MiHIN) was created in 2005 to promote the secure exchange of health information to improve the quality of clinical care. The MiHIN, a public and private partnership that involves significant Michigan healthcare stakeholder representation, will advance regional and state-level health information exchange while moving toward nationwide interoperability. The ARRA funded State HIE Cooperative Agreement Program has provided funding to rapidly build capacity for exchanging health information across the health care system both within and across states. Michigan was awarded \$14.9 million in ARRA funding to implement the necessary technical and policy framework needed to provide statewide health information exchange connectivity through the MiHIN. With strong statewide

connectivity in place, the necessary quality data collection described in the ACA will be achieved through connection with the MiHIN. The MiHIN will be a key partner for the health insurance exchange in Michigan as the MiHIN becomes operational and data needs become imminent.

Operating rules will be adopted for all transactions, reducing variations in how individual health plans and clearinghouses currently implement HIPAA transaction standards. A single set of operating rules for eligibility verification, claims status, claims remittance / payment and electronic funds transfer will be provided to states and HIT systems will be required to adapt to those standards. The ARRA created a set of standards for implementing the shift to EHR standards. CMS will use these criteria to determine whether providers are making enough “meaningful use” of EHR systems to qualify for incentive payments.

The ongoing initiatives are focused on preparing the health IT infrastructure at local and statewide levels to promote the goals of ACA. Close coordination is necessary between these ARRA Health IT programs and policy makers focused on implementing the provisions of ACA to ensure that these programs are developed to support ACA needs.

2. Coordination between Michigan’s Insurance Exchange and the Medicaid Program

The ACA requires Michigan, as a condition of participation in Medicaid, to simplify Medicaid enrollment and coordinate with state health insurance exchanges and the State Children’s Health Insurance Program (MICHild). Specifically, Michigan must establish procedures so that individuals applying for premium assistance under the exchange are first processed for Medicaid or MICHild eligibility. Conversely, there will need to be a closely coordinated process to refer individuals applying for and failing Medicaid and MICHild eligibility to the exchange for a premium assistance determination. The streamlining and simplification principles in the ACA allow individuals to apply for Medicaid and to enroll or re-enroll in Medicaid through an Internet website. This strongly suggests a unified application and eligibility determination process for Medicaid, MICHild, and the exchange premium assistance program. The state agencies responsible for administering Medicaid, MICHild and the state exchanges will be required to utilize a secure website to allow for an eligibility determination and enrollment. Finally, the state agency must provide coordination of benefits for individuals within families that are enrolled in either Medicaid or MICHild and in a health plan through the insurance exchange.

- ❖ The ACA requires health insurance exchanges to be self sustaining by 2015 so funding for enrollment support can be included in the cost of operating the exchange.
- ❖ Federal support is available through the ACA for development of new and adaptation of existing technology systems to implement HIT enrollment standards and protocols.

The ACA requires health insurance exchanges to be self sustaining by 2015 so funding for enrollment support can be included in the cost of operating the exchange. Additionally, there is federal support available through the ACA for the development of new and the adaptation of existing technology systems to implement HIT enrollment standards and protocols. Such

systems will be required to enroll individuals in federal and state health and human services programs. Also, Medicaid currently provides funding for their enrollment activities.

Michigan has recently implemented a new eligibility determination and case management system, a “single entry” concept across all human services programs. This system, Bridges, is an integrated eligibility and enrollment system and is ultimately able to recognize multiple social program eligibilities. A systems capability analysis needs to be completed to determine whether Bridges can support a streamlined integrated eligibility process for Medicaid, MICHild, and premium assistance through the health insurance exchange.

Michigan has also recently updated its Medicaid payment system to a web based Medicaid Management Information System named CHAMPS (Community Health Automated Medicaid Processing system) that is well placed to meet the payment demands of the increased health care coverage challenges contained in the ACA. Michigan will have to examine all of its systems to determine the best configuration to support the functionality required under the ACA. Michigan’s health insurance exchange planning grant referenced earlier will provide decision makers with an analysis of available options, their strengths, weaknesses and costs.

3. Administrative Simplification within Insurance Reform

Originally adopted as a part of the Health Insurance Portability and Accountability Act (HIPAA), administrative simplification requires standardized, electronic transactions between health plans and providers. The ACA includes a significant expansion of the administrative simplification requirements under HIPAA. The ACA requires a designated federal “review committee” to, beginning in 2014 and at least biennially, review the standards and rules and to recommend updates and improvements. The Secretary must develop new uniform standards which: (1) enable eligibility and financial responsibility determinations to be made prior to or at the point of care; (2) minimize the need to supplement claims with paper attachments or other communication; (3) provide for timely acknowledgment, response and status reporting of claims (including claim denial, adjudication and appeals); (4) describe all data elements (including reason and remark codes) in unambiguous terms; and (5) provide that data elements must be required or conditioned upon set values in other fields and prohibit additional conditions (except where necessary to implement state or federal law or to protect against fraud and abuse). The ACA specifically requires the Secretary to develop a standard concerning electronic funds transfers and a standard for health claims attachments.

Michigan will be required to adopt and implement these measures. Health plans will be required to certify that their data and information systems are in compliance with any applicable standards and operating rules. To be in compliance, a health plan must document that it conducts electronic transactions in a manner that fully complies with the Secretary’s regulations and that the plan has completed end-to-end testing for such transactions with its partners, such as hospitals and physicians. Certification deadlines will vary by standard and rule but will begin as early as December 31, 2013. Under ACA, a health plan is responsible for ensuring that all entities it contracts with to provide services also comply in a timely manner with the applicable standards and operating rules and certify their compliance.

The Secretary is responsible for carrying out these administrative simplifications initiatives. However, the Secretary may designate independent, outside entities to certify that a health plan, for instance, has complied with these requirements and provide certification that compliance was in accordance with any standards and operating rules issued by the Secretary. These tasks may fall to State government.

Michigan adheres solidly to the tenets of the Health Insurance Portability and Accountability Act and can be expected to follow similar guidance from the Federal Government once released.

Attachment A-1: HEALTH INSURANCE EXCHANGES

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>§1311 Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Requires the Secretary to:</p> <ul style="list-style-type: none"> Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures. Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal. Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances. 	<p><u>2010</u></p> <ul style="list-style-type: none"> Identify stakeholders and develop input for planning activity, begin outreach efforts Apply for HHS planning grant and receive notice of grant award Perform a feasibility study, assess current structures, programs, relative to available staffing levels, specialties, and resources and capabilities. Review and analyze past legislation Determine available resources of financial expertise, form a workgroup to assess cost and revenue projections of the exchange Perform the information technology assessment either through DTMB or an outside vendor Begin monthly workgroup meetings with stakeholders to discuss regulatory/policy issues and for input on specific operations 	<p>Annual one million dollar federal planning grants 2010 – 2013. Direct appropriation to HHS. No grants will be awarded after January 1, 2015; state must ensure exchange is self-sustaining.</p> <p><i>“Cooperative Agreements to Support Innovative Exchange Information Technology Systems”</i> – Funding Opportunity Number TBA. Deadline: December 22, 2010</p>	<p>Federal criteria for health plans</p> <p>Federal procedures to allow agents or brokers to enroll individuals and employers in qualified health plans and assist them in applying for tax credits and cost-sharing reductions</p> <p>Federal standards for exchanges, qualified health plans, reinsurance, and risk adjustment. States required to implement these standards by 2014.</p> <p>State Statute to establish exchange</p>	<p>Start up costs offset by planning grant</p>	<p>DELEG - OFIR (lead)</p> <p>DCH-MSA</p> <p>DHS</p> <p>DTMB</p> <p>DOT</p>
<p>§1312 Allows qualified individuals, defined as individuals who are not incarcerated and who are lawfully residing in a State, to enroll in qualified health plans through that State's Exchange. Allows qualified employers to offer a choice of qualified health plans at one level of coverage; small employers qualify to do so, and States may allow large employers to qualify beginning in 2017. Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) in each market, regardless of whether plans are offered through Exchanges. Requires the offering of only qualified health plans through Exchanges to Members of Congress and their staff. Also requires the HHS Secretary to establish procedures to</p>	<p><u>2011</u></p> <ul style="list-style-type: none"> Engage Michigan's Medicaid enrollment stakeholders on issues related to exchange Begin and complete the feasibility study. Review the results. Begin formulation of a budget for running an exchange Continue assessment and testing of existing technology regarding the functions needed for the exchange Finance experts report on status of the financial projection Determine state information technology capabilities as it relates to the Exchange. As part of the determination, 	<p>Notice of Proposed Rulemaking on Federal funding for Medicaid eligibility determination and enrollment activities released 11/3/10 proposes that Medicaid eligibility determination systems may qualify for an enhanced Federal match rate of 90% (through 12/31/15) and 75% (beyond 12/31/15) for development and maintenance activities, respectively. Rates are available for exchange-related and non-exchange-related eligibility system changes.</p>			

