Minnesota Health Care: What’s in Store for 2020

Mary Krinkie
Friday, Jan. 10
2:30 – 3:40 p.m.
Northland Ballroom

Sponsored by:
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Mary Krinkie

Mary Krinkie makes politics and the formation of public policy her vocation and her avocation. Since 2001, she has been the vice president of government relations at the Minnesota Hospital Association, directing MHA’s policy and advocacy efforts. Mary is the MHA staff person our government officials see at the Capitol and the one who provides us with the most up-to-date information during the legislative session and then helps us make sense of what happened after the legislative session is over.
We are more connected than ever

- Since its inception in 1973, mobile device connections have surpassed the number of people in the world, making it the fastest adopted man-made technology ever.
  - There are now over 9.32 billion mobile connections worldwide, which surpasses the current world population of 7.74 billion.
  - 5.15 billion people have mobile devices worldwide. (66.6% of the world's population has a mobile device.)
  - There are 3.3 billion smartphone users in the world today. (42.63% of the world’s population has a smartphone.)
But are we really more connected?

- Suicides are on the rise among young Americans, contributed to lower life expectancy overall.
- In 2017, suicide was the 10th most common cause of death among Americans of all ages. It was the second leading cause of death among young Americans age 15 to 24.
- Between 2000 and 2007, the suicide rate among youth ages 10 to 24 was 6.8 deaths per 100,000 people. In 2017, the rate of deaths was 10.6 deaths per 100,000, a 56% increase.
- One out of five adolescents have said they are thinking/or have thought about suicide.

**How can we as health care advocates do a better job of connecting care and communities?**

Political landscape

- The 2020 Presidential race is non-stop and always present in the media.
- Minnesota could be in the national spot light:
  - Will Senator Amy Klobuchar be on the national ticket?
  - Is the 2020 U.S. Senate race in play?
- MN is poised to have two (or three) competitive congressional races: (Districts 1, 2 and 7)
Political landscape

• 2020 very political legislative session, election looms large
  ✓ Only state in the country with a split majority controlled legislature
  ✓ All 201 state legislative seats are on the ballot
  ✓ House: 75 DFL & 59 GOP members (39 freshmen)
  ✓ Senate: 35 GOP & 32 DFL members

• Posturing around Medicare-for-all and/or Gov’s OneCare proposal

• Headline issues:
  ✓ Gun regulations
  ✓ Legalizing marijuana vs. new vaping regulations

November budget forecast for FY 2020-21

- Projected balance now $1.332 billion for FY 2020-21.
- Budget reserve reaches $2.359 billion cap.
  • Added $284 million to the budget reserve.
- Economic outlook improved, but slowdown in forecast.
  • Forecast change of an additional $501 million in revenues.
  • With increased revenue forecast, FY 2022-23 shows structural balance.
- Remember, don’t have to do anything with the budget.
  • New spending, or tax relief, one-time or on-going?
November budget forecast for FY 2020-21

- Projected spending nearly unchanged:
  - Going from a projected state budget of $48.470 billion to $48.463 billion.
  - Projected increases in HHS spending going down by $97 million, to $14.677 billion.
  - HHS spending is projected to be 30.2% of the budget.

- Recent DHS presentation:
  - 2011-2016 average managed care capitation rates decreased 5.7% a year. (The competitive bid policy has saved the state money.)

2020 Issues

- Department of Human Services
  - Proposals to increase oversight standards and organizational changes, splitting department
  - PMAP procurement and role of county-based purchasing

- Insulin issue: Lots of interim attention
  - Medica & UCare $25 monthly co-pay cap; BCBS a zero co-pay policy
  - DFL wants a new tax/fee on insulin manufacturers as funding mechanism
  - Senate Republican plan contains mandate on manufacturers to supply insulin as requested by a prescriber on behalf of a patient – without a charge
  - What is and is not the appropriate role for hospital emergency rooms

- 2020 Capital Investment Bonding Bill
  - Likely to be at least $1 billion+ dollars in new infrastructure projects
What didn’t happen in 2019 *(Issues carryover in 2020)*

*Of broader interest:*
- Alec Smith Insulin Act, HF 485/SF 472
- Family/medical leave, HF 5/SF 1060
- Safe and sick time, HF 11/SF 1597
- Modernizing the MN Health Records Act, HF 831/SF 1575
- Drug production cost transparency (tied to a level of price increase), HF 1246/SF 1098

What didn’t happen in 2019 *(Issues carry forward in 2020)*

*Of specific concern to MHA:*
- Prohibiting physician non-compete contracts, HF 557/SF 350
- Nurse staffing ratio, SF 2901
  - As of now, no House companion
- Violence reporting/staffing complaints, HF 1398/SF 1576
MHA’s 2020 legislative priorities

Priority issues for MHA to advance:

• Look for opportunities to expand state support of investments in mental health services.

• Pass legislation providing better consumer protections from the growing use of prior authorization of medically necessary health care services.

