

OUTLOOK ON
REFORM

A
MINNESOTA
VIEW

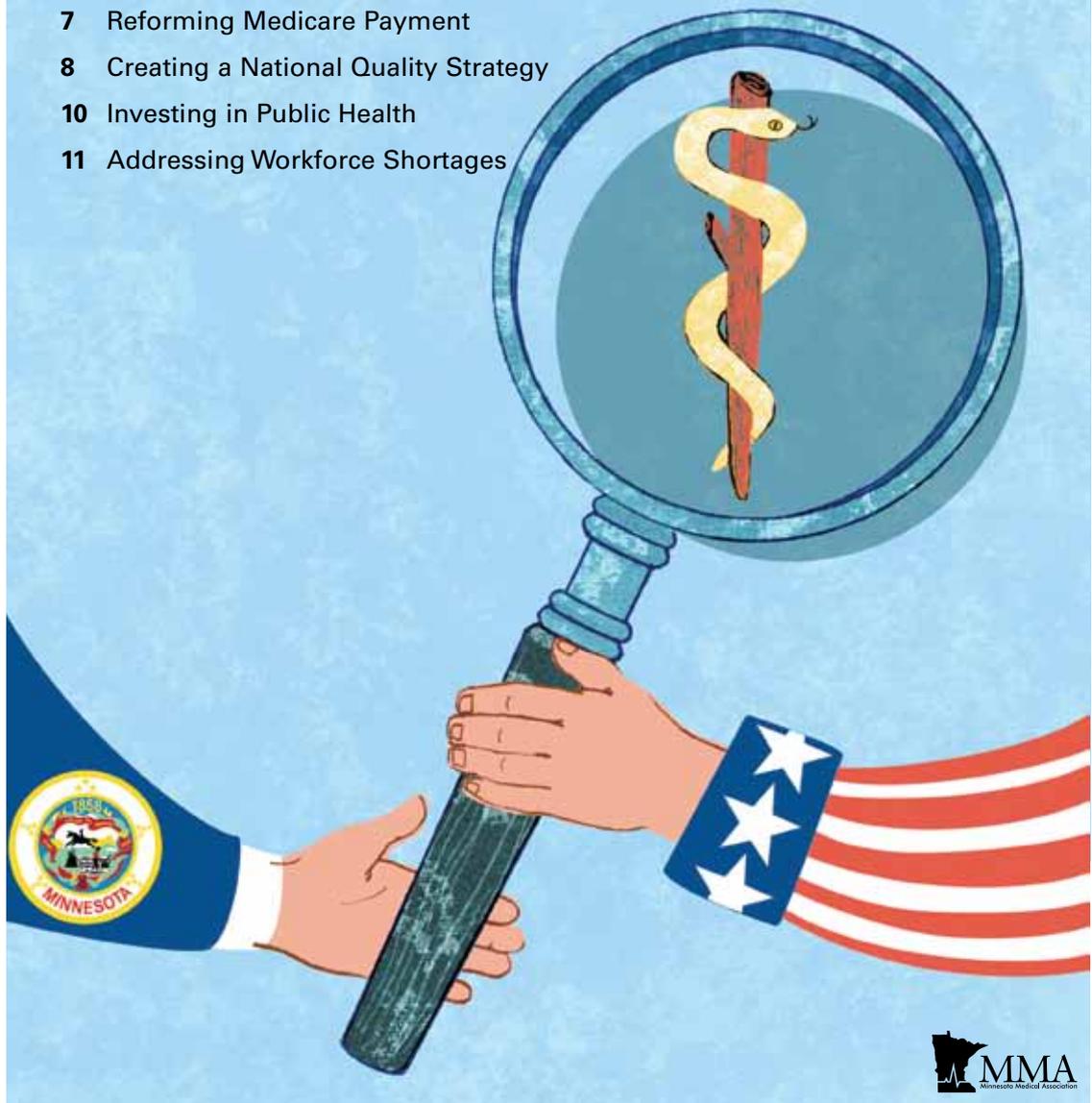




OUTLOOK ON REFORM A MINNESOTA VIEW

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Reform: A Work in Progress

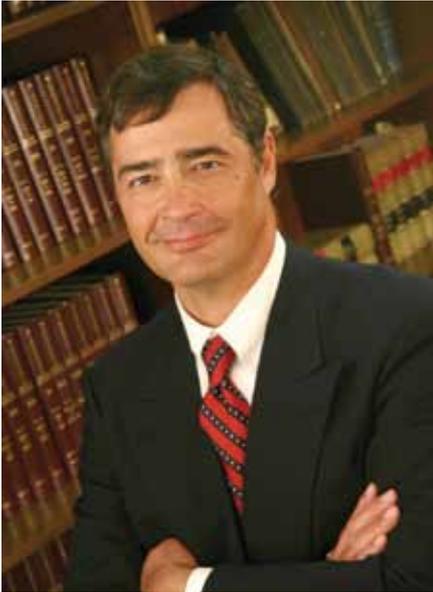


Photo by Scott Walker

Benjamin Whitten, M.D.



Photo by Steve Wewerka

Dave Thorson, M.D.

Since President Barack Obama signed the Patient Protection and Affordable Care Act into law in March, new attention has been focused at both the state and federal levels on health care coverage, delivery, payment, quality, and costs.

For physicians and patients in Minnesota, the key question is whether the new federal law will improve or impinge on Minnesota's own efforts to provide every resident with affordable, quality health care. Some hope federal officials will see Minnesota as a high-achieving outpost that can serve as a resource, model, and testing ground for innovation, since many elements of the federal reform law resemble those that Minnesota endorsed when it passed its own reform legislation in 2008. Others fear Washington will impose processes, mandates, or timelines that will slow down or reverse our state's progress.

Given that this complex and ambitious law will take many years to implement, there's no telling what the final outcome will be. But it is clear that the new law creates opportunities that Minnesota can and should take advantage of. For example, the MMA has called on our governor to accept new federal matching dollars and shift enrollees in the General Assistance Medical Care program to Medical Assistance.

We believe that Minnesota should take a proactive approach and reach out to federal policy makers because those who take the lead now will be able to chart the course later. This publication introduces components of the federal health care reform law particularly relevant to Minnesota physicians in the areas of coverage, insurance reform, quality improvement, and public health and disease prevention. It is designed to provide factual information about the law as seen through a Minnesota lens.

Benjamin Whitten, M.D.
MMA President