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>allow agents or brokers to enroll individuals and employers in qualified health plans and assist them in applying for tax credits and cost-sharing reductions</p>	<p>indicate if an outside vendor should provide the information technology services for the operation of the exchange.</p> <ul style="list-style-type: none"> · Issue interim report on exchange development by end of FY 11 · Provide a list of potential legislative initiatives to legislative staff, create a final interim legislative list 				
<p>§1313 Requires Exchanges to keep an accurate accounting of all expenditures and submit annual accounting reports to the Secretary. Requires Exchanges to cooperate with Secretarial investigations and allows for Secretarial audits of Exchanges. If the Secretary finds serious misconduct in a State, allows the Secretary to rescind up to 1 percent of Federal payments to the State. As amended by Section 10104, narrows the application of the False Claims Act's public disclosure bar to ensure that whistleblowers who play a significant role in exposing fraud can be included in otherwise meritorious litigation. Also, requires GAO to study the cost and affordability of qualified health plans offered through Exchanges.</p>	<p><u>2012 - 13</u></p> <ul style="list-style-type: none"> · Continue all development activities described for 2010 and 2011 · Determine the capabilities required to meet the interoperability needs of the Exchange · Continue with legislative initiatives · Continue to monitor federal guidance · Continue to develop forms and marketing strategies for use by the Exchange 				
<p>§1321 Requires the HHS Secretary, in consultation with NAIC, to set standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. Requires States to implement these standards by 2014. If the Secretary determines before 2013 that a State will not have an Exchange operational by 2014, or will not implement the standards, requires the Secretary to establish and operate an Exchange in the State and to implement the standards. Presumes that a State operating an Exchange before 2010 meets the standards, and establishes a process for the State to come into compliance with the standards.</p>	<ul style="list-style-type: none"> · Make a declaration to HHS that Michigan intends to establish an Exchange by FY 2013. · Communicate with high risk pool carriers to discuss transition from high risk pool to Exchanges · Begin marketing and promotions of the Exchange in 2013 · Begin initial enrollment period for the Exchange · Update guidance to industry stakeholders about the Exchange <p><u>2014 and beyond</u></p> <ul style="list-style-type: none"> · Begin coverage for enrollees · Monitor activities and make regulatory changes as necessary 				

Attachment A-2: HEALTH INSURANCE REFORM

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>Coverage Reforms</p> <p>§1001 No lifetime or annual limits; prohibition on rescissions; coverage of preventive health services; extension of dependent coverage; development and utilization of uniform explanation of coverage documents and standardized definitions; disclosure of claims payment policies and rating practices; employers prohibited from limiting eligibility for coverage to highly compensated individuals; ensuring quality of care; rebate to enrollees from plans spending less than 80 percent of premium revenue on clinical services; mandates for effective internal appeals process of coverage determinations and claims.</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> • OFIR staff trained on the coverage requirements under the act • Review compliant policies, certificates, and amendatory riders submitted through SERFF • Review current Michigan edicts to evaluate amendatory drafting needs • Work with issuers and producers on understanding the requirements of the act <p><u>2011</u></p> <ul style="list-style-type: none"> • Begin drafting required amendatory language • Pass legislation giving OFIR authority to enforce provisions of the ACA • Continue working with stakeholders concerning coverage issues <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> • Continue to assess legislative needs relative to coverage requirements • Continue to work with stakeholders concerning coverage issues • Continue facilitating issuers in getting ACA compliant products to Michigan consumers in an efficient manner • Ensure that all products in the Michigan health plan market are in compliance with the ACA by January 1, 2014 <p><u>2014 - Beyond</u></p> <ul style="list-style-type: none"> • Monitor coverage in the market and make regulatory changes as needed 	<p>n/a</p>	<p>HHS Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage for applicants, policyholders or certificate holders, and enrollees</p> <p>HHS Secretary to develop guidelines for use by health insurers to report information</p> <p>State statute to replace emergency rules</p>	<p>n/a</p>	<p>DELEG - OFIR (lead)</p> <p>CSC</p> <p>OSE</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>Consumer Protections</p> <p>§1002 Health insurance consumer information, assistance, and related data to be reported to HHS</p> <p>§1003 Ensuring that consumers get value for their dollars with an annual review and reporting of unreasonable premium increases for health insurance coverage</p> <p>§1101 Immediate access to insurance for uninsured individuals with a preexisting condition (PECIP)</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · Establish and begin enrollments in a preexisting condition insurance plan · Develop a plan for the office of the health insurance ombudsman · Begin to develop and/or post fact sheets to the OFIR website relative to consumer protection requirements · Review current Michigan edicts to evaluate amendatory drafting needs · Work with issuers and producers on understanding the consumer protection requirements of the ACA <p><u>2011</u></p> <ul style="list-style-type: none"> · Begin drafting required amendatory language · Pass legislation giving OFIR authority to enforce provisions of the ACA · Continue working with stakeholders concerning consumer protection issues <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Continue to assess legislative needs relative to consumer protection requirements · Continue to work with stakeholders concerning consumer protection issues · Continue facilitating issuers in meeting ACA compliance with regards to consumer protection provisions · Ensure that all marketing strategies in the Michigan market are in compliance with the act by 1/1/14 <p><u>2014 - Beyond</u></p> <ul style="list-style-type: none"> · Monitor consumer protection issues in the Michigan market 	<p>The federal government is offering grant opportunities, totaling \$30 million to states to establish the ombudsman office. OFIR awarded \$900,000.</p> <p>Direct appropriation of \$5 billion to HHS to pay claims for high-risk pool enrollees through January 1, 2014. Michigan is entitled to \$141,000,000 to reimburse a contractual administer for the preexisting conditions insurance program.</p>	<p>n/a</p>	<p>n/a</p>	<p>DELEG - OFIR (lead)</p> <p>CSC</p> <p>OSE</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
	<ul style="list-style-type: none"> · Make regulatory changes as needed 				
<p>Marketing</p> <p>§1304 Defines the small group market as the market in which a plan is offered by a small employer that employs 1-100 employees. Defines the large group market as the market in which a plan is offered by a large employer that employs more than 100 employees. Before 2016, a State may limit the small group market to 50 employees. As amended by Section 10104, defines an “educated health care consumer,” and requires Exchanges to consult with enrollees who are educated health care consumers.</p> <p>§1311 Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement.</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · Begin to develop and/or post fact sheets to the OFIR website relative to marketing requirements · Review current Michigan edicts to evaluate amendatory drafting needs · Work with issuers and producers on understanding the marketing requirements of the ACA <p><u>2011</u></p> <ul style="list-style-type: none"> · Begin drafting required amendatory language · Pass legislation giving OFIR authority to enforce provisions of the ACA · Continue working with stakeholders concerning marketing issues <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Continue to assess legislative needs relative to marketing requirements facilitating issuers in meeting ACA compliance · Ensure that all products and marketing strategies in the Michigan health plan market are in compliance by 1/1/14 · Support legislation that redefines a small group 	n/a	n/a	n/a	DELEG - OFIR (lead)

Attachment A-2: HEALTH INSURANCE REFORM

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
	employer under chapter 37 of the Insurance Code <u>2014 - Beyond</u> • Monitor marketing issues in the Michigan market • Make regulatory changes as needed				

