For the first time since 2007, lawmakers walked into the state Capitol in January without the specter of a budget deficit hanging over their heads. For that reason, observers, including the MMA, were optimistic that lawmakers could make progress on a number of issues related to health care.

As it turned out, the 2012 legislative session became more about course correcting—revising and improving past legislation, and rendering it more physician friendly.

“Because of the budget surplus, there were no crisis issues that had to be addressed,” notes Dave Renner, MMA director of state and federal legislation. “The Legislature did not feel a need to pass any particular bill.”

Although lawmakers did restore some funding to the Health and Human Services budget, they missed out on several opportunities to help physicians and their practices—and health care in general. “For example, funding for our residency training sites was drastically slashed in 2011,” Renner points out. “We had an opportunity to replace some of those funds this year but failed to do so.”

(continued on next page)
Here the Physician Advocate examines some of the critical hits, misses and vetoes of the 2012 session.

**THE HITS**

**More background provided to patients**

Information regarding malpractice judgments, criminal convictions and actions by other licensing boards will now be available to Minnesotans thanks to legislation passed this session.

The health licensing disclosure bill (often referred to as the BMP bill) was the result of an investigative report in the Minneapolis Star Tribune that called into question the Board of Medical Practice’s lack of transparency regarding physician disciplinary actions.

“Throughout the discussion of the BMP and the licensing board disclosure bill, the MMA focused on how to ensure that patients get information that will be helpful to them when choosing a health care provider,” Renner says. “We want to make sure that the physicians and other health care providers who practice in our state meet the highest standard possible for providing care.”

The emphasis on “helpful” information is what compelled the MMA to push for removal of language that called for including malpractice settlement information in the online data available to consumers. “We’ve maintained that settlements are not an accurate tool to gauge the quality of a physician,” Renner says.

The disclosure bill also calls for studies:

- To develop recommendations for a standardized approach to criminal background checks, which may include fingerprinting;
- Of how the BMP implements the Medical Practice Act (to be conducted by the Office of the Legislative Auditor);
- Of whether the Medical Practice Act provides protections and transparency for the public (to be conducted by the Commissioner of Health). This effort will involve an advisory committee that will include two MMA appointments.

The new BMP information will be available online starting July 1, 2013. Only malpractice judgments, criminal convictions and actions by other licensing boards occurring on or after that date will be posted.

**Provider peer grouping reforms**

Hospitals and clinics will now have adequate time to review information on cost and quality before it is released to the public, thanks to revised provider peer grouping (PPG) legislation.

“The new provider peer grouping legislation creates more realistic deadlines for public reports and provides an opportunity for clinics and hospitals to verify the accuracy of their reports,” Renner says.

It also includes language creating a committee to advise the health commissioner on patient attribution, quality scoring and cost-scoring methodologies. In addition, the bill streamlines the appeals mechanisms for hospitals and clinics that have concerns about their reports.

“The passage of the PPG bill will be felt when the Department of Health begins developing and releasing cost and quality reports on specific clinics,” Renner says. “The law shifts the emphasis of these reports away from simply providing tools for health coverage purchasers to providing information to hospitals and clinics to use for quality improvement. This is the greatest value of PPG.”

**Supplemental funding for Health and Human Services**

During last year’s session, lawmakers cut $1.3 billion from the state’s Health and Human Services budget, so the fact that $18 million was re-allocated this year can be considered a victory, albeit a small one.

The Legislature restored funding to several programs and called for a number of studies. Here’s a breakdown.
**The Health and Human Services bill allocated:**
- $5.9 million to personal care attendants;
- $4.9 million to reinstate coverage for dialysis and cancer treatment for Emergency Medical Assistance patients;
- $1.1 million for audits of the Prepaid Medical Assistance Program (PMAP) beginning in 2014 (then occurring every other year);
- $235,000 for a study of the value of managed care in the state’s public programs;
- $200,000 for an autism study by the University of Minnesota.

**The bill called for studies of:**
- The design of the Emergency Medical Assistance program;
- PMAP satisfaction, access and ability to produce high-quality outcomes;
- The repeal of Rule 101, which requires health care providers’ participation in state public health care programs as a condition of participation in the state employee health plans;
- Capacity of radiation therapy treatment facilities throughout the state;
- Methods to better protect patient records from unauthorized access and release, and mechanisms to inform patients if their records are inappropriately accessed or released;
- Cost-sharing structures and requirements for patients.

