Minnesota Medical Association: Background and Opportunities

House Health & Human Services Finance Committee

February 8, 2011

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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.

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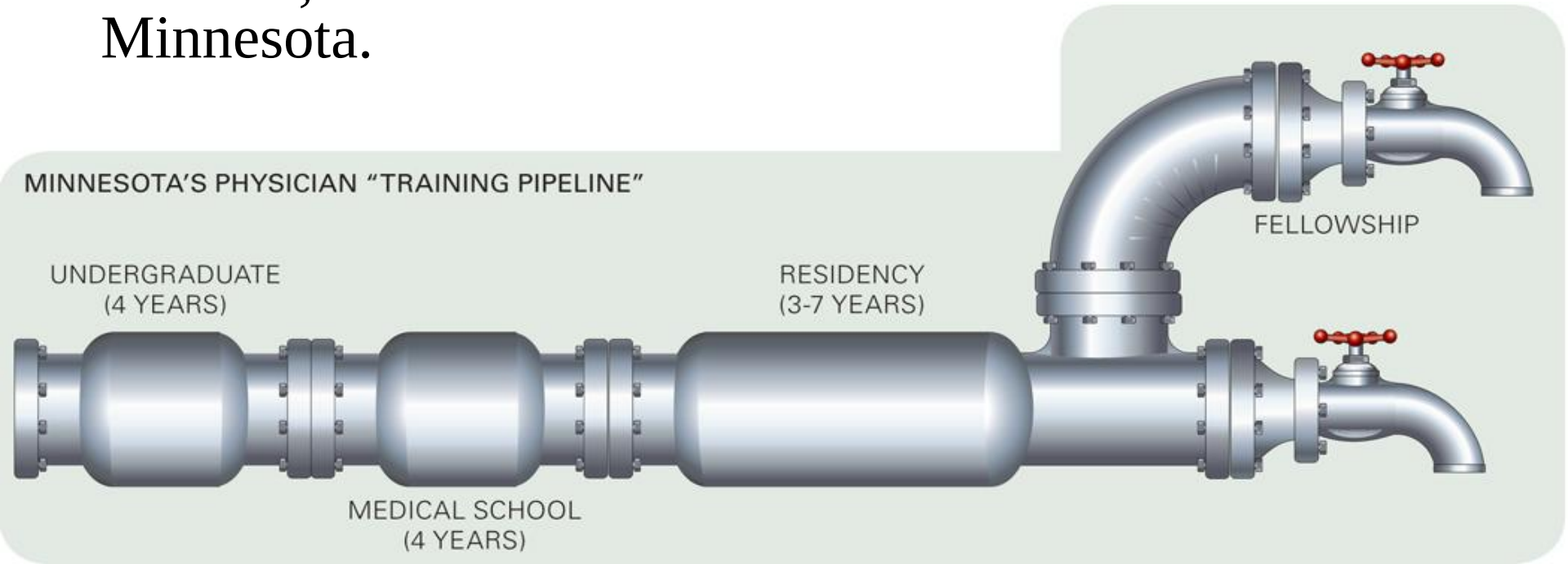
Minnesota Physicians: Quick Facts