Mental health – What happened in the 2019 Session

- Doubled Psychiatric Residential Treatment Facility (PRTF) capacity (+150 adolescent beds)
- Authorized spending over the next 4 years:
  - $23 million to sustain and expand Certified Community Behavioral Health Clinics (CCBHCs)
  - $10 million more in school-linked mental health funds, expanded criteria
  - $13 million more for suicide prevention
  - $13 million for mobile mental health crisis
- New mental health parity enforcement
2020 mental health work

- Work of newly appointed task forces:
  - Opioid Task Force, making community grants
  - Competency Restoration Task Force

- Collaborate with MN Association of Counties in the implementation of the crisis center grants.

- Explore opportunities:
  - Supplemental budget bill?
  - Another big bonding bill?
  - Support for tele-psych programs?

AMA national survey
P.A. challenges not unique to MN

Patient perspective:
- 26% reported waiting more than 3 business days for a P.A. decision.
- 91% of responding physicians said access to necessary care was delayed.
- 75% reported that P.A. had led to some of their patients abandoning care.
- 91% of responding physicians said that P.A. had significant or somewhat negative impact on clinical outcomes.
AMA national survey
P.A. challenges not unique to MN

Physician impact:
• 86% of responding physicians said the burden from P.A. was high or extremely high.
• 88% responded that burden has increased in the last five years.
• Physicians and their staff spend two business days each week (14.9 hours) completing P.A.s.
• 36% of physicians have staff that work exclusively on P.A.

Addressing growing concerns about prior authorization

- Broad coalition working on this legislation. Includes: MHA, MMA, MMGMA, many others.
- Elements of a bill likely to include:
  - Disclosure of criteria used to evaluate requests for P.A.
  - Maximum response times to P.A. requests or request is deemed authorized
  - Protections from retrospective denials
  - Qualified professional in same specialty to review appeals
  - Public reporting of prior authorization practices:
    ✓ Number of prior authorizations made, number of denials, number of appeals & number of reversals
MHA’s 2020 legislative priorities

*Defense, or at least not an MHA initiative:*

- If insulin legislation passes, work to ensure that it does not include burdensome new mandates on hospitals or clinics.
- Price transparency legislation (*state and federal issue*)
- Preserve some ability for hospitals to have a physician non-compete contract.
- Defeat nurse staffing ratio legislation.
- Prevent the establishment of a new MDH data base mandating the reporting of incidences of hospital violence.

MHA’s insulin comments

- Community pharmacies should be the distribution site for emergency insulin. Ensure that community pharmacies are made financial whole. This should include:
  - A “restocking” of the insulin supply given to eligible program participants.
  - A reasonable dispensing fee to cover administrative burden.
- Insulin manufacturers should either provide the insulin to the pharmacies free of charge (for qualifying individuals) or pay the designated fee to the state.
- Hospital ERs – provide emergency care to diabetics in crisis.
New price transparency mandate

Itemized bill in plain language must be sent to every self-pay or commercial “fully insured” patient within 30 days of discharge, except for:

- Emergency services
- Lab
- Imaging
- Ancillary services from providers not employed by hospital/clinic
- Can be provided online through patient portal

Aug. 1, 2020

Calls for more hospital price transparency (state)

- Legislation being drafted mandates that hospitals provide a list of current standard charges, as reflected in the hospital’s charge master for all items.
  - Must be on the hospital’s public website
  - Must be in a machine-readable format
  - Must include the CPT codes or healthcare common procedure coding system (HCPCS) code
  - Must include a short text description
  - If applicable, must include the national uniform billing committee revenue code
  - Must include the charge or fee assigned by the hospital to the item or service
  - Must also be submitted to the Commissioner of Health

- Not very helpful to consumers.
- Hard to defeat in the legislative process.
Last Year’s Federal CMS Price Transparency from FY2019 OPPS

- Hospitals directed to post their chargemaster
- In a machine readable format
- Updated at least annually
- On each hospital’s website
- Required starting January 1, 2019

President’s Executive Order, June 24, 2019

- The President signed an Executive Order (EO) on Improving Price and Quality Transparency in American Healthcare to Put Patients First:
  - “It is the policy of the federal government to increase the availability of meaningful price and quality information for patients.”

- The EO directed the Secretary of HHS to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information.
CMS Published Price Transparency Final Rule on Nov 15, 2019

• To be implemented January 1, 2021
• Five types of “Standard Charges” to be displayed
  • “Item and service” includes both individual items and packaged services that can be provided in an inpatient or outpatient setting including those furnished by physicians or other practitioners for which a hospital has established a standard charge.
• Non-compliance carries a maximum $300 per day penalty

CMS Definition of “Standard Charges”

• **Gross charge**: The charge for an individual item or service that is reflected on a hospital’s chargemaster, absent any discounts
• **Discounted cash price**: The charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service
• **Payer-specific negotiated charge**: The charge that a hospital has negotiated with a third party payer for an item or service
• **De-identified minimum negotiated charges**: The lowest charge that a hospital has negotiated with all third-party payers for an item or service
• **De-identified maximum negotiated charges**: The highest charge that a hospital has negotiated with all third-party payers for an item or service
CMS Price Transparency Final Rule (cont.)