Along with funding and the call for studies, the bill expanded civil penalties for illegal release of patient records to include unauthorized access of patient records.

**The bill did not:**
- Include any new funding for the Medical Education Research Costs fund;
- Restore last year’s 3 percent cut to physicians treating patients under fee-for-service Medical Assistance;
- Fund a for-profit HMO study or transfer of HMO regulation from the Department of Health to the Department of Commerce;
- Fund a health insurance mandate study.

**Newborn screening to continue, process modified**
The Minnesota Department of Health can continue its newborn screening program thanks to legislation that establishes a “standard retention period” for blood spots of 71 days (and two years for test results) before they are destroyed. Practitioners use these blood spots to screen for more than 50 genetic and congenital defects.

The legislation also allows parents to give consent for long-term storage (up to 18 years) of the spots and test results and permits researchers to use the spots for development of new tests. Notably, the legislation allows the health department to use the spots within the 71-day window for test calibration and quality control, activities that were not clearly authorized by the Minnesota Supreme Court in its Bearder decision, which placed restrictions on the retention and use of the spots.

“Allowing the Department of Health a mechanism to keep blood spots for longer periods is key as it will enhance the development of new tests,” says Eric Dick, the MMA’s manager of state legislative affairs. “The MMA has been a long-time advocate of newborn screening. The process identifies approximately 100 babies a year that can be saved from death or disability through early treatment.”

To address the decision’s impact on the state’s greater public health work, the bill provides immunity from court challenge to the Department of Health as it studies what further refinements to the law are necessary to continue its public health mission. A report to the Legislature on this is due in January 2013.

The legislation also directs the Department of Health to make information and forms about the newborn screening program available to prenatal health care providers for use with expectant parents. In addition, the department will make information and forms available to expectant parents and parents of newborns both electronically and through other avenues.

**E-prescribing conformity**
In April, Gov. Mark Dayton signed into law a bill that would make Minnesota law conform to federal regulations on electronic prescribing of controlled substances, a position the MMA supports.
THE MISSES

Legislation that stalled during the session:

**Insurance exchange**
Many questions remain about establishing an insurance exchange in Minnesota after a Senate bill regarding its creation went down in defeat in late March. The federal Affordable Care Act permits states to create their own exchange by January 2013 or use the exchange that will be established by the federal government. The MMA supports creating a Minnesota exchange and will work with Gov. Dayton and legislative leaders to keep this objective moving forward.

**Tobacco tax increase**
A bill that would increase the tax on cigarettes and other tobacco products stalled this spring. The MMA supported this bill, believing a higher tax on cigarettes will ensure fewer kids start smoking and more adults quit.

**Firearm gag rule**
This bill would have prohibited health care providers from asking patients about access to firearms in their homes. The MMA opposed this bill. We believe physicians should be able to freely ask patients questions related to their safety.

**Rule 101 repeal**
Rule 101 requires health care providers to participate in state public health care programs as a condition of participation in the state employee health plans. The MMA supported repeal of this law.

**Minor consent**
This legislation called for modifying minor consent laws so that physicians could not provide any kind of treatment to minors without a parent’s consent. The MMA was against this legislation and supports the current law allowing physicians to treat minors without parental consent on issues pertaining to reproductive health, mental health, and chemical and alcohol dependency.

**Cosmetic laser regulation**
Two competing proposals related to the use of lasers in cosmetic procedures were introduced. An MMA-supported bill would have regulated the use of laser treatment for such cosmetic procedures as removal of facial hair and skin spots. It would have required patients to have a medical exam before any procedure involving a laser. Another competing proposal would have expanded the ability of nonphysicians to use lasers for a variety of cosmetic procedures.

