MINUTES

MINNESOTA MEDICAL ASSOCIATION
HEALTH CARE ACCESS, FINANCING, AND DELIVERY COMMITTEE

BROADWAY PLACE WEST
1300 GODWARD STREET NORTHEAST
SUITE 2500
MINNEAPOLIS, MN 55413

WEDNESDAY, JUNE 15, 2011
6:00 P.M.

Members Present:
Douglas L. Wood, M.D., Chair
Maya Babu, M.D., Resident Fellow Section
Alternate (via conf. call)
Rahul Koranne, M.D.
Kristina McCaughtry, M.D. (via conf. call)
Maria B. Mendoza-Kundel, M.D.
Aaron J. Milbank, M.D.
Randy J. Rice, M.D. (via conf. call)
Roy A. Yawn, M.D. (via conf. call)

Members Absent:
Lynn Cornell, M.D.
Judson Crow, M.D.
Michael J. Cumming, M.D.
Elizabeth Doty, M.D.
Mounif El-Youssef, M.D.
Robert Fraser, Med. Student Section
Roger G. Kathol, M.D.
Alicia Majkrzak, M.D.
Lisa R. Mattson, M.D.
Brian Muthyala, M.D. (Resident Fellow Section)
Abdul Parpia, M.D.

Staff Present
Janet Silversmith

I. **Call to Order**
Doug Wood, M.D., chair, called the meeting of the MMA Health Care Access, Financing, and Delivery Committee (AF&D) to order at 6:10 p.m.

II. **Approval of Minutes of April 26, 2011**
With no changes noted, the minutes of the April 26, 2011 meeting were **APPROVED**.

III. **HOD-10 Subst. Resolution 201: Prior Authorization of Medications**
The committee was asked to assist in the implementation of HOD-10 Resolution 201 (Prior Authorization of Medications), which reads as follows:

> RESOLVED, that the Minnesota Medical Association, in its meetings with the Minnesota health plans, advocate for developing an online clearinghouse for information pertaining to requirements for medical and mental health prior authorizations from all of Minnesota's health plans, and be it further
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> RESOLVED, that the Minnesota Medical Association, address in its meetings with Minnesota health plans, decreasing hassles related to prescribing, which negatively impact

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> patient care, including formulary changes, the use of Pharmacy Benefits Managers (PBMs), and specific qualifications of those making coverage decisions, and be it further
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> RESOLVED, that the Minnesota Medical Association partner with the Minnesota Pharmacists Association to examine concrete ways to improve information exchanges about medication prior authorizations between pharmacies and physician offices and ways to decrease the administrative burdens related to prior authorizations.

Doug Wood, M.D., chair provided an overview of the resolution and identified a variety of approaches the committee might want to consider to address the issue including the use of electronic transactions, e-prescribing, and formulary standardization. Janet Silversmith, committee staff, noted the previous work within the state on this issue including the development of a uniform form for prescription drug prior authorization requests and formulary exceptions. Legislation passed in 2009 would have mandated by January 1, 2011 that drug prior authorization requests be submitted electronically. During community discussions to implement the law, a variety of barriers were found including, most notably, the lack of an established national electronic standard. An interim solution, to create data specifications for standard, direct data-entry web portals, was strongly opposed by many in the community as potentially duplicative, expensive, and of modest value; the legislation was changed in 2010 to extend the deadline to 2015).

Although an available electronic standard transaction for prior authorization does exist (i.e., ASC X12N 278, Health Care Services Review Standard), it is functionally limited to authorizations for services and procedures only; it does not meaningfully support authorization for prescription drugs and is not widely used. Work is continuing on the national level to develop a functional prescription drug authorization standard that would be integrated with current e-prescribing standards.

During discussion, a variety of experiences with the hassles of drug prior authorization were shared. There was agreement that the MMA should focus on the development of a more rational process for prescription drug prior authorizations. A 3-pronged approach was suggested consisting of 1) describe the ideal process for managing prescription drug costs (e.g., role of prior authorization, formularies, etc.) and support policies to see to its implementation; 2) support efforts to develop a functional electronic standard for prescription drug prior authorizations; 3) work with Minnesota health plans to establish standardization in drugs subject to prior authorization and criteria used for processing requests. Further details on this work will be shared with the committee at future meetings.

