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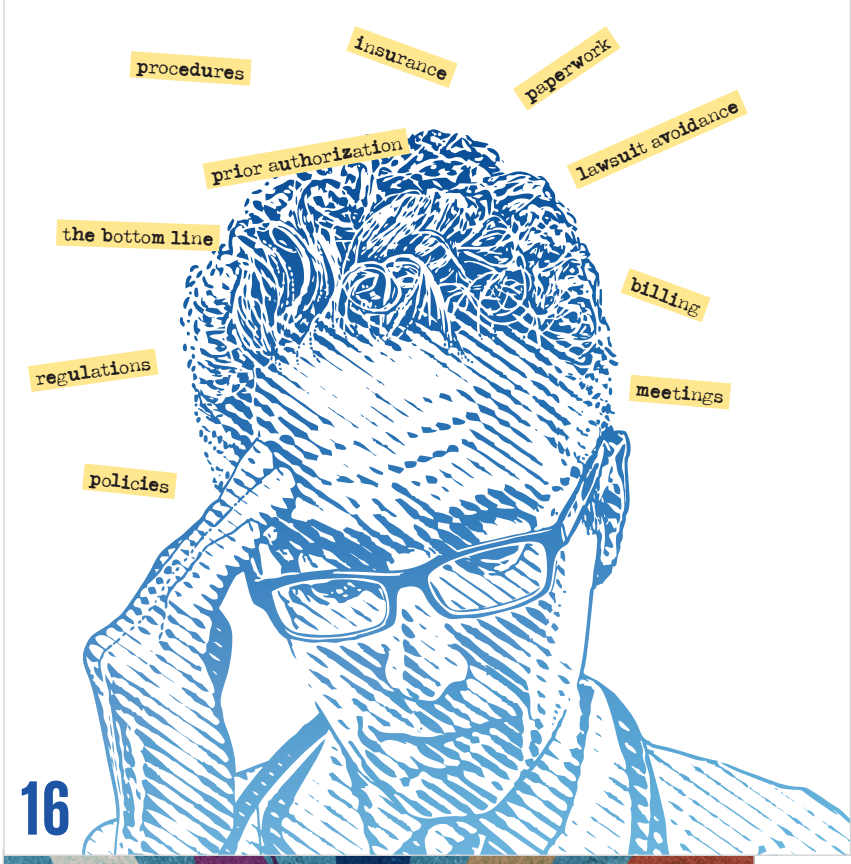

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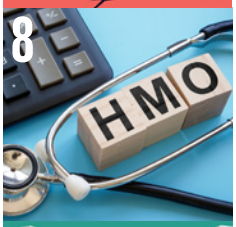

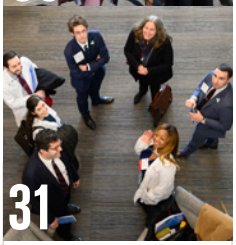

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Rahel Nardos, MD

Administrative harm in healthcare

This issue of *Minnesota Medicine* highlights several important challenges in our overly complex multipayer, multiclinician, and multicenter healthcare industry. It sheds light on the significant yet often overlooked administrative harm and the astronomically high healthcare cost needed to sustain this bloated administrative infrastructure. It also raises concern about an increasingly profit-driven private equity takeover of our healthcare industry that challenges our ability to prioritize the wellness of our stakeholders—patients and the healthcare professionals who care for them.

The decentralized U.S. healthcare industry has over 6,000 hospitals, 11,000 nonemployee physician groups, and 900 private payers, not to mention other significant players in this ecosystem, such as pharmaceutical and medical device companies, according to a recent report by Definitive Healthcare. An estimated $950 billion is spent annually on nonclinical administrative activities to support this complex system that employs two administrative staff for every frontline healthcare professional. According to a 2021 report in *JAMA*, that is more than twice as many administrative staff as typical in the U.S. service industry.

According to a 2021 report in *JAMA*, there are more than twice as many administrative staff as typical in the U.S. service industry. This level of complexity combined with high administrative turnover, low administrative memory, conflicting incentives, and a fee-for-service model that disincentivizes value-based care provides the perfect recipe for inefficiencies, growing healthcare cost, and harm.