THE VETOES

Gov. Dayton vetoed several health-related bills. They included:

- Two abortion-related bills. One called for physicians to be physically present when a patient takes abortion-inducing drugs, and the other called for creating a new licensing requirement for clinics and other outpatient health centers in which 10 or more abortions are performed per month.
- The Health Care Compact legislation that called for Minnesota to withdraw from federal health care programs such as Medicare and Medicaid and instead receive federal block grants.
- Legislation that would have allowed for a several-week period preceding the July 4 holiday, during which aerial or exploding fireworks could be legally purchased and used in Minnesota.
- A bill that would authorize the use of new premium trust accounts to pay for health insurance premiums.

Looking ahead to 2013

This November, all 201 legislative seats will be up for grabs due to redistricting. In addition, more than 20 percent of the current crop of legislators are either retiring or running for a different office. That means there will be a lot of new faces at the Capitol come January. And they are expected to be faced with a deficit of more than $1 billion.

EDITOR’S NOTE: Keep track of legislative events through MMA News Now — delivered to your email box free each Thursday. To subscribe go to the MMA website and look for “MMA News Now” under the “Publications” tab.
THE EXAMINING ROOM
The 2012 legislative session

Dominated by debates on issues such as the Vikings stadium, taxes and bonding bills, this past legislative session proved to be contentious at times. However, lawmakers were able to pass some health care-related items. The Physician Advocate solicited MMA members for their opinions on the recently completed session.

Marilyn Peitso, M.D.
President, Minnesota Chapter, American Academy of Pediatrics

Top on my “Maybe this is a good thing” list is the passage of the newborn screening amendment. This amendment clarifies and allows necessary quality monitoring and parental consent procedures in the wake of the Minnesota Supreme Court’s Bearder decision, which left Minnesota’s newborn screening program in jeopardy. It was gratifying to see bipartisan support for an approach that will maintain this important program for our state’s children and families. The accompanying genetic testing amendment allows breathing room for the Minnesota Department of Health to examine how the Bearder decision affects its work with other genetic information.

Top on my “I’m really disappointed” list is the resistance of the Legislature to building a Minnesota insurance exchange. This is important for access to health care for families and young adults. It looks like the insurance exchange has become the victim of partisan politics to the detriment of Minnesota citizens.

I am pleased that the Legislature required that more information be provided to new mothers regarding postpartum depression, that it will study homelessness among children and appropriated funds to study autism in the Somali-American community. However, my “Penny wise pound foolish” list includes no serious attempts to improve coverage for uninsured children.

Philip Stoyke, M.D.
Chair, Minnesota Academy of Family Physicians’ legislative committee

I would say that from a family practice/primary care perspective, very little was accomplished. Yes, the provider peer grouping law passed, which is important. There are some other small items that passed; but we came away with very little. I do not blame the MAFP or MMA or doctors in general. Rather, I think very little got done because other issues were more dominant.

One issue that needs attention is health care homes. They are proceeding but are fairly clunky and require too much paperwork to be effective and to reduce costs. Hopefully, we can be successful next session. We know health care homes can reduce costs and improve care, something that should have the support of both parties.

I also think that everybody is in a holding pattern with regard to further health care reforms as we are awaiting the results of the Supreme Court ruling on the Affordable Care Act as well as the outcome of the November elections.

Lyle Swenson, M.D.
MMA President

A bill modifying provider peer grouping was passed that will hopefully result in more accurate and helpful data on hospitals and clinics, with a more realistic timeline for the reporting of cost and quality information. A bill was passed and signed by the governor that institutes independent audits of health plans that contract with the state to manage the Prepaid Medical Assistance Program. It is hoped that this will lend much-needed transparency regarding how the state’s payments to these plans are being spent.

The Republican-controlled House and Senate offered up an alternative to the health insurance exchange concept, but it was vetoed by the governor, leaving the state with no legislative support for a Minnesota health insurance exchange.

Legislation was enacted that ends the moratorium on construction of new radiation oncology facilities in the Twin Cities beginning August 1, 2014, but requires any new facility to be owned by a hospital and not be within seven miles of an existing facility. This bill also has language affecting the information doctors must give patients regarding radiation options, and requires physicians to disclose any financial interests they have in these facilities. Finally, there was no effort to change the current phase-out of the provider tax, which is scheduled to be completely eliminated by 2020.
Whenever Dionne Hart, M.D., visits a school to talk with kids about what it’s like being a doctor, the first question she inevitably hears is: “How much do you make?”

