News Briefs

MMA scrutinizes Blue Cross Blue Shield’s prior auth practices
Since spring 2018, Blue Cross Blue Shield of Minnesota (BCBS) has dramatically increased its use of prior authorization and other utilization management policies affecting hundreds of procedure codes in both inpatient and outpatient settings.

Among the policies generating the greatest concern to physicians was BCBS’ decision, effective April 2019, to strictly enforce the requirement that authorization be obtained before a service is rendered and to no longer allow appeals for failure to obtain advance authorization for medical necessity reasons. In other words: even if the service was medically appropriate and necessary for the patient, BCBS will not pay for the service if prior authorization was not requested and received before the service was rendered. The MMA notified BCBS of its concerns with this provision and its potential to delay and disrupt patient care given the realities of patient scheduling and the often-slow wait times associated with the authorization process.

Amid the added administrative complexity, BCSB is also working to implement a “Gold Card” program, designed to create a “fast track” option around the routine prior authorization process for physicians and other providers who meet defined eligibility criteria. Although the details of the program are still in development, the MMA has mixed feelings and has communicated as much to BCBS. “A Gold Card program has the potential to streamline the prior-authorization process, but it needs to be part of a selective, focused use of prior authorization,” says MMA CEO Janet Silversmith. “That is not the current BCBS context.”

The Minnesota Hospital Association sent a letter to regulators in July urging them to investigate the practices and cited particular concern with a new BCBS site-of-service policy that will no longer pay for colonoscopies performed at certain hospitals, based on where the hospital is located.

The MMA will continue to work with BCBS and, as appropriate, with state regulators to protect patients from harmful delays or disruptions in care. Administrative requirements, including prior authorization—for both procedures and medications, an issue the MMA has been working to streamline for several years—are clear contributors to physician burnout. When such requirements have the potential to compromise patient care, the impact is compounded.

The MMA urges members to share their prior authorization experiences via email (mma@mnmed.org) or by phone (612-378-1875).

MMA partners with Bounce Back Project to host annual well-being conference
The MMA is partnering with the Bounce Back Project to host the 4th annual Bounce Back Conference dedicated to improving physician and other health professional well-being and resiliency. The conference will take place December 4 and 5 at the Crowne Plaza Hotel in Plymouth.

The conference is a collaboration of physicians, nurses and hospital leaders from multiple health systems working to impact the lives of individuals, communities and organizations by promoting health through resilience.

The conference objectives include:

- Share knowledge, the results of research and lessons learned on the prevalence, drivers and consequence of burnout among health care providers.
- Discuss strategies addressing the challenges and barriers we face as health care providers in today’s complex health care environment.
- Identify and discuss best practices and experiences in building individual and organizational resilience.
- Foster resilience through the building of relationships and social connections.

“One of the MMA’s top priorities is to support professional satisfaction,” says MMA CEO Janet Silversmith. “So, partnering with the Bounce Back Project to expand and extend their groundbreaking work is an ideal opportunity for MMA, our members and everyone in health care in Minnesota.”

The Bounce Back Project was born out of loss, after two highly respected and loved Buffalo Hospital physicians died in 2014. These deaths caused the project’s founders to pause and ask some important questions—about not only how fragile life is, but also about the choices made every day.

Funding partners include Stellis Health, Allina Health and CentraCare Health.

For more information and to register, visit www.bounceback-project.org.

On the calendar

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Medical cannabis appears to be working for PTSD patients

A Minnesota Department of Health (MDH) Office of Medical Cannabis survey recently found nearly three-quarters of patients using medical cannabis for post-traumatic stress disorder (PTSD) reported a high level of benefit. PTSD was added to the list of eligible qualifying conditions in 2016.

MDH researchers surveyed 751 patients who listed PTSD as a qualifying condition when enrolling in the state’s medical cannabis program during the five months after PTSD became an approved condition for medical cannabis use in Minnesota. Most of the patients surveyed saw benefits based both on the MDH survey and on a validated measure of PTSD severity.

At enrollment, 96 percent of the PTSD patients included in the survey scored above 33 points on an initial checklist, meeting the threshold for a PTSD diagnosis. Of those who completed the same checklist three months after their first cannabis purchase, 71 percent saw their scores improve by at least 10 points.

