Health Care for All MN & Physicians for a National Health Program/MN

Support the Patient-Centered Care bill (SF 1059 and HF 255)

We're here to urge you to vote for the **"direct provider payment" Patient-Centered Care (PCC) bill, SF 1059/HF255**, authored by Senator John Marty and Rep. Tina Liebling**.** This legislation would replace Minnesota's delivery and payment system for a fifth of Minnesotans – those in Medical Assistance (a.k.a. Medicaid) and MinnesotaCare – with a "Patient-Centered Care" (PCC) system. Under it, the Department of Human Services (DHS) would:

- Pay providers (clinics, doctors, hospitals) directly for the care they deliver to patients, eliminating the use of health plans as a middleman. The state would not renew the contracts with HMOs or Integrated Health Partnerships (IHPs) for either MinnesotaCare or Medical Assistance.
- On top of the payments for medical care services, MN would pay primary care providers a small monthly fee for coordinating care. Patients would be encouraged to choose a primary care provider, who would help them navigate the health care system.
- Collaborate with community clinics to do outreach to people who are not receiving care.

Simplifying these programs and lowering their costs has always been desired, but it's even more important today when Congress intends to slash federal spending on Medicaid. Minnesota gets about half the money for Medical Assistance from the federal government. Below are the problems caused by the insertion of HMOs into our public programs, followed by the solutions as outlined in the PCC bill.

Problem

In the years before HMOs were inserted into Medical Assistance and MinnesotaCare, DHS paid health care providers directly without funneling tax dollars through the middlemen. DHS spent just 4 - 5% of its total expenditures to administer the programs. After HMOs were inserted, total administrative spending soared because taxpayers had to pay for both DHS's administrative costs *and* HMO administrative costs. HMOs use 15% of every dollar they get from DHS for administrative costs (such as telling doctors how to practice medicine). This raised the payments for the huge increase in administrative spending – DHS's 4 - 5% plus the HMOs' 15%.

Other problems caused by inserting HMOs into our public health programs:

- Patient services delayed and denied (which may offset increased administrative costs, but at patients' expense).
- Continuity of care disrupted for enrollees when they are forced into an HMO when they first sign up for the programs, when they disenroll from them, and when HMO contracts with DHS change or end].
- Higher administrative costs for the clinics and hospitals that treat the enrollees because physicians must waste time arguing with insurance companies to get the care their patients need.
- Worsening of physician burnout.
- Reduced transparency (e.g. do we know what HMOs do with the extra payments they get from DHS to "coordinate care"?), and therefore significant loss of accountability to the legislature.

Solution

The PCC Bill will restore quality by terminating DHS's contracts with HMOs and restoring to doctors and patients the freedom to decide which medical treatments patients get. Other benefits include:

- Approximately $1 billion would be saved by no longer paying for HMO overhead.
- Transparency, accountability, and continuity of care will improve.
- Networks will be eliminated.
- Coordination of care will be improved by directly paying primary care clinics to coordinate care instead of paying HMOs, which are incapable of "coordinating care" from afar, and are incentivized to manage claims, not care.
- Elimination of a second layer of middlemen called "Integrated Health Partnerships," (mini-HMOs) to which enrollees are assigned (usually without their knowledge).
- Social workers and other community health workers will be paid to locate people who have trouble seeking medical care (due to addiction, for example).