

**2017 MMA Open Issues Forum:
Panel Recommendations for Council Action**

Submitted Issues:

- Issue 1: Maintenance of Certification (*adopt new policy*)
- Issue 2: Preferential health plan coverage of controlled vs. non-controlled substances (*do not adopt*)
- Issue 3: Direct primary care (*refer to MMA Board*)
- Issue 4: Behavioral health care in medical settings (*adopt new policy*)
- Issue 5: Access to no-cost contraception (*retain current policy as edited*)
- Issue 6: Tobacco sales to members of the US military under age 21 (*reaffirm current policy*)
- Issue 7: Audio recordings of patient visits (*refer to MMA Board*)
- Issue 8: State X-ray rule revisions (*refer to MMA Board*)
- Issue 9: Cost sharing for preventive services (*reaffirm current policy*)

Issue Details:

Issue #	Topic	Submitter's Name (Society, if applicable)
1	Maintenance of Certification (MOC)	Paul Goering, MD

Panel's Recommendation:

Adopt new policy as follows:

The MMA, consistent with AMA policy, does not support maintenance of certification (MOC) as a mandatory requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

Recommendation Rationale:

The panelists noted that there are efforts underway nationally to address some MOC issues that have been raised among certain specialties (e.g., the MMA is attending a national meeting in early December with other state medical associations, national specialty societies, and representatives from the American Board of Medical Specialties). The panelists agreed that a national venue was most appropriate to address specific MOC implementation concerns, but that state policy regarding the use of MOC was appropriate for MMA consideration.

The panelists shared the concerns reflected in this submission and in some of the forum comments about the impact that mandatory use of MOC may have on physicians' ability to practice, particularly given the unresolved concerns about MOC implementation among some specialties. The proposed recommendation would make clear that the MMA opposes the mandatory use of MOC as a requirement for practice, without commenting on its potential value in demonstrating ongoing competence. The panelists recognized that some states have sought to limit MOC through legislation, but they stopped short of including that in the recommendation given the potential for unintended consequences.

MMA Staff-Identified Background Information (brief):

Specialty certification (or recertification) is not required for Minnesota medical licensure. The Minnesota Board of Medical Practice accepts certification or recertification by a specialty board in lieu of compliance with the state's

continuing medical education (CME) requirements during the cycle in which certification or recertification is granted (similar to Idaho, North Carolina, Oregon and West Virginia). Under the Interstate Medical Licensure Compact, of which Minnesota is a member state, a physician must hold a specialty certification or time-unlimited certification by an ABMS or AOABOS board to qualify (among other requirements). The Interstate Medical Licensure Compact is a voluntary, one-stop pathway for physicians seeking multi-state licensure.

Several Minnesota health plans require board certification as a condition of network credentialing. Data on the extent to which certification is required for medical staff privileges in Minnesota was not available for inclusion in this background document.

Beginning in 2016, concerns with MOC prompted several state legislatures to limit its use, including Georgia (precludes requiring MOC as a condition of licensure, staff privileges, employment in certain facilities, reimbursement, or malpractice insurance coverage); Maryland (prohibits board certification or MOC to obtain a license or as a condition to renew a license); Missouri (may not require any form of maintenance of certification as a condition of physician licensure, reimbursement, employment, or admitting privileges at a hospital in this state); North Carolina (state cannot deny a license or renewal based solely on failure to become board certified); Oklahoma (prohibits MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital in the state); Tennessee (no licensed facilities can deny a physician hospital staff privileges based solely on the physician's decision not to participate in any form of maintenance of licensure, including requiring any form of maintenance of licensure tied to maintenance of certification); and, Texas (a facility may not differentiate between physicians based on a physician's maintenance of certification if the facility or hospital has an organized medical staff or a process for credentialing physicians, with some exceptions including if the physician members of the medical staff vote to allow differentiation).¹

Concern with MOC has been a frequent topic at recent meetings of the AMA House of Delegates. The MMA, along with several other state and specialty societies, is scheduled to meet with representatives of the American Board of Medical Specialties (ABMS) in early December to exchange concerns about MOC and understand potential changes.

Submitter's Request of MMA:

Should MMA have a position on MOC in case the MN Board of Medical Practice (or other entities) decides to create expectations for its use?

Submitter's Rationale/Background:

Wondering about Maintenance of Certification recently related to Board Certification. As some State Medical Boards are now developing expectations for MOC for everyone (even those grandfathered in with lifetime certification), I am curious about unintended consequences. In psychiatry we have a huge access challenge, and many of our docs are near retirement. Many I have spoken to have expressed a plan to retire as opposed to complete MOC. So, while the quality argument seems clear for MOC, I wonder if there is an access challenge that would be created in the state if such a practice occurred.

Current MMA Policy:

380.276 Resolution Regarding Discontinuing the Secure Examination as Part of the ABMS MOC Program

The Minnesota Medical Association delegation to the American Medical Association will request that the AMA work with the American Board of Medical Specialties to discontinue the requirement for a secure examination as part of their Maintenance of Certification program. (HD-R205-2011)

¹ Anti-MOC Laws Picking Up Steam across the United States. June 28, 2017. Policy & Medicine Website.

Current AMA Policy (*emphasis added*):

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. *The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.*
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.
 20. Any assessment should be used to guide physicians' self-directed study.
 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
 23. Physicians with lifetime board certification should not be required to seek recertification.
 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
 26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
- (CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17)

Issue #	Topic	Submitter's Name (Society, if applicable)
2	Preferential health plan coverage of controlled vs. non-controlled substances	William Dicks, MD

Panel's Recommendation:

Do not adopt/no further action

Recommendation Rationale:

The author of the submitted issue was unable to attend the open issues forum. Although the issue was introduced at the forum, there was no discussion or input provided. Given the lack of input at the forum, staff sought additional input (via email) from members of the MMA Opioid Task Force and received some limited, but conflicting, information. The panelists did not believe they had sufficient information to support the request as submitted and noted some concerns regarding both the cost and effectiveness of the some of the non-opioid medications for which the author appears to want preferential coverage. The panelists recommend that no additional action on this issue occur at this time, but that staff encourage the author to provide additional information to clarify how the proposal can be drafted to balance access to opioid alternatives with issues of cost and effectiveness.

MMA Staff-Identified Background Information:

Staff was not able to review information about health plan formularies/preferred drug lists in time to be included in this background document.

Submitter's Request of MMA:

Pursue legislation to make it illegal for insurance companies to refuse low control or non-controlled substances but allow schedule II or III drugs (e.g., morphine but not tramadol, or hydromorphone but not Lidoderm patches, or, not cyclobenzaprine, but Soma.)