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>§1003 Provides \$250 million in funding to States from 2010 until 2014 to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage and in providing information and recommendations to the HHS Secretary. Allows for the establishment of medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.</p> <p>§1201 Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1). Section 10103 clarifies that this provision applies to insured plans in the large group market, not self-insured plans</p> <p>§1252 Rating reforms must apply uniformly to all health insurance issuers and group health plans. Standards and requirements adopted by States must be applied uniformly to all plans in each relevant insurance market in a State.</p> <p>§1341 Transitional reinsurance program for individual and small group markets in each State. For 2014, 2015, and 2016, requires States to establish a nonprofit reinsurance entity that collects payments from insurers market and makes payments to insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total \$25 billion over the three years.</p> <p>§1342 Establishment of risk corridors for plans in individual and small group markets. Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums,</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · Apply for federal grant for rate review · Begin to develop and/or post fact sheets to the OFIR website relative to rating requirements · Review current Michigan edicts to evaluate amendatory drafting needs · Work with issuers and producers on understanding the rating requirements of the ACA <p><u>2011</u></p> <ul style="list-style-type: none"> · Begin drafting required amendatory language · Pass legislation giving OFIR authority to enforce provisions of the ACA · Continue working with stakeholders concerning rating issues <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Continue to assess legislative needs relative to rating requirements · Continue to work with stakeholders concerning rating issues · Continue facilitating issuers in meeting ACA compliance with regards to rating in health plan products sold to Michigan consumers · Ensure that all products and marketing strategies in the Michigan health plan market are in compliance with the ACA by January 1, 2014 <p><u>2014 - Beyond</u></p> <ul style="list-style-type: none"> · Monitor rating issues in the Michigan market · Make regulatory changes as needed 	<p>Direct appropriation to HHS of \$250 million for grants to states to support the review process. Eligible states would receive between \$1 and \$5 million per grant year. Grant program is for a five year period - fiscal years 2010 through 2014. Michigan has already received a \$1 million grant from the program.</p> <p>States may collect additional amounts from insurers for the transitional reinsurance program, including for administrative expenses to operate the program. Insurer contributions are specified for plan years 2014, 2015, and 2016.</p>	<p>n/a</p>	<p>n/a</p>	<p>DELEG - OFIR (lead)</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>Administration Simplification</p> <p>§1104 Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. The goal is to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.</p> <p>§1413 Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs. Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · Begin assessing Michigan's information technology capabilities and compatibilities · Begin outreach to stakeholders for the development administration simplification processes · Work with issuers and producers to gain an understanding of current industry information technology capabilities and compatibilities <p><u>2011</u></p> <ul style="list-style-type: none"> · Begin drafting required amendatory language · Continue working with information technology stakeholders concerning administration simplification processes <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Continue to assess legislative needs relative to information technology needs as they relate to administration simplification · Continue to work with stakeholders · Continue facilitating issuers in meeting ACA compliance with regards to administration simplification · Ensure that all administration processes in the Michigan health plan market are in compliance with the administration simplification requirements under the ACA by January 1, 2014 <p><u>2014- Beyond</u></p> <ul style="list-style-type: none"> · Monitor coverage issues in the Michigan market · Make regulatory changes as needed 	<p>n/a</p>	<p>n/a</p>	<p>n/a</p>	<p>DELEG - OFIR (lead)</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>Reporting Requirements</p> <p>§1001 Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.</p> <p>§1313 Requires Exchanges to keep an accurate accounting of all expenditures and submit annual accounting reports to the Secretary. Requires Exchanges to cooperate with Secretarial investigations and allows for Secretarial audits of Exchanges. If the Secretary finds serious misconduct in a State, allows the Secretary to rescind up to 1 percent of Federal payments to the State. As amended by Section 10104, narrows the application of the False Claims Act's public disclosure bar to ensure that whistleblowers who play a significant role in exposing fraud can be included in otherwise meritorious litigation. Also, requires GAO to study the cost and affordability of qualified health plans offered through Exchanges.</p> <p>§1502 Amends the Internal Revenue Code to require the reporting of health insurance coverage. Requires every person that provides coverage to report certain information about the coverage to the IRS.</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · Review current reporting requirements to evaluate amendatory drafting needs · Work with issuers and producers on understanding reporting requirements under the ACA · Determine what support and resources will be available from the NAIC relative to the reporting requirements <p><u>2011</u></p> <ul style="list-style-type: none"> · Begin drafting required amendatory language · Pass legislation giving OFIR authority to enforce provisions of the ACA · Continue working with stakeholders concerning reporting requirement issues <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Continue to assess legislative needs relative to reporting requirements · Continue facilitating issuers in meeting ACA compliance with regards to reporting requirements <p><u>2014 - Beyond</u></p> <ul style="list-style-type: none"> · Monitor reporting requirement issues in the Michigan market · Make regulatory changes as needed 	<p>n/a</p>	<p>n/a</p>	<p>n/a</p>	<p>DELEG - OFIR (lead)</p>
<p>Employer Responsibilities</p> <p>§1511 Automatic enrollment for employees of large employers. Requires employers with more than 200 employees to automatically enroll new full-time</p>	<p><u>2010</u></p> <ul style="list-style-type: none"> · OSE must assess the impact of the Act on Michigan · OSE must begin developing a method by which reporting to 	<p>n/a</p>	<p>n/a</p>	<p>n/a</p>	<p>DELEG - OFIR (lead) CSC OSE</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.</p> <p>§1512 Employer requirement to inform employees of coverage options. Requires that an employer provide notice to their employees informing them of the existence of an Exchange. Also, if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium assistance tax credit and cost sharing reduction. Finally, if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.</p> <p>§1513 Shared responsibility for employers. Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. Section 10106 clarifies that the calculation of full-time workers is made on a monthly basis, and that an "applicable large employer" with respect to "construction industry employers" as employers with at least five full-time employees and with an annual payroll in excess of \$250,000. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$400 for any full-time employee in a 30-60 day waiting period and \$600 for any full-time employee in a waiting period longer than 60 days. An employer with more than 50 employees that does offer coverage but</p>	<p>HHS will be done</p> <p><u>2011</u></p> <ul style="list-style-type: none"> · Monitor employer issues in Michigan <p><u>2012 - 2014</u></p> <ul style="list-style-type: none"> · Monitor employer issues in Michigan · Continue to evaluate regulatory needs <p><u>2014 - Beyond</u></p> <ul style="list-style-type: none"> · Monitor employer issues in Michigan · Make regulatory changes as needed 				

Attachment A-2: HEALTH INSURANCE REFORM

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.</p> <p>§1514 Reporting of employer health insurance coverage. Requires large employers to report to the Secretary whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of the total allowed costs of benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage.</p> <p>§1515 Offering of exchange-participating qualified health plans through cafeteria plans. Amends the Internal Revenue Code related to cafeteria plans. Plans provided through the exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except in the case of qualified employers (i.e., small employers, and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange.</p>					

Attachment A-3: MICHIGAN MEDICAID

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>§1202 ACA provides for increases in payments for fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014, and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009. Primary care services are defined as evaluation and management services and services related to immunizations. (fully funded for 2 years).</p>	<p>January 1, 2013 for services provided in calendar year 2013. Discussions with CMS have begun.</p>	<p>100% of the Medicare payment rates for 2013 and 2014, and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009.</p>	<p>Federal Guidance Pending</p>	<p>Would the 100% match rate revert to 90% or the regular FMAP after the 2 year period?</p>	<p>DCH – MSA (lead)</p>
<p>§1203 DSH reductions beginning 2014 and continuing through 2019 based on methodology developed by HHS</p>	<p>October 1, 2013</p>	<p>n/a</p>	<p>HHS Secretary to develop methodology to distribute the DSH reductions that impose the largest reduction in DSH for states with the lowest percentage of uninsured, imposes smaller reductions for low-DSH states (Michigan is a not low DSH state)</p>	<p>Michigan receives about 2.3% of approximately \$11.7 billion in total DSH funding. Estimate that this change will reduce total available funding by 4% in fiscal 2014 up to over 40% in fiscal 2019.</p>	<p>DCH – MSA (lead)</p>
<p>§2001 Creates a mandatory eligibility group that expands Medicaid to 133% of Federal Poverty Level (FPL) for all individuals under the age of 65, without regard to categorical eligibility. Excludes people who are eligible for Medicaid through another mandatory eligibility group, who are entitled to Medicare Part A or who are enrolled in Medicare Part B. Includes an income disregard based on the dollar amount of 5% of the 133% FPL level. Increases the mandatory income eligibility level for children age 6-19 to 133% FPL;</p>	<p><u>2011</u></p> <ul style="list-style-type: none"> • Determine systems changes necessary for new eligible populations and interaction with the existing programs. Requires Interaction with the Exchange and DHS. • Determine data needs (i.e. costs for individuals, number of people who would be both newly eligible and eligible but not enrolled, etc) <p><u>2012</u></p> <ul style="list-style-type: none"> • Develop policy and procedure to implement by January 1, 2014 	<p>Individuals who become newly eligible for Medicaid for years 2014 through 2016, , 100% FFP, 95% FFP in 2017, 94% FFP in 2018, 93% FFP in 2019, and 90% FFP in perpetuity starting in 2020. Individuals, eligible for Medicaid prior to the mandatory expansion but not enrolled receive the regular FMAP.</p>	<p>Federal Guidance Pending - limited guidance to date, only an option to expand early to childless adults early at regular FMAP</p>	<p>Will there be adequate federal match for the long term? Will there be mandatory enrollment into HMOs, and if so, will need to consider rates and other factors</p>	<p>DCH – MSA (lead)</p>
<p>§2001(e) Optional eligibility category to cover individuals above 133% FPL to 200% otherwise eligible for the Exchange. Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the</p>	<p><u>2010 – 2011</u></p> <ul style="list-style-type: none"> • Analyze the basic health plan option in conjunction with planning for • Development of the Exchange • The mandatory enrollment into Medicaid of persons with income less than 133% of the poverty who are not currently enrolled • Coverage to be included in a 	<p>n/a</p>	<p>Federal Guidance Pending</p>	<p>State needs to assess the costs and benefits of providing a basic health plan as opposed to offering premium subsidies through the exchange.</p>	<p>DCH – MSA (lead)</p>