Dave Thorson, M.D.
Chair, Board of Trustees



Reform Timeline

The federal health care reform law sets in motion a number of changes, most of which will take place between now and 2014. Here's a summary of when some of the provisions that are particularly relevant to Minnesota physicians will go into effect.

2010

- Establishes a temporary \$5 billion high-risk health insurance pool for people with pre-existing conditions who have not had insurance for at least six months. Gov. Tim Pawlenty's administration indicated in April that Minnesota would not administer this high-risk pool. Instead the state's high-risk pool, the Minnesota Comprehensive Health Association (MCHA), will continue to operate in addition to the new federal option.
- Allows states the option of enrolling adults with incomes up to 133 percent of poverty in Medicaid. The federal government will match state spending on coverage of these people based on current rates (Minnesota's is 50 percent). During the 2010 legislative session, lawmakers passed a measure giving Minnesota's governor until January 15, 2011, to sign an executive order triggering the expansion for individuals earning less than 75 percent of poverty—essentially those Minnesotans currently covered by

the state General Assistance Medical Care program. On June 22, Gov. Pawlenty announced that Minnesota would not pursue the option during his tenure.

- Expands dependent coverage to young adults up to 26 years of age. Minnesota law currently allows continued coverage for dependents up to 25 years of age in fully insured plans. The federal law applies to both self-insured and fully insured plans.
- Prohibits insurers from denying coverage to children who have pre-existing health conditions.
- Bars lifetime dollar limits on coverage.
- Starts shrinking the Medicare prescription drug coverage "donut hole" by providing a \$250 rebate to seniors affected by the current coverage gap.
- Reduces Medicare payments to hospitals, home health agencies, nursing homes, hospices, and other providers.
- Extends by one year the 5 percent Medicare payment increase for psychotherapy services.