- 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

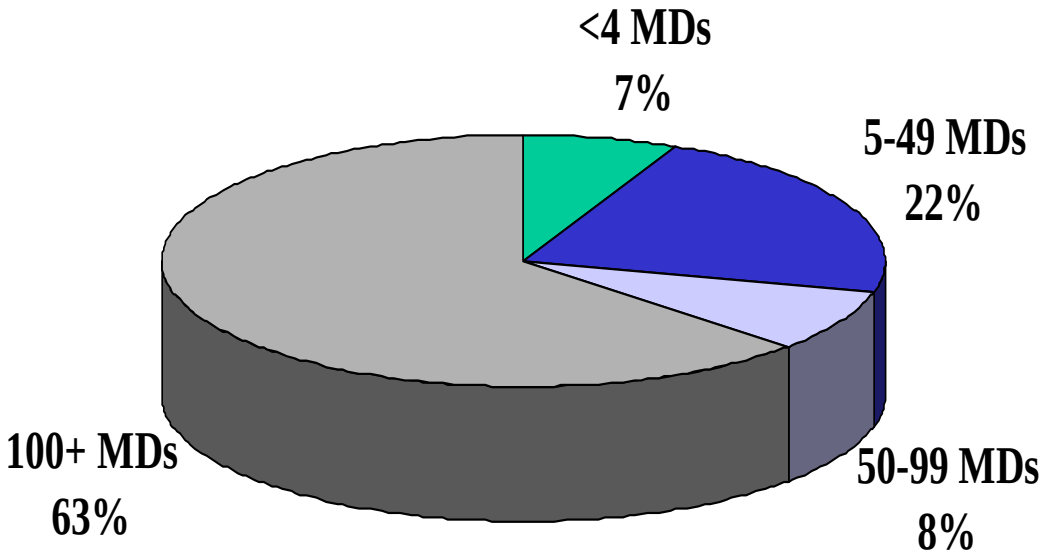
Education & Training

- 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)

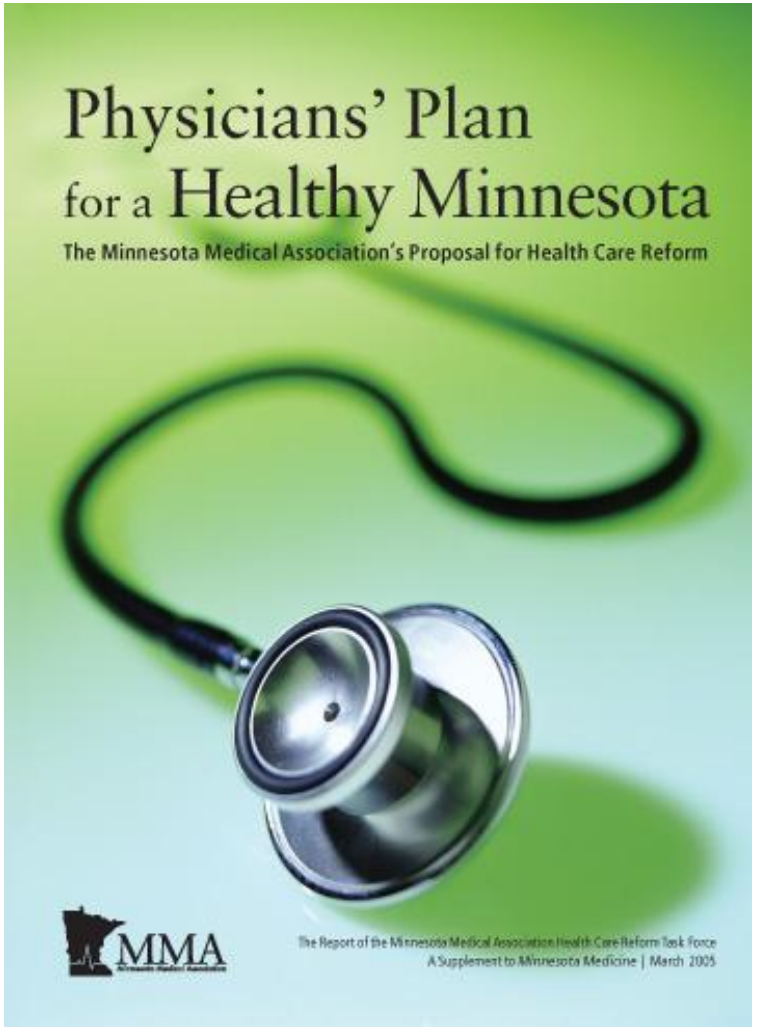
- Output: **$16.3 billion** in direct and indirect output (i.e., sales revenues)

- **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.

Source: The Lewin Group. The Economic Impact of Office-Based Physicians in Minnesota. January 2011.