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
<p>essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.</p>	<p>benchmark benefit</p> <p><u>2012</u></p> <ul style="list-style-type: none"> Through this analysis, the State will determine whether or not the use of a basic health plan would allow for the provision of coverage to more people that would be available through the Exchange, and what the comparable cost would be <p>Implement by January 1, 2014</p>				
<p>§2002 Mandatory use of "modified adjusted gross income" for purposes of determining eligibility for certain Medicaid groups. MAGI is defined as "adjusted gross income increased by any amount excluded from gross income under section 911, and any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax. States will be prohibited from applying income disregards when determining eligibility, premiums or cost sharing (except for the 5% disregard included in the Reconciliation Bill). Requires states to establish and "equivalent income test" to make sure that no individuals lose eligibility due to the transition to MAGI.</p> <p>The move to MAGI will be for some Medicaid groups, NOT all Medicaid groups (excluded are Aged, Blind, Disable, Medically Needy, and Extended Care). In addition to the move to MAGI for certain eligibility groups, ACA requires the continued utilization of existing methodologies to protect existing beneficiaries from losing coverage during the transition to the MAGI. This essentially requires operating two distinct methodologies.</p>	<p><u>2011</u></p> <ul style="list-style-type: none"> Research and develop a concrete plan with detailed plans in conjunction with the development of the exchange to address all of the provisions Address procedural and systems implications that will be complicated and costly <p><u>January 1, 2014</u></p> <ul style="list-style-type: none"> States to operate parallel eligibility methodologies in the first year with the idea of protecting people from losing Medicaid in the first year due to the move to MAGI 	n/a	Federal Guidance Pending	States must apply a 5% disregard bringing new eligibility level to 138% FPL; transition plan will be due prior to this date	DCH – MSA (lead)
<p>§2003(a)(1)(A); §10203(b)(2)(B) Premium assistance program for all Medicaid eligibles (including cost effectiveness test). Permits states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries, when it is cost-effective to do so.</p>	<p><u>2011</u></p> <ul style="list-style-type: none"> Research requirements of the provision Perform a detailed needs assessment focusing on infrastructure needs, e.g. 	n/a	Federal Guidance Pending	States required to pay premium and cost sharing amounts that exceed the limits placed on premiums	DCH – MSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
	technology, physical processes, contracts, staffing, etc. · Develop plan for implementation on January 1, 2014			and nominal cost-sharing in Medicaid.	
§2004; §10201 Mandatory Medicaid coverage of Foster Care children up to age 26. This new mandatory categorically eligible group is comprised of individuals who are under age 26; who are not eligible for Medicaid through another mandatory elig. group (except the 133% expansion); and who were in foster care and enrolled Medicaid on the day that they turned 18 (or the day that the individual turned whatever age individuals age out of foster care in the state). This group is exempt from mandatory enrollment in the Medicaid Benchmark Benefits package. Additionally, if an individual simultaneously qualifies for this group and for the 133% expansion, the state must enroll them into the categorical group.	<u>2010 – 2013</u> · Increasing the upper age limit of this group to 26 by implementing a new SPA to cover these children or by expanding the existing Foster Care Transition group <u>January 1, 2014</u> · Minimal changes to existing systems completed	n/a	Federal Guidance Pending	n/a	DCH – MSA (lead)
§2101; §10203 Enhanced FMAP for targeted low-income children increased by 23% but no increase in allotment. From fiscal year 2013 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100%.	<u>2012</u> · Actual 2010 and projected 2011 program expenditures should be analyzed to determine what the federal allotment will be in FY 2012 · Decision made prior to October 1, 2015	Expands FMAP for CHIP by 23 percent from fiscal years 2013 through 2019	Federal Guidance Pending	Since the federal allotment is not increased, the total money (state + federal) could potentially be smaller with a higher FMAP and hence a reduced state contribution. .	DCH – MSA (lead)
§2202 Permit hospitals to make presumptive eligibility determinations for all Medicaid eligible population. States may permit any hospital participating in Medicaid to determine presumptive eligibility for all Medicaid categories (not just the current groups that allow presumptive eligibility). The presumptive eligibility determinations made by hospitals will have the same requirements that apply to current presumptive eligibility processes. Payments made for medical assistance during the presumptive period are not subject to review for improper payments based upon state eligibility determinations.	<u>2011</u> · Develop plan for implementation of PE process prior to January 1, 2014	n/a	Federal Guidance Pending	Implementation of an expansive PE process requires significant systems upgrades and additional DCH training staff.	DCH – MSA (lead)
§2403 Medicaid Money Follows the Person (MFP) demonstration program extends existing demonstration authority to award grants to states for the Medicaid Money Follows the Person program, established by	Michigan currently has a MFP grant for \$67 million, originally scheduled to end in 2011. MSA is in the process of applying for additional grant funds that would expand its	Direct appropriation to HHS for \$2.25 billion to extend the program. Authorizes funding for	n/a	n/a	DCH – MSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
the Deficit Reduction Act. The MFP grants support states' efforts to transition nursing facility residents to home and community-based services.	nursing facility transition services. MSA will examine other opportunities for expanding the project, such as including additional target groups. The current grant serves the elderly and adults with physical disabilities. The MDCH could consider including individuals with mental illness.	fiscal years 2011 through 2016. “Money Follows the Person Rebalancing Grant Demonstration” – Funding Opportunity Number CMS-1LI-11-001. Deadline: January 7, 2011			
§2501 Drug rebate increases for brand and generic drugs, with increase refunded wholly to federal government	<u>January 1, 2010</u> We are working with our Department Budget and Accounting staff and the Pharmacy Benefits Manager (PBM) Rebate staff to ensure the rebate system will be enhanced to track the FMAP portion and the 100% 'offset' portion of the Federal rebate and that the Department is capable of reporting FMAP vs. 100% offset rebate dollars on the quarterly CMS64 reports. instructions and new rates from CMS breaking out the FMAP portion of rebate vs. 100% offset portion of rebate and estimated offset amounts for CMS64 reporting.	n/a	April 22, 2010: SMD 10-006	n/a	DCH – MSA (lead)
§2702 as amended by §10303(b) Prohibits Medicaid payments to providers to treat “health care acquired conditions.” The intent of the provision is to prevent payment for treating a health problem arising out of a patient’s care at a facility if the secondary problem could reasonably have been avoided. Medicare has a similar prohibition on payment for “hospital-acquired conditions.”	<u>July 1, 2011</u> Michigan Medicaid currently has a policy in development that will follow Medicare’s provision for non-payment for hospital-acquired conditions	n/a	Health and Human Services to identify current State practices that prohibit payment for health care acquired conditions and to have regulations in place by July 1, 2011. In July 2010, CMS said it was issuing a survey for information from States.	n/a	DCH – MSA (lead)
§2703 The ACA creates a new Medicaid State Plan option to permit Medicaid enrollees with at least two chronic conditions, one chronic condition and the risk of developing a second, or at least one serious and persistent mental health condition to designate a provider, a team of health care professionals, or a health team as the individual's health home for the purposes of providing health home services to the individuals. The provision would allow a 90% match for 2	<u>January 1, 2011</u> Currently being analyzed	\$25 million maximum planning grant award per state beginning January 1, 2011. State contribution required in order to receive a planning grant.	State needs to make extensive changes to the Medicaid State Plan Federal Guidance Pending	State must have available the 10% match to implement the program. What happens to the matching rate after two years?	DCH – MSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
years for health home services including care management, care coordination and health promotion, transitional care, patient and family support and referral to community and social support services and use of HIT where feasible and appropriate.					
§2704 Start of demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary; 1) with respect to an episode of care that includes a hospitalization; and 2) for concurrent physician services provided during a hospitalization. The demonstration will be conducted in up to eight states. A state may target particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular regions of the state.	<u>January 1, 2012</u> MSA believes that this is a project that Medicaid may want to pursue. Beginning FY11 State will assess viability and develop a plan.		Federal Guidance Pending	n/a	DCH – MSA (lead)
§4106 FMAP (1%) increase for evidence-based prevention services with no cost-sharing. States have the option to expand diagnostic, screening, preventive, and rehab services to include any clinical preventive services that are assigned a grade of A or B by the US Preventive Services Task Force and adult vaccines recommended by ACIP. States that elect to cover these services, and that do not require cost-sharing for these services, will receive a 1% FMAP increase for preventive services and tobacco cessation services.	<u>Prior to January 1, 2013</u> MSA needs to determine if the 1% FMAP increase would make this a cost effective option to pursue	1 percentage point increase in FMAP for preventive services. Enhanced match available beginning January 1, 2013.	Federal Guidance Pending	Costs not covered by the FMAP increase	DCH – MSA (lead)
§10202 Incentive payments to states (available for a 5-year period) to increase percentage of long-term care expenditures spent on non-institutional services	<u>October 1, 2011</u> <ul style="list-style-type: none"> · Continue to leverage contract with Medicaid Health Plans as the primary means of administering incentives · May need to formalize contract language and reporting requirements to track changes in health risk and outcome 	States spending less than 25% of total long-term care services and supports (LTSS) expenditures on HCBS will be eligible to receive a 5% increase; states with 25-50% will receive a 2% increase. \$3 billion cap on spending for this program. Program active October 1, 2011 through September 30, 2015.	Federal Guidance Pending	n/a	DCH – MSA (lead)