Submitter's Rationale/Background:

This is outrageous behavior and must be stopped. It promotes the opioid epidemic. I see this behavior every day in prescribing these medications. I'm sure almost every prescriber sees it, too.

Current MMA Policy:

50.38 Prescription Opioid Public Health Statement

In recognition of the public health epidemic associated with the addiction, abuse, and diversion of prescription opioids, and understanding the paradigm shift in the treatment of pain, the MMA supports looking at all options for treatment, including the appropriate use of opioid therapy in patients exhibiting non-cancer, acute or subacute pain, as well as the appropriate use of opioid therapy in the management of patients with active cancer and/or receiving palliative or hospice care. In addition, the MMA believes that the use of opioid therapy for chronic pain requires a comprehensive evaluation of the benefits and harms associated with its use, given the limited available evidence to support long-term use. (BT 09- 16)

Issue #	Topic	Submitter's Name (Society, if applicable)
3	Direct primary care	Robert Koshnick, MD (MAFP)

Panel's Recommendation:

Refer the issue of direct primary care to the MMA Board of Trustees for further deliberation.

Recommendation Rationale:

The panelists believed that this issue was quite complex and would benefit from more specific analysis and deliberation to determine what, if any, role the MMA should play with respect to the direct primary care model of practice. A greater understanding of the advantages, disadvantages, and specific barriers is needed before the MMA decides whether or not to facilitate the growth and/or adoption of the model in Minnesota.

MMA Staff-Identified Background Information:

According to the American Academy of Family Physicians (AAFP), direct primary care (DPC) is:

“a subset model of the retainer-based practice framework for primary care practices. There is not a single DPC practice model; rather the model represents a broad array of practice arrangements that share a common set of characteristics. Perhaps the defining characteristic of DPC practices is that they offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. DPC practices are distinguished from other retainer-based care models, such as concierge care, by lower retainer fees, which cover at least a portion of primary care services provided in the DPC practice.”

One of the main advantages of participating in direct primary care, according to AAFP, is that physician practices can reduce their overhead costs associated with claims filing, as many direct primary care practices do not maintain contracts with insurers. A smaller patient base has also been noted, allowing longer patient visits, which may be advantageous to physician practices but may pose challenges for patients seeking access to primary care.

Patients choosing to participate in direct primary care practices generally need to add additional insurance coverage, such as a catastrophic plan, to cover care that falls outside of the scope of services covered by the direct primary care monthly fee. Although the covered services can vary, insurance is often needed to cover prescription drugs, inpatient care, complex imaging or laboratory services, and most specialty care. Some self-insured employers have also showed interest in direct primary care.

An online search of direct primary care practices in Minnesota found approximately a dozen primary care practices, and about three specialty practices (ophthalmology, ENT, PM&R) associated with PrimaCare Direct. PrimaCare Direct describes itself as, “a cooperative of clinics in Minnesota that want to lower the cost of health care to the patient, while focusing on providing exceptional care centered on wellness.”²

Provisions of the Affordable Care Act, and some state laws, specifically exclude direct primary care from the definition of “insurance,” but some practical barriers remain. The exclusion from the definition of insurance is important, proponents argue, as insurance products are subject to state regulation, including capital

² PrimaCare Direct company information. Accessed online at <http://www.primacaredirect.com/our-company>

requirements. Nevertheless, the Internal Revenue Service considers direct primary care a “gap” insurance product, which means that an individual cannot use or contribute to a health savings account because the addition of the “gap” product means that the individual no longer has a qualifying high deductible health plan (which is required in order to be eligible for an HSA). In addition, there is uncertainty whether the monthly fees that patients pay to direct primary care practices can be recognized as “qualified medical expenses” for purposes of tax deductibility, or for purposes of flexible spending account expenses.

Direct primary care must also navigate the complex Medicare regulations. Medicare does not cover retainer fees. In addition, physicians who accept Medicare assignment cannot charge patients extra fees for Medicare-covered services, which means any direct primary care fees charged to Medicare patients cannot include services that Medicare usually covers.

Submitter’s Request of MMA:

Pursue legislation to define direct primary care as not a health plan (insurance) but make it eligible as a qualified health expense for HSAs, Medicare, Medicaid, etc.

Submitter’s Rationale/Background:

Changes are needed to enable adoption of the direct primary care model in Minnesota. Good examples of model legislation include Wyoming, Oklahoma and Tennessee.

Current MMA Policy:

None

Current AMA Policy:

Direct Primary Care H-385.912

Our AMA supports inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service. (Res. 103, A-16)

Opinion 11.2.5 Retainer Practices

Physicians are free to enter into contracts to provide special non-medical services and amenities with individual patients who are willing and able to pay additional costs out of pocket for such services. While such retainer contracts are one among many diverse models for delivering and paying for health care, they can also raise ethical concerns about access, quality, and continuity of care.

Regardless of the model within which they practice, physicians must uphold their primary professional obligation of fidelity and their responsibility to treat all patients with courtesy and respect for patients’ rights and dignity, and ensure that all patients in the physicians practice receive the same quality of medical care, regardless of contractual arrangements for special, non-medical services and amenities.

Physicians who enter into retainer contracts with patients must:

- (a) Present the terms of the retainer arrangement clearly to patients, including implications for the patients’ current health care insurance, if known, and take care not to imply that more or better medical services will be provided under a retainer contract.
- (b) Ensure that patient decisions to accept retainer contracts are voluntary and that patients are free to opt-out of entering into a retainer agreement.
- (c) Facilitate transfer of care for any patient who chooses not to participate in a retainer practice. If it is not feasible to transfer a patients care to another local physician, the physician should continue to provide care under the terms of the patients existing health care insurance until other appropriate arrangements for ongoing care can be made.
- (d) Ensure that treatment recommendations for all patients are based on scientific evidence, relevant professional guidelines, sound professional judgment, and prudent stewardship.

(e) Uphold standards of honesty and transparency in billing and clearly distinguish charges for special services or amenities provided under a retainer contract from medical services reimbursable by the patients' health care insurance or third-party payer.

(f) Uphold professional obligations to promote access to health care and to provide care to those in need regardless of ability to pay, in keeping with ethics guidance. (AMA Principles of Medical Ethics: I,II,VI,VIII,IX).

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issue #	Topic	Submitter's Name (Society, if applicable)
4	Behavioral health care in medical settings	Roger Kathol, MD

Panel's Recommendation:

Adopt new policy as follows:

The MMA will support legislative efforts to transition payment for behavioral health services from standalone payment to integrated payment models covering all other health benefits.

