ISSUE BRIEF:
Minnesota’s All-Payer Claims Database and Provider Peer Grouping

MMA POSITION:
The MMA supports efforts to indefinitely suspend the Provider Peer Grouping (PPG) project and instead leverage the state’s all-payer claims database (APCD) for research about health and health care in Minnesota. In particular, the MMA urges improved understanding of population health; the determinants of health; and the utilization, distribution, cost, delivery and outcomes of care.

BACKGROUND:
In 2008, the Minnesota Legislature charged the Minnesota Department of Health with establishing an APCD. All health plans and third-party administrators with at least $3 million in paid claims and all pharmacy benefit managers with at least $300,000 in paid claims are required to submit their claims to the APCD. Medicare and Medicaid claims are also included in the database. All data is one-way encrypted and patient information is de-identified prior to submission.

The 2008 law limited the APCD’s use to the Minnesota Department of Health for creating hospital and clinic-specific comparisons of their total cost and quality of care – a project known as Provider Peer Grouping (PPG). For a variety of reasons, the PPG project has not succeeded. At the same time, Minnesota’s APCD remains severely underutilized at a time when data analytics are needed to inform policy development and improve care delivery.

Claims or administrative data have some clear limitations in terms of describing the delivery and quality of care, but they also have tremendous potential. Among the most well-regarded research that relies on medical claims data is the Dartmouth Atlas of Health Care. Using population-based small-area analysis, the Dartmouth Atlas examines how medical resources are distributed and used in the United States. This work has been extremely informative and influential among physicians, academicians and policy makers. Ultimately, the MMA envisions a Minnesota Health Atlas Project that leverages the state’s APCD and improves transparency in all aspects of the health care system.

HF 2656 (authored by Rep. Tom Huntley, DFL-Duluth) and SF 2106 (authored by Sen. Tony Lourey, DFL-Karrick) would create a work group that would develop recommendations for the 2015 Legislature regarding how the APCD could best be utilized, whether and how access to the database should be expanded, what new or additional data privacy and security provisions are needed, and what type of governance or oversight is needed to support expanded use. The legislation would also grant the Minnesota Department of Health authority to demonstrate the value of the APCD data. In particular, the department could use the APCD for health care home evaluation, analysis of hospital readmissions to support the RARE (Reducing Avoidable Readmissions Effectively) project and analyses of geographic or population-based variation in illness burden and utilization, cost and quality of care. None of these efforts would identify specific physicians, hospitals, clinics or other care providers. The proposal also suspends the PPG project unless explicitly reauthorized by the Legislature.

TALKING POINTS:
➤ The Minnesota all-payer claims database (APCD) offers tremendous potential for expanding our collective knowledge about health and health care in Minnesota.
➤ Current law limits the APCD to the state’s Provider Peer Grouping (PPG) project. The PPG project has not been successful and it is time to set it aside in favor of more valuable studies.
➤ Although there are limitations associated with the use of claims data, such data have been shown to be extremely powerful to inform planning, policy development and care delivery, as evidenced most clearly by the Dartmouth Atlas of Health Care.
➤ HF 2656 and SF 2106 launch the work needed to advance use of Minnesota’s APCD. The bills would suspend indefinitely the PPG project, establish a process and timeline for the development of recommendations on the specifics associated with expanding the APCD, and give the health department limited authority to use APCD for discrete research purposes.
➤ The MMA strongly urges passage of HF 2656 and SF 2106.
ISSUE BRIEF:

Advocating for physician-led team-based care

MMA POSITION:

The MMA supports patient-centered, team-based care to ensure that patients receive the right care from the right practitioner. The independent practice of advanced practice registered nurses (APRNs) is not consistent with this approach.

BACKGROUND:

Minnesota law defines APRNs as nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. Some of these practitioners practice primary care while others do more procedure-based work.

Minnesota law requires APRNs to practice “within the context of collaborative management,” which is defined as “a mutually agreed-upon plan between an advanced practice registered nurse and one or more physicians or surgeons licensed under chapter 147 that designates the scope collaboration necessary to manage the care of patients.” (MS 148.171, Subd. 6). Current law also requires APRNs to have a written prescribing agreement with a delegating physician in order to prescribe medications.

The emerging model of health care delivery requires teams of physicians, nurses, APRNs, physician assistants, dieticians, care coordinators, pharmacists and others to work side by side in caring for the patients.

Amid advances in collaborative, team-based care, legislation has been introduced to allow the independent practice of APRNs.