“It’s either that or ‘How long does it take to become a doctor?’” Hart says with a laugh as she describes the visits she makes on behalf of the Doctors Back to School Program (DBTS), which was founded by AMA members. Since forming in 2002, the program has connected its volunteers with more than 100,000 students across the country.

Hart, a psychiatrist, became involved in DBTS four years ago because she strongly believes in its mission: to increase the number of minority physicians and work toward eliminating racial and ethnic disparities in health care. Through DBTS, Hart and other physicians as well as minority medical students go into the community to introduce children to the medical profession and serve as potential role models. “It really helps for [the students] to see physicians who look like them,” she says.

Hart says she and her DBTS associates are always trying to increase the “heads up factor.” That’s saying something that causes students to sit up and take notice. “When you speak from your heart about what you did and how you felt when you were their age, the students can connect...
because of the seriousness of this case, the MMA and the AMA sought to file the brief early.

This case calls into question the enforceability of medical staff by-laws—whether they are essentially a contract or are otherwise binding on the hospital—and how they may be changed in Minnesota.

In her denial of the amicus, the District Court judge stated that the court "appreciates and is mindful of the policy issues identified by the proposed amici curiae . . . [however] there is no reason for the Court to believe that the parties to the litigation are unwilling or unable to identify and describe relevant policy issues, including those identified by the proposed amici curiae."

The case will now proceed on its merits, and the MMA will continue to explore other ways to support the profession as it moves forward.

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PHYSICIAN ADVOCATE

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Lessons for the future

By now you have probably read stories about the Attorney General’s review of the debt collection and quality management practices used by Accretive Health on behalf of Fairview Health Services. In 2010, Fairview entered into a contractual relationship with the Chicago-based company for revenue cycle management and quality and total cost of care management. Minnesota Attorney General Lori Swanson has called into question the appropriateness of the relationship, citing, among other things, the fact that Accretive had access to information on patient health. The news about the Accretive-Fairview relationship prompted me to think about the challenges physicians face as we are held more accountable for the cost and quality of care we provide. I’ve identified three issues that I believe physicians should carefully consider; there are likely more.

New payment models require us to pay greater attention to the cost of services we provide.

New payment models require us to pay greater attention to the cost of services we provide. The news about the Accretive-Fairview relationship prompted me to think about the challenges physicians face as we are held more accountable for the cost and quality of care we provide. I’ve identified three issues that I believe physicians should carefully consider; there are likely more.

Partnering with outside vendors

Monitoring the quality and cost of care delivery for a large group of patients requires sophisticated analytics. Such expertise is generally not among the core competencies for most physician practices. Vendors can offer practices the ability to complete such tasks as apply risk-assessment methods to better target resources and interventions. Is your practice prepared to work with a vendor who can provide these services? And what role will health plans play in supporting this analysis function?

Aligning behavior and financial incentives

Changing or aligning financial incentives is an oft-repeated goal of state and federal health care reform proposals. The MMA has supported the idea of changing the way in which health care is paid for to better support quality care delivery, to allow more flexibility in how and where care is delivered, and to support better health outcomes.

Implicit in this goal is changing physician behavior. New payment models require us to pay greater attention to the cost of services we provide.

As physicians’ practices assume greater accountability for cost and outcomes, they will have to become more adept at analyzing practice patterns, a responsibility that has largely been the domain of health plans and has led to initiatives such as prior authorization, retrospective reviews and performance profiling. Is your clinic prepared to monitor and manage the utilization patterns of its partners? How do you think physician utilization management programs should be structured to mitigate inappropriate financial conflicts of interest? How will physicians be assured that their management staff or their contracted vendors are using appropriate standards for valid and reliable performance measurement? How can physicians who serve complex and noncompliant patients feel comfortable continuing to care for those individuals?

Ensuring transparency

There is broad support for greater transparency in health care, including subjecting insurance rates, physician performance data, patient satisfaction scores and other information to greater public scrutiny. As physician practices assume new responsibilities, what information can and should be communicated to patients?

