The Physician Advocate

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MMA Federal Reform Statement

Here's an excerpt from the reform law statement the MMA made to the media in March: "The MMA acknowledges the controversial nature of the bill but applauds the expansion of health care coverage to approximately 30 million uninsured Americans, the inclusion of an individual requirement to purchase insurance, the protection of patients from insurance industry abuses, and the recognition of the need for improved payment rates for physicians serving Medicaid patients. The bill is not perfect and much work remains to be done ... but as the debate winds down, the physicians of the MMA will work to help implement the numerous details in an effort to further improve medicine in Minnesota."

Reform Sets Stage for State Program Changes

Law opens up the possibility for eliminating several state-run insurance programs as well as the provider tax.

(AP Photo/Charles Dharapak)

The federal health care reform law will significantly influence health care delivery and payment in Minnesota. President Barack Obama signs the health care reform bill, Tuesday, March 23, 2010, in the East Room of the White House in Washington, as Marcelas Owens, 11, from Seattle, Wash., left, and Rep. John Dingell, D-Mich., right, look on.

The passage of national health care reform promises an influx of new federal dollars that may allow the state to do away with some of the programs it has created over the years to help uninsured Minnesotans.

For example, the Minnesota Comprehensive Health Association (MCHA) was established in 1976 to offer health insurance coverage to Minnesota residents who have been turned down by private insurers because they have pre-existing medical conditions. But starting in 2014, MCHA may no longer be needed because insurers won't be allowed to refuse coverage to people with pre-existing conditions.

The new law also gives the state the option of enrolling adults with incomes of up to 133 percent of the federal poverty level in Medical Assistance (MA). Previously, adults without children who earn less than 75 percent of poverty have been covered by General Assistance Medical Care (GAMC).

MinnesotaCare could also be eliminated in 2014, when the federal government will start providing subsidies for low-income individuals to purchase private insurance. Sunsetting MinnesotaCare also would remove the current justification for the provider tax, which funds the program.

In April, state lawmakers were exploring options for obtaining new federal dollars; but it was unclear whether they could capitalize on the opportunity. Securing federal funds may ease the state's budget troubles this biennium by reducing costs associated with GAMC by $60 million during the first six months of 2011. But the additional federal funding would come with a price tag later on, as the state would be required to match any dollars it accepts. This would result in increased costs to the state in fiscal years 2012 and 2013. For that reason, lawmakers may instead decide to stick with the GAMC fix they passed in March. That plan maintains coverage for single adults with incomes less than 75 percent of poverty and includes severe payment cuts to providers and hospitals that treat GAMC enrollees. The MMA contends that the GAMC program doesn't cover the cost of caring for this population and that reducing those payment rates will force providers to either refuse to treat GAMC patients or shift costs to the private sector. Dave Renner, the MMA's director of state and federal legislation, testified in April that lawmakers should go after the federal dollars and transfer GAMC enrollees to Medical Assistance. "The new federal reform law provides Minnesota with an opportunity to capture hundreds of millions of new federal dollars that can be used to start rebuilding Minnesota's safety net, which has been undermined by recent budget cuts."

Seeking Fairness among States

The federal health care reform law addresses Minnesota's maddening Medicare payments.

The Patient Protection and Affordable Health Care Act, approved by Congress and signed by President Obama on March 23, along with additional commitments by the Obama administration create a framework for changing the way Medicare reimburses doctors. Over the next two years, Congress and the U.S. Department of Health and Human Services will take several steps to establish a value index and address geographic disparities that affect physician payments.

"This is a very positive and significant advance for Minnesota," said MMA President Benjamin Whitten, M.D. "The MMA has been working to address geographic disparities for years, and the provisions in the act and the additional commitments made by HHS should result in Minnesota physicians seeing increased Medicare payments."

CREATING A VALUE INDEX

Minnesota physicians and hospital administrators have told lawmakers for years that inequities in the Medicare payment system penalize providers in areas that provide low-cost, high-quality care. For example, in Miami, per capita Medicare expenditures are about twice what they are in Minneapolis, although the quality of care is higher in Minneapolis. Much of this variation is caused by regional practice differences that result in greater utilization of services such as inpatient and specialist care.

To begin to rectify this inequity, the MMA supported the establishment of a value index, which would reward Minnesota physicians for value, not just volume. Sen. Amy Klobuchar successfully negotiated for the inclusion of a value index provision in the reform law. The changes to the Medicare payment system will be administered, starting in 2012, by the Secretary of Health and Human Services, who will work to establish uniform measures of quality and cost that will form the basis a value-based payment modifier in the physician fee schedule. Beginning January 1, 2015, the value index will be used to determine payments for a limited number of physicians and physician groups, with full implementation by January 1, 2017. Adjustments will likely occur at the medical group level.

The provision is budget neutral, which means that Medicare physician payments will be redistributed based on measures of quality and cost, rather than simply on geography. Minnesota is expected to fare well under the new system; however, the value index's full impact is unknown, because the portion of Medicare payments that will be subject to the value index was not spelled out in the law.

ADDRESSING GEOGRAPHIC DISPARITIES

In addition to the provisions in the health care reform act, the Obama Administration has agreed to address other factors driving the geographic variation in Medicare spending.

In particular, Health and Human Services Secretary Kathleen Sebelius has committed to commissioning two Institute of Medicine (IOM) studies. One will examine the data and factors used to develop the Medicare physician payment geographic adjustments or Geographic Practice Cost Indices (GPCIs), and the other will look at overall geographic variation in volume and intensity of health care services utilization. Sebelius plans to use the IOM's findings to change physician payment rates by December 31, 2012. She also plans to convene a National Summit on Geographic Variation, Cost, Access, and Value in Health Care later this year.