Attachment A-4: HEALTH SYSTEMS

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§2703 State option to provide health homes for enrollees with chronic conditions	January 1, 2011	\$25 million maximum planning grant award per state beginning January 1, 2011. State contribution required in order to receive a planning grant.	n/a	n/a	DCH – MSA, PHA - Div CDIC (lead)
§2706 Pediatric Accountable Care Organization Demonstration Project	January 1, 2012	Authorizes funding from January 1, 2012 through December 31, 2016. Budget savings requirement. Discretionary money per CBO.	n/a	n/a	DCH – MSA (lead) PHA - Div CDIC
§2951 Maternal, Infant and early childhood home visiting programs	March 23, 2010 - interdepartmental team in progress	Direct appropriation to HHS totaling \$1.5 billion over 5 years (fiscal years 2010 – 2014). Michigan awarded approximately \$2,014,745 through “Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program” - Funding Opportunity Number HRSA-10-275.	n/a	n/a	DCH - PHA
§2952 Support, education and research for postpartum depression	March 23, 2010	Grants. \$3 million for the program for FY10; funding as necessary in FY11 and FY12. Discretionary money per CBO.	n/a	n/a	DCH - PHA
§2953 Personal responsibility education	March 23, 2010 Mid-July 2010	\$75 million per year. State allotments with minimum grant amount to states would \$250,000. Authorizes funding for fiscal years 2010 through 2014. Michigan Department of Community Health awarded \$1,754,708.	n/a	n/a	DCH - PHA
§2954 Restoration of funding for abstinence education	March 23, 2010 Mid-July 2010	Continues funding at \$50 million per fiscal year, fiscal years 2010 – 2014.	n/a	n/a	DCH - PHA

Attachment A-4: HEALTH SYSTEMS

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies	n/a	n/a	n/a	n/a	DCH - OSA
§3024. Independence at home demonstration program	n/a	n/a	n/a	n/a	DCH - OSA
§3025. Hospital readmissions reduction program	October 1, 2012	n/a	n/a	n/a	DCH – PHA, HPRA (lead)
§3026. Community-Based Care Transitions Program	January 1, 2011	n/a	n/a	n/a	DCH – MSA, PHA
§3105 Extension of ambulance add-ons	March 23, 2010 MCRH will alert rural ambulance service providers of the extension of the "super rural ambulance" exception effective date	n/a	n/a	n/a	DCH – MSA, PHA - Div CDIC (lead)
§3106 Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities	March 23, 2010 CON will acknowledge the extension of the moratorium on LTACHs	n/a	n/a	n/a	DCH – MSA, MHSA, HPRA (lead)
§3108 Permitting physician assistants to order post-Hospital extended care services	January 1, 2011	n/a	n/a	n/a	DCH – PHA, MSA, HPRA (lead)
§3122 Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas	July 1, 2010 Tracking only	n/a	n/a	n/a	DCH – MSA (lead) HPRA
§3123 Extension of the Rural Community Hospital Demonstration Program	March 23, 2010 Tracking only	Funding to expand number of participating states to 20 and number of participating hospitals to 30. Discretionary money per CBO.	n/a	n/a	DCH – HPRA (lead)
§3124 Extension of the Medicare-dependent hospital (MDH) program	October 1, 2010 Tracking only	n/a	n/a	n/a	DCH – HPRA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§3125 Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals	March 23, 2010 Tracking only.	n/a	n/a	n/a	DCH – HPRA (lead)
§3126 Improvements to the demonstration project on community health integration models in certain rural counties	March 23, 2010 MCRH will alert rural communities to the availability of demonstration projects for community health integration models	n/a	n/a	n/a	DCH – HPRA (lead)
§3127 MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas	Tracking only	n/a	n/a	n/a	DCH – HPRA (lead)
§3128 Technical correction related to critical access hospital services	March 23, 2010 MDCH will alert Michigan's CAHs of technical change in definition of 101 % of reasonable cost reimbursement	n/a	n/a	n/a	DCH – HPRA (lead)
§3129 Extension of and revisions to Medicare rural hospital flexibility program	March 23, 2010 MDCH will alert Michigan's CAHs to the ability for them to use FLEX funds to implement applicable portions of PPACA	Grants. Authorizes funding for fiscal years 2011 through 2012. Money available until expended.	n/a	n/a	DCH – HPRA (lead)
§3132 Hospice reform	January 1, 2011	n/a	n/a	n/a	DCH – MSA (lead) PHA
§3302 Improvement in determination of Medicare part D low-income benchmark premium	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§3402 Temporary adjustment to the calculation of part B premiums	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§3403 Independent Medicare Advisory Board	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§3501 Health care delivery system research; Quality improvement technical assistance	March 23, 2010 Michigan's PCO will reach out to parties interested in conducting delivery system research with an offer to partner as applicable	Grants or contracts; requires matching funds of \$1 to \$5 federal.	n/a	n/a	DCH – PHA HPRP (lead)

Attachment A-4: HEALTH SYSTEMS

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§3502 Establishing community health teams to support the patient-centered medical home	March 23, 2010 Michigan's PCO will reach out to parties interested in creating health teams with an offer to partner as applicable	Grants available.	n/a	n/a	DCH – PHA HPRP (lead)
§3503 Medication management services in treatment of chronic disease	March 23, 2010	Grants available no later than May 1, 2010.	n/a	n/a	DCH – PHA (lead) HPRP
§3504 Design and implementation of regionalized systems for emergency care	March 23, 2010 SEE EMS UNIT FOR PLAN	Grants. Authorizes funding for fiscal years 2010 through 2014, \$24 million per FY. Requires matching funds - \$1 to \$3 federal. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)
§3505 Trauma care centers and service availability	March 23, 2010 SEE EMS UNIT FOR PLAN	Grants. Authorizes funding for fiscal years 2010 through 2015. Authorization for \$100 million for each fiscal year. Discretionary money per CBO. The state must supplement, not supplant, state funding otherwise available for similar purposes.	n/a	n/a	DCH – PHA HPRP (lead)
§3506 Program to facilitate shared decision making	March 23, 2010	n/a	n/a	n/a	DCH – OSA (lead) PHA
§3508 Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals	March 23, 2010 SEE BHP FOR PLAN	Requires matching funds - \$1 to \$5 federal.	n/a	n/a	DCH – HPRA (lead)
§3509 Improving women's health	March 23, 2010	n/a	n/a	n/a	DCH – PHA (lead)
§3601 Protecting and Improving Guaranteed Medicare Benefits	n/a	n/a	n/a	n/a	DCH – OSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§4002 Prevention and Public Health Fund	March 23, 2010	<p>For fiscal year 2010, \$500 million; for fiscal year 2011, \$750 million; for fiscal year 2012, \$1 billion; for fiscal year 2013, \$1.25 billion; for fiscal year 2014, \$1.5 billion; and for fiscal year 2015, and each fiscal year thereafter, \$2 billion.</p> <p>“Strengthening Public Health Infrastructure for Improved Health Outcomes” – Funding Opportunity Number CDC-RFA-CD10-1011. Michigan Department of Community Health awarded \$400,000.</p> <p>“Prevention Center for Healthy Weight” – Funding Opportunity Number HRSA-10-303. Deadline: August 16, 2010</p> <p>“Competitive Supplement to CDC-RFA-HM08-805: Strengthen and Improve the Nation’s Capacity through National, Non-profit, Professional Public Health Organizations to Increase Health Protection and Health Equity” – Funding Opportunity Number CDC-RFA-HM08-8050301SUPP10. Deadline: August 24, 2010</p> <p>“Supplemental Funding to Funding Opportunity Announcement (FOA) PS08-802, HIV/AIDS Surveillance: Enhancing Laboratory Reporting” –</p>	n/a	n/a	DCH – PHA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		<p>Funding Opportunity Number CDC-RFA-PS08-8020302SUPP10. Deadline: September 2, 2010</p> <p>“State Supplemental Funding for Healthy Communities, Tobacco Prevention and Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System” – Funding Opportunity Number RFA-DP09-90101SUPP10. Deadline: September 3, 2010</p>			
§4003 Clinical and community preventive services	March 23, 2010	n/a	n/a	n/a	DCH – PHA (lead)
§4004 Education and outreach campaign regarding preventive benefits	March 23, 2010	<p>\$500 million for prevention and health promotion outreach. Sums as necessary for funding of campaign to raise awareness of preventive services for Medicaid enrollees. Discretionary money per CBO.</p>	n/a	n/a	DCH – PHA (lead)
§4101 School-based health centers	March 23, 2010	<p>Grants. \$50 million for each fiscal year, 2010 – 2013, for establishment of school-based health centers. “Affordable Care Act (ACA) School-based Health Centers Capital Program” - Funding Opportunity Number HRSA-10-276. Deadline: July 30, 2010</p> <p>Such sums as necessary, fiscal years 2010 - 2014, for operation of school-based health centers. “Affordable Care Act -</p>	n/a	n/a	DCH – PHA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		Grants for School-Based Health Center Capital (SBHCC) Program” – Funding Opportunity Number HRSA-11-127. Deadline: December 1, 2010			
§4102 Oral healthcare prevention activities	March 23, 2010	Grants, allocations, or cooperative agreements. Authorizes such sums as necessary. Discretionary money per CBO.	n/a	n/a	DCH – PHA (lead)
§4103 Medicare coverage of annual wellness visit providing a personalized prevention plan	January 1, 2011	n/a	n/a	n/a	DCH – MSA (lead) PHA
§4104 Removal of barriers to preventive services in Medicare	January 1, 2011	n/a	n/a	n/a	DCH – PHA (lead) MSA
§4105 Evidence-based coverage of preventive services in Medicare	January 1, 2010	n/a	n/a	n/a	DCH – PHA (lead) MSA
§4106 Improving access to preventive services for eligible adults in Medicaid	January 1, 2013	1 percentage point increase in FMAP. Enhanced match available beginning January 1, 2013.	n/a	n/a	DCH – MSA (lead) PHA
§4107 Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid	October 1, 2010	n/a	n/a	n/a	DCH – MSA (lead) PHA
§4108 Incentives for prevention of chronic diseases in Medicaid	January 1, 2011	Grants. Appropriates \$100 million for the 5- year period beginning by January 1, 2011. State initiatives will be carried out for at least a 3- year period. Amounts appropriated remain available until expended.	n/a	n/a	DCH – PHA (lead) MSA