- Establishes the Patient-Centered Outcomes Research Institute to support comparative effectiveness research.
- Establishes the Workforce Advisory Committee to develop a national health care workforce strategy.
- Levies a 10 percent tax on indoor tanning 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 enrollees.
- Starts a five-year program to pay 10 percent Medicare bonuses to general surgeons practicing in underserved areas.
- Provides a 10 percent bonus Medicare payment to primary care physicians if 60 percent or more of their charges are for office, nursing facility, and home visits.
- Modifies payments to Medicare Advantage plans.
- Provides states 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.
- Requires Medicaid coverage for use of freestanding birthing centers.
- Requires chain restaurants and food sold in vending machines to disclose nutritional contents of items.
- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports.

FAST FACTS

According to estimates, the new law will:

- Cover 32 million of 55 million uninsured Americans
- Reduce the federal deficit by \$143 billion during the 2010-2019 period
- Be funded with tax provisions and dollars saved by reduced spending on Medicare and Medicaid
- Cost \$938 billion over 10 years



ABCs OF ACOs

Accountable care organizations (ACOs) have the potential to change Minnesota's delivery and payment systems.

An ACO is generally defined as a group of health care providers who accept accountability for the cost and quality of care delivered to a defined population of patients. The ACO model is intended to allow for a variety of provider and payment arrangements. ACOs could emerge from existing specialty groups, integrated systems, or independent practice associations. They may be small groups of physicians acting as medical homes and only taking responsibility for coordinating the care of patients with chronic diseases, or they may be large integrated systems that assume responsibility for the total cost of caring for patients.

How providers will be reimbursed for delivery of these services is yet to be determined. The reform law calls for Medicare to test various payment models. It appears that Medicare will first try a shared-savings approach, under which physi-

cians would get a share of dollars saved from care improvements such as fewer hospitalizations.

Another approach is to give providers lump-sum payments. The ACO model is intended to avoid the problems associated with capitation by limiting physician exposure to unpredictable events, adjusting payments based on patient risk factors, and distributing bonuses or penalties based on quality measure scores.

The MMA's position is that the ACO model has promise but that participation should be voluntary. Many questions remain unanswered about whether the ACO model will work for rural and small practices and whether quality measures and risk-adjustment methods are sophisticated enough to allow the model to succeed. Minnesota is in the process of trying to answer some of these questions. The Legislature passed a law in 2010 that calls for the Minnesota Department of Health to establish an ACO demonstration project involving the state's health care safety-net programs by July 2011.

2012

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

2013

- Increases Medicaid payments to at least Medicare rates for evaluation and management services and immunizations provided by family physicians, general internists, and pediatricians for 2013 and 2014.
- Creates a Medicare pilot pro-

gram for bundled payments.

- Requires new financial disclosures from manufacturers of drugs, medical devices, biologics, or medical supplies for payments and transfers of value made to physicians or teaching hospitals.
- Standardizes health insurance company rules for eligibility and claims status transactions.

2014

- Requires U.S. citizens and legal residents to have qualifying health coverage, with a phased-in tax penalty for those who don't.
- Prohibits insurers from denying coverage to people with medical problems and imple-

ments limits on premium rate variation.

- Creates new state-run health insurance exchanges and provides income-based tax credits to individuals with incomes between 133 percent and 400 percent of poverty.
- Establishes the Medicare Independent Payment Advisory Board to make recommendations for reducing Medicare spending if the target spending rate is exceeded. The recommendations must be implemented unless overridden by Congress.
- Expands Medicaid to all non-elderly, nondisabled individuals younger than 65 years of age who earn up to 133 percent of poverty.