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

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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

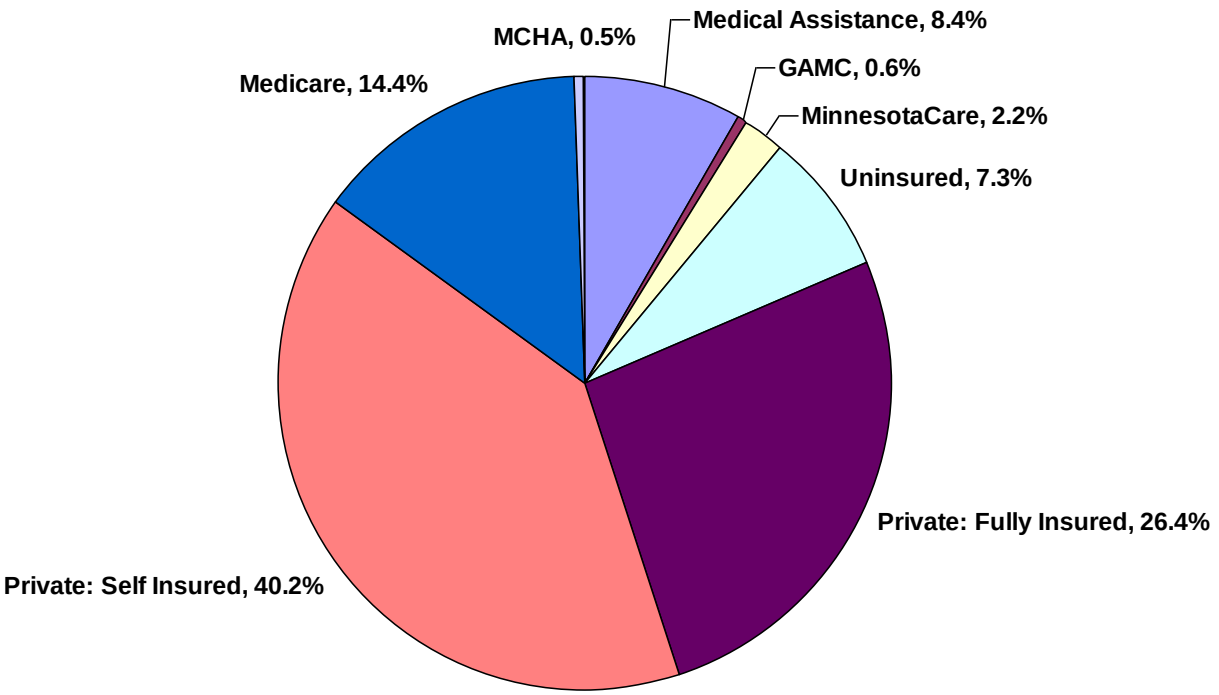
Prevention & Health Promotion

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

Source: County Health Rankings, 2010. University of Wisconsin Population Health Institute.

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



MN Population by Source of Insurance Coverage, 2008

Source: Minnesota Department of Health. Issue Brief: Distribution of Health Insurance Coverage in Minnesota, 2008. November 2010.