Those supporting more independence for APRNs say it’s a strategy for addressing the shortage of primary care physicians. Substituting APRNs for physicians is not the answer, however. APRNs clearly have an important role to delivering care effectively and efficiently, but preserving the collaborative approach is in the best interest of all patients.

The increasing problems of prescription drug abuse, primarily opioid abuse, urges restraint in expanding prescribing authority to those with limited training.

TALKING POINTS:

➤ A patient-centered, team-based care, that includes physicians, nurses, advanced practice nurses, physician assistants, dieticians, care coordinators, pharmacists and others, ensures the most effective use of the health care workforce.

➤ Authorizing the independent practice of APRNs without maintaining the requirement that they work in a collaborative manner conflicts with the strategy of team-based care.

➤ The focus of any legislative change needs to be on patient safety. Certain procedures, such as interventional pain medicine, is the practice of medicine and only should be performed by physicians with specific training.

➤ Amid increasing concerns with prescription drug abuse, primarily opioid abuse, caution is needed when considering expanding the authority of APRNs to independently prescribe Schedule II narcotics.
ISSUE BRIEF:

Regulating e-cigarettes

MMA POSITION:

The dramatic growth of e-cigarette use is a public health concern that warrants careful attention. The MMA supports efforts to restrict the availability and use of e-cigarettes, as well as regulate the devices and the substances they deliver.

BACKGROUND:

E-cigarettes are battery-powered products that deliver nicotine and other chemicals and flavorings through a vapor inhaled by the user. In the decade since their introduction, e-cigarette use has grown dramatically, with sales in 2013 topping $1 billion.

The safety of e-cigarettes remains in question. Some studies have detected the presence of carcinogens and heavy metals in e-cigarette vapor. E-cigarettes are not governed by the FDA, so the concentration of nicotine and other potentially harmful ingredients is not regulated, nor are ingredient lists required.

E-cigarettes have not been approved by the FDA as a smoking cessation device. Until more rigorous studies can be conducted, people seeking to quit smoking should use aids that are proven to be effective.

Use of e-cigarettes among young people is rising dramatically. A study by the U.S. Centers for Disease Control and Prevention showed that e-cigarette use by middle and high school students doubled between 2011 and 2012. E-cigarette manufacturers and retailers have responded by flavoring these products in ways that appeal to kids. E-cigarettes may well serve as a "gateway" to young people using conventional cigarettes and other tobacco products with known risks.

TALKING POINTS:

- Little is known about the health risks associated with or the secondhand vapor emitted by e-cigarettes. Until more is known, legislators should include e-cigarettes in the state's Freedom to Breathe law.
- Given the increased use by young people, e-cigarettes should be treated the same way conventional cigarettes are in the retail environment. Sellers should be required to hold tobacco licenses and to keep these products behind store counters.
- Legislators have taken great strides in protecting the public health by reducing nicotine exposure by passing the Freedom to Breathe Act and raising the tobacco tax. With so much unknown about the safety of e-cigarettes, the Legislature should err on the side of protecting public health through careful, thoughtful policies that mirror those addressing the use and sale of tobacco.
- It took far too long for policy makers to recognize the tremendous harm done by tobacco and to take steps to regulate its use. We want to avoid making the same mistake with e-cigarettes.

ISSUE BRIEF:

Restoring the newborn screening program

MMA POSITION:
The Legislature should restore the state’s newborn screening program to its previous nation-leading status by removing the arbitrary limits on how long samples and data can be retained.

BACKGROUND:
The state’s newborn screening program tests for more than 50 rare genetic and congenital disorders. Each year, more than 100 newborns are identified with debilitating and even fatal conditions that— if detected early—can be treated. Since the program’s inception in 1965, more than 5,000 newborns have been saved from death or a lifetime of disabilities or permanent brain damage.

Following a series of court decisions, the Minnesota Supreme Court ruled in 2011 that the state’s newborn screening program, which uses a spot of blood retrieved from a newborn’s heel during the first 24 to 48 hours after birth, violated the state law that governs genetic material. In response, the Legislature passed a bill in 2012 that established “standard retention periods” for how long newborn screening blood spots and test data may be stored. Under the law, negative blood spots must be destroyed within 71 days, and positive tests within two years. All test data must be destroyed no later than the child’s second birthday. Subsequent legal action has forced the Minnesota Department of Health to destroy more than 1 million blood spots.

