MGMA MINNESOTA

1. Support Protection for Patients and Providers from Unilateral Health Plan Changes to Contract Terms, Policies, Procedures and Fee Schedules

Messerli & Kramer Lead: Nancy Haas
MMGMA Lead: Melissa Larson and Jim Reimann

Support statutory changes which provide penalties when health plans change contract terms, policies and procedures, and fee schedules without notification and consent by providers.

Health plans occasionally need to change policies and procedures (e.g. billing procedures, medical policies, etc.) during the term of a contract because of state and federal legislation. However, health plans often make changes to policies and procedures that directly affect provider reimbursement that are not required by law.

Unless a change is required due to legislation, changes that affect reimbursement, access, or covered services should not be implemented through passive amendments and unilateral decision making by the health plans once a contract is signed between the health plan and the provider. These changes affect patient care and/or provider reimbursement, and mutual written consent should be required and enforced. This statutory change will benefit stakeholders – most importantly, the patients who will not be left paying for a service that is no longer reimbursed by a health plan mid-contract. This effort will eliminate health plan and provider staff costs associated with submitting appeals and resolving denied claims – not to mention delayed cash flow for providers and/or incorrect patient billing.

Too often, proper notice is not given to providers about contract changes and updated fee schedules and thus **MMGMA supports HF2678/SF2402** which creates penalties in statute for failing to follow the 45 day notice period currently in law. It is critical that policy changes affecting patient care are communicated with sufficient notice to providers not only for purposes of having a constructive dialogue with the medical directors of the health plans, but also to allow providers adequate time to inform patients of any changes affecting their care especially in situations when such changes involve services that will no longer be covered by their health plan or reimbursed to the provider. Creating penalties in law will ensure proper notice is given and claims will not be denied while the parties consider the changes being proposed.

2. Promote Protection from Unilateral Health Plan Actions that Exclude Qualified Providers from Health Plan Network Participation

Messerli & Kramer Lead: Nancy Haas
MMGMA Lead: Sandy Rutherford and Rachael Perlinger

MMGMA promotes requirements that health plans must enter into service agreements with all qualified providers who seek entry to a health plan network. Health plans should provide a transparent appeal process to any providers denied network participation.

Health care plans exert control over a patient's ability to choose their healthcare provider. Such control may cause patients to leave their current providers, with whom they have established trusting relationships, to receive care from alternative providers whom they do not know. There is additional concern for patients in ongoing treatment.

Healthcare plans increasingly eliminate high-quality providers from network participation by excluding from a product of by offering only products with extremely narrow networks that include only a small portion of the plan's total contracted providers. When plans decide unilaterally to limit the network (after providers have met contracted terms and conditions of participation), providers find themselves excluded from providing covered service to patients who have been placed into the narrow network. Providers have no input or recourse, and patient care can be disrupted.

MMGMA promotes efforts to ensure that health plans issuing benefits must enter into provider service agreements with all providers who are qualified under the laws of the State of Minnesota. Should a health plan deny a provider entry into a service agreement, the health plan must issue a letter explaining the reasons for denial, and offer a transparent appeal process to the provider group.

3. Support Risk Sharing Between Insurers and Providers in High Deductible Products

Messerli & Kramer Lead: James Clark
MMGMA Lead: Greg Maurer and Jim Reimann

Because health plans manage the financial relationship with patients who purchase health insurance, MMGMA supports action to hold health plans—instead of only providers—accountable for collecting deductibles. MMGMA supports risk-sharing between health plans and providers when the patient deductible is unaffordable.

MNsure reported in December 2015 that since open enrollment started in November of that year, 50 percent of those buying private plans through the exchange selected bronze plans. That number rose from 34 percent the previous year. Under Bronze level plans, deductibles range from approximately $4,500 to $7,000. Premiums in the individual market rose an average of 67 percent from 2016 to 2017. As more patients purchase high-deductible health plans from insurers, health plans protect their own bottom lines by raising premiums, which they collect from patients or will cancel coverage. Health care providers, meanwhile, are left trying to collect higher and higher deductibles, which often the patient cannot afford. Health plans consider such deductibles, copays and coinsurance as "cost sharing" with patients to discourage unnecessary care and to reduce the health plan's costs. When cost sharing requires patients to pay several thousand dollars, many patients choose to forego care for chronic conditions, allowing health issues to become acute before seeking help. Ultimately, this pattern drives up cost of care and negatively impacts population health.