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

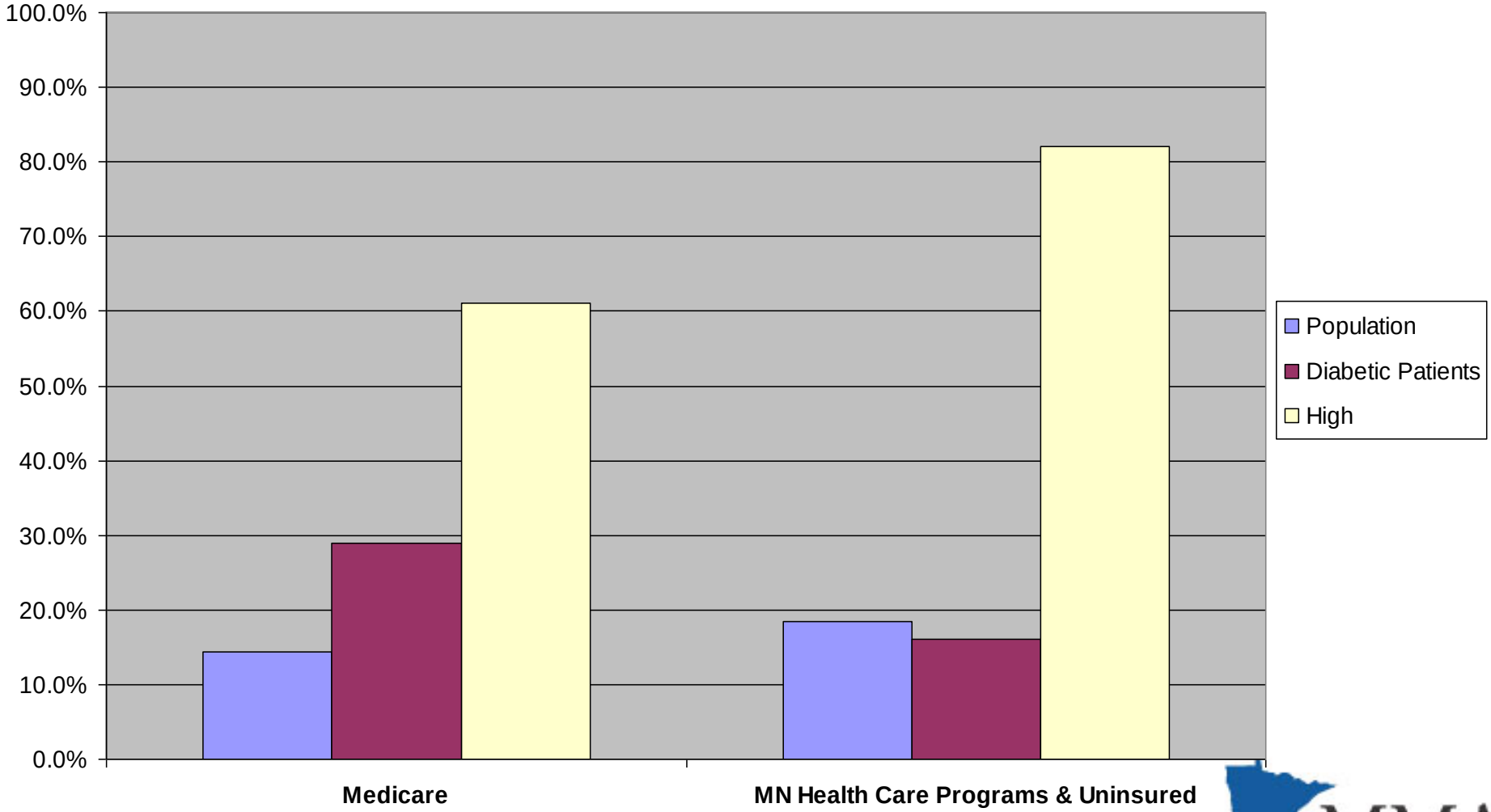
Delivery System Reform Opportunities

- 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



Source: Minnesota Department of Health. Issue Brief: Distribution of Health Insurance Coverage in Minnesota, 2008. November 2010; Minnesota Department of Health. 2010 Health Care Quality Report: Physician Clinic Measures, November 2010.