Should we have to reveal changes in compensation arrangements that include incentives for meeting utilization targets? Most of us would agree that patients should not have to worry that their physician is more concerned with saving money than with providing needed care; similarly, patients should not worry that their physician is willing to provide unnecessary care to generate money. But how can we assure our patients?

Many physicians, clinics and hospitals will need to work with vendors and other partners in order to report and use data, implement new reimbursement systems and develop relationships with other providers. The Accretive-Fairview experience may provide lessons for all of us as we navigate these uncharted waters.
Eurasian health care leaders visit MMA offices

It’s a long way from Bishkek, Kyrgyzstan, to Minneapolis—at least physically. But in terms of health care issues, the two locales are not that far apart.

A group of 20 mid- to senior-level physicians and health care executives from nine Eurasian countries visited the MMA in early May as part of a month-long tour exploring the U.S. health care system.

“It's interesting to hear that these physicians and health care administrators from the other side of the globe are dealing with many of the same issues we face in America—administrative burdens, quality of care, politics, training, etc.,” says Robert Meiches, M.D., MMA CEO.

The two-hour lunch meeting, which was also attended by Lyle Swenson, M.D., MMA president, and member Elena Polukhin, M.D., covered a variety of topics from credentialing to education to quality improvement.

The Eurasian delegation asked, among other things, if the MMA could endorse presidential candidates, whether the U.S. health care system provides incentives for preventive care and early diagnosis of disease, and for further explanation of the concept behind nonprofit health plans. This last question led to several follow-ups including an inquiry of what the health plans do with any profits they make.

The visit, organized by the U.S. Department of Commerce and International Trade Administration, was part of a SABIT (Special American Business Internship Training) Hospital Administration mission. The group also made stops in Washington, D.C., New York, Philadelphia and Tampa, Florida.

ACOs: One size doesn’t fit all

Although they are certainly a hot topic these days, accountable care organizations (ACOs) are not a one-size-fits-all proposition. Many physicians who belong to independent practices are trying to figure out how to work with them. Included in that group are MMA members Stuart Cox, M.D., head of an ear, nose and throat practice based in Woodbury, and Dave Thorson, M.D., board chair, and head of the Family Health Services clinic in St. Paul.

Earlier this year, Sen. Al Franken touched upon the subject of ACOs during a visit with the MMA’s trustees. Cox wanted to hear more, so the MMA convened a meeting with the senator’s staff.

The creation of ACOs has been spurred by the 2010 Affordable Care of Act, which authorized the Medicare Shared Savings Program, and by the Pioneer ACO initiative developed by the Centers for Medicare and Medicaid Services (CMS). Several ACOs have formed in Minnesota through larger organizations such as Allina, Fairview and Park Nicollet; but many physicians who are not part of large systems, such as Cox and Thorson, are still figuring out how to best work with these new entities.

“The challenge for us is to come up with pared-down specific ideas that will improve the delivery and cost of health care and are politically feasible,” Cox says.

Dave Renner, the MMA’s director of state and federal legislation, says he thought the meeting was a good first step. “We appreciate the senator’s openness and interest in helping independent practitioners. While we support the new payment models designed to align incentives for quality patient care, ACOs are not the only way to achieve payment reform.”

Franken’s staff offered to follow up with CMS to ensure that independent clinics are part of future payment reform discussions.

Members making a difference

This spring, Carl Patow, M.D., MMA member and executive director of HealthPartners Institute for Medical Education, received the Weinberg Award for academic medicine leadership from the Alliance of Independent Academic Medical Centers (AIAMC). Patow has served on the AIAMC board since 2006 and was its president from 2009 to 2012.

In late April, the Minnesota Academy of Family Physicians selected MMA member Andrew Burgdorf, M.D., as its 2012 Family Physician of the Year. Other MMA members honored by the MAFP include Macaran Baird, M.D., who received the President’s Award; Laura Wellington, M.D., Resident of the Year; Mark Yeazel, M.D., Researcher of the Year; Ben Pederson, Medical Student Award for Contributions to Family Medicine; and Glenn Nemec, M.D., Merit Award for outstanding contributions to family medicine.

Also in April, MMA member Maya Babu, M.D., was appointed to a one-year position as the Resident and Fellow Section member of the AMA Council on Legislation.

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