“This study shows many patients with PTSD enrolled in the program are experiencing substantial benefits,” says Tom Arneson, MD, a research manager with the MDH Office of Medical Cannabis. “It is particularly encouraging to read comments from some patients that their participation in the program has made their engagement with other therapies for PTSD more feasible or more effective.”

In addition, when asked on the survey how much benefit they’ve received from medical cannabis, 76 percent of responding patients indicated a benefit rating of 6 or 7 on a scale of 1 (no benefit) to 7 (great deal of benefit). Across all responding patients, a small proportion of patients indicated little or no benefit: 4 percent gave a rating of 1, 2 or 3. About one fifth of patients reported side effects, including a few who reported increased anxiety.

When patients were asked about the most important benefit, 23 percent indicated anxiety reduction, 16 percent indicated improved sleep, 13 percent indicated improved mood and/or emotional regulation and 12 percent indicated pain reduction. When asked via a similar survey, health care practitioners saw benefit levels similar to the patient ratings.

As of late May, there were 2,873 people with PTSD in Minnesota’s medical cannabis program.

The report is available on the MDH website.

MMA petitions Congressional delegation on surprise billing legislation

The MMA sent letters to the Minnesota Congressional delegation in early July urging lawmakers to consider a more physician-friendly approach to potential “surprise billing” legislation.

Congress is considering several proposals that address surprise billing by mandating that when a patient receives unanticipated out-of-network care, the patient’s insurance will pay the physician at the median in-network rate.

The MMA believes that negotiated, in-network rates should not be used as a benchmark to determine fair payment to out-of-network physicians. Establishing such a benchmark incentivizes insurance companies to reduce rates paid to physicians or eliminate physicians with contracts above the median rate.

“The MMA applauds efforts to protect patients from the financial impact of unanticipated medical bills that arise when a patient receives care from an out-of-network physician or facility,” says the letter signed by MMA President Doug Wood, MD. “The MMA cautions that any legislation that mandates a median in-network payment rate has the potential to reduce physicians’ ability to negotiate fair contracts with payers.”

Instead, the MMA supports an independent dispute resolution process, often referred to as “baseball-style” arbitration. “This is a fair and balanced model that can reconcile differences between physician charges and plan payments while at the same time protecting patients by removing them from the dispute resolution process,” the letter says.

This “baseball-style” process has been successfully implemented in New York. Under the model, the insurer and the physician each make their case for a fair payment rate to an arbiter, who chooses the payment they deem to be fairest.

New mentorship program launched

In an effort to help Minnesota medical students grow their network with residents and practicing physicians, the MMA kicked off a new pilot mentorship program with a small reception in July at the MMA office.

The program has connected 16 residents/practicing physicians with 16 medical students from the University of Minnesota Medical School (Twin Cities campus and Duluth campus) and the Mayo Clinic Alix School of Medicine.

There has been great interest in the program, and additional mentor/mentee connections are waiting to be made.

Mentors will be available to answer questions and offer informal advice on topics such as the residency application process and choosing a specialty, as well as on professional development.

The pilot program will run for one year. If successful, it will continue connecting Minnesota’s medical students with their future colleagues.

New laws on prescribing and public health go into effect

Several new Minnesota laws impacting prescribing, public health and requirements for facility fee disclosures took effect August 1.

Opioids

The 2019 legislative session included passage of landmark legislation related to opioids. While most of the public debate focused on the bill’s means to generate revenue to fight the opioid epidemic, several pieces of the law are aimed at physicians who prescribe opioids. The new law sets dose limits of seven days (five days for patients under the age of 18) for the treatment of acute
pain using Schedule II through IV opiates or narcotic pain reliever. The law allows prescribers to deviate from the limits if it is in their professional clinical judgment to do so.

The opioid law includes a requirement that prescribers consult the state’s Prescription Monitoring Program (PMP) before prescribing opioids. Of note, this provision includes several exceptions, including post-surgical, hospice, inpatient, emergencies, if the PMP is not functioning, and if the prescriber has a current or ongoing relationship to the patient of more than one year.

A separate section of the opioid law precludes refills for Schedule III or IV opiate or narcotic pain relievers from being dispensed more than 30 days after the previous date on which the prescription was filled or refilled. In addition, the new law allows patients to include in their medical record and health care directive instructions to preclude opioids from being prescribed or administered to the patient.

