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Capitol Update April 11, 2008

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Budget Conference Committee Begins

The House and Senate have begun efforts to resolve their differences in addressing the state budget deficit. As previously reported, neither the House nor Senate incorporated the Governor's proposal to transfer \$250 million from the HCAF. However, there are a number of items that will affect physicians. The most concerning are in the Senate bill. They include:

1. Permanent 3% cut to fee-for-service payment rates for medical services under MinnesotaCare, GAMC and Medical assistance, excluding medical supplies, transportation, mental health, dental and pharmacy. Unfortunately the state fee schedule is the basis for most managed care (PMAP) rates.
2. Increases the PMAP health plan withhold by 3 percent without language to prevent it from being passed on to providers. It is unclear how many provider contracts will prohibit plans from passing it along.
3. DHS must require prior authorization for at least 20 more services beginning July 2008 for MinnesotaCare, GAMC and Medical Assistance. There will be no comment period or opportunity to impact the outcome per the legislative language.
4. \$5 surcharge on professional and occupational licenses. In 2009 the revenue is deposited in the General Fund to help balance the state budget then the funds are dedicated to the Office of Enterprise Technology to develop an electronic licensing system. The Board of Medical Practice already has such a system in place funded by a licensing fee increase in 1999.

The MMA issued an Action Alert to members to urge them to contact their legislators and oppose the proposed 3% reimbursement cut. In less than two minutes you could send a note yourself by going to: <http://capwiz.com/mnmed/issues/alert/?alertid=11245656&PROCESS=Take+Action>

House Passes Health Care Reform Bill

Following eight hours of debate and 42 amendments, 14 of which were adopted, the House last night passed the Health Care Reform bill, HF3391 (Huntley, DFL-Duluth). The House bill is significantly different than the Senate companion bill and does not include the controversial provisions on payment reform that physicians oppose.

The MMA submitted a letter of support of the House version, noting they would "vigorously oppose any efforts by the conference committee" to move in the direction of a payment system based

on total cost of care that turns physicians into insurers and managers of risk (Level 3). The Mayo Clinic also distributed a letter of support of the House bill, but with reservations on how the reforms in Minnesota could adversely affect the national practice which Mayo performs. Since many of you may be interested in the letter from the MMA it is attached.

Like Mayo and the MMA, advocacy organizations for all stripes seem to prefer the House version of the health care reform effort with the exception of business groups and the Governor who still want to see Level 3 payment reform pass. Because of this key disagreement, insiders are still uncertain whether a bill will pass into law at all.

The House bill includes the following provisions to reach the goal of 98% insured by 2013:

Health Care Transformation Commission

- 13-member group tasked with developing a design for payment reform; establishing a uniform definition and methodology for calculating relative utilization and health care costs; provide assistance to providers to participate in the restructured health care system; and oversee development of standardized quality measures, benefit set and cost comparisons.

Access Expansion

- Families with children from 275% to 300% federal poverty guidelines, July 2009
- Corresponding increase for children under the age of two from 280% to 305% percent federal poverty guidelines, January 2010
- Removing total income cap, which prohibited eligibility for parents if gross income exceeds \$50,000
- Single adults and households with no children increased from 215% to 300% FPG, July 2009
- Increasing the cap on inpatient hospital services under Minnesota Care from \$10,000 to \$20,000 effective July 2009
- More accessible renewal, including one month grace period before disenrollment
- Removal of the requirement that MinnesotaCare applicants be uninsured for four month uninsured prior to eligibility allowing individuals to maintain seamless coverage, July 2010
- New premium prices for MinnesotaCare enrollees based on a new affordability scale, minimum premium remains \$4 for children in families at or below 150% FPG
- Waive first month of MinnesotaCare premium for new enrollees
- “Affordability” defined as the sum of premiums, deductibles, and other out-of pocket costs. Standard is graduated up to families with gross income under 400% FPG who are expected to contribute 8%
- For those eligible for public programs who have access to private insurance through their employers but the cost exceeds affordability standards, the state will subsidize premiums rather than enroll them on a public program

Insurance Reform

- Analysis of premium rating of high deductible health plans (per recent media attention)
- Quality Measurement: Develop rules for a standardized, limited set of measures by which to measure provider performance including mechanisms to adjust for health status, and racial,

ethnic or language factors that affect quality outcomes; reduce administrative burden of on providers

- Requires Department of Health to recommend a community benefit standard to be required by law of nonprofit health plans in the state
- Development of a standardized benefit set

