

Referred to: Reference Committee: C

REPORT #21, COMMITTEE ON MEDICAL PRACTICE & PLANNING

To: Minnesota Medical Association, House of Delegates
Convening September 17, 2008

The Medical Practice and Planning Committee (MP&P) has met five times since the 2007 MMA Annual Meeting. The following is a summary of the issues considered by the committee since its last report.

2006 Resolution 410: Remuneration for Physicians on Call

As referred to the MMA Board of Trustees, Resolution 410 reads as follows:

RESOLVED, that the Minnesota Medical Association establish a task force to investigate, study, and make recommendations regarding the policy of physician remuneration by hospitals while on call, and let it be further

RESOLVED, that the task force report its findings to the 2007 MMA House of Delegates.

The committee noted that the issue of remuneration for on-call physician services is an important topic. There are, however, legal considerations associated with this discussion that are relevant both to physicians as well as to the MMA.

The committee discussed this topic at some length. There was consensus that a task force should not be established to address this topic, but several committee members noted that a broad policy statement from the MMA would be valuable.

Ultimately, the committee submitted the following policy statement for consideration by the MMA Board of Trustees:

The MMA recognizes the need for hospitals to maintain adequate on-call physician coverage to serve the needs of patients in their communities. Paying physicians for on-call coverage may, in some cases, be a reasonable practice for hospitals and/or medical groups. The MMA urges physicians, however, to be mindful of ethical and legal ramifications that may be associated with payment for on-call services, including possible violation of medical staff bylaws, federal and state anti-kickback laws, and self-referral prohibitions.

The Board approved the recommended language.

2006 Resolution 319 – Prisoners' Health Care

The committee considered 2006 Resolution 319, which reads as follows:

RESOLVED, that the Minnesota Medical Association study the issues of access to and payment for appropriate medical care for prisoners (including those on work release) as well as adolescents in out-of-home placements.

To best manage the resolution, the following goals were identified:

- To understand how general health care is delivered to Minnesota prisoners;
- To identify the role of community physicians in delivering care to prisoners (and those on work release and adolescents in out-of-home placement);
- To understand how payment (both public and private) for health care services delivered to prisoners (and those on work release and adolescents in out-of-home placement) is managed; and,
- To identify any barriers to payment for services delivered to prisoners (and those on work release and adolescents in out-of-home placement).

To assist the committee in its review of these items, Nan Larson and David Paulson, M.D., from the Minnesota Department of Corrections joined the discussion.

The committee heard a brief overview of the changes implemented in the late 1990s by the Department of Corrections to consolidate health care purchasing for prisoners through a contract with Correctional Medical Services (CMS). Under this contract, approximately 9,100 offenders are provided medical care at nine state facilities (seven for adult men, one for adult women, and one for juveniles). It was noted that health care services delivered in jails are managed at the local (i.e., city/county) level; although the state has authority over inspection and enforcement at the local level, there are no standards for the types of health services/support that must be provided in jails.

Upon incarceration, offenders lose all state/federal benefits, including Social Security Disability Insurance, Medical Assistance, General Assistance Medical Care, VA benefits, and MinnesotaCare.

Offenders who participate in work release programs (approximately 215 individuals) are caught in a health care coverage gap. As a result of the contractual relationship between the state and the offender participating in work release, the offender agrees to assume responsibility for any health care costs incurred while outside of the correctional facility (CMS services are not provided to offenders outside of the facility). An example was given about a man who was out on work release who suffered a heart attack; his care and hospitalization were not covered by the state and, presumably, were not paid and ended up as bad debt to the hospital. Although some of the work release participants may qualify for benefits through their employment, the representatives from the Department of Corrections were unable to define what level of coverage is provided by the employers and they noted that the provision of such coverage is very low.

Although the Department of Corrections officials were not able to describe how health care coverage for offenders on work release from city/county jails was managed, they did note that far more individuals are on work release from jails than from state facilities.

The committee members had a fairly lengthy discussion about the issue and agreed that there is a significant gap in coverage for prisoners out on work release; several thought the state's policy to only cover offenders while between the walls of the prison (i.e., not while out on work release) was an abrogation of their responsibility. The committee also recognized, however, that there should not be incentives provided to offenders on work release to obtain care that could otherwise be provided within the prison.

Ultimately, the committee recommend to the MMA Board of Trustees that the MMA support efforts to extend health care coverage for catastrophic and chronic care services to prisoners who are out on work release, and the financial responsibility for such care should fall to the state for offenders confined to state facilities and to counties/cities for offenders confined at the local level.

The Board adopted the committee's recommendation.

The Board further asked the committee to discuss several other related issues including health care coverage during patient transport, other out-of-facility situations, and financial responsibility (county vs. state) for the cost of caring for persons in county jails.

