Minnesota Medical Association: Background and Opportunities

House Health & Human Services Finance Committee
February 8, 2011
Objectives

- Overview of the MMA
- Quick Facts about MN Physicians
- Shared Goals
- Strategies & Opportunities
  - Public Health
  - Insurance Reform
  - Delivery Reform
  - Payment Reform
  - Environment
The MMA

• 158-year history
• 11,000 members
  – All specialties, statewide
• Mission: to provide advocacy, information, education, and leadership for Minnesota physicians and their patients.
• 2 relevant strategic – and shared – goals:
  – Minnesotans are the healthiest in the nation.
  – Minnesota is the best place to practice medicine.
Minnesota Physicians: Quick Facts

• 19,600 licensed physicians (2010)
  – Not all actively practice or live in MN
• 264 actively practicing per 100,000 population (254 US; 13th)
• 102.3 primary care physicians per 100,000 (89 US; 11th)
• 20% > age 60
Education & Training

- Physician education - minimum of 11 years
- MN graduates ~ 280 new physicians per year
  - U of M
  - Mayo
- About 2,200 medical residents train in Minnesota.
Medical Practices: MD Distribution

- Clinics vary significantly – size, specialty composition, location, service offerings, capacity, etc.
- What works for one, may not work for others…
Economic Impact: Office-Based MDs (2009)

• Output: $16.3 billion in direct and indirect output (i.e., sales revenues)

• 67,483 direct and indirect jobs
  – On average each office-based MD supported 5.8 jobs, including her own.

• $12.1 billion in direct and indirect wages and benefits
  – On average each physician supported $1,031,349 in total wages and benefits.

MMA: A Commitment to Health Care Reform

- 2005 report
- Healthy Minnesota Partnership
  - 2007 legislation: groundwork for Governor’s Transformation Task Force
- Emphasized need for comprehensive view & solutions
Goals: Healthiest People & Best Place to Practice Medicine

• Overlapping strategies
  – Public health
    • Prevention and health promotion
  – Affordable coverage
    • Insurance reform
  – Delivery system reform
    • High quality, safe, and efficient care
  – Payment reform
  – An environment that supports care, education, and practice
Prevention & Health Promotion

- HEALTH Determinants =
  - Social & economic factors (40%)
  - Health behaviors (30%)
  - Clinic care (20%)
  - Physical environment (10%)

Affordable Coverage

• Coverage for all
  – An effective and fair insurance system
• Responsibility – full participation
  • Individual mandate & enforcement
• Subsidies and support for low-income, vulnerable populations

Affordable Coverage Opportunities

• Insurance exchange
  – Ease of insurance comparisons/transparency
  – Simplified and streamlined eligibility processes

• MinnesotaCare reform, elimination?
  – Subsidies for those 133% - 400%
  – Changes need for provider tax
Delivery System Reform

• Patient-centered, effective, safe, efficient care

• Industry activities
  – MN Community Measurement
    • Quality measurement and public reporting
  – MN Alliance for Patient Safety (MAPS)
    • Medication reconciliation, health literacy/informed consent, “just” culture
  – MN Credentialing Collaborative
  – Administrative Uniformity Committee
Delivery System Reform Opportunities

• Health care homes
  – Continued state support needed
  – Medicare participation – critical

• Administrative savings
  – Prior authorization standards
  – Formulary management
  – Quality data collection

• Peer grouping (QI)
  – Clinic and hospital-specific data on cost and quality performance
  – Data from all payers – comprehensive picture
Payment Reform

• Access
  – Financial viability

• Public programs’ fair share
  – Cost shifting

• Payment that rewards value
Population & Diabetic Patient Distribution: MN Clinics

Access: Artificial?

• Rule 101
  – Requires physicians to participate in public programs in order to participate with other state-sponsored programs
    • Work comp, state employees, public employees, MCHA
  – Up to 20% of caseload
• Health plan contract stacking
Public Program Payments

• Methodology recently updated
  – Resource Based Relative Value Scale (RBRVS)
  – 4 years late (2007 deadline)

• Budget neutral
  – Generally, a shift in dollars from procedures and toward primary care
  – Gained greater equity across services
  – Still underfunded

• 3 conversion factors
  – Recommend that any future adjustments be made to CFs, not services or specialties
The Cost Shift

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Pre-2011 Rate</th>
<th>Current MN Medical Assistance</th>
<th>Pre-2011 Rate</th>
<th>Current MN Medical Assistance</th>
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<tbody>
<tr>
<td>New Patient, 20-min office visit (99202)</td>
<td>$0.00</td>
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<td>$40.00</td>
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<td>Establish. Patient, 25-min office visit (99214)</td>
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<td>$120.00</td>
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</table>

Sources: Minnesota M.A. data based on fee-for-service fee schedule published by Department of Human Services (1/31/11); 2008 median private data as published by MN Community Measurement.
Trends: Medicaid, Medicare & Inflation

Sources: Medical Assistance data based on changes in fee-for-service rates excluding targeted programmatic code changes; Medicare data based on changes in Medicare’s conversion factor as published by the Centers for Medicare and Medicaid Services; CPI-U data from US Bureau of Labor Statistics; annual average change.
Managed Care Rate Increases (MA, GAMC, MNCare)
Cumulative Percentage Change, 1998-2008

Source: Minnesota Department of Human Services. Note - figures do not include MNDHO or MSHO. Rates include price and utilization increases, benefit and eligibility changes, and rateable reductions (2003). 2006 drop includes the effect of Medicare Part D pharmacy carve out for dual-eligible seniors.
Payment Models: 5 Likely Options

• Fee for service
  – Payment (discounted) for each service/procedure

• Pay for coordination
  – Payment for specified care coordination services (medical home)

• Pay for performance
  – Payment or financial incentive (e.g., a bonus) associated with achieving defined and measurable goals

• Episode or bundled payments (baskets of care)
  – Single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings

• Comprehensive care (total cost of care)
  – Single risk-adjusted payment for the full range of health care services needed by a specified group of people for a fixed period of time
Payment Reform Opportunities

• No single payment model solution
  – Complexity of care delivery
  – Geographic variations in provider structures, size, capacity
  – Variety of delivery models

• Support flexibility & innovation

• Support health care home model

• ACA demonstrations
Environmental Supports

- Tort reform
  - MMA supports cap on non-economic damages
    - Improved risk & premium predictability
- Medical education
  - Keep medical school affordable
- Business climate
  - Provider tax
    - Strong “negative” for Minnesota

Average Debt of Medical School Grads

<table>
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<th>U of M</th>
<th>National Avg.</th>
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<td>$168,000</td>
<td>$157,990</td>
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Additional Information:

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