The time frames established in 2012 are arbitrary and risky. In some cases, a confirmatory diagnosis can take more than six months. Stored spots provide valuable protection if a child becomes critically ill, provide data for siblings who may show hard-to-diagnose symptoms, and reduce the need for duplicative testing. More broadly, allowing for extended storage of spots and data supports new test development, quality assurance and refinement of existing tests. MMA supports robust privacy protections to allow parents to opt out of storage should they wish.

Minnesota’s program was long considered a model for the nation; that is no longer the case.

TALKING POINTS:

⇒ Newborn screening saves lives and resources by identifying dangerous and deadly disorders in the hours after a newborn’s birth. State law should fully support this process.

⇒ Destruction of blood spots and test data inhibits the development of new tests, refinement of existing tests, and quality assurance. It can lead to duplicative testing, additional expense and needless worry for families.

⇒ Minnesota’s newborn screening program was once a model for the nation. But arbitrary retention periods for blood spots and data, as well as the destruction of more than 1 million stored samples, has led Minnesota’s program to become one of the weakest in the nation, threatening newborns, their families and public health.
ISSUE BRIEF:
Prohibiting tanning bed use by minors

MMA POSITION:
The MMA supports legislation to prohibit the use of indoor tanning devices by minors, require a warning notice be provided to users, update posted warning signs, and create a licensing fee for tanning facilities to pay for enforcement.

BACKGROUND:
The number of cases of melanoma and other skin cancers in the U.S. is growing. Nearly 200 Minnesotans die from melanoma each year. The use of tanning beds is increasing according to a 2013 Minnesota student survey. One-third of white 11th-grade Minnesota girls reported having tanned indoors in the past year, according to the state survey, and more than half of them used artificial tanning devices at least 10 times in a 12-month period.1

Although many believe there are health benefits associated with using tanning devices to “build up a base coat of a tan,” study after study has shown the increased health risk of even “casual use” of these devices. A study in the journal *Pediatrics* found indoor tanning beds deliver 10 to 15 times more ultraviolet (UV) radiation than natural sunlight.2

Studies have shown tanning bed users have a 75 percent increase in risk for developing melanoma compared with those who have never used them; heavy users have a 2.5 to 3 times greater risk. Researchers at the Mayo Clinic recently reported that the melanoma risk in women younger than 40 is now eight times greater than it was in the 1970s - before the growth in tanning salons - and that the risk in women ages 40 to 60 is now 24 times greater than it was 40 years ago.3

The World Health Organization has classified the UV radiation from tanning beds as a known carcinogen. Thus, there is no “safe” tan.

In addition to the health risk associated with artificial tanning, there is a financial cost to society. The direct cost of skin cancer in the U.S. was estimated to be $1.5 billion in 2004. The cost of melanoma alone was nearly $300 million that year.

Minnesota must protect minors from the cancer risks associated with indoor tanning. Seven states have already banned tanning beds for minors (California, Connecticut, Illinois, Nevada, New Jersey, Texas, and Vermont). It's time for Minnesota to become the eighth.

TALKING POINTS:
- The ultraviolet radiation from artificial tanning is a known carcinogen that causes melanoma and other skin cancers.
- There is no safe level of tanning, and tanning beds are not safer than exposure to the sun. In fact, they are more dangerous.
- Users of artificial tanning devices have a 75 percent increased risk of developing melanoma.
- Minnesota must protect minors from cancer risks associated with indoor tanning and prohibit the use of tanning beds by all children under age 18.
- Many types of melanoma are preventable. Minnesota children deserve protections from this deadly and costly disease.

1 Minnesota Student Survey, 2013, Minnesota Department of Health
3 Mayo Clinic Proceedings, April 2012, “Increasing Incidence of Melanoma Among Young Adults”
ISSUE BRIEF:

Battling prescription opioid misuse

MMA POSITION:
To effectively prevent the misuse of prescription opioids, the MMA supports improvements to the functionality of Minnesota's Prescription Monitoring Program (PMP), and efforts to create an opioid prescribing protocol. In addition, the MMA supports expanding access to naloxone among community-based organizations and creating a Good Samaritan law in Minnesota.

BACKGROUND:
According to the Centers for Disease Control and Prevention (CDC), prescription opioid abuse has become a deadly epidemic. Prescription opioids are responsible for three out of four prescription drug overdoses, and in 2008, they caused 14,800 deaths—more than twice as many as cocaine and heroin combined. In addition, in 2009, prescription opioids were the cause of more than 475,000 emergency department visits. In Minnesota, emergency department visits that involved prescription narcotic analgesics (i.e., prescription opioids) more than doubled between 2004 and 2011. During the first half of 2013, 10.1 percent of treatment admissions were for “other opiates” (the majority being prescription painkillers). Prescription opioid abuse also carries a significant economic burden. One study estimated that the total cost of nonmedical use of prescription opioids in the U.S. was $53.4 billion in 2006 figure. It also found that the misuse of oxycodone, hydrocodone, propoxyphene and methadone accounted for two-thirds of the total economic burden.