Subsequent committee review determined that coverage during prisoner transport is not an issue, as coverage rests with the entity that has custody. Additional clarification is needed from the Department of Corrections, however, on coverage for those on home monitoring and those residing in halfway houses.

With respect to the issue of the financial responsibility for jail inmates, the committee intends to explore this issue at a future meeting, noting that this issue can be significant as one severely ill patient can quickly deplete budgeted county funds. In addition, counties are highly variable with respect to their ability to manage and absorb such costs.

2007 Resolution 201: Enrollee Access to Insurance/Health Plan Provider Agreement Details

The resolution, which was referred to the Board by the MMA House of Delegates, reads as follows:

RESOLVED, that the Minnesota Medical Association establish as its policy that patients as insurance company/health plan enrollees shall have access to all provisions in provider agreements that pertain to payments to physicians and provider pay-for-performance incentives or penalties, which affect their care, and be it further

RESOLVED, that the Minnesota Medical Association urge all clinics and provider organizations that employ physicians to disclose upon patient request

their policies for salary contingencies or bonuses for pay-for-performance programs, and be it further

RESOLVED, that the Minnesota Medical Association delegation to the American Medical Association submit a similar resolution to the AMA House of Delegates.

As part of their review, the committee members considered Minnesota Statute 62J.72. This provision requires health plans and providers to disclose to enrollees/patients relevant reimbursement and payment information. In particular, the state law reads (in part) as follows:

...shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the general nature of the reimbursement methodologies used...to pay providers. The description must explain clearly any aspect of the reimbursement methodology that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees... (b) Health plan companies, health care network cooperatives, and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to, the following information:

- (1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;
- (2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and
- (3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

Ultimately, the committee concluded that current state law reasonably and adequately addresses the issues identified in the first paragraph of the resolution. With respect to the second paragraph, the committee members had a lengthy discussion. They acknowledged that the current state disclosure law does not require physicians/clinics to disclose their group's internal payment policies, but several committee members also expressed concern about the need and value of payment disclosure at this level, as well as the potential impact such disclosure may have on the patient-physician relationship.

Ultimately, the committee recommended to the MMA Board that the resolution not be adopted. The Board adopted the committee's recommendation.

2007 Resolution 202: Prospective Online Enrollee Insurance Benefit and Medication Formulary Details

The resolution, which was referred to the Board by the MMA House of Delegates, reads as follows:

RESOLVED, that the Minnesota Medical Association advocate that Minnesota health plan/insurance companies make readily available to their enrollees specific details online about the individual enrollee's health coverage and pharmaceutical benefits before and during the doctor visit, and be it further

RESOLVED, that the Minnesota Medical Association delegation to the American Medical Association submit a similar resolution to the AMA House of Delegates.

Committee members acknowledged that a variety of changes have occurred in the market with respect to improving both physicians' and patients' access to information about pharmaceutical benefits and other levels of insurance coverage. Sorting through the information on benefits and coverage during an office visit, however, is not always an efficient use of time. For some physicians, looking up pharmaceutical benefits online is more time-consuming than responding to calls from pharmacists (about a prescribed medication not being on the formulary and making necessary changes).

There was, however, general consensus among the committee members that efforts to improve patients' access to information about their coverage and benefits would be valuable. There were concerns, however, about creating expectations that such information would or should be accessed during the course of an appointment.

The committee recommended that the Board modify the original resolution by striking "before and during the doctor visit" from the first paragraph. The Board adopted the committee's recommendation.

2007 Resolution 208: Support for Quality of Care in Supervisory Agreements

The resolution, which was referred to the Board by the MMA House of Delegates, reads as follows:

RESOLVED, that the Minnesota Medical Association endorse the American Academy of Family Physicians Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners, and Physician Assistants (C 1992, 2002), and encourage its acceptance by the Minnesota Psychiatric Society, the Minnesota Academy of Family Physicians, the Minnesota Nurses Association, and the Minnesota Hospital Association for use by all medical professionals who treat patients with psychiatric diagnoses, and be it further

RESOLVED, that the Minnesota Medical Association educate physicians, physician assistants and advanced practice nurses who have supervisory agreements on the general principles included in the guidelines.

During its review of the resolution, committee members reviewed both the above-referenced AAFP guidelines as well as the MMA Q&A document (available online) for physicians entering into prescribing or collaborative agreements with advanced practice nurses. After significant discussion, committee members agreed that the MMA

document, which includes state-specific references and citations, is more valuable for and relevant to Minnesota physicians than the more general AAFP document.

The committee recommended to the MMA Board that in lieu of the original resolution the following policy be adopted:

The MMA strongly encourages physicians to utilize *written* agreements when entering into collaborative management plans with advanced practice registered nurses (APRNs). To assist physicians, the MMA will provide specific educational materials and resources for physicians who enter into collaborative practice with APRNs.

The Board adopted the committee's recommendation.