Recommendation Rationale:

The panelists noted the strong and positive comments provided on this issue during the forum. The recommendation is similar to the original submission, but without the specific three-year timeline.

MMA Staff-Identified Background Information:

According to information provided by the open issue submitter, over 80 percent of patients with behavioral health conditions present only or primarily in the primary or specialty medical/surgical setting; of these, 60 to 70 percent receive no treatment for their behavioral health conditions; fewer than one in nine who do receive treatment are exposed to a behavioral health intervention that would be expected to improve symptoms or return a person to productive health.³ Separate financing and payment models for behavioral health (whether “carved” in or out) appear to further complicate efforts to integrate the delivery and management of patients with behavioral health conditions. Mental health parity and related laws seek to require that mental health services are available and paid on par with medical services. These laws do not address where and how services are delivered or in what way financing and payment for such services are managed.

Submitter's Request of MMA:

Write and support legislation that would transition payment for behavioral health services from standalone payment procedures to payment as part of all other health benefits over the next three years.

Submitter's Rationale/Background:

Since this is not a "turn-key" issue, it will take approximately 3 to 5 years to achieve. It will take longer for clinical services to transition but this will not start until payment comes from one source, i.e., from medical benefits.

Current MMA Policy:

400.41 Mental Health Access and Insurance

The MMA reaffirms existing MMA policy regarding psychiatric and mental health care, specifically parity, usual and customary fees, mental health carve-outs, network and HMO barriers or restrictions to patient referrals, and patient access to mental health services. HD-R402-2007 (Retained as edited BT 07-17)

400.39 Medical, Surgical and Psychiatric Service Integration And Reimbursement

The Minnesota Medical Association will advocate for health care policies that ensure access to and reimbursement for integrated medical, surgical and psychiatric care regardless of the clinical setting, including the clinical and administrative management of all psychiatric services as a part of general medical care, and general medical care as part of psychiatric care. HD-R306-2005 (Retained BT 07-16)

³ Kathol R, Sargent S, Sacks L. Chapter 11, Non-Traditional Mental Health and Substance Use Disorder Services as a Core Part of Health in CINs and ACOs. Clinical Integration in Population Health and Accountable Care, Third Edition. (2015).

Issue #	Topic	Submitter's Name (Society, if applicable)
5	Access to no-cost contraception	Lisa Erickson, MD and Beth Elfstrand, MD (MN-ACOG & TCMS)

Panel's Recommendation:

Retain current policy (630.394) as edited:

The MMA supports insurance coverage for all FDA-approved contraceptive medications and devices, which require prescriptions, as they would for other prescription medications. The MMA supports the continuation of policies that require all-FDA approved contraception methods to be available to patients free of cost sharing. The MMA encourages appropriate prescribing of contraceptive medications/devices to acknowledge the cost of the relevant medication or device.

Recommendation Rationale:

The panelists noted the strong and positive testimony in support of the submitted issue and acknowledged the value of no-cost contraceptive coverage. The edits to current MMA policy are intended to reflect the clarifying guidance issued by HHS in 2015 (see below), and also to encourage physicians to consider the cost of the various contraceptive options as they work with patients to choose a method that is most effective for them.

MMA Staff-Identified Background Information:

The MMA Policy Council, and subsequently the MMA Access, Financing & Delivery Committee (now called the Medical Practice & Quality Committee), considered a similar open issue request in 2014 and concluded that the requested policy change was well addressed in current policy. Based on the committee's recommendation, the MMA Board of Trustees in 2015 reaffirmed current policy (630.394).

In May 2015, the US Department of Health and Human Services issued guidance on the ACA contraception mandate clarifying that insurers must cover without cost-sharing at least one form of contraception in each of the current 18 methods approved by the FDA. The guidance was issued in response to reports of variation in insurance coverage among the various methods. Insurers may still use formularies or other incentives to encourage specific products within a method.

Nearly since adoption of the ACA, the inclusion of contraceptives as a covered women's preventive health benefit has been controversial. In 2014, the US Supreme Court ruled in *Burwell v Hobby Lobby* that closely held for-profit corporations are allowed to be exempt from the provisions of the ACA that require all private health plans to cover (without cost to patients) all FDA-approved contraception for women (this is part of the ACA's preventive health services requirement for essential health benefits).⁴ The Supreme Court's decision was based on the Religious Freedom Restoration Act (RFRA), a law passed by Congress in 1993. It is worth noting that the RFRA applies only to the federal government and not to states or other local municipalities.

Following the *Hobby Lobby* ruling, the US Department of Health and Human Services issued proposed rules that would have expanded the availability of the original accommodation (i.e., for religious colleges/other nonprofit groups to inform the government of their religious objections and the government would then contact insurance companies and arrange the birth control coverage at no cost to the employer or its employees) to include a closely

⁴ 134 S. Ct. 2751 (2014)

held for-profit entity. The proposed rules faced additional legal challenges and an alternative proposal was not finalized before the Obama administration left office in early 2017.

In May 2017, the Trump administration issued an executive order to “address conscience-based objections to the preventive-care mandate.” An interim final rule was released on October 6 extending the prior religious objection and adding a limited exemption for those with a moral objection. Several states have already filed legal challenges.

Submitter’s Request of MMA:

Amend current MMA policy (630.394 Fair Coverage for Contraceptive Medications and Devices) as follows:

The MMA supports insurance coverage for all FDA-approved contraceptive medications and devices, which require prescriptions, as they would for other prescription medications. The MMA supports the continuation of policies that require all-FDA approved contraception methods to be available to patients free of cost sharing.

Submitter’s Rationale/Background:

Current MMA policies have room for improvement. The argument for strengthening existing MMA policies is to align with current ACA and federal HHS requirements. In this time of uncertainty in health reform, coupled with the Administration’s efforts to undermine access to women’s reproductive health care, affirming support for the current requirements would be a strong message from the provider community.

Current MMA Policy:

630.394 Fair Coverage for Contraceptive Medications and Devices

The MMA supports insurance coverage for contraceptive medications and devices, which require prescriptions, as they would for other prescription medications. (HDR300-1998; Retained 2008; Reaffirmed BT 01-15)

Issue #	Topic	Submitter's Name (Society, if applicable)
6	Tobacco sales to members of the US military under age 21	Robert Koshnick, MD

Panel's Recommendation:

Reaffirm current MMA policy (110.17):

110.17 Sale of Tobacco from Vending Machines/Sale of Tobacco to Minors

The MMA supports a total ban on cigarette sales from vending machines. Also, the MMA supports efforts to ban the sale of tobacco to individuals under 21 years of age. (BT-1/90) (Retained 2004)

Recommendation Rationale:

The panelists noted that the bulk of the testimony and input supported restricting tobacco sales to individuals under 21 years of age, without specific reference to members of the military. The panelists acknowledged the language in California's recent statewide law (increasing minimum age from 18 to 21), which exempts active-duty members of the military and gives military base commanders the option to enforce the law on their bases. But the panelists agreed that a unique policy for the military would be less effective than a comprehensive message for the full population. The panelists also confirmed that restricting sales of tobacco to those under 21 is existing AMA policy.

