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Capitol Update

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Health Care Reform Debates Start in Earnest

The legislation resulting from the Governor's Health Care Transformation Task Force and the Legislative Commission on Health Care Access has now been introduced. In the Senate, SF 3099 has been introduced by Sen. Linda Berglin (DFL-Minneapolis) and in the House, HF 3391 has been introduced by Rep. Tom Huntley (DFL-Duluth). Both of these bills are designed to adopt "transformational" reform to our health care system in the areas of insurance reform, payment reform, marked transparency, and public health improvement.

Hearings on both bills began this week. Both bills focus on chronic disease management, implementing a medical home model for care, increased payments for primary care services, and expand eligibility for MinnesotaCare to ensure that health care is affordable for low-income Minnesotans. There are many questions, however, with other parts of the bills, specifically related to some of the proposed payment reforms.

In the House, the payment reform is focused on two areas. What is referred to as Level 1 payment, is a focus on increased payment incentives related to the provision of high quality care. These are similar to the pay-for-performance programs that many payers are currently using in the market. The second reform, referred to as Level 2 payment, is the medical home model (the House bill refers to this as a "Health Care Home," but the concept is the same.) While the direction of this proposal is consistent with other efforts sponsored by primary care, it is unclear what mechanisms will be put in place to ensure Medical Home does not become simply a gatekeeper model. The bill would provide a care coordination fee of no more than \$50 per person per month to pay for the medical home activities.

To qualify as a medical home, a clinic would need to do the following:

- Each patient in a health care home would have an ongoing, long-term relationship with a personal clinician to provide first contact, continuous, and comprehensive care.
- The clinician shall coordinate care across all provider types and care locations.
- The health care home must provide or arrange access to care 24-hours a day, seven days a week (excluding urgent care and MinuteClinic).

- The health care home must encourage the patient to actively participate in decision making.
- Care delivery must be facilitated by the use of health information technology.
- The health care home must meet process, outcome, and quality standards.
- The health care home must complete a comprehensive health assessment for each enrollee.
- The health care home must employ care coordinators who are nurses, social workers, or other clinicians, to manage patients with complex or chronic conditions.

Legislators have been very clear they do not see Medical Homes as exclusively being provided by primary care, rather that some specialists would at times serve as a medical home. It is unclear how frequently otolaryngology, head and neck surgery would qualify or whether members would seek the designation.

The Senate bill has similar language on both Level 1 and Level 2 payments. In addition, it proposes a Level 3 for payment reform. This is one of the more controversial portions of the bill. It would establish a system where providers submit bids to the state “for the total costs of providing care” to a set group of patients. The bill would allow integrated systems to bid on all aspects of care, and it would allow individual providers to bid only on their portion of care or “baskets of care” (i.e., total hip) and that would be combined with other clinics bids to determine the total cost of care. The proponents of this program argue that this is the real reform of the bill and that it is designed to allow innovative payment methods that will reward providers for keeping patients healthy and out of the hospital. Critics argue that it sounds very similar to a return to capitation and providers accepting insurance risk. There are many unanswered questions about how this will work in the real world.

The Senate bill also includes a new Public Health Improvement Assessment that will be levied on hospitals beginning June 1, 2009. The 0.2 percent assessment on patient revenues is being promoted as a way to recapture the savings that the bill expects to achieve. The new tax has also become very controversial.

There is a bipartisan effort to move health care reform forward this year. The bills will be heard in a half dozen committees over the next two weeks as they try to pass something this year. The MAO will continue to actively monitor the progress of the bills.

New Budget Numbers Show Larger Deficit

Last November the Minnesota Department of Finance announced its budget forecast showing a \$373 million deficit for the remainder of the biennium that ends June 30, 2009. This forecast showed that the slowing economy was having a negative impact on the state’s budget and that the Legislature would have to act to address the problem.

Last Thursday, February 28, the Department of Finance announced its updated February forecast that shows the deficit is growing. It is now projected that the state budget will have a deficit of \$935 million by the end of the biennium.

This is very concerning. Historically, whenever the state has had a deficit for which budget cuts were needed, a disproportionately high level of those cuts have come out of the human services budget. This has meant cuts to provider reimbursement levels and eligibility levels for low-income health programs and also increases in co-pay levels for patients who can’t afford them. In addition,

many are worried that funds like the Health Care Access Fund, where the provider tax revenues are deposited, will be looked to balance the budget. The HCAF is running a surplus of over \$330 million.

The growing deficit also makes it much harder for the Legislature to adopt the health care reforms they want. While the goal of the health care reform is to cut health care spending, many of the proposals, like the medical home idea, require some upfront investments to achieve long-term savings.

Chiropractic Expansion

As we've come to expect scope of practice expansion is rampant at the legislature. Chiropractors are pursuing dramatic expansion in response to the efforts of the physical therapists this year and in years past. The bill, HF3501(Thao-St. Paul)/SF3240 (Koering-Brainerd), redefines chiropractic in broad terms as a "health care science based on the body of knowledge taught in chiropractic educational institutions." This is a significant expansion from the current definition which limits practice to adjustments of the body particularly of the spinal column. Additionally concerning is that the bill says the practice of chiropractic includes, but is not limited to "clinical, physical, laboratory, and other diagnostic measures, including all types of diagnostic imaging" among many other items. (Currently, chiropractic imaging authority is limited to x-ray.)

In response we have expressed serious concerns with legislators on the basis that chiropractors are essentially working to obtain the full scope of practice allowed physicians. We have also raised questions about why, in a time when imaging services provided by physicians are under greater scrutiny, chiropractors would be allowed to jump into the fray. The bill was scheduled to be heard Monday evening but has been removed from the agenda.

Naturopath Registration

Legislation is moving that would register doctors of naturopathy who have graduated from an accredited school of naturopathy. Part of the purpose of the bill is to distinguish for consumers the difference from a trained naturopath and someone who calls themselves a "traditional naturopath." The other purpose of the bill would be to provide more credibility for naturopathy and to begin to define their scope of practice.

The bill, HF 1724 (Walker-DFL, Minneapolis) would register naturopaths under the Board of Medical Practice. As originally drafted, the bill allowed registered naturopaths to prescribe legend drugs, perform minor surgery and natural childbirth. The bill also granted diagnostic authority similar to physicians. Since advocates indicated the bill was designed to allow them to be registered without expanding their scope from what they currently are doing without registration, the expansions of scope were removed (prescriptive authority, surgery and diagnostic authority). With that amendment it was passed out of the House Health Licensing Subcommittee. The Senate version of the bill has not been heard yet.