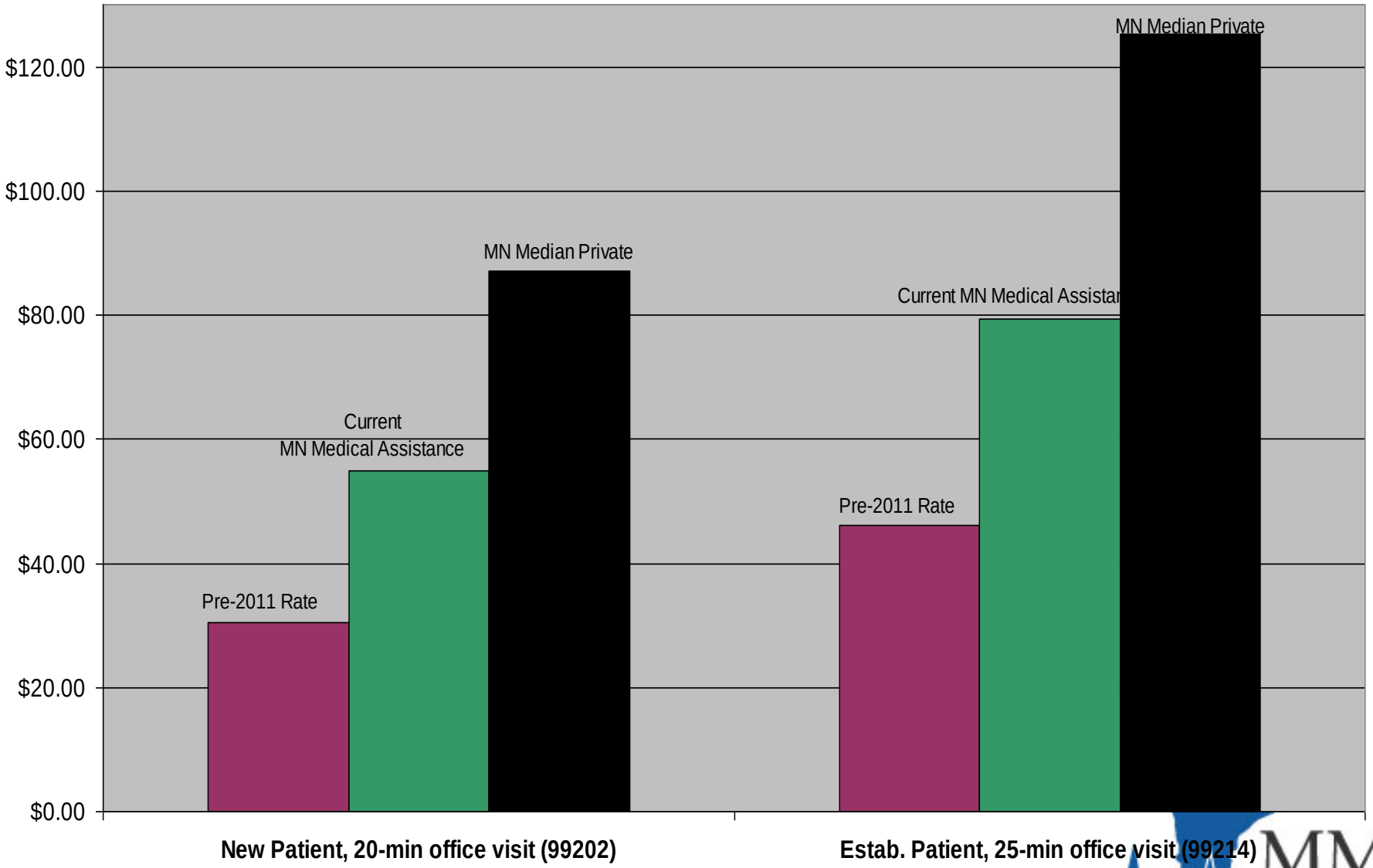
Access: Artificial?

- 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



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.