To reduce the number of prescription opioid overdoses in Minnesota, the MMA supports efforts to expand access to naloxone among community-based organizations and create a Good Samaritan law. Naloxone, if properly administered, can typically reverse an opioid overdose. Good Samaritan laws provide limited immunity for those who report an overdose, something that is often not done because of fear of reprisal. The proposed “911 Good Samaritan + Naloxone” legislation will be useful in helping reduce prescription opioid overdoses.

In 2012, the MMA created a task force to address prescription opioid addiction, abuse and diversion. The MMA is working to improve opioid prescribing by partnering with the Institute for Clinical Systems Improvement (ICSI) to develop an evidence-based acute pain assessment and opioid prescribing protocol. To improve the functionality of the PMP and make it easier to use, the MMA is working to better integrate it into electronic health record systems.

TALKING POINTS:
- Patients with pain should be safely and effectively treated. Efforts to address prescription opioid abuse should ensure that access to medically appropriate pain medicine is not diminished.
- Prescription drug abuse is costly for Minnesota, and creates a threat to both public safety and public health.
- Improvements to the functionality of the PMP are needed to expand its use and increase its value to prescribers. One idea is to have the PMP send alerts to prescribers about patients who may be “doctor shopping.”
- Efforts to expand access to naloxone among community-based organizations will allow naloxone to be placed in the hands of those who come into contact with drug overdose victims, and increase the likelihood that their overdose can be reversed.
- Creation of a Good Samaritan law in Minnesota will encourage those who witness a drug overdose to seek medical assistance for the victim, without fear of arrest and prosecution.

1 Centers for Disease Control and Prevention, Policy Impact - Prescription Painkiller Overdoses, November 2011
2 Id.
3 Id.
5 Other opiates include prescription narcotic analgesics, opium and all opiates other than heroin, see Carol L. Falkowski, Drug Abuse Dialogues, “Drug Abuse Trends in Minneapolis/St. Paul, Minnesota: June 2013,” available at: http://drugabusedialogues.com/drug_abuse_trends_reports/2013_June_.pdf
ISSUE BRIEF:
Ensuring the provider tax phase-out

MMA POSITION
In bipartisan fashion, the Legislature voted in 2011 to repeal the provider tax by the end of 2019. This repeal must remain intact.

BACKGROUND
Passed into law in 1992, the provider tax is a 2 percent tax on medical services provided by physicians, hospitals, dentists, chiropractors and other health care providers. Funds from the tax are deposited into the Health Care Access Fund (HCAF), which is used primarily to pay for the MinnesotaCare program.

Legislators and Gov. Mark Dayton passed a phase-out and repeal of the tax as part of the 2011 budget agreement. Under current law, the provider tax will be permanently repealed on Dec. 31, 2019.

With the passage of the Affordable Care Act, Minnesotans covered under MinnesotaCare will now qualify for Medical Assistance (MA), the state’s Basic Health Plan, or receive federal subsidies to purchase private insurance coverage.

Since 2004, more than $1 billion has been transferred out of the HCAF and into the General Fund to help balance the state’s budget. In 2014, half of the HCAF expenditures will fund the MA program, even though MA has always been a General Fund obligation.

Though the provider tax was created to support the MinnesotaCare program, it is increasingly being used to fund General Fund programs.

The original intent of the provider tax has been significantly distorted, thus its repeal should proceed.

TALKING POINTS
➔ Physicians and other providers are pleased that the provider tax has been repealed. It has always been a regressive tax on healthcare that falls most heavily on the sick and adds to the overall cost of care.

➔ Nearly half of the HCAF revenue is being spent on General Fund programs (MA) in 2014 and more than $1 billion has been transferred to the General Fund since 2004.

➔ The provider tax repeal doesn’t take place until after Dec. 31, 2019. Do not support the use of the tax for new programs as this will delay or threaten the legislated phase-out.

➔ Broad-based funding is needed for programs that expand access to care.

➔ The MMA opposes any effort to rescind the provider tax repeal or to fund other, new uses for the funds raised by it.