REFORM SETS STAGE FOR STATE PROGRAM CHANGES

With significant changes in Medicaid eligibility and new subsidies for individuals with incomes between 133 and 400 percent of poverty, the new federal health care reform law has the potential to change and streamline Minnesota's current public health insurance programs. The potential for change in Medical Assistance (Minnesota's Medicaid program), General Assistance Medical Care (GAMC), and MinnesotaCare was already evident during the 2010 legislative session when lawmakers sought to take advantage of a provision in the reform law that gives states the option of expanding Medicaid to adults with incomes of up to 133 percent of the federal poverty guideline prior to 2014, when all states will be required to do this. This provision opened up the possibility of transferring people from GAMC to Medical Assistance (MA).

During last-minute negotiations, lawmakers created the legal structure and allocated funding for the MA expansion. The provision would provide Minnesota with \$1.4 billion in additional federal money over three years with a state investment of \$188 million. Gov. Tim Pawlenty or his successor has been given until January 15, 2011, to invoke the change by executive order, which would effectively shift GAMC enrollees to MA. On June 22, the governor announced that Minnesota would not pursue the option during his tenure.

The MMA strongly supported the early expansion option, particularly in light of the dramatic cuts and changes that were made to GAMC this session. The expansion option would result in better coverage for enrollees, better reimbursement rates for providers, and a more streamlined state-supported health care system.

MinnesotaCare

Federal reform also will likely mean significant changes for MinnesotaCare, the state-funded health insurance program for low- and moderate-income working Minnesotans who do not otherwise have access to coverage. Enrollment in the program is limited to families with children, pregnant women, and children younger than 21 years of age with incomes up to 275 percent of poverty, and to adults without children who have incomes up to 250 percent of poverty. All enrollees pay premiums on a sliding scale.

Starting in 2014, however, many of the adults currently enrolled in MinnesotaCare will be eligible for new federal subsidies to purchase private health insurance. When this happens, MinnesotaCare will likely be a very different program.

But the state's coverage of children will not change, since all states, including Minnesota, are required to maintain their current commitments to coverage for children through 2019.

Minnesota Comprehensive Health Association

The federal reform law included a provision for the creation of a temporary, high-risk insurance pool for those who lack health care coverage because of pre-existing conditions. The temporary pool would operate until 2014, when insurers will no longer be allowed to refuse coverage to people with pre-existing conditions. The pool described in the new law is conceptually similar to the Minnesota Comprehensive Health Association (MCHA), which was established in 1976.

The U.S. Department of Health and Human Services estimates that \$68 million will be available to cover eligible Minnesotans. The law granted the states the option of administering the new pool on their own or having the federal government manage it. Citing differences in eligibility between the federal high-risk pool and MCHA, as well as concerns about the adequacy of federal financing to meet the needs of potential enrollees, Gov. Pawlenty announced in April that Minnesota would not take on management of the new pool.

For the time being, the state and federal programs will operate separately.

The MMA will be working with policy makers to capitalize on the opportunities afforded under the new law to streamline and improve Minnesota's programs.





REFORMING MEDICARE PAYMENT

The federal health care reform law and 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 steps to establish a value index and address geographic disparities that affect physician 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 parts of the country that provide low-cost, high-quality care. 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 law establishes a value index, which will modify the formula used to establish the Medicare physician fee schedule. Minnesota Sen. Amy Klobuchar successfully negotiated for the inclusion of a value index provision in the reform law. Value is defined as measures of quality of care divided by measures of cost of care.

The Secretary of Health and Human Services will establish the quality and cost metrics. But the law specifies that quality must be based on a composite of measures that reflect health outcomes and be appropriately risk-adjusted. Cost must be based on a composite measure as well and will be adjusted for patient risk factors and geographic differences in payments.

Starting in January 2015, the value index will be used as one determinant of payments for a limited number of physicians and physician groups, with full implementation taking place by January 1, 2017. The provision is budget-neutral. Minnesota is expected to fare well under the new system; however, the full impact of the value index is unknown because the law did not spell out what portion of Medicare payments will be determined by the value index.

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 will commission 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); 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 in 2010.