MMA Staff-Identified Background Information:

According to a 2011 Department of Defense survey, active duty military personnel smoke at higher rates than civilians (24% compared to 19%).⁵ The same survey found that nearly half of all military service members (49.2%) used a nicotine product in the past 12 months. Smoking rates vary significantly by branch of service – the U.S. Marine Corps had the highest rate of smoking at 30.8 percent, followed by the Army (26.7%), the Navy (24.4%), and the U.S. Air Force (16.7%). Current cigarette smoking among active duty personnel was also more common for males (25.2%) and those with a high school education or less (37.1%).

As noted in a July 2014 Perspective in the New England Journal of Medicine, the use of tobacco among members of the military is often considered to be both a right (although such a right has not been legally defined) and needed for stress relief; however, tobacco users in the military report higher levels of stress than do nonusers.⁷

Defense department policy announced in 2016 requires that tobacco prices in military commissaries match "the prevailing local pricing in the community, including the effect of all applicable taxes that local consumers pay."⁸

⁵ Department of Defense, 2011 Health Related Behaviors Survey of Active Duty Military Personnel, <http://prevent.org//data/files/actiontoquit/final%202011%20hrb%20active%20duty%20survey%20report-release.pdf>, February 2013.

⁶ Campaign for Tobacco-Free Kids. Tobacco Use and the Military. March 30, 2017. Accessed at <https://www.tobaccofreekids.org/research/factsheets/pdf/0369.pdf>

⁷ Smith EA, Jahnke, SA, Walker, SC, et al. Is It Time for a Tobacco-free Military? N Engl J Med 2014; 371:589-591 August 14, 2014 DOI: 10.1056/NEJMp1405976

⁸ Policy Memorandum 16-001. Department of Defense Tobacco Policy; [Accessed July 28, 2016]. Available at: <http://www.med.navy.mil/sites/nmcphc/Documents/health-promotion-wellness/tobacco-free-living/INCOMING-CARTER-Tobacco-Policy-Memo.pdf>.

Neither “prevailing” nor “local” is defined, however. Prior studies have shown that the lack of explicit policy guidance has resulted in military prices that can be as much as 73% lower than those at the local Walmart.⁷ In 2009, the Institute of Medicine called for a tobacco-free military and identified recommendations to move the military and the VA toward that goal.⁹

Efforts to increase the legal age to purchase tobacco from 18 to 21 are increasing across the country and in Minnesota. To date, five states have enacted statewide laws, with the first being in 2016 in Hawaii. Other states include New Jersey (2017), Maine (2017), Oregon (2017), and California (2017). The California law is noteworthy, however, because it specifically exempts active-duty members of the military. Military base commanders do have the option to enforce the law on their bases, if they choose to do so. There are several large military bases in California and thousands of active-duty personnel.

Submitter’s Request of MMA:

Bring forward resolution to the AMA urging them to lobby Congress to prohibit the sale of tobacco products by military commissaries to members of the US military under the age of 21

Submitter’s Rationale/Background:

Tobacco kills 480,00 people a year in our country; tobacco products are often sold considerably under market prices at military commissaries and exchanges; many young people pick up the smoking habit while in the service; people that have had military service have higher smoking rates than the civilian population (32.2% among military personnel versus 21% civilian rate in 2005); military personnel are expected to be in top physical condition and smoking has known effects on health; soldiers have many other requirements regarding weight, fitness and cardiovascular health; allowing tobacco use devalues the service members long term quality of life; the submarine fleet has already established a smoke-free policy in 2010 without any notable negative consequences; the current tobacco-free basic training has already provided a starting point for the implementation of such a policy.

Current MMA Policy:

110.17 Sale of Tobacco from Vending Machines/Sale of Tobacco to Minors

The MMA supports a total ban on cigarette sales from vending machines. Also, the MMA supports efforts to ban the sale of tobacco to individuals under 21 years of age. (BT-1/90) (Retained 2004)

Current AMA Policy (*emphasis added*):

H-490.913 Smoke-Free Environments and Workplaces

On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA:

(1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of

⁹ Institute of Medicine (US) Committee on Smoking Cessation in Military and Veteran Populations; Editors: Stuart Bondurant and Roberta Wedge. Washington (DC): National Academies Press (US); 2009. ISBN-13: 978-0-309-13767-6 ISBN-10: 0-309-13767-5

ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) *will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities;* and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues.

Issue #	Topic	Submitter's Name (Society, if applicable)
7	Audio recordings of patient visits	Carl Burkland, MD

Panel's Recommendation:

Refer the issue of recordings of patient visits to the MMA Board of Trustees for further deliberation.

Recommendation Rationale:

The panelist's noted that there was significant interest and discussion on this issue during the Open Issues Forum. Conflicting input was provided, with some urging a change to an all-party consent standard, and others encouraging physicians instead to embrace recordings as a way of improving communication and patient care. Given the complexity of the issue and similar questions regarding the use of video recordings, the panelists recommend that the issue be referred to the MMA Board of Trustees so that an MMA committee can consider the ethical, legal, and practical aspects of the topic in greater detail.

MMA Staff-Identified Background Information:

Much of the information noted below from the open issue submitter comes from an August 8, 2017 Viewpoint in the Journal of the American Medical Association.¹⁰ Minnesota is a one-party consent state, meaning patients may record medical visits (and other communication) without the consent of the physician or other provider.¹¹ The authors conclude the article by recommending that clinicians, patient advocacy groups, and policy makers work to develop guidelines to facilitate the positive use of digital recordings of medical encounters.

Submitter's Request of MMA:

Adopt and advocate for a policy that supports an all-party consent law for audio recordings of medical encounters between physicians and their patients.

Submitter's Rationale/Background:

Some clinicians' patients are making audio recordings of their office visits, with or without permission; the motivation is often reasonable: patients want a recording of clinic visit information to listen to again, improve their recall and understanding of medical information, and share the information with family members. Audio recordings have been found to be highly valued: across the studies, 72% of patients listened to their recordings, 68% shared them with a caregiver, and individuals receiving recording reported greater understanding and recall of medical information.

Liability insurers maintain that the presence of a recording can protect clinicians, but many clinicians and clinics have concerns about the ownership of recordings and the potential for these to be used as a basis for legal claims and complaints.