MMGMA supports HF2563/SF2340 a task force to study issues related to the direct or indirect costs, including hidden costs of high deductible health plans. The task force, with members including commissioners, legislators, and members of MMGMA, will issue recommendations in a report to the legislature.

4. Promote Payment Parity for Services Rendered in Accordance with Published State or Federal Fee Schedules

Messerli & Kramer Lead: Nancy Haas and James Clark
MMGMA Lead: Rachael Perlinger and Jim Reimann

MMGMA promotes language that requires health plans to pay providers no less than the Medicare or Minnesota Medical Assistance fee schedules for the specific services rendered.

In Minnesota during 2016, 55 percent of Medicare patients assigned their Medicare benefits to a Medicare Advantage plan[1]. This means that health plans such as Blue Cross Blue Shield of MN, HealthPartners, UCare and Humana, among others, are the only health plans for Medicare-eligible patients. Many medical assistance enrollees chose a Prepaid Medical Assistance Plan (PMAP) through a Minnesota HMO. The health plans reimburse providers and hospitals for the services they render, but some plans pay less than the Medicare fee schedule or Minnesota Medical Assistance fee schedule.

MMGMA promotes language that would ensure no health plan doing business in Minnesota may pay providers less than the current year's published fee schedules for services delivered in accordance with the patient's federal or state government health program.

1 http://kff.org/medicare/issue-brief/medicare-advantage-2016-spotlight-enrollment-market-update/

5. Promote Shared Responsibility for Price Transparency

Messerli & Kramer Lead: Nancy Haas
MMGMA Lead: Lisa Belak and Tom Lorentzen

MMGMA promotes changes to statutory language which does not just strengthen the current law but actually improves health care price transparency in Minnesota by getting the most accurate cost information to the patient or consumer whenever possible and charging the entity that holds the data with providing the price transparency.

There are at least two reasons why the current law doesn't work as intended, and why strengthening it or enforcing it more vigorously won't produce the price transparency that patients want and deserve. The first reason is that a current law and many health plan contracts strictly prohibit providers and clinics from sharing or posting fee schedules or negotiated reimbursement rates. So at best providers can post a cash, uninsured price for care and services. While that constraint could and should be remedied, it does not change the second problem which is that providers and clinics don't actually have all the benefit plan data (deductible status, co-pays, co-insurance, etc.) which are needed to provide a patient with the most accurate price based on their coverage, and ultimately their patient responsibility.

In recent years, a number of other solutions have been proposed, including requirements to: (a) post prices only for certain CPT codes or a list of the most-often-billed procedures or care services; (b) post prices for elective procedures and care that someone might have the time or ability to "shop" for; (c) post the "average" prices charged for care and services; or (d) post prices for care under coverage categories such as self-pay, commercial health plans, and government health plans. Each of these proposals has merit, but each would result in limited expectations of health care price transparency from certain providers or types of care, and without always providing the patient or consumer with the desired information.

For all those reasons, MMGMA advocates for placing the responsibility for those disclosures with the entity that holds the most complete data about the price to be charged (i.e., medical providers, hospitals and clinics would be responsible for price transparency to any patient that is uninsured or self-paying; commercial health plans would be responsible for price transparency to their covered members; and patients with coverage through a government plan would seek that price transparency through already-published rates). Only the entity providing coverage can know the intricacies of an individual's particular benefit plan details (deductible status, co-pays, co-insurance, etc.).

MMGMA also supports changing current law to allow for utilization of the MN All Payer Claim Database (APCD) as an access platform for consumer price transparency, and in ways that continue to protect patient information but benefit the public beyond research purposes.

6. Promote Timely Provider Credentialing by Health Plans

Messerli & Kramer Lead: James Clark
MMGMA Lead: Sandy Rutherford and Mike Foley

MMGMA supports the creation of a standard time requirement for health plans to process provider credentialing.