The law also extended through 2010 the floor for the physician work GPCI. This floor was established in 2004 and provides a net benefit to Minnesota physicians. In 2010 and 2011, the law allocates \$400 million

Medicare's Value Index as Compared with Minnesota's Peer Grouping Initiative

The federal government's value index and Minnesota's provider peer-grouping efforts both attempt to assess the value of care being provided by analyzing cost and quality data. The federal government will be developing its value index during the next few years. Minnesota's peer-grouping project is well underway. It will measure and publicly report the performance of clinics and hospitals in terms of cost and quality of care. Clinics are expected to get a first look at their data this fall.

Although the federal value index and the peer grouping program will both produce cost and quality data, that data will be used for different purposes. The value index will be used to adjust Medicare physician payment rates, whereas Minnesota's peer grouping results will be used by private and public payers to encourage patients to choose high-quality, low-cost providers.

to increase the practice expense GPCI for all localities, including Minnesota, that are below a value of 1.0. The MMA strongly supported these changes, which together result in an average payment increase of nearly 1 percent for Minnesota physicians.



SUPPORTING PRIMARY CARE

The new federal reform law emphasizes primary care services and care coordination. The new Center for Medicare and Medicaid Innovation will research, develop, test, and expand new health care delivery models including medical home. A Medicare pilot program will be created in January 2012 that will reward providers who make their practices medical homes by offering medication management, language interpretation services, and shared decision-making.

These medical home pilots may complement Minnesota's own health care home initiative, which started offering care coordination payments to certified clinics in July.

Minnesota hopes to include Medicare patients in its health care home initiative as part of the Medicare Advanced Primary Care Practice demonstration project. The Centers for Medicare and Medicaid Services expects to select up to six states to participate.

The MMA has called for a medical or health care home for all Minnesotans, and the inclusion of Medicare patients would be an important step toward moving the state in that direction.



Creating a National Quality Strategy

A number of provisions in the new federal reform law focus on improving quality, and Minnesota's reputation as a health care quality leader provides the state with the opportunity to influence those efforts.

Minnesota providers have led the nation in their willingness to adopt clinical measures and to collect and share data, through efforts such as MN Community Measurement. The hope is that Minnesota will become a testing ground for federal initiatives and perhaps partner with organizations such as the National Quality Forum, which endorses measures. By getting in on the ground floor, Minnesota could help set a direction for the nation that would build on the work already being done here. Minnesota could help federal policy makers resolve many unanswered questions about which measures to choose, how to collect data, and how to structure programs to generate the highest possible level of buy-in and participation.

The following are some of the key components of the federal reform law that address quality improvement.

Measuring Performance

One strategy for improving the quality of care is to make information about the performance of hospitals, physicians, and other care providers widely available. The law instructs the Department of Health and Human Services, the Agency for Health Care Research and Quality, and the Centers for Medicare and Medicaid Services to work together to identify and implement performance measures that focus on clinical outcomes and patient experience; standardize collection and use of race, ethnicity, and language data; and track health outcomes disparities.

Comparing Research

Another strategy for improving quality is to provide better information about which health care interventions work best under certain circumstances and make this information available to physicians, patients, and payers. The law creates the Patient-Centered Outcomes Research Institute, which will conduct, support, gather, and disseminate research findings with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures.

In response to concern regarding how the information may be used, the law prevents the government from using these findings as the sole basis for incentive programs and coverage decisions.

Paying for Reporting

The new law extends the Physician Quality Reporting Initiative (PQRI), Medicare's voluntary pay-for-reporting program, through 2014 and requires physician participation starting in 2015. Bonuses offered through the initiative will gradually decrease between 2012 and 2014. Starting in 2015, Medicare payments to physicians who do not participate in the program will be reduced by 1.5 percent with a 2.0 percent reduction in subsequent years.

Comparing Physicians

Building on current Medicare public reporting for hospitals and nursing homes, the new law extends the approach to physicians. Starting in 2011, Medicare will establish a Physician Compare website that will provide information on physician quality and patient experience measures.