This level of complexity combined with high administrative turnover, low administrative memory, conflicting incentives, and a fee-for-service model that disincentivizes value-based care provides the perfect recipe for inefficiencies, growing healthcare cost, and harm. These are not theoretical problems. As someone who practices in a surgical subspeciality, I have experienced first-hand the simple yet impossible task of building a highly skilled patient-care team due to high staff and management turnover. I have seen essential services needed to provide quality patient care cut to save cost. As healthcare professionals, we are tracked for our productivity and required to do countless online training to reduce patient harm, yet there seem to be no routine training and tracking to rectify the harm done from our administrative inefficiencies and misaligned values. This reality is at the root of the moral injury and burnout experienced by frontline healthcare professionals, who are feeling increasingly lonely as guardians of what should be our collective mission—keeping patients healthy and alleviating their suffering.

What would it take for all players in our healthcare system to align behind this mission? In *The Healing Organization*, Raj Sisodia and Michael J. Gelb argue that organizations can be profitable without choosing shareholders over stakeholders. They call these "healing organizations" that say, "Our quest is to alleviate suffering and elevate joy. We serve the needs of all stakeholders, including our employees, customers, communities and the environment. We seek to improve the lives of all stakeholders while making a profit so we can continue to grow and bring healing to more of the world."

How apt would it be for healthcare, whose mission is literally to heal, to embody this? Astronauts who have the privilege of viewing our beautiful and lonely blue planet suspended in space express overwhelming awe and a sense of connection to other people and the Earth. This cognitive shift causes many of them to become less motivated by individual goals and gravitate towards a life of service. We don't need to go to space to experience this cognitive shift in healthcare. We just have to remember the last time we were patients or cared for our loved ones and realized what it felt like to have a healthcare system that truly cared about us. **MM**

Rahel Nardos, MD, MCR, is associate professor, Department of Obstetrics, Gynecology and Women's Health, and director, Global Women's Health, at the University of Minnesota. She is one of three medical editors for *Minnesota Medicine*.

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Court dismisses case against MMIC for denial of malpractice coverage

Is a referral a medical incident? Court rules no.

In mid-October, the Minnesota Court of Appeals upheld a district court's granting of summary judgment to MMIC Insurance in a lawsuit filed by Minnesota physician James A. Hoffman, MD, challenging its decision to deny coverage of a physician's expenses incurred in defense of a lawsuit. The MMA, along with the AMA and the American Society for Aesthetic Plastic Surgery (ASAPS), submitted an amicus or "friend of the court" brief in support of Hoffman.

The initial case that gave rise to the lawsuit against MMIC involved Hoffman, a plastic surgeon, who was sued for discrimination by a transgender patient seeking breast augmentation surgery. Hoffman acknowledged that he did not have the requisite training or experience to perform the surgery, and referred the patient to another specialist.

The discrimination case against Hoffman was dismissed because the court found "no evidence" that Hoffman or his

The decision that "MMIC had no duty to defend me, as the complaint was based on alleged discrimination in violation of the Minnesota Human Rights Act, and not based on a medical incident" was puzzling. The courts "seem incapable of hearing that referral is part and parcel to the practice of medicine." – JAMES A. HOFFMAN, MD

clinic "were motivated by a purpose or intent to discriminate against transgender people when they referred [the patient] to the University of Minnesota."

MMIC, Hoffman's medical liability insurer, denied coverage for Hoffman's legal expenses in the discrimination case, citing a policy exclusion for claims based on "violations of Minnesota law." Hoffman sued MMIC for its denial of coverage and the district court granted summary judgment to MMIC. The case was appealed to the Minnesota Court of Appeals, which upheld the district court's granting of summary judgment to MMIC.

In its amicus brief, the MMA, AMA, and ASAPS argued that determining the type of care a physician is or is not qualified to perform, and referring the patient to an appropriately qualified physician, are precisely the types of medical decision-making a malpractice insurer is expected to cover in its liability policies. The brief further noted that physicians purchase medical malpractice liability insurance to provide coverage for their medical decision-making. Denying malpractice insurance coverage for a physician who decided not to provide medical care outside of his or her training and experience would have a harmful effect on the quality of care provided to Minnesota patients.

Hoffman has the option to appeal the ruling to the Minnesota Supreme Court, which can decide whether or not it will review the case.

Hoffman says the legal case has had disastrous effects on his practice and personal life. Since the case began in 2021, the case "would consume the next four years my life, result in the loss of my home, my marriage, my business, and nearly cost me my life."