The Obama administration agreed to this course when the Quality Care Coalition, a group of 30 House Democrats from the Midwest and the Pacific Northwest, including Rep. Betty McCollum (D-Minn), secured a written commitment from Sebelius to address the issue of geographic disparity. McCollum says that an important aspect of the reform law is its acknowledgment that Medicare has not reimbursed physicians and hospitals in a fair and equitable manner. "Saying that in statute," she said, "puts us in a really good place as we work with [Secretary Sebelius] to move forward to make sure that our doctors and hospitals are reimbursed fairly."

Reform Law Includes $400M for Geographic Disparities

Medicare uses three Geographic Practice Cost Indices (GPCIs) to regionally adjust payments based on differences in costs. The use of GPCIs and their validity has been extremely controversial. The three GPCIs mirror the components of the relative value units (RVUs). They are physician work (or cost of living), practice expense (or overhead), and liability insurance. The Patient Protection and Affordable Health Care Act extended a floor for the physician work GPCI, so that all physicians will receive payments equal to or above the national average in 2010. The law also allocates $400 million for revising the calculation of the practice expense GPCI in 2010 and 2011 to reduce the variation across the country. The MMA strongly supported these changes, which will result in a payment increase of nearly 1 percent for Minnesota physicians.

Health Care Reform Timeline

The federal reform law sets in motion numerous changes most of which will be launched between now and 2014. Here's a timeline of provisions particularly relevant to Minnesota physicians.

2010

- Sets up a temporary, $5 billion high-risk health insurance pool to provide coverage for people with pre-existing conditions who have lacked insurance for at least six months. It may overlap with Minnesota's high-risk pool, the Minnesota Comprehensive Health Care Association.
- Allows Minnesota the option of enrolling adults with incomes up to 133 percent of poverty in Medicaid and receiving a 50 percent match on spending for their care. Minnesota already offers coverage for this population through state-funded General Assistance Medical Care program and MinnesotaCare.
- Maintains dependent coverage for children until they turn 26 years of age ; Minnesota law currently allows continued coverage up to 25 years of age in fully insured plans. The federal law applies to self-insured as well as fully insured plans.
- Prohibits insurers from denying coverage to children because of pre-existing health conditions.
- Bars lifetime dollar limits on coverage.
- Begins narrowing the Medicare prescription coverage donut hole by providing a $250 rebate to seniors affected by the coverage gap.
- Reduces projected Medicare payments to hospitals, home health agencies, nursing homes, hospices, and other providers.
- Includes a 5 percent payment increase for psychotherapy services.

2011

- Authorizes five-year grants to states to develop, implement, and evaluate alternative medical liability reform initiatives.
- Eliminates cost-sharing for proven preventive services delivered to Medicare and Medicaid enrollees.
- Includes a 10 percent bonus payment to general surgeons practicing in underserved areas in 2011-2016.
- Provides a 10 percent bonus payment in 2011-2016 for office, nursing facility, and home visits provided by primary care physicians whose charges for such services account for at least 60 percent of their total Medicare charges.
- Modifies payments to Medicare Advantage plans.
- Provides a 90 percent Medicaid match for two years for medical home care coordination services.
- Boosts funding for community health centers.
- Creates a national quality-improvement strategy and establishes a national council to develop a comprehensive public health strategy.

2012

- Encourages demonstration projects involving accountable care organizations.
- Reduces Medicare payments to hospitals with high rates of preventable readmissions.
- Creates Medicaid bundled payment demonstrations.

2013

- Increases Medicaid payments to at least Medicare rates during 2013 and 2014 for evaluation and management services and immunizations provided by family physicians, general internists, and pediatricians.
- Creates a Medicare pilot program for bundled payments.
- Requires financial relationship disclosures for physicians.
- Standardizes administrative operating rules for eligibility and claims status transactions. Minnesota's work in this area could prove influential.

2014

- Prohibits insurers from denying coverage to people with medical problems and implements individual coverage mandate.
- Creates new state-run health insurance exchanges and provides income-based tax credits to individuals between 133 percent to 400 percent of poverty.
- Establishes the Medicare Independent Payment Advisory Board to recommend proposals to reduce Medicare spending if the target rate of growth is exceeded. The recommendations must be implemented unless overridden by Congress.
- Extends Medicaid to all individuals under 65 years of age earning up to 133 percent of poverty.

Demonstration Project Opportunities for Minnesota

The reform act creates the Center for Medicare and Medicaid Innovation, which will test new care delivery and payment models. The innovation center is expected to partner with states to test new concepts, such as payment bundling, medical homes, and accountable care organizations. This should create an opportunity for Minnesota to win funding and to have more flexibility to experiment with care delivery and payment strategies. For example, under Minnesota's current health care home initiative, Medicare enrollees are not eligible for care coordination payments, but the reform law opens the door to that possibility.

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photo courtesy of The White House

INSIDE:

National Reform Sets Stage for State Changes

Federal reform law opens up the possibility for eliminating several state-run insurance programs as well as the provider tax.

Reforms Address Medicare Payments

Over the next two years, Congress and the U.S. Department of Health and Human Services will take steps to establish a value index and address geographic disparities that affect physician payments.

National Health Care Reform Timeline

The reform law includes numerous changes, most of which will be launched during the next four years.

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