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§4201 Community transformation grants	March 23, 2010 PCO and MCRH will promote this opportunity to communities across Michigan, offering to partner as applicable	Competitive grants. Authorization for such sums as may be necessary for each fiscal year 2010 through 2014. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)
§4202 Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries	March 23, 2010 SEE PHA UNIT FOR PLAN	Grants. Authorization for funding for 5-year pilot programs, fiscal years 2010 through 2014. Discretionary money per CBO.	n/a	n/a	DCH – PHA (lead) MSA
§4203 Removing barriers and improving access to wellness for individuals with disabilities	March 23, 2010	n/a	n/a	n/a	DCH – PHA (lead)
§4206 Demonstration project concerning individualized wellness plan in FQHCs	PCO will work collaboratively with MPCA to encourage implementation of individualized wellness plans within practices	Pilot program. Authorizes such sums as necessary. Limited to 10 community health centers. Discretionary money per CBO.	n/a	n/a	DCH – HPRA (lead)
§4301 Research on optimizing the delivery of public health services	March 23, 2010 PCO will offer to work collaboratively with the PHA to conduct delivery system research as applicable	n/a	n/a	n/a	DCH – PHA, HPRA (lead)
§4302 Understanding health disparities: data collection and analysis	March 23, 2010 PCO will adopt health disparities data collection, analysis, and quality practices in preparing the MI Critical Health Indicators report	n/a	n/a	n/a	DCH – PHA, HPRA (lead)
§4303 CDC and employer-based wellness programs	March 23, 2010	n/a	n/a	n/a	DCH - PHA (lead) DTMB, OSE
§4305 Advancing research and treatment for pain care management	June 30, 2011	Grants, cooperative agreements, and contracts. Authorizes such sums as necessary for fiscal years 2010 through 2012. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§4306 Funding for Childhood Obesity Demonstration Project	March 23, 2010	Extends funding for the childhood obesity demonstration program established under CHIPRA (P.L. 111-3). Direct appropriation to HHS-CMS totaling \$25 million. Authorizes funding for fiscal years 2010 through 2014.	n/a	n/a	DCH – PHA (lead)
§4402 Effectiveness of Federal health and wellness initiatives	n/a	n/a	n/a	n/a	DCH – PHA (lead)
§5102 State health care workforce development grants	March 23, 2010 PCO will work collaboratively with other state agencies to prepare workforce development grants	Planning grants: authorization for \$8 million for fiscal year 2010 and such sums as necessary thereafter. Up to \$150,000 per state partnership. Implementation grants: authorization for \$150 million for fiscal year 2010. “Affordable Care Act (ACA): State Health Care Workforce Planning Grants” – Funding Opportunity Number HRSA-10-284. Deadline: July 19, 2010; and “Affordable Care Act (ACA): State Health Care Workforce Implementation Grants” – Funding Opportunity Number HRSA-10-285. Deadline: July 19, 2010	n/a	n/a	DCH – HPRP (lead)
§5103 Health care workforce assessment	March 23, 2010 PCO will work collaboratively with other state agencies to prepare workforce assessment grants	Grants. Authorization for \$4.5 million per year for each of fiscal years 2010 through 2014. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)
§5201 Federally supported student loan funds	March 23, 2010 PCO will integrate federally supported student loans into the recruitment and	n/a	n/a	n/a	DCH – HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
	retention programming conducted by the unit				
§5202 Nursing student loan program	March 23, 2010 PCO will integrate federally supported nursing student loans into the recruitment and retention programming conducted by the unit	n/a	n/a	n/a	DCH – PHA HPRP(lead)
§5203 Health care workforce loan repayment programs	March 23, 2010 PCO will expand our recruitment and retention programming to include the new categories outline in amended PHSA, Sec 775	n/a	n/a	n/a	DCH – HPRP (lead)
§5204 Public health workforce recruitment and retention programs	March 23, 2010 PCO will expand our recruitment and retention programming to include the new program for public health professionals	n/a	n/a	n/a	DCH – PHA HPRP (lead)
§5205 Allied health workforce recruitment and retention programs	March 23, 2010 PCO will expand our recruitment and retention programming to include the new program for allied health professionals	n/a	n/a	n/a	DCH – HPRP, PHA
§5206 Grants for State and local programs	March 23, 2010 PCO will seek additional state and local support to expand our state loan repayment program to include mid-career professionals	n/a	n/a	n/a	DCH – PHA HPRP (lead)
§5207 Funding for National Health Service Corps	March 23, 2010 PCO will expand our efforts to recruit and place NHSC professionals into shortage areas in Michigan	For fiscal year 2010, \$320,461,632; for fiscal year 2011, \$414,095,394; for fiscal year 2012, \$535,087,442; for fiscal year 2013, \$691,431,432; for fiscal year 2014, \$893,456,433; for fiscal year 2015, \$1,154,510,336; for fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of (A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and (B) one	n/a	n/a	DCH – HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.			
§5208 Nurse-managed health clinics	March 23, 2010	Grants. \$50 million for fiscal year 2010; as necessary for remaining fiscal years (2011 – 2014). “Affordable Care Act (ACA) Nurse Managed Health Clinics” – Funding Opportunity Number HRSA-10-282. Deadline: July 19, 2010	n/a	n/a	DCH – PHA HPRP (lead)
§5301 Training in family medicine, general internal medicine, general pediatrics, and physician assistantship	March 23, 2010 PCO will track for info	Grants. Physician Assistant Education Program - \$125 million for fiscal year 2010; as necessary for remaining fiscal years (2011 – 2014). “Affordable Care Act (ACA) Expansion of Physician Assistant Training Program” – Funding Opportunity Number HRSA-10-278. Deadline: July 19, 2010 Primary Care Residency Expansion Initiative - \$168 million for fiscal years 2010 through 2014. “Affordable Care Act (ACA) Primary Care Residency Expansion (PCRE) Program” – Funding Opportunity Number HRSA-10-277. Deadline: July 19, 2010	n/a	n/a	DCH – PHA HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§5302 Training opportunities for direct care workers	March 23, 2010 PCO will track for info	Grants. \$10 million for the project period - fiscal years 2011 through 2013	n/a	n/a	DCH – HPRP (lead)
§5303 Training in general, pediatric, and public health dentistry	March 23, 2010 PCO will track for info	Grants or contracts. \$30 million for fiscal year 2010; as necessary for remaining fiscal years (2011 – 2015). Discretionary money per CBO.	n/a	n/a	DCH – HPRP (lead)
§5304 Alternative dental health care providers demonstration project	March 23, 2010 PCO will track for info	Grants are for no less than \$4 million for 5-year project period; authorizes such sums as necessary. Begins no later than March 23, 2012 and concludes no later than March 23, 2017. Discretionary money per CBO.	n/a	n/a	DCH – HPRP (lead)
§5305 Geriatric education and training; career awards; comprehensive geriatric education	March 23, 2010	\$150,000 grants; \$10,800,000 total for the period of fiscal year 2011 through 2014. Not more than 24 geriatric education centers will receive the award. Funds must supplement, not supplant, federal, state, and local funds. Discretionary money per CBO.	n/a	n/a	DCH – HPRP, PHA (lead)
§5306 Mental and behavioral health education and training grants	March 23, 2010 PCO will offer to work collaboratively with MH/BH unit within Department	Grants. Authorizes \$35 million total, split into pools for each specialty area (\$8 million for social work; \$12 million for psychology; \$10 million for child and adolescent health; \$5 million for paraprofessional training in child and adolescent work) for fiscal years 2010 through 2013. Discretionary money per CBO.	n/a	n/a	DCH – MHSA, HPRA (lead)
§5308 Advanced nursing education grants	March 23, 2010 PCO will offer to work collaboratively with the Nurse Executive as appropriate	Reauthorizes Title VIII of the PHS Act - the primary source of Federal funding for nursing education. \$30 million in funding for fiscal	n/a	n/a	DCH – PHA HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		years 2010 through 2014. All funding is provided in fiscal year 2010, but there will be limitations on the amount of funds that can be drawn down each year. “Affordable Care Act (ACA) Advanced Nursing Education Expansion” – Funding Opportunity Number HRSA-10-281. Deadline: July 19, 2010			
§5309 Nurse education, practice, and retention grants	March 23, 2010 PCO will offer to work collaboratively with the Nurse Executive as appropriate	Grants or contracts. Authorizes funding for fiscal years 2010 through 2012. Discretionary money per CBO. “Affordable Care Act (ACA): Nursing Assistant and Home Health Aide Program” – Funding Opportunity Number HRSA-10-273. Deadline: July 22, 2010	n/a	n/a	DCH – PHA HPRP (lead)
§5310 Loan repayment and scholarship program	March 23, 2010 PCO will offer to work collaboratively with the Nurse Executive as appropriate	n/a	n/a	n/a	DCH – HPRP (lead)
§5311 Nurse faculty loan program	March 23, 2010 PCO will offer to work collaboratively with the Nurse Executive as appropriate	n/a	n/a	n/a	DCH – HPRP (lead)
§5312 Authorization of appropriations for parts B through D of title VIII	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5313 Grants to promote the community health workforce	March 23, 2010 PCO will track for info	Grants. Authorizes funding for fiscal years 2010 through 2014,	n/a	n/a	DCH – PHA HPRP (lead)