E-cigarette restrictions
As of August 1, e-cigarettes cannot be used in public spaces where tobacco use is already prohibited. While previous law precluded the use of these devices in many public areas, including schools, health care facilities and state-owned buildings, the new law extends the prohibition to include bars, restaurants and most indoor workplaces. The MMA joined dozens of other health care organizations, public health advocates, insurers and others in supporting passage of the provision.

Hands-free mobile phone use
Also taking effect August 1 was legislation to further restrict the use of hand-held electronic devices such as cell phones and tablets. Texting while driving has been illegal for some time; the new law precludes the use of all electronic devices when a vehicle is in motion or part of traffic unless the device is operated via a “hands-free” feature such as Bluetooth.

Facility fee disclosure requirements
Facility fees are the subject of another law that went into effect August 1. Under the new requirements, clinics affiliated with a hospital or hospital-based system that charges a facility fee shall provide notice to any patient stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense. The law also requires that clinics prominently post in places accessible and visible by patients, including the website, a statement noting that the clinic is part of a hospital and the patient may receive separate charges. The law excludes laboratory services, imaging, or other ancillary health services provided by staff who are not employed by the health care facility or clinic.

MMA book club kicks off; second event planned for October
The MMA kicked off its book club, Author Rounds, in July with a chat with Tom Combs, MD, and his novel, Nerve Damage. Hosted by Board Member Carolyn McClain, MD, the event included a fun discussion about the craft of writing and combining literature and medicine.

The MMA will host its second book club October 11 from 7:30 to 8:30pm online. The book will be What Patients Say, What Doctors Hear by Danielle Ofri, MD. Ofri is on the faculty of NYU School of Medicine and sees patients at Bellevue Hospital in New York.

Ofri’s book explores the high-stakes world of physician-patient communication.

For more information, visit www.mnmed.org/authorrounds.
The poster child for what’s wrong with prescription meds

Although the 2019 legislative session has been over since May, there is one debate that continues in St. Paul—what to do about the high cost of insulin, the life-saving drug that has been available to patients for a century but has skyrocketed in price in recent years.

Earlier in the year, there seemed to be bipartisan agreement that help was needed to ensure that insulin was affordable to all Minnesotans. As the session concluded, however, many legislators expressed frustration that they were unable to come to an agreement and several called for a special session just to resolve the issue.

Since adjournment, a bipartisan group of Minnesota lawmakers has been meeting informally to find a solution. In late July, they reached an agreement to create a program that would provide a 20-day emergency supply to diabetics who have a prescription, but the legislators have not agreed on how to pay for it. DFL members have indicated that they support an assessment on insulin manufacturers to pay for the new program, while some Republican legislators have proposed using the Health Care Access Fund.

Insulin has become the poster child for what’s wrong with prescription drug pricing. A treatment that has been on the market for decades, where there has been very little change for many years, yet manufacturers have raised prices to the point that some diabetics cannot afford the treatment they need to stay alive and are rationing their supply.

One such instance involved Alec Smith, a 26-year-old Type 1 diabetic in Minneapolis, who after moving off his parent’s insurance plan, rationed his supply of insulin to make it last longer. He ended up dying of ketoacidosis. His mother, Nicole Smith-Holt, has become a passionate champion in her fight against the pharmaceutical industry. She will serve as a panelist on a discussion regarding pharmaceutical costs at the MMA’s Annual Conference in Duluth later this month.

In the past 14 years, the price of insulin has increased nearly 600 percent. Keep in mind, this is a medication that has been around since the 1920s and costs relatively little to manufacture. Frederick Banting, Charles Best and James Collip sold the original insulin patent for $1 each, with Banting reportedly claiming that “insulin belongs to the world, not to me.”

As physicians, it is hard to understand how prices have gone up so much when there is no increase in the cost of production. It is hard to understand why patients are being harmed through market forces that seem to be motivated solely by profit.

The fact that both sides of the aisle are working together on this issue shows just how egregious the situation is. Our lawmakers need to stop the rising cost of insulin—and of other drugs that patients need to live. We need to keep the focus on how we can make Minnesotans the healthiest in the country and advocate for removing barriers between our patients and their prescribed medications.

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