Wiretapping or eavesdropping statutes provide the primary legal framework guiding recording practices and protect against non-consensual recording of conversations when individuals have a reasonable expectation that their conversation is private. These laws vary at the state level; wiretapping laws differ as to whether one or all parties must consent to the recording. In so-called all-party jurisdictions, covert recording (recording without the expressed permission of all parties) is illegal because all who are being recorded must consent; in contrast, in

¹⁰ Elwyn G, Barr PJ, Castaldo M. Can Patients Make Recordings of Medical Encounters? What Does the Law Say? *JAMA*, July 2017 DOI: [10.1001/jama.2017.7511](https://doi.org/10.1001/jama.2017.7511)

¹¹ M.S. §626A.02

single-party jurisdictions, the consent of any one party to the conversation is sufficient, including the person making the recording; therefore, if patients wish to record a clinical encounter, they can do so without obtaining the clinician's consent. Statutes in 39 of the 50 states and the District of Columbia conform to the single-party consent rule; the 11 all-party jurisdictions are California, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania, and Washington. The consequences of violating wiretapping laws can be severe.

If a clinician in a single-party jurisdiction is asked by a patient to allow a recording, the clinician may ask the patient not to proceed, but the patient has the right to record the clinical encounter. The clinician can choose to continue, accepting that the conversation is being recorded, or terminate the visit. Clinicians in single-party jurisdictions should be aware that patients may be recording covertly. In all-party jurisdictions, a clinician can refuse to grant patients permission to make recordings. In these jurisdictions, illegal recordings may be reported to the authorities. Patients are free to share the content of recordings in single-party consent states, but require agreement of those who were recorded in all-party consent states. Most patients use this right to share the recording with a family member or caregiver but not on social media. This freedom may not apply to recordings modified or used to the detriment or harassment of the clinician captured in the recording. Using the recording to harm or damage the reputation of the clinician recorded could lead to legal action by the person affected.

A single-party consent rule statute for audio recording of conversations may hinder a relationship of trust and open communication between physicians and their patients. An all-party consent rule statute poses less of a threat to the all-important physician patient trusting and open communicating relationship.

Current MMA Policy:

None

Current AMA Policy:

3.1.3. Audio or Visual Recording Patients for Education in Health Care

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:

- (a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
- (b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
- (c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
 - (i) about the purpose of recording, the intended audience(s), and the expected distribution;
 - (ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
 - (iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
 - (iv) that the patient may withdraw consent at any time and if so, what will be done with the recording;
 - (v) that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
- (d) Ensure that the patient has had opportunity to discuss concerns before and after recording.

- (e) Obtain consent from a patient (or the authorized decision maker):
 - (i) prior to recording whenever possible; or
 - (ii) before use for educational purposes when consent could not be obtained prior to recording.
- (f) Respect the decision of a patient to withdraw consent.
- (g) Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.
- (h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the films educational content and value.
- (i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
- (j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records. (AMA Principles of Medical Ethics: I,IV,V,VIII)

3.1.4 Audio or Visual Recording of Patients for Public Education

Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld. Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).

Physicians involved in recording patients for public broadcast should:

- (a) Participate in institutional review of requests to record patient interactions.
- (b) Require that persons present for recording purposes who are not members of the health care team:
 - (i) minimize third-party exposure to the patient's care; and
 - (ii) adhere to medical standards of privacy and confidentiality.
- (c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
- (d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
- (e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
- (f) Inform a patient (or authorized decision maker) who is to be recorded:
 - (i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
 - (ii) about the intended audience(s);
 - (iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
 - (iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
 - (v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
 - (vi) whether the physician was compensated for his participation and the terms of that compensation.
- (g) Ensure that the patient has had the opportunity to address concerns before and after recording.
- (h) Ensure that the patient's consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
- (i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patient's care) perceives that recording may jeopardize patient care.

- (j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
- (k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record. (AMA Principles of Medical Ethics: I,IV,VII,VIII)

Issue #	Topic	Submitter's Name (Society, if applicable)
8	State X-ray rule revisions	Ronnell Hansen, MD (MN Radiological Society)

Panel's Recommendation:

Refer the issue of revisions to the state x-ray rules to the MMA Board of Trustees for further deliberation.

Recommendation Rationale:

The author of this open issue was unable to attend the Open Issues Forum and no specific input or comments were provided by attendees at the forum. The panelist's noted that the MMA has a representative on the health department's x-ray rules advisory committee and the rules are a work in progress (a final draft isn't expected until spring or summer 2018). As a result, the panelists recommend that the MMA continue to monitor the proposed rule changes and that this issue be referred to the MMA Board of Trustees so that further input and discussion on the changes of concern can be identified.

MMA Staff-Identified Background Information:

In July 2016, the Minnesota Department of Health announced its intent to begin a process to revise Minnesota Rules for ionizing radiation (M.R. 4732), also known as the X-ray rules. In its announcement, the department noted that the reason for the planned revision is to, "address advances in equipment technology, scope of practice for operators of x-ray equipment, service provider responsibilities, inspection requirements, and other related matters."¹²

The scope of potential changes is broad and the rule provisions are very detailed. Among the more controversial topics that have been identified for possible change are operator qualifications and training (e.g., should licensure be required, what is scope of allowed practice, what are ongoing educating and training standards); and, fluoroscopy (e.g., who is allowed to order, perform and supervise this service, and what are associated training requirements).

Legal authority for x-ray operation by APRNs is split between scope of practice statutes/regulation (Minnesota Board of Nursing) and radiation control (x-ray) regulations (Minnesota Department of Health). According to the Board of Nursing, state law permits all APRNs (i.e., certified clinical nurse specialists, certified nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists) to order, perform, supervise and interpret diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography.

According to the Board of Nursing, the current x-ray rules permit all APRNs, with the exception of CRNAs, to order diagnostic x-rays; allow only CRNAs to perform diagnostic x-rays, including fluoroscopy/CT;¹³ and, prohibit all APRNs from supervising fluoroscopy.

The department has convened an advisory committee, which includes a representative from the MMA. Given the rulemaking timeline, a proposed rule is not expected until spring or summer 2018.

¹² Minnesota Department of Health. X-Ray Rules, Rules Revision page. Access online at <http://www.health.state.mn.us/divs/eh/radiation/xray/rules/xrayrulerev.html>

¹³ See also M.S. §144.121. Subd. 5a.

Submitter's Request of MMA:

Invite further medical community discussion and broader input into the proposals for the rule revisions to create workable solutions, find agreeable standards, allow adequate transition time, and maintain reasonable access to care.