2007 Resolution 310: Essential Benefit Set

The resolution, which was referred to the Board by the MMA House of Delegates, reads as follows:

RESOLVED, that the Minnesota Medical Association create a task force for the purpose of establishing a physician-defined benefit set.

The amendment recommended by the reference committee, but not acted upon by the House, read as follows:

RESOLVED, that the Minnesota Medical Association Board of Trustees work to explore options for how best to advocate the development of an essential benefit set and report back on its progress to the 2008 Minnesota Medical Association House of Delegates.

The amendment proposed on the floor of the House, but not acted upon by the House, read as follows:

RESOLVED, that the Minnesota Medical Association Board of Trustees work to explore options between the Annual Meeting and the November Board of Trustees meeting for how best to advocate the development of an essential benefit set and initiate the process by December 31, 2007. Progress will be reported to the 2008 Minnesota Medical Association House of Delegates.

During its initial discussion of this resolution, the committee considered recently passed legislation that calls on the Commissioner of Health to establish a work group to create an essential health benefit set by October 2009. The committee members also briefly reviewed past MMA and state of Minnesota work in developing benefit sets. Although the development of a detailed list of covered services will ultimately need to be created in order to assign an actuarial cost to it, the committee members concluded that the most effective role for the MMA would be to establish key principles to guide benefit set

development. The committee will be discussing the resolution in greater detail over the next several months.

Proposed Changes to Minnesota Pharmacy Practice Act

The committee met with representatives from the Minnesota Pharmacists Association to consider two proposed changes to the state pharmacy practice act.

The first sought to change pharmacists' authority to administer vaccines. Under authority adopted in 2003, pharmacists currently can administer influenza and pneumococcal vaccines to adults 18 years of age and older under a standing order written by a physician. The proposal sought to allow pharmacists to administer vaccines to anyone over the age of 10 for all ACIP-recommended vaccines.

The committee had a lengthy discussion about this item and discussed a variety of concerns, including vaccine supply and access, liability, potential public health benefits, communication and the use of registries, and implications of the proposal on the medical home model. The committee expressed general opposition to the proposal, but suggested that further consideration of the proposal by the MMA Public Health and Preventive Medicine Committee was warranted.

The second proposed change sought to modify the collaborative practice agreement language that allows pharmacists to participate in the practice of managing drug therapy on a "case-by-case basis," according to a written protocol with a physician. The proposed change would eliminate the words "case-by-case basis."

The committee again had a lengthy discussion about the proposal and was fairly evenly split between those who were concerned that the removal of the case-by-case language would further erode primary care physicians' relationship with their patients, and those who believed the language change would have little impact, as physicians would still be able to decide whether or not to even enter into written protocols and determine the content of them. Additional concerns about how the change would play out in large health systems and retail clinics were identified; no committee action was taken.

Price/Payment Transparency

In a joint meeting with the MMA Quality Committee, the committee members reviewed MMA policy on price and payment transparency in light of the increased attention to the issues by the Governor's Transformation Task Force, the MMA in its recent resolutions (e.g., 2007 resolution 201), and others.

The group heard a staff presentation on price and payment transparency, the purpose of which was to review current MMA policy on cost (price) transparency, the forces driving cost (price) transparency, and to seek clarification on roles, responsibilities, and opportunities associated with such transparency.

The group ultimately agreed that the most useful information on price and cost is the allowed amount and that the best source of that information is health plans.

The attendees then shifted their attention to the issue of resource use and efficiency measurement and transparency.

A staff presentation explained common definitions, described driving forces, reviewed current methodologies, and identified a process for further refining MMA policy and advocacy efforts.

With little time available for discussion, the group reached a consensus that in order to better address these issues and develop corresponding MMA policy, a subgroup should be created. This group has not yet convened, but expects to before the end of 2008.

Health Care Reform

The committee received regular updates on the status of the 2008 Minnesota health care reform legislation.

Concluding Remarks and Acknowledgements

I continue to enjoy the opportunity to serve as chair of the Medical Practice and Planning Committee. The thoughtful participation and expertise of the committee members is appreciated. The members of the 2008 committee were: Barbara Allen, M.D.; Greg Barsness, M.D.; Kevin Christensen, Medical Student Section; Julie Gilkeson, M.D., Resident/Fellow Section; Morton Kane, M.D.; Roger Kathol, M.D.; Pramod Kelkar, M.D.; John Kuncaitis, M.D.; Matthew Layman, M.D.; Merle Mark, M.D.; Teresa McCarthy, M.D.; Maria Mendoza-Kundel, M.D.; Randy Rice, M.D.; Shanthi Sivanandam, M.D.; Lyle Swenson, M.D.; Annelise Swigert, M.D.; Roy Yawn, M.D.; Darla Morris-Preble, MMGMA representative; Hieu Cabak, PA-C, Minnesota Academy of Physician Assistants representative; and, Janet Silversmith, MMA staff.

Doug Wood, M.D.
Chair