Hoffman began his professional career as a dentist. In 1984 he met Joseph Murray, MD, a prominent plastic surgeon now known as a pioneer in organ transplantation. The meeting changed his life. "After I met Dr. Murray, it became clear to me that pursuing a career in pediatric plastic surgery would change my life. It afforded me the chance to correct deformities in children born less than perfect. I hold a certificate from the Children's Hospital, Los Angeles, in pediatric and craniofacial surgery. When one sets his sights on becoming a pediatric plastic surgeon, one does so with the realization that he would be in the lower 5% of compensation made by plastic surgeons in America," he says.

Though Hoffman won the discrimination case, the refusal by MMIC, his malpractice carrier, to pay for his defense was financially devastating, he says.

The decision that "MMIC had no duty to defend me, as the complaint was based on alleged discrimination in violation of the Minnesota Human Rights Act, and not based on a medical incident" was puzzling, he says. The courts "seem incapable of hearing that referral is part and parcel to the practice of medicine."

Even though the court in the original lawsuit found he did not discriminate, the insurance company successfully argued it as not responsible to defend against alleged discrimination. "So they would prefer that I perform an operation that I have never seen, never ever contemplated, an operation that I had no competence to perform? And, furthermore, I hold no surgical privileges to perform transgender surgery of any kind. No hospital or surgery center would allow me to perform such a surgery," says Hoffman.

"This is an absolute miscarriage of justice. In the last four years I have suffered the complete destruction of my life as I once knew it. I have spent nearly a million dollars defending myself. I carry the following medical diagnoses: major depression, post-traumatic stress disorder, and suicidality. My home is in foreclosure, my once-thriving practice is shuttered, I have staggering financial debt, and my marriage was destroyed in the process," he says.

"This too, could happen to you." MM

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UnitedHealth ends fight to keep for-profit HMOs in Minnesota

In mid-October, UnitedHealth Group ended its fight to keep for-profit health maintenance organizations (HMOs) operating in Minnesota.

Up until 2017, Minnesota had allowed only nonprofit HMOs to operate in the state. That changed when the Legislature passed a bill that ended the prohibition and allowed for-profit corporations to operate HMOs in Minnesota. With the bill's passage, UnitedHealth, a for-profit corporation, entered into contracts with the Minnesota Department of Human Services (DHS) to provide services to Minnesota's publicly funded programs.

In 2024, the Minnesota Legislature passed a bill that reinstituted the prohibition on for-profit HMOs from participating as providers in publicly funded plans, but still allows them to participate in the state-regulated commercial market, as they have been allowed to do prior to 2017.

Following the bill's passage, DHS terminated and refused to renew multiple UnitedHealth contracts, prompting the company to file a lawsuit against the state to force DHS to renew the contracts. UnitedHealth raised several arguments, including claiming that the prohibition on for-profit HMOs did not apply to contract renewals, only to new contracts.

The Minnesota Council of Health Plans participated as amicus curiae in the case before the Court of Appeals, arguing in favor of the state of Minnesota and DHS.

A district court in Minnesota found for the state and refused to require DHS to renew their contracts. UnitedHealth filed an appeal with the Minnesota Court of Appeals, but withdrew its appeal October 15.

State attorney general's settlement with BCBS will improve access to mental health services

On November 1, Keith Ellison, Minnesota's attorney general, reached a settlement with Blue Cross Blue Shield of Minnesota (BCBS MN) to make mental health services more accessible to all Minnesotans.