Submitter's Rationale/Background:

The ongoing revision has the opportunity to potentially improve and clarify use/performance privileges for both fluoroscopy and the taking of images using ionizing radiation - departing from the current umbrella term designation - moving to implementation and confirmation of appropriate training and demonstration of proficiency, as relates to use and safety of ionizing radiation as it relates to optimal patient care, as is the trend in the federal system and several states. Even radiologists within the VA medical system must now complete and pass interval training in the use of fluoroscopy in order to maintain privileges, in addition to the extensive training in medical physics received in residency. Likewise - individuals allowed to take (and possibly even order) imaging using ionizing radiation may be an area subject to confirmation of proficiency in the rule making - likely top tier being equivalent to ARRT program certification, as example.

California has a credentialing program for performing films as modules which need to be completed and certified in order to be allowed to perform individual exams - which may be a reasonable pathway for MN to follow to ensure proper training for all levels within the health care system - including physicians, APN, CNA, and others in medical systems who may currently be using fluoroscopy, taking images, and potentially even ordering films - providers who may have otherwise had limited training in the actual use and implications to safety of various modalities in medical imaging.

Current MMA Policy:

None

Issue #	Topic	Submitter's Name (Society, if applicable)
9	Cost sharing for preventive services	Lisa Erickson, MD and Beth Elfstrand, MD (MN-ACOG & TCMS)

Panel's Recommendation:

Reaffirm current MMA policy (290.51):

290.51 Essential Benefit Set

The MMA adopts the following policies and principles to guide development of an essential benefit set:

Purpose of an Essential Benefit Set:

- To determine what “insured” means for purposes of Minnesota health care coverage.
- To encourage access to care, including early diagnosis and routine care, as opposed to merely asset protection (i.e., financial protection for severe illness or catastrophic event)

Essential Benefit Set Definition: A set of services that is sufficiently comprehensive to sustain the health of an individual.

Principles:

- The essential benefit set is the minimum level of coverage that would be guaranteed for every Minnesotan.
- The essential benefit set will be comprehensive and adequate to maximize the health of every Minnesotan through all phases of life and health.
- Behavioral health services will be covered in the same way as care for other illnesses.
- The essential benefit set will be standardized across insurers and buyers (public, private and self-insured).
- The essential benefit set should facilitate the development of health care homes.
- The essential benefit set should have standardized copays and deductibles.
- The essential benefit set should be affordable.
- The essential benefit set should facilitate achievement of the “Triple Aim” for health reform in Minnesota by:
 - Improving the experience of individuals with the health care system eliminating confusion about coverage and benefits
 - Improving the health of individuals and the population by improving access to care and assuring coverage for essential services
 - Reducing the cost of health care by reducing dependence on emergency department care and reducing preventable hospitalizations

Other Recommendations:

- There should be no co-pays for primary care visits, immunizations and covered preventive services.
- There should be no need to have mandated covered services when the essential benefit set is established
- There should be coverage for clinical trials for patients for whom there are no available therapeutic options.
- There should be no coverage for services that have a class III recommendation (contraindicated) in clinical guidelines. (BT-05/09)

Recommendation Rationale:

Although there was very limited discussion and input on this item during the forum, the panelists expressed support for the goal of eliminating financial barriers to the use of preventive services. The submitted issue suggested a change to the MMA's Physicians' Plan for a Healthy Minnesota policy, but the panelists noted that other MMA policy is more explicit on this topic and appears to sufficiently address the issues raised by the submitters. The suggestion to list out specific preventive services, as in the submission, was not supported by the panelists. The panelists recommend reaffirmation of current policy in lieu of the original submission.

MMA Staff-Identified Background Information:

Essential health benefits (EHB) were defined in the Affordable Care Act (ACA), and subsequent regulations, for purposes of defining minimum essential coverage for individual and small group products sold both on and off insurance exchanges. Included in the EHB are preventive health benefits for all adults, for women, and for children. Insurers are required to cover the defined preventive health services without cost sharing (i.e., no co-pay or deductibles), when such services are delivered by in-network providers.

It is worth noting that the EHB requirement does not apply to large group plans (101+ employees), self-insured plans, or to grandfathered plans. Grandfathered plans are also exempt from several other provisions of the law, including the requirement to cover preventive services without cost sharing. Grandfathered plans are plans that were in place at the time of ACA passage; they may continue to be renewed, provided that the plan has not had significant changes that reduce benefits or increase employee costs (e.g., any changes in co-insurance percentage, elimination of all or most benefits necessary to diagnose or treat a particular condition). Approximately 26% of insured workers were enrolled in grandfathered plans in 2014, but those numbers are expected to continue to decrease.¹⁴ The percentage of grandfathered plans in the individual market is even lower. The degree to which Minnesotans with EHB-exempt plans face cost sharing for preventive health services is unknown.

Submitter's Request of MMA:

Amend current MMA policy (290.2483 Physicians' Plan for a Healthy Minnesota) to include the following words:
"Support for maintaining current requirement that all private health plans, Medicaid expansion programs and Medicare plans cover preventive services - including immunizations, contraception, breast and cervical cancer screenings and STI counseling and screening - without cost sharing."

Submitter's Rationale/Background:

The argument for strengthening existing MMA policies is to align with current ACA and federal HHS requirements. In this time of uncertainty in health reform, coupled with the Administration's efforts to undermine access to women's reproductive health care, affirming support for the current requirements would be a strong message from the provider community.

Current MMA Policy (emphasis added)

290.2483 Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association (MMA) adopts the following health care reform policy statements (developed by the Health Care Reform Task Force):

I. MMA Vision for Health Care Reform

The MMA vision for health care reform is as follows: A) *The MMA envisions a health care system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner.* B) Strong patient/physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine.

¹⁴ Kaiser Family Foundation/Health Research Educational Trust. Employer Health Benefits: 2014 Summary of Findings, 2014 Annual Survey.

C) Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost conscious choices, *and incentives that reward all parties for a greater focus on prevention and enhanced health.*

D) The ideal health system will deliver significantly greater returns in improved health status for the dollars invested and will deliver equity for all in access, treatment quality, and outcomes. E) Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state. F) In order to achieve this higher-performing system, we need a fundamental change in the financing approach and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices, with a patient-centered market in which *incentives are aligned to encourage the use of preventive services and effective care* without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.