Provider credentialing is the process of evaluating a healthcare provider's past history and qualifications including education, training, residency, licenses and certifications. Credentialing must be complete and approved by health plans before a provider can see patients and by facilities before a provider can practice at the location.

The time that it takes for health plans to review and approve the application varies from health plan-to-health plan and is inconsistent from case-to-case. The timeline often extends out past 90 days. Health plans have little incentive to complete the credentialing process in a timely manner. When seeking a status update, health plans offer little transparency and often will not provide detailed update. Currently, health plans doing business in Minnesota will only confirm receipt of the application that is in process and not a tentative effective date.

This impacts clinic operations and patient care. A clinic does not know what date a provider can actually start to see patients and cannot open their schedules until they have these dates from each health plan. There are also multiple participation dates because each health plan has its own timeline and rules which compounds the scheduling challenge.

MMGMA supports language that establishes timelines for the credentialing review process and for transparency of the status to clinics when they request a status update on the application. This transparency would include confirmation of the expected effective date of participation

MMGMA seeks a 45 day turnaround time and confirmation of an effective date upon receipt of a clean application. If the health plan doesn't comply, credentialing would become effective on the 45th day and subsequently claims would be considered as clean claims as submitted.

7. Oppose Workers' Compensation and No-Fault Fee Reductions

Messerli & Kramer Lead: James Clark
MMGMA Lead: Jim Reimann

MMGMA promotes efforts to ensure fair and adequate reimbursement with respect to workers' compensation and no-fault claims.

MMGMA opposes any reduction in reimbursement for these services. Treating patients who have been injured on the job or in an auto collision requires many complicated and time-consuming administrative activities that are not required when treating other patients. The health care costs embedded in workers compensation and no-fault systems represent approximately one-third of the workers compensation premium and less than 10% of the automobile premium. Reducing provider reimbursement likely would create access issues for patients.

8. Promote Simplification and Streamlining of Health Care Homes to Expand Patient Access and Keep Primary Care Viable

Messerli & Kramer Lead: James Clark
MMGMA Lead: Lisa Belak and Tom Lorentzen

MMGMA promotes efforts to simplify and streamline Health Care Home rules to permit broader participation by patients with chronic conditions and reduce administrative overhead for providers. Studies have shown that Health Care Homes improve the quality of care for patients with chronic conditions and reduce overall costs of care. A series of reports issued by the University of Minnesota estimates the state's Health Care Home program reduced health care costs by $1 billion. Given the program's success, the pool of eligible patients should be expanded and the definition of eligibility simplified. To simplify administrative burden on providers, we advocate tying the Health Care Homes program requirements into the Medicare Access and CHIP Reauthorization Act (MACRA) requirements to make the provider eligible for the Advanced Payment Model (APM) track of MACRA. Health plan reimbursement should also be standardized and increased. We advocate simplifying Health Care Home reporting, with use of a single per member, per month payment.

9. Support Phase Out of the Provider Tax

Messerli & Kramer Lead: James Clark
MMGMA Lead: Mike Foley and Corinne Abdou

MMGMA supports phase out of the Provider Tax, and opposes use of the proceeds of the Provider Tax for purposes other than MinnesotaCare. The only exception would be using the Provider Tax to support the provider's costs to comply with mandated quality reporting.

In 2012, the Legislature passed a bi-partisan proposal to phase out the Provider Tax by 2019. Proponents thought that with the expansion of Medicare Assistance (MA) under the Affordable Care Act, MinnesotaCare would see a significant reduction in covered lives, permitting the phase out of the Provider Tax to begin in 2014. However, many industry experts now project a significant shortfall for MinnesotaCare; some legislators are signaling they will attempt to repeal the Provider Tax phase out.

The Department of Health continues to mandate additional quality reporting requirements, which cost providers substantial resources to compile and maintain. We believe permitting providers to offset these substantial costs from their Provider Tax obligation would be fair and reasonable.

Please let us know if you have any questions about our 2018 Legislative Priorities, need more information, or have additional suggestions! Together we can have a major impact on public policy for the benefit of our patients and practices.

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