Payment Reform

- *Medical Home and Care Coordination.* For qualified health care homes, a per-patient, per-month care coordination fee will be paid for care coordination services, varied by care complexity.
 - Public program enrollees will be encouraged to select a primary care clinic.
 - Enrollees with complex or chronic health conditions will be provided with health care homes.
 - Certification process for becoming a health care home involves the ability to provide or arrange for access to care 24 hours a day; an ongoing relationship with the patient; ability to provide or monitor health care needs (or for arranging, or assisting with arrangements for, appropriate care with other qualified professionals; active patient participation in decision making; patient registries; continuous quality improvement; care plans; utilization of care coordinators; participation in health care home collaboratives.
 - Selection of a health care home does not limit a patient's ability to seek care from other providers.
- *Quality Incentives.* The Commission must report to the legislature for approval of a risk-adjusted system that links payment to quality.
- *Package Pricing.* Rather than proceeding to total cost of care pricing, the Commission (under the House bill) must recommend a mechanism and standard format to allow providers to set prices for packages of care for coronary heart disease, diabetes, asthma, COPD, and depression.
- *Single Pricing.* Providers may not vary the amount they accept as payment in full for care included in their package price with the exception of state public health programs, workers' compensation, no fault auto insurance and charity care. State employee health coverage and all political subdivisions must be able to pay providers based on their package price (if they offer a package price) by January 2012.
- *Price and Quality Disclosure.* By January 2010 providers must annually establish prices for each procedure, service, or package of services electronically to the Commission who will make it publically available.

Public Health

- \$100 million from the HCAF in grants to local community health boards to reduce smoking and obesity rates from 2009 - 2011.

Financing

- The House bill is financed entirely from the Health Care Access Fund. Earlier estimates placed the cost of the entire package at \$43.6 million in FY09 and \$220 million for FY10-11.

- During floor debate some legislators indicated they feared the bill, which uses the surplus in the Health Care Access Fund (HCAF) to pay for expansions to MinnesotaCare and investments in a Statewide Public Health Improvement Program, will spend the HCAF down to a zero balance, possibly even spending the fund into a deficit. An updated fiscal note was not available to review.

Senate Health Care Reform Contains Stark Differences

The Senate version of the Reform package passed last week. The list of supporters for the bill was much shorter than for the House version. Although the individual mandate and Insurance Exchange have been removed from both bills, significant differences exist in the Senate version in the following areas:

Access Expansion

- Most timelines for expansion contingent upon meeting cost containment goals and availability of funding

Insurance Reform

- *Technology Assessment.* Health Technology Advisory Committee to recommend assess benefit of medical technology and devices.
- *Section 125 plans.* Employers with more than 11 full-time employees must offer Section 125 tax-status health plans.

Payment Reform

- *Greater Advisory Role for Providers.* Includes a Technical Advisory Committee to the Transformation Commission made up of appointments directly from organizations (MMA, Council of Health Plans, Hospital Association, MMGMA, Chamber of Commerce) to advise Commission on payment reform and other provider and payer issues.
- *Primary Care Rate Increase.* Raises Medical Assistance fee-for-service rates to primary care providers by up to 50% for those serving in designated primary care shortage areas.
- *Total Cost of Care.* In addition to voluntary package pricing, providers may also set a global capitated rate for total cost of care.
- *Single Pricing.* Applies to all prices, not just package prices as in House bill.

Public Health

- Department of Health to establish a body-mass index monitoring program to assist in targeting obesity efforts.

Financing

- \$39.1 million in FY09 from the HCAF
- Establishes a “health improvement assessments” on health plans and hospitals for the public health improvement program (0.15% on net patient revenue in FY09, then up to 0.3% [to achieve \$40 million in revenue] in FY10-13; expiring July 2013)
- Establishes a “savings recapture assessment” on health plans and third-party administrators for self-insured plans, beginning January 2010 at a rate to be determined based on actual versus projected savings, up to 33% of savings.

If you are interested, the full text of the House bill can be found at <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H3391.5.html&session=ls85>. The full text of the Senate bill can be found at <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S3099.8.html&session=ls85>.

Final passage was partisan, with two exceptions in the Senate and only one in the House. To see who voted for the bills, click on the following links:

Final House Passage (83-50)

http://www.house.leg.state.mn.us/votes/votes.asp?ls_year=85&session_number=0&year=2008&id=1019

Final Senate Passage (39-23)

<http://www.senate.leg.state.mn.us/journals/2007-2008/20080331096.pdf#Page58>