Next Steps

The law stipulates that the Secretary of Health and Human Services (HHS) establish a national quality-improvement strategy by January 1, 2011. The question is how this national

strategy will affect the work already being done in Minnesota, which is in the process of implementing its own statewide quality reporting system, that includes measures of diabetes and cardiovascular care and health information technology use. Minnesota is also in the process of developing its provider peer grouping system, which will provide data about the quality and cost of care provided at clinics and hospitals.

The MMA helped develop and monitor Minnesota's quality improvements efforts and will likewise monitor federal efforts.

Defining an Essential Benefit Set

The federal reform law's individual mandate for health insurance coverage raises the thorny issue of what benefits must be included in an essential benefit set.

This is a question Minnesota has been unable to answer. The state's 2008 Health Care Reform Act created an Essential Benefit Set Work Group that was tasked with developing a set of benefits that would be covered by private insurers. The work group punted on listing a set of comprehensive services to be covered and instead recommended the creation of an essential benefit set certification process. To date, no movement has been made to advance the work group's recommendations.

At the federal level, the Secretary of Health and

Human Services will have to define an essential set of services by 2014. The set is expected to be equal in scope to a typical employer plan and will include such things as ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management, and pediatric services including oral and vision care. Health plans participating in the new health insurance exchange, as well as those offering products in the individual and small-group markets must, at minimum, offer the essential benefits package beginning in 2014.

What the Exchange Could Look Like

When the insurance exchange starts in 2014, there will be five types of plans that will all cover the essential benefit set.



Young Invincible

Catastrophic plan for enrollees with premiums greater than 8 percent of income or who are younger than 30 years



Bronze

Covers 60 percent of enrollee medical costs



Silver

Covers 70 percent of enrollee medical costs



Gold

Covers 80 percent of enrollee medical costs



Platinum

Covers 90 percent of enrollee medical costs

Out of pocket limits \$5,950 individuals, \$11,900 families

Investing in Public Health

Minnesota is well-positioned to take advantage of federal grant money flowing from the Patient Protection and Affordable Care Act in the area of public health and disease prevention.

The new law provides significant funds for sustaining and expanding state public health programs and also supports a number of new public health pilot and demonstration projects.

The law establishes a Prevention and Public Health Fund that will receive \$15 billion in public health funding over 10 years. The fund will expand and sustain national investments in public health research, preventive screening, education and outreach, and immunization campaigns.

Secretary of Health and Human Services Kathleen Sebelius will make available an additional \$500 million to convene a national public-private partnership dedicated to prevention of disease and health promotion education and outreach.

It is expected that the federal government will take an approach similar to the one Minnesota pursued with its Statewide Health Improve-

ment Program (SHIP), where money was funneled to local communities working to encourage healthy behaviors and upstream prevention of chronic disease.

Minnesota's SHIP program has already received federal grant money for two communities, Minneapolis and Rochester. In 2009, Rochester adopted Complete Streets language that ensures city planners take into consideration the needs of pedestrians, bicyclists, and transit users as well as automobiles when building or renovating roads. Federal prevention dollars are helping city planners implement that policy.

Minneapolis and Rochester are also using federal money to develop media and social network marketing strategies to better engage people in adopting healthy behaviors. Federal funding is also helping schools implement the Institute of Medicine's guidelines for school meals and develop active transportation programs that promote walking and biking to school.

Given Minnesota's good timing in this area, the state's public health community is optimistic that it will

be able to secure more federal dollars for those projects that can demonstrate outcomes.

Here is a look at some of the law's public health provisions.

National Public Health Strategy

The law creates a new interagency National Prevention, Health Promotion, and Public Health Council, which the president brought into being with an executive order June 10. The council is to guide the nation's prevention and health-promotion strategy. The council includes representatives from 12 critical sectors of the federal government, including the secretaries and chairs of homeland security, transportation, agriculture, labor, health and human services, and education. It will be chaired by the Surgeon General. The law requires the council to issue its first report in 2010 and to provide yearly reports thereafter.