IV. **HOD-10 Resolution 301 (Disparities between Hospital-Based and Office-Based Reimbursement for Physician Services)**

The committee considered HOD-10 Resolution 301, which was referred to the MMA Board of Trustees with report back to the 2011 House of Delegates. The resolution reads as follows:

> RESOLVED, that the Minnesota Medical Association meet with representatives from federal and state government funded health programs and health plan companies in Minnesota to promote transparency of the difference between hospital-based and office-based reimbursement for physician services, and be it further
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> RESOLVED, that the Minnesota Medical Association develop and lobby for legislation at the state level, and promote and support legislation at the federal level, to bring reimbursement for office-based services to an equitable level in comparison for hospital-based reimbursement from all payers.

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Committee members reviewed a staff-developed memorandum on this issue that included background information and comparative payment data.

It was noted that the problem described in the resolution of inequitable payments between sites of service is generally confined to the Medicare program.[1] Two different Medicare payment policies affect payment based on the location of the service – 1) the Medicare physician fee schedule and the use of facility and non-facility practice expense values, and 2) the Medicare hospital Outpatient Prospective Payment System (OPPS). Only the Medicare physician fee schedule provision affects payments for physician/professional services. The OPPS includes the additional payment of a facility fee, which is not payable to physician clinics that are not owned or part of a hospital.

The committee engaged in a detailed discussion of the resolution and the implications of trying to achieve equitable payment across sites of service. It was noted that some hospitals are trying to force physician practices into becoming hospital-based providers so that the hospitals could, for at least a while, increase their billings, although physicians would likely not see any increased income from these arrangements.

Committee members also expected that as payment reforms based on accountability for total cost of care are established, there will be more pressure on the hospitals to move care into the lowest cost site of service, or not charge a facility fee. The Affordable Care Act (ACA) also begins to restrict payments to certain facilities, specifically ambulatory surgical centers. Committee members also considered that for many small to mid-sized hospitals in the state, facility fee revenue can help offset losses incurred on other government program patients (Medicaid especially).

From a practical perspective, since the problem of disparity in payment is largely confined to the Medicare program, the implications of a solution beg consideration of the unintended consequences. Specifically, any effort to achieve equity would not likely result in higher payments for office-based physician services, but rather a reduction in facility payments. For smaller hospitals especially, this loss of revenue could threaten their viability (remember that the Medicare actuary has estimated that 10-12 percent of Medicare Part A providers will likely close as a consequence of the ACA). Members of the committee were uncomfortable with adopting a solution that might threaten smaller hospitals.

The resolution would direct the MMA to promote transparency about the payment disparity. The committee discussed this issue in some depth. Members of the committee felt that this payment differential is generally well known among all payers, many of whom have decided against adopting it. The members of the committee that are part of physician-owned practices that have a hospital also observed that facility fees have now been established long enough that there are relatively few patient complaints about facility fees, although this often means higher out-of-pocket costs for patients. As such, transparency for patients also did not seem to be a major problem.

The resolution suggests that MMA develop and promote state and federal legislation to seek equity of payment between office and facility based payments. The problem, however, is predominantly a Medicare issue. Thus, state legislation is not an effective solution. Federal legislation would be difficult to establish as a stand-alone solution. Given the budget neutrality requirements for Medicare physician services (Part B), the results would be unpredictable, and could result in a net loss of income for providers if the fee schedule were adjusted across the board to maintain relative

[1] Minnesota fee-for-service Medicaid also utilizes Medicare's outpatient prospective payment system and the APC methodology.

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value. The committee also had concerns about the amount of staff resources that would be required to develop and lobby for federal legislation.

Following the discussion, the committee concluded that the requested solution to this problem would have potentially undesirable consequences. A **MOTION** was made and seconded that the committee recommend to the MMA Board of Trustees that Resolution 301 not be adopted. The motion passed.

V. **Adjourn**

There being no time for additional business, the meeting was adjourned at 8:10 p.m.

Minutes submitted by:
Janet Silversmith

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