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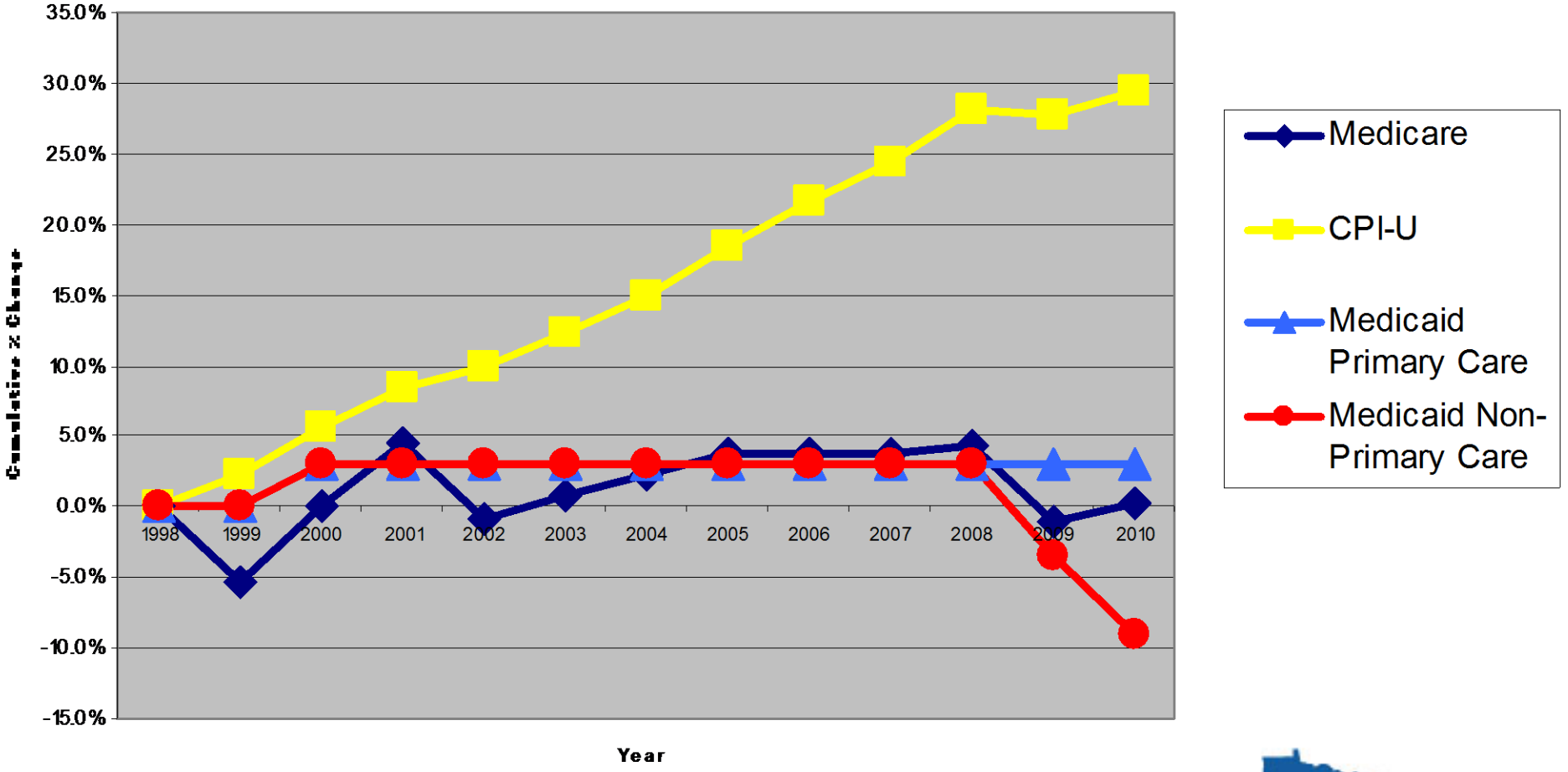
Trends: Medicaid, Medicare & Inflation



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.