II. Stakeholder Responsibilities in Health Care Reform

The MMA anticipates that the roles of all stakeholders will change in a reformed health care system, including new or renewed levels of responsibility. Those expectations are as follows: A) The community has a responsibility

1. To ensure affordable access to basic care;
2. To broadly share the risk and cost of medical needs;
3. To assist the population in using health care resources wisely;
4. To provide the conditions and environment in which people can be healthy and make healthy choices;
5. To maximize the proportion of health spending that goes to effective care for all who need it;
6. To secure the future capacity of the health care system to provide sustained high quality and affordable health care, through investments in prevention, medical education, medical research, and improvements in the system's infrastructure.

B) Individuals have a responsibility to the community

1. To participate financially in sharing the cost of the system that benefits all;
2. To use the system wisely and draw on collective resources judiciously;
3. To take personal responsibility for their own health behaviors and reduce their own health risks;
4. To become more health literate (e.g., educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision making process).

C) Physicians and other clinicians have responsibilities to individual patients and to the broader community

1. To accurately assess patient needs and recommend appropriate and effective care;
2. To advocate honestly for needed and effective care for their patients;
3. To help individuals achieve measurable improvements in health;
4. To exercise stewardship over collective health care resources;
5. To participate in care management as members of an effective multidisciplinary health care team;
6. To foster health literacy among patients and the broader population;
7. To create and foster continuous learning environments in the organizations in which they practice.

D) Group purchasers (private-sector employers and government) have responsibilities as members of the community

1. To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers;
2. *To emphasize prevention strategies (including those with longer-term payoff) in benefits design;*
3. To share in the needed investments in improvements to the infrastructure of the health system;
4. To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care funds.

E) Health plans/insurers have responsibilities as members of the community

1. To create payment systems that foster care efficiency and health improvement;
2. To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs;
3. To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits;
4. To minimize the complexity of the system and the costs of administration, and to assist patients/members in navigating the system;
5. To share in the needed investments in prevention strategies and infrastructure improvement;
6. To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results;
7. To create and foster continuous learning environments for the improvement of health care administration and delivery.

III. The MMA Model for Health Care Reform

The MMA model for health care reform includes four interconnected features: 1) A strong public health system; 2) A reformed insurance market that delivers universal coverage; 3) A reformed health care delivery market that creates incentives for increasing value; and, 4) Systems that fully support the delivery of high quality care.

IV. A Strong Public Health System

A. Public Health Leadership

To strengthen the public health system, the MMA will provide greater leadership in making public health more prominent by linking its public health policies to broader health care reform and cost containment efforts.

B. Coordinated Action to Improve Health

To improve the health of individuals and the population of Minnesota, the MMA urges the creation of a statewide, coordinated and strategic action agenda to address the leading modifiable risk factors for disease.

V. A Reformed Insurance Market

A. Universal Insurance Coverage

The MMA supports universal insurance coverage to be achieved through a requirement that all individuals have coverage for an essential set of benefits that provides for the protection of individuals and public health. The MMA believes that behavioral health services should be covered on the same basis as any other clinical service. Affordability of coverage shall be ensured through financial subsidies to those individual with limited financial means.

B. Fairness in Insurance Risk

The MMA supports a fairer system of spreading insurance risk and sharing the cost of health care to be achieved, in part, through the establishment of statewide community rating and guaranteed issuance of an essential benefit set.

VI. A Reformed Delivery Market

A. Value, Not Volume

The MMA supports reforms in the health care delivery market that will replace the current incentives for volume with incentives for value.

B. Patient Engagement

To transform changes in the delivery of care, the MMA supports efforts to more effectively engage patients in making value-based health care decisions – for both the choice of physician/provider and the options for treatment. Patients can make better health care decisions if they have access to valid and useful information about the cost and quality of care.

C. Cost-Shifting

The MMA urges the elimination of cost-shifting by all payers, particularly government payers, that only serves to distort the cost of health care.

VII. Systems to Support High-Quality Care

A. Increase the Delivery of Effective Care

While recognizing the high quality care delivered in Minnesota, which is among the best in the nation, the MMA strongly supports efforts to increase further the amount of effective care that is provided to Minnesota patients. Several immediate efforts that the MMA supports to expand quality care are the following: 1. Appropriate Use of Evidence-Based, Physician-Developed Guidelines – The MMA supports the appropriate use of evidence-based, physician-developed clinical guidelines as an important tool for clinical and shared decision-making. The MMA believes that guidelines must be developed in an open, multi-specialty process and that closed, proprietary development models are unsupportable. 2. Expansion of the Information Infrastructure – The MMA urges statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions. 3. A Medical Home for Every Minnesotan – To promote continuous healing relationships and to better coordinate care, the MMA urges the establishment of a "medical home" for every Minnesotan. In an effort to increase the likelihood that patients can identify and sustain a relationship with their medical home, the MMA will encourage employers and public and private payers to adopt supportive payment and enrollment policies. 4. Chronic Disease and Cost Control – Recognizing the disproportionate consumption of health care resources by a small percentage of the population, the MMA will

urge employers and health plans to support efforts to improve care delivery for patients with chronic disease through refinements in payment policies and by eliminating barriers to primary and secondary prevention.

B. Transparent Quality Measurement and Reporting

The MMA supports transparent measurement and public reporting of changes and improvements in various dimensions of the health system's performance in order to improve the quality of care, to improve information available to both patients and physicians, and to improve the function of the health care marketplace. The MMA supports performance measurement at the medical group and hospital/facility level. Given the need for statistical validity and the limitations of current measurement techniques, the MMA does not support clinical performance measurement at the individual physician level. The quality of health care is multi-dimensional and it must be measured comprehensively. The MMA supports approaching performance measurement using the six aims defined by the Institute of Medicine (IOM) – safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The MMA recognizes that the implications for physicians of performance measurement and public reporting can be significant in terms of both business/economic impact and professional reputation. The selection of appropriate measures is, therefore, critical. The MMA supports, at a minimum, clinical performance measures that are statistically valid, evidence-based, clinically important, cost-effective, and prospectively defined. The MMA recognizes two primary types of measures to evaluate the clinical quality of care delivered – process and outcome. 1) Process measures measure some aspect of the process of care that was performed (e.g., proportion of heart attack patients given aspirin); 2) Outcome measures measure a result or experience of care (e.g., proportion of treated patients with pressures below 140/90; proportion of hypertensive patients who have heart attacks). While the MMA believes that performance measures that publicly report health outcomes are the ideal, real and significant barriers to adequately measuring health outcomes require that their use be limited. Among the barriers to using outcomes measures are the low frequency of many clinical events, the probability associated with outcomes/the need for large numbers, and the often limited (or unknown) amount of the variance in outcome that is actually controlled by the subject of the measurement. Given current methodological limitations, the MMA believes that in most circumstances process measures that are linked to meaningful differences in outcomes are the most viable metrics for evaluating the quality of clinical care. The MMA will take a leadership role in working with stakeholders to identify, collect, and report appropriate measures that can be used for system improvement and to aid in improved decision making by all stakeholders. The MMA supports the following minimum parameters to guide its involvement in this area:

- Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;
- Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;
- Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;
- The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and,
- Criteria to be used for selection of measures should include whether good evidence exists, and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

C. Simplified Measurement and Reporting Transactions.

The MMA will work to eliminate duplicative quality measurement and reporting efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA will explore opportunities to facilitate the transition from manual to electronic chart abstracting.