• In addition, required to publicly display a list of 300 “shoppable services”
• Provide standard charges and payer-specific negotiated charges for each service
  • CMS provides 70 ‘starter’ services
• Hospitals that have an online estimator tool are exempt from this section as long as the tool is available to the public and meets the requirements of this section to report 300 shoppable services

Requirements for “shoppable services” list

- For each shoppable service displayed, the hospital must:
  • Include a plain-language description
  • Group the primary shoppable service with the ancillary services typically associated with the service
  • Indicate the location at which the shoppable service is provided (hospital, inpatient, outpatient, clinic, etc.)
- Format: Hospital’s discretion
- Location and accessibility requirements
  • Displayed prominently on each hospital’s website without restrictions on access
- Updated at least annually
Prohibiting physician non-compete contracts

- National discussion on this issue. Evolving AHA position does not reflect current MHA position.
- Not defined in statute
- Physician non-compete contracts mean different things to different people, to different hospitals, to different legislators.
- Status of bill:
  - On the House floor, in the Senate Judiciary Committee
  - Somewhat partisan, but not entirely
  - May need to find compromise language

Nurse staffing ratio bill

- Nurse staffing ratio bill will certainly get a House author.
- HHS Policy Chair Rena Moran will likely hear at least one (if not both) of the MNA’s two priority bills.
- Language similar to previous years. Key provisions include:
  - Dictates the ratios for each unit of the hospital, and says “at all times.”
  - Staffing plans must be developed in agreement with direct care RNs.
  - “If staffing inadequacies cannot be resolved….the hospital must suspend nonemergency admissions and elective surgeries.”
  - Other nurses cannot be assigned to a unit until they can demonstrate “competence” and received “orientation.”
  - Other employees cannot be laid off.
  - The bill imposes a $25,000 penalty for staffing violations and reporting violations to be imposed by the Commissioner of Health.
Nurse staffing ratio bill (continued)

- Amends the current nurse staffing disclosure law by:
  - Requiring staffing plans must have the consent of bargaining reps;
  - Requiring quarterly submissions of staffing plans to MHA instead of annually;
  - Breaking out reporting by shift (right now it is an average);
  - The Commissioner of Health must accept complaints regarding situations in which a hospital scheduled fewer staff for a patient care unit than specified.

MNA’s violence reporting & staffing complaints bill

- Requires MDH to create a “violence prevention database.”
- Allows MDH to mandate security plan improvements.
- Requires hospitals to allow employees to review and submit concerns about violence, “during the health care worker’s work shift,” to a database portal.
- Mandates hospitals to create and implement a procedure for a health care worker to officially request additional staffing.
  - Hospital must document all requests for additional staffing made because of a concern over a risk of an act of violence.
- Requires each hospital to make its action plans publicly available by posting the plan and results of its annual review on its website.
Concerns about a new government data base

- Very concerned about MDH creating a new data base and collecting information as reported by any hospital staff.
  - Would be burdensome to providers
  - Reported incidents would not have been vetted and could be duplicative of the same event. More of a staff complaining process.
  - If hospitals were named, would likely be a disservice to hospitals that provide inpatient mental health services.

MHA member initiatives on violence prevention

- Many new hospital initiatives underway. 100% of MN hospitals using the “Gap Analysis” best practices road map.
- Hospitals doing more to encourage all incidents of violence to be reported. Including verbal harassment by patients.
- More hospitals are doing quarterly or even monthly violence incidents reviews with safety committees.
- More doing root cause analysis of incidents.
- Significant new spending on security staffing and redesign of facilities to improve staff safety.
- Most hospitals now doing daily huddles with patient assessment tools to try and be more predictive about potentially violent patients.
Potential for “emerging” concerns

- Reverse “Certificate of Need” legislation;
- More reporting mandates on inpatient hospital costs and prices;
  - Amount paid for pharmaceuticals vs. hospital charges for those items.
  - Attempts to limit hospital prices to a certain percentage above Medicare.
- Regulating a certain threshold of charity care in order to qualify for non-profit status.
- Regulating a certain threshold of community benefit to qualify for non-profit status.
  - Dictating what projects, or types of projects must be included in a hospital’s community benefit activities.

Next steps and legislative outreach efforts

- The 2020 legislative session starts on Tuesday, February 11.
- Pursue legislative district meetings prior to the start of Session.
- Contributions to your favorite state candidate, eligible for MN’s political contribution rebate program. Or donations to MHA’s PAC will count toward your hospital’s PAC goal.
Connecting care and communities

A unique role for a hospital trustee:

• Look at data – can challenge entrenched perceptions about your community

• Reassess hospital community benefit – ever evolving to meet the challenges of your communities:
  ✓ Example: Hospitals doing food sustainability projects
  ✓ Example: Hospitals providing wellness and fitness opportunities

• Explore non-traditional partnerships and new collaborations.

• Be the eyes, ears, voice of the communities’ needs.