§5314 Fellowship training in public health	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5316 Demonstration Grants for Family Nurse Practitioner Training Programs	March 23, 2010	Three-year grants not to exceed \$600,000. Authorizes such sums as necessary for fiscal years 2011 through 2014. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§5317 Demonstration Grants for Family Nurse Practitioner Training Programs	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5401 Centers of excellence	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5402 Health care professionals training for diversity	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5403 Interdisciplinary, community-based linkages (AHEC)	March 23, 2010 PCO looks to collaborate and partner with AHEC initiatives in the State	Grants. Each award will total at least \$250,000; \$125 million for each fiscal year total, 2010 – 2014. 50-50 matching requirement, at least half of which must be cash. May apply for a waiver of up to 75% of match requirement in first 3 years. Discretionary money per CBO. “Area Health Education Centers (AHEC) Infrastructure Development Awards and Area Health Education Centers Point of Service Maintenance and Enhancement Awards” – Funding Opportunity Numbers HRSA-10-251 and HRSA-10-252. Deadline: May 26, 2010	n/a	n/a	DCH – HPRP (lead)
§5404 Workforce diversity grants	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5405 Primary care extension program	March 23, 2010 PCO will offer to work collaboratively with others to create primary care extension Hubs	Competitive grants. Authorization for \$120 million for each of fiscal years 2011 and 2012, and such sums as may be necessary for fiscal years 2013 and 2014. Discretionary money per CBO.	n/a	n/a	DCH – PHA HPRP (lead)
§5501 Expanding access to primary care services and general surgery services	January 1, 2011 PCO will track for info and impact.	n/a	n/a	n/a	DCH – HPRP (lead)
§5502 Medicare Federally qualified health center improvements	January 1, 2011 PCO will work collaboratively with PCA to alert FQHCs to the expansion	n/a	n/a	n/a	DCH – HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
	of Medicare covered services and implementation of PPS.				
§5503 Distribution of additional residency positions	July 1, 2011 PCO will work collaboratively with PCA to alert FQHCs to the changes in the distribution of residency positions.	n/a	n/a	n/a	DCH – HPRP (lead)
§5504 Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs	July 1, 2010 PCO will offer to work collaboratively with the Nurse Executive as appropriate.	n/a	n/a	n/a	DCH – HPRP (lead)
§5505 Rules for counting resident time for didactic and scholarly activities and other activities	October 1, 2011 PCO will track for info.	n/a	n/a	n/a	DCH – HPRP (lead)
§5506 Preservation of resident cap positions from closed hospitals	March 23, 2010 PCO will track for info	n/a	n/a	n/a	DCH – HPRP (lead)
§5507 Demonstration projects To address health professions workforce needs; extension of family-to-family health information centers	March 23, 2010 PCO will track for info	Three funding opportunities: 1. \$80 million per fiscal year, 2010 through 2014. “Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-income Individuals” – Funding Opportunity Number HHS-2010-ACF-OFA-FX-0126. Deadline: August 5, 2010 “Health Profession Opportunity Grants for Tribes, Tribal Organizations or Tribal College or University” – Funding Opportunity Number HHS-2010-ACF-OFA-FY-0124. Deadline: August 5, 2010 2. \$5 million per fiscal year, 2010 through 2012. “Affordable Care Act (ACA): Personal and Home Care Aide State Training Program” – Funding Opportunity	n/a	n/a	DCH – PHA HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		<p>Number HRSA-10-288. Deadline: July 19, 2010 3. Up to \$97,500 per fiscal year, 2011 through 2012. “Affordable Care Act Family Professional Partnership/Family-to-Family Health Information and Education Centers” – Funding Opportunity Number HRSA-11-035. Deadline: December 15, 2010</p>			
§5509 Graduate nurse education demonstration	March 23, 2010 PCO will track for info	Authorizes \$50 million for each fiscal year, 2012 through 2015.	n/a	n/a	DCH – HPRP (lead)
§5601 Spending for Federally Qualified Health Centers (FQHCs)	March 23, 2010 PCO will work collaboratively with PCA and communities to increase the number of FQHCs in Michigan	For fiscal year 2010, \$2,988,821,592; for fiscal year 2011, \$3,862,107,440; for fiscal year 2012, \$4,990,553,440; for fiscal year 2013, \$6,448,713,307; for fiscal year 2014, \$7,332,924,155; for fiscal year 2015, \$8,332,924,155. Adjusted annually thereafter. Discretionary money per CBO.	n/a	n/a	DCH – HPRP (lead)
§5602 Negotiated rulemaking for development of methodology and criteria for designating health professions shortage areas	March 23, 2010 PCO will offer commentary to the negotiated rulemaking committee regarding shortage designations methodology	n/a	n/a	n/a	DCH – HPRP (lead)
§6001 Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals	July 1, 2011 CON will track for info and impact on hospitals	n/a	n/a	n/a	DCH – MSA, HPRA (lead)
§6002 Transparency reports and reporting of physician ownership or investment interests	March 31, 2013 CON will track for info and impact on hospitals	n/a	n/a	n/a	DCH – HPRP (lead)
§6101 Required disclosure of ownership and additional disclosable parties'	January 1, 2012 CON will track for info and potential	n/a	n/a	n/a	DCH – HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
information.	inclusion into CON review standards for compliance				
§6102 Accountability requirements for skilled nursing facilities and nursing facilities	December 31, 2011 CON will track for info and potential inclusion into CON review standards for compliance.	n/a	n/a	n/a	DCH – HPRP (lead)
§6103 Nursing home compare Medicare website	March 22, 2011 CON will track for info and use in current revision of nursing home CON review standards.	n/a	n/a	n/a	DCH – HPRP (lead)
§6104 Reporting of expenditures	CON will track for info.	n/a	n/a	n/a	DCH – HPRP (lead)
§6105 Standardized complaint form	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6106 Ensuring staffing accountability	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6111 Civil money penalties	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6112 National independent monitor demonstration project	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6113 Notification of facility closure	March 22, 2011 CON will track for info.	n/a	n/a	n/a	DCH – HPRP (lead)
§6114 National demonstration projects on culture change and use of information technology in nursing homes	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6121 Dementia and abuse prevention training	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6201 Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6301 Patient-Centered Outcomes Research	March 23, 2010	n/a	n/a	n/a	DCH - PHA (lead)
§6402 Enhanced Medicare and Medicaid program integrity provisions	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6404 Maximum period for submission of Medicare claims reduced to not more than 12 months	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6407 Face to face encounter with patient required before physicians may certify eligibility for home health services under Medicare	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6408 Enhanced penalties	n/a	n/a	n/a	n/a	DCH – OSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§6410 Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6501 Termination of provider participation under Medicaid if terminated under Medicare or other State plan	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§6701 Elder Justice	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§8001 CLASS Act	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§9007 Additional requirements for charitable hospitals	March 23, 2010 Policy unit will track for info to provide an analysis of total uncompensated care costs	n/a	n/a	n/a	DCH – HPRP (lead)
§9011 Study and report of effect on veterans health care.	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§9012 Elimination of deduction for expenses allocable to Medicare Part D subsidy	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§9013 Modification of itemized deduction for medical expenses	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§10202 Incentives for States to offer home and community based services as a long-term care alternative to nursing homes	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§10212 Establishes a Pregnancy Assistance Fund	March 23, 2010	Grants. Authorizes \$25 million per fiscal year, 2010 – 2019. Grants not to exceed 3 years. “FY10 Support for Pregnant and Parenting Teens and Women FOA” – Funding Opportunity Number AH-SP1-10-003. Deadline: August 2, 2010	n/a	n/a	DCH - PHA (lead)
§10325 Revision to skilled nursing facility prospective payment system	n/a	n/a	n/a	n/a	DCH – OSA (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
§10326 Pilot testing pay-for-performance programs for certain Medicare providers	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§10328 Improvement in Part D medication therapy management (MTM) programs	n/a	n/a	n/a	n/a	DCH – OSA (lead)
§10333 Community-based collaborative care networks	March 23, 2010 Revisions	Grants. Authorizes funding for fiscal years 2011 through 2015. Discretionary money per CBO.	n/a	n/a	DCH – PHA (lead) HPRP
§10407 Better diabetes care	March 23, 2010	n/a	n/a	n/a	DCH – PHA (lead)
§10408 Grants for small businesses to provide comprehensive workplace wellness programs	March 23, 2010	Funding available to small businesses. \$200 million appropriated for the period of fiscal years 2011 through 2015.	n/a	n/a	DTMB OSE DCH – PHA (lead)
§10410 Centers of excellence for depression	March 23, 2010	Grants on a competitive basis. Authorizes \$100,000,000 for each of the fiscal years 2011 through 2015; 150,000,000 for each of the fiscal years 2016 through 2020. Grant period is 5 years – may be renewed for another 5 year period. Discretionary money per CBO. Requires matching funds - \$1 to \$5 federal.	n/a	n/a	DCH - PHA (lead)
§10503 Community Health Centers and National Health Service Corps Fund	March 23, 2010 Revisions	For Community Health Centers: \$700 million for fiscal year 2011; \$800 million for fiscal year 2012; \$1 billion for fiscal year 2013; \$1.6 billion for fiscal year 2014; and \$2.9 billion for fiscal year 2015 In addition, \$1.5 billion available for fiscal years 2011 through 2015 for construction and renovation of community	n/a	n/a	DCH – HPRP (lead)