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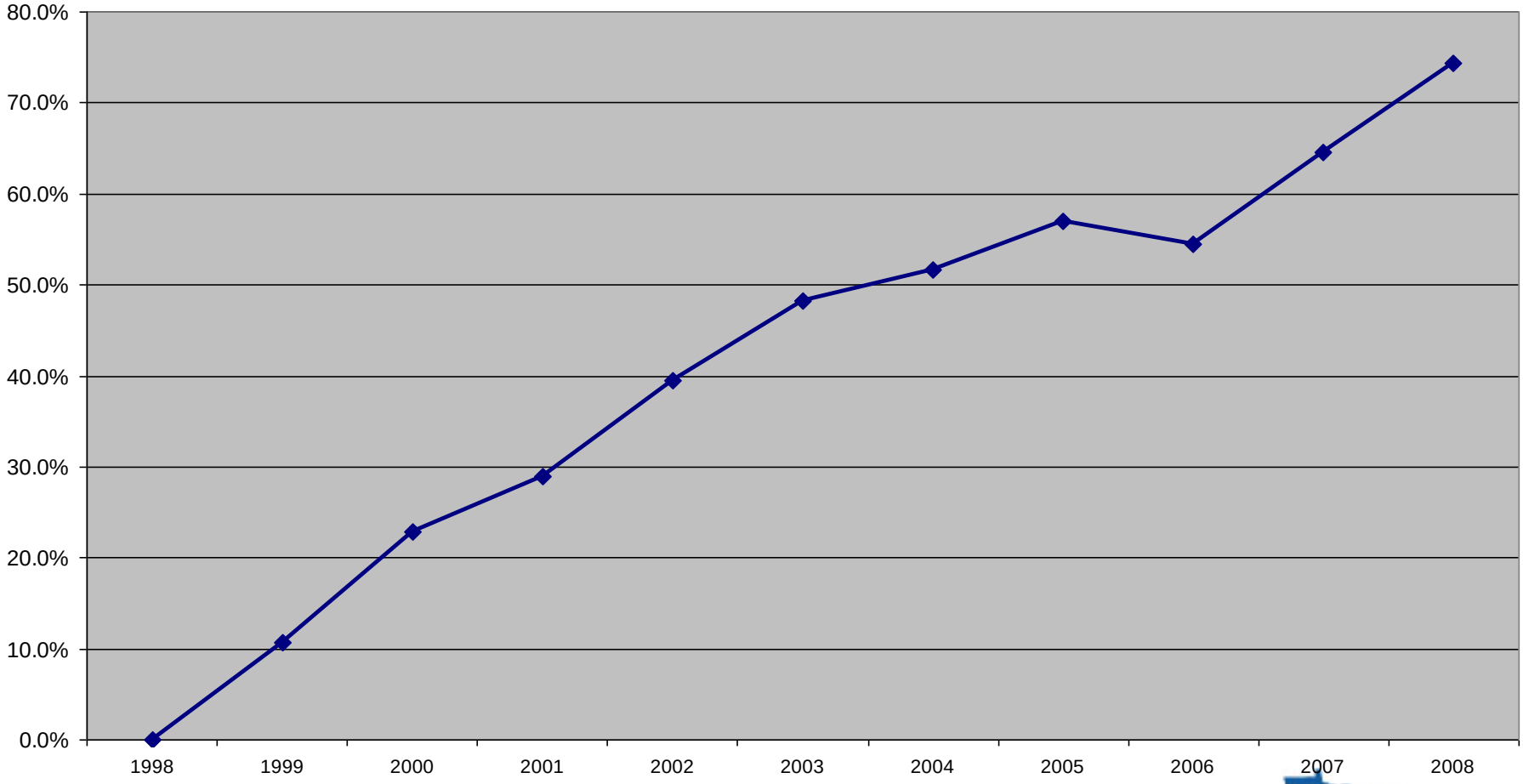
Managed Care Rate Increases (MA, GAMC, MNCare) Cumulative Percentage Change, 1998-2008



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.

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Payment Models: 5 Likely Options

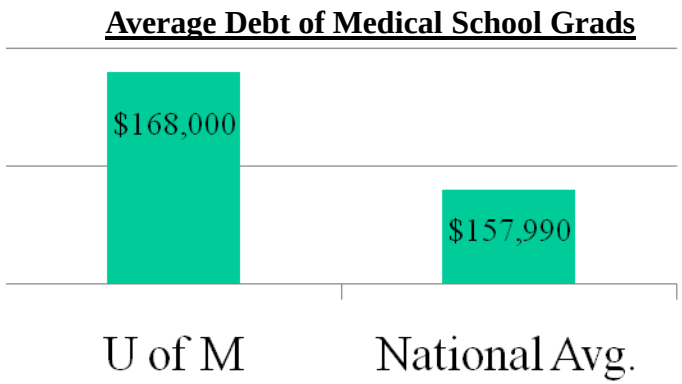
- Fee for service
  - Payment (discounted) for each service/procedure
- Pay for coordination
  - Payment for specified care coordination services (medical home)
- Pay for performance
  - Payment or financial incentive (e.g., a bonus) associated with achieving defined and measurable goals
- Episode or 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



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