State and Local Grants

Grant money will be available starting in 2010.

Community Transformation grants will be awarded to state and local government agencies and community-based organizations for programs focused on evidence-based community prevention and wellness. The programs must aim to reduce chronic disease, prevent secondary conditions, or address disparities and will include activities such as those that support offering healthful food in schools.

Healthy Aging, Living Well grants also will be awarded to state or local health departments and Indian tribes to carry out five-year pilot projects focused on reducing chronic disease among people ages 55 to 64 years.

COVERING PREVENTIVE SERVICES

Starting in September, newly issued health plans must cover many preventive health services, routine screenings, immunizations, and other care without requiring copayment, coinsurance, or a deductible. As many as 88 million Americans could benefit from this by 2013. The requirement will kick in for many enrollees in January, when their policies renew.

In addition, by January 1, 2011, Medicare must cover the full cost of most preventive services. State Medicaid programs that do so will receive a 1 percent bump in federal Medicaid matching funds for those services beginning in 2013.

ADDRESSING WORKFORCE SHORTAGES

The influx of newly insured patients that is expected to occur as a result of federal health care reform will likely exacerbate shortages of primary care providers.

Aware of the problem, the Obama Administration in June unveiled \$250 million in investments to expand the nation's primary care workforce, including measures to train more than 500 new primary care physicians by 2015 and provide training dollars for physician assistants and nurses.

Leaders at the University of Minnesota Medical School favor measures such as tuition support and debt forgiveness to medical students.

The university also plans to address the physician shortage by helping foreign-educated physicians who are living in Minnesota become licensed here. This past session, the Minnesota Legislature approved \$150,000 in seed money for a program that this fall will start helping these physicians pass the necessary tests to get licensed.



Primary Care Workforce Funding

The federal government announced in June that it would provide \$250 million in investments to expand the nation's primary care workforce. Here's how the funding will be used:

- \$168 million Primary care residency slots
- \$32 million Physician assistant training
- \$30 million Nursing education
- \$15 million Nurse practitioner-led clinics
- \$5 million State planning grants

Source: U.S. Department of Health and Human Services

Other grants will target projects that address depression, pregnant and parenting teens, victims of sexual or domestic violence, abstinence and contraception education, immunization rates, and other topics ranging from breast cancer education for young women to oral health promotion.

Public Health Training

The law also calls for enhancements to the nation's public health workforce. Money will be pumped into the National Health Service's scholarship and loan repayment program as well as a new Public Health Workforce Loan Repayment Program. The law also calls for several training programs including ones for mid-career public health professionals and for people interested in careers in public health,

epidemiology, and emergency preparedness. The Secretary of Health and Human Services also will be given funds to address certain state and local public health workforce shortages.

Patient Empowerment

The law will attempt to put tools in the hands of patients that can help them live healthier lives. These might include risk assessments and personalized disease-prevention plans for Medicare beneficiaries, at-risk individuals, and people in medically underserved areas. Grants will be given to states, health departments, hospitals, clinics, Federally Qualified Health Centers, and other nonprofit entities to promote positive health behaviors and outcomes through the use of community health workers. Medicaid will provide full

coverage for tobacco cessation services for pregnant women beginning October 1, 2010.

Wellness Programs

Employee wellness programs around the nation will be surveyed to glean best practices and evaluate their effectiveness. Funding and technical assistance will be available to small employers wishing to establish such programs. In addition, employers will have more leeway to offer employees rewards for healthy behavior beginning in 2014.

Nutrition Labels

Nutrition labeling will be required for chain restaurant and vending machine food items starting in 2011.



The doctor will
see you now.

As a physician, your focus is on your patients.

When they come to you with a concern, you examine them and give them the information, care and medication to heal or stay well.

At the MMA, our focus is on you. When health system reform was enacted, we studied the details to provide you the knowledge you need to continue doing what you do best – seeing your patients.

Your membership support allows the MMA to continue being the Minnesota physician resource for health system reform.

The MMA thanks you for your membership commitment. And so do your patients.