D. Payment Systems to Support Quality Practice

The MMA will advocate for the adoption and expansion of payment policies by public and private payers (sometimes referred to as "pay for use") that will financially reward physician actions to improve their capacity and ability to deliver more efficient, effective care (e.g., the installation of electronic health records, computerized

pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc.). The MMA recognizes that significant national and local attention is being paid to the notion of "pay-for-performance" with little or no existing evidence to indicate that it will achieve the desired improvements in quality or cost reduction that many seek to achieve. Under the MMA model for a reformed health care system, the concept of pay-for-performance becomes moot, because patients will decide for themselves about the value offered in terms of performance and cost. In the short-term, however, the MMA will support payment models that link payment with process measures, but will oppose pay-for-performance models that link payment with outcomes measures. (BT-07/2005) Reaffirmed, in part (VII(D)), HD-SR203-2006. (Retained BT 07-16)

290.51 Essential Benefit Set

The MMA adopts the following policies and principles to guide development of an essential benefit set: Purpose of an Essential Benefit Set:

- To determine what "insured" means for purposes of Minnesota health care coverage.
- To encourage access to care, including early diagnosis and routine care, as opposed to merely asset protection (i.e., financial protection for severe illness or catastrophic event)

Essential Benefit Set Definition: A set of services that is sufficiently comprehensive to sustain the health of an individual.

Principles:

- The essential benefit set is the minimum level of coverage that would be guaranteed for every Minnesotan.
- The essential benefit set will be comprehensive and adequate to maximize the health of every Minnesotan through all phases of life and health.
- Behavioral health services will be covered in the same way as care for other illnesses.
- The essential benefit set will be standardized across insurers and buyers (public, private and self-insured).
- The essential benefit set should facilitate the development of health care homes.
- The essential benefit set should have standardized copays and deductibles.
- The essential benefit set should be affordable.
- The essential benefit set should facilitate achievement of the "Triple Aim" for health reform in Minnesota by:
 - Improving the experience of individuals with the health care system eliminating confusion about coverage and benefits
 - Improving the health of individuals and the population by improving access to care and assuring coverage for essential services
 - Reducing the cost of health care by reducing dependence on emergency department care and reducing preventable hospitalizations

Other Recommendations:

- *There should be no co-pays for primary care visits, immunizations and covered preventive services.*
- There should be no need to have mandated covered services when the essential benefit set is established
- There should be coverage for clinical trials for patients for whom there are no available therapeutic options.
- There should be no coverage for services that have a class III recommendation (contraindicated) in clinical guidelines. (BT-05/09)

290.52 Principles for Sustainable Health Care Payment Systems

Effective health care reform in the United States will require delivery system and payment system reforms that will address the significant problems of uneven quality and rapidly rising costs. The payment systems currently used represent a frayed patchwork of solutions that were intended to solve a variety of problems. Generally, the predominant method of payment, fee-for-service, has become substantially distorted in its ability for patients and consumers, as well as others, to make true value judgments and purchasing decisions. The profound payment inequities imposed by Medicare and Medicaid have forced cost shifting that exacerbates the problems of inequity in costs and access. Years of imposed price controls in these government programs have not produced greater quality nor have they helped to constrain overall health care spending. In short, current payment systems have not helped to foster the creation of value in the health care system. Physicians and other health care providers must work to create value in health care and government and payers must work to implement payment systems that reward value. The combination of delivery system reform and payment system reform should improve individual and population health, make affordable health insurance accessible to all, and slow the rate of increase in overall health care spending. Many proposals have been made for payment system reform, and some will soon be implemented in the State of Minnesota. Federal reforms are several years away. The following principles are intended to guide future MMA policy making as well as to inform state policy makers about the need to link payment system and delivery system reform. The goals or expected outcomes of payment systems should be to:

- 1) Promote the development of continuous healing relationships between physicians and patients. Payment systems should reward physicians for understanding the needs and desires of patients and jointly making better decisions about health care;
- 2) Promote the development and support of coordinated care. Payment systems should reward better outcomes with better coordination of care, especially for patients with chronic disease and patients who require inpatient care, or care provided by multiple clinicians;
- 3) Improve clinical outcomes and safety. Payment systems should reward better clinical outcomes and safer care, which will improve health;
- 4) Improve the efficiency of care. Payment systems should reward physicians for their efforts to maximize the efficient use of health care resources; payment systems should reward care that demonstrates value to patients;
- 5) Improve the effectiveness of care. Payment systems should reward the appropriate use of care and should not support care that causes harm without benefit. The attributes of effective payment systems should include:
 - 1) Transparency. The payment system – from collection of premium dollars to payment for services delivered – should be completely transparent to all users. The measures of clinical outcomes, patient-reported outcomes, costs and payments should be clear and easily understood by all users;
 - 2) Understandable. The payment system should be easy for all users to understand, including the price and actual amount paid for care; the payment system should help patients make better decisions about their care in consultation with their physicians;
 - 3) Flexibility. The payment system should utilize multiple payment options and structures to promote the creation of value by providers. Multiple payment options/structures allows for recognition of differences in geography, specialty, practice size, and practice type. Such options include creating payment structures that support primary care, as well as encouraging creation of value in procedural-based care and complex diagnostic care and treatment. Different payment mechanisms, and blends of mechanisms, will be needed to achieve the goals of payment reform;
 - 4) Support for innovation in delivery systems. The payment system should encourage physicians and others to work together in finding better care methods, including non-visit care or care delivered outside a traditional office or hospital setting that would improve outcomes and reduce overall costs;
 - 5) Support for development of evidence-based care. The global payment system – including payments by states and the federal government, industry, and insurers – should facilitate clinical trials and studies for patients and physicians to determine the best approaches where evidence is lacking;
 - 6) Equity. The payment system should not create barriers to access or create unfairness by allowing cost-shifting among purchasers of care;
 - 7) *Preventive Health. The payment system should encourage and reward preventive care and strategies that improve health;*
 - 8) Support for medical education. The payment system should support education of medical students and other health care providers.

BT 05/10 (Reaffirmed: HD-R305-2010)