Brief Description	Implementation Timeline	Funding	Federal/State Action Required	State Budget Impact	Affected Agency(ies)
		<p>health centers.</p> <p>Enhanced funding for the National Health Service Corps: \$290 million for fiscal year 2011; \$295 million for fiscal year 2012; \$300 million for fiscal year 2013; \$305 million for fiscal year 2014; and \$310 million for fiscal year 2015.</p> <p>“Health Center New Access Points Funded Under the Affordable Care Act of 2010” – Funding Opportunity Number HRSA-11-017. Deadline: November 17, 2010</p>			
§10504 Demonstration project to provide access to affordable care	March 23, 2010 Revisions	\$2 million to each of 10 states for the duration of the 3-year project.	n/a	n/a	DCH – HPRP (lead)
§10608 Extension of medical malpractice coverage to free clinics	March 23, 2010 Revisions	n/a	n/a	n/a	DCH – HPRP (lead)

Attachment B

State Budget Office Discussion on Budget Implications

State Budget Decision and Impact Timelines

The following tables outline significant state budget decisions and impacts that will occur as a result of the implementation of health care reform.

Decision: Implement early expansion of Medicaid eligibility based on income

DATE	ACTION
4/2011	Make decision to expand Medicaid eligibility based on income prior to required federal expansion, effective 1/1/2014
10/2011	Appropriate funds to implement early expansion program by stated date

Decision: Implement Exchange

DATE	ACTION
10/2010	Received federal planning funds to assess Exchange options
2/2011	Make decision to create one or two Exchanges, join regional Exchange, or allow federal government to operate Exchange ✓ If an Exchange will be created or joined, continue in decision-making process; If not then stop here Estimate cost of project in FY2012 and assess available federal funding
10/2011	Appropriate funds for Exchange planning and implementation in FY2012
12/2011	Pass legislation needed to implement the Exchange by stated date
10/2012	Appropriate funds for Exchange planning and implementation in FY2013
2/2013	Develop financing structure to sustain the Exchange
10/2013	Appropriate funds for Exchange implementation in FY2014
1/2014	Launch Exchange with full functionality
1/2015	Exchange must have self-sustaining financing structure; no additional federal funds are available

Impact: Anticipated increase in Medicaid eligibles that enroll due to the individual mandate and/or the Exchange

DATE	ACTION
2/2013	Estimate cost of additional eligibles in FY2014
10/2013	Appropriate funds for caseload cost of additional eligibles within the existing Medicaid program for FY2014 <ul style="list-style-type: none">▪ Estimated addition of 40,000 to 60,000 Medicaid eligibles on an annual basis▪ Additional caseload is financed at the regular federal match rate▪ Increased ongoing state cost of between \$60 million and \$80 million occurs in FY2014, beginning in the second quarter
1/2014	Caseload increase occurs
10/2014	Appropriate funds for remaining caseload cost of additional eligibles in FY2015 <ul style="list-style-type: none">▪ Increased ongoing state cost of between \$20 million and \$40 million in FY2015, for the remaining fiscal quarter

Impact: Mandatory expansion of Medicaid eligibility to cover up to 133% of the federal poverty level

DATE	ACTION
2/2013	Estimate cost of additional eligibles in FY2014
10/2013	Appropriate 100% federal funds to cover new eligibles in Medicaid for FY2014 <ul style="list-style-type: none">▪ Estimated addition of 300,000 to 500,000 Medicaid eligibles on an annual basis▪ Receive new federal funds of \$1.5 billion to \$2.5 billion▪ No additional cost to state
1/2014	Mandatory expansion of eligibility occurs and caseload increases
10/2014	Appropriate 100% federal funds in Medicaid for FY2015
10/2015	Appropriate 100% federal funds in Medicaid for FY2016
10/2016	Appropriate 96.25% federal funds in Medicaid for FY2017 <ul style="list-style-type: none">▪ Additional ongoing state cost of approximately \$100 million
10/2017	Appropriate 94.25% federal funds in Medicaid for FY2018 <ul style="list-style-type: none">▪ Additional ongoing state cost of approximately \$50 million
10/2018	Appropriate 93.25% federal funds in Medicaid for FY2019 <ul style="list-style-type: none">▪ Additional ongoing state cost of less than \$50 million
10/2019	Appropriate 90.75% federal funds in Medicaid for FY2020 <ul style="list-style-type: none">▪ Additional ongoing state cost of between \$50 million and \$100 million
10/2020	Appropriate 90% federal funds in Medicaid for FY2021 and future years <ul style="list-style-type: none">▪ Additional ongoing state cost of less than \$50 million

Note: While federal statute specifies Federal Medical Assistance Percentage (FMAP) rates by calendar year, this table uses annual average FMAPs by fiscal year, beginning October 1.

Decision/Impact: Reductions to the Disproportionate Share Hospital (DSH) allotment require state budget decisions

DATE ACTION

- 2/2013 Begin making annual decisions to restructure existing DSH payments
- DSH payments currently either go to providers or are used to generate budgeted savings for the state
 - Reducing DSH payments result in costs to either providers or the state
 - Decision-making must occur every year that Michigan's allotment is reduced
 - Based on preliminary estimates, Michigan will receive the following approximate reductions in federal funding by fiscal year:

FY2014 \$10 million

FY2015 \$15 million

FY2016 \$15 million

FY2017 \$40 million

FY2018 \$120 million

FY2019 \$130 million

FY2020 \$90 million

Attachment C

Resource Links

Association of State and Territorial Health Officials

<http://www.astho.org/Programs/Health-Reform/>

Federal Funds Information for States

<http://www.ffis.org/issues/health-care-reform>

Federal Government Healthcare Website

<http://www.healthcare.gov/index.html>

Health Reform GPS from the Robert Wood Johnson Foundation

<http://www.healthreformgps.org/>

The Henry J. Kaiser Family Foundation's site on Health Care Reform

<http://healthreform.kff.org/>

The National Conference of State Legislators Health Care Reform Implementation

<http://www.ncsl.org/Default.aspx?TabID=160&tabs=831,139,1146#1146>

National Governor's Association section on health reform implementation

<http://www.nga.org>

Attachment D

Acronyms

ACA	Patient Protection and Affordable Care Act of 2010
ADRC	State Aging and Disability Resource Center
ARRA	American Recovery and Reinvestment Act of 2009
CLASS	Community Living Assistance Services and Supports
CMS	Centers for Medicare and Medicaid Services
CSHCS	Children's Special Health Care Services
DELEG	Department of Energy, Labor, and Economic Growth
DHS	Department of Human Services
DSH	Disproportionate Share Hospital
EHR	Electronic Health Records
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GF	General Fund
HCBS	Home and Community Based Services
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchanges
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HMO	Health Maintenance Organization
MAGI	Modified Adjusted Gross Income
MARS	Michigan Assistance Referral Service
MCAC	Medical Care Advisory Council
MDCH	Michigan Department of Community Health
MHIAC	Michigan Health Insurance Access Advisory Council
MichUHCAN	Michigan Universal Healthcare Access Network
MiHIN	Michigan Health Information Network
MLR	Medical Loss Ratio
MPCC	Michigan Primary Care Consortium
OFIR	Office of Financial and Insurance Regulation
OSA	Office of Services to the Aging
PACE	Programs of All-inclusive Care for the Elderly
PCMH	Patient Centered Medical Home
PCO	State Primary Care Office
PHSA	Public Health Service Act
PPO	Preferred Provider Organization
SEARCH	Student/Resident Experiences & Rotations in Community Health
SHP	State Health Plan
SSA	Social Security Act
SSI	Supplemental Security Income