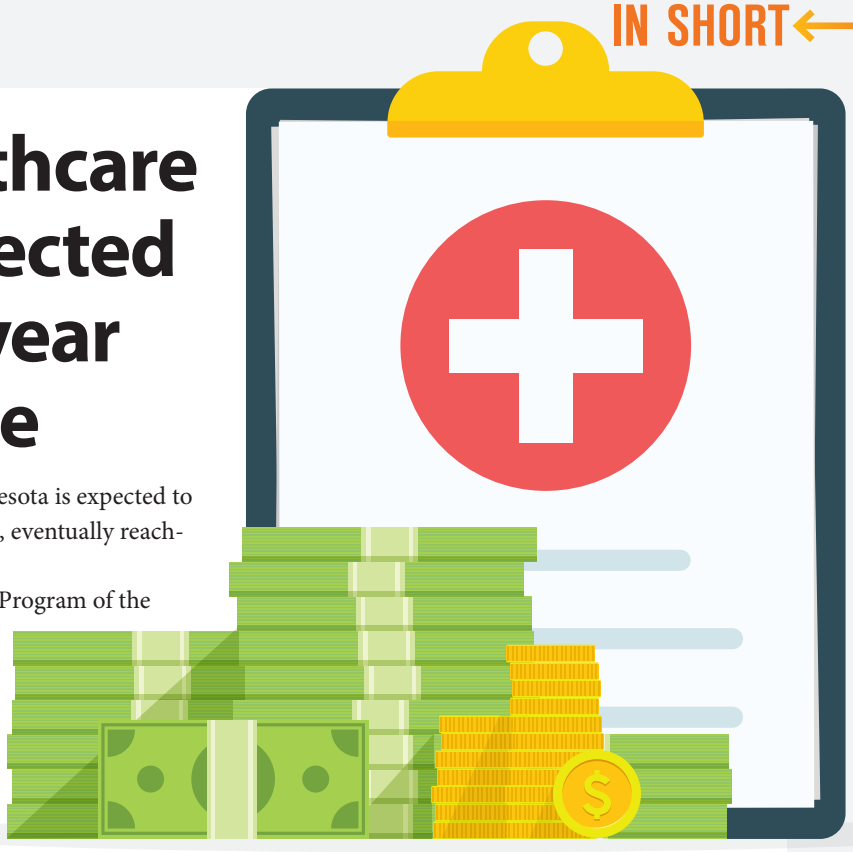
The settlement is the result of a multiyear investigation into BCBS MN's compliance, or lack thereof, with Minnesota's laws requiring parity between the provision of mental and behavioral health services and physical health services. The investigation found that BCBS MN may not have entirely complied with the requirements of the mental health parity laws.

The settlement resolves the investigation and requires BCBS MN to:

- "Make decisions about the vast majority of requests for prior authorization for behavioral health services within five days";
- "Approve or deny a behavioral health provider's request to join Blue Cross' network within 45 days";
- "Implement initiatives to increase behavioral healthcare access and provide data to the Attorney General's Office to evaluate the success of those initiatives";
- Pay a consultant selected by the attorney general's office who will review and ensure that BCBS is not imposing more restrictive limitations on mental health benefits than on medical or surgical benefits; and
- "Respond within 30 days to any complaint about behavioral health parity submitted to the Minnesota Attorney General's Office." Complaints can be submitted to the attorney general's office.

In addition, BCBS MN will contribute $600,000 to Minnesota State University, Mankato for use by the Center for Rural Behavioral Health. BCBS MN also agreed to a stayed civil penalty in the amount of $300,000 which will be paid to the state of Minnesota if BCBS MN is found to have violated the terms of the settlement, which lasts until December 31, 2028.

Minnesota healthcare spending is expected to grow 5.6% a year over next decade



Between 2022 and 2031, healthcare spending in Minnesota is expected to grow 5.6% per year compared to the previous 10 years, eventually reaching $108.7 billion.

This prediction comes from the Health Economics Program of the Minnesota Department of Health, which regularly prepares estimates of healthcare spending for Minnesota residents. The most recent reports detail healthcare spending for 2021 and projections from 2022 through 2031.

In 2021, healthcare spending increased at a more rapid pace than the year before, rising 6.4% between 2020 and 2021, to reach $63.4 billion. Increased public program enrollment and hospital spending contributed to increased spending in 2021.

Though both public and private payers' spending will increase over the next 10 years, the department projects that public payer spending will grow more rapidly than private payer spending (5.9% compared to 5.3% per year). Hospital spending is expected to remain a major driver of spending growth through 2031.

U of M researchers find connection between blood protein and increased heart failure risk

New research led by a University of Minnesota Medical School research team found a connection between a lower level of factor XI—a protein that helps with blood clotting which is targeted by new blood thinners—and an increased risk of heart failure.

Researchers are exploring a new type of blood thinners called factor XI inhibitors, which may be associated with a lower risk of bleeding than current blood thinners. Preclinical model studies have shown that factor XI may protect the heart from fibrosis, heart failure and abnormal heart rhythms, including atrial fibrillation. Until now, no human evidence has linked lower levels of factor XI to heart failure or atrial fibrillation.

This study, published in *Circulation*, involved two large community-based cohorts, the Atherosclerosis Risk in Communities (ARIC) Study and the Cardiovascular Health Study (CHS). Researchers found that a lower factor XI level was associated with a higher risk of developing heart failure. In addition, ARIC participants with lower factor XI levels showed a greater likelihood of atrial fibrillation and worse heart function.

"Based on the findings of this research, doctors and scientists should be mindful of potential side effects as researchers develop factor XI inhibitors as a new class of blood thinners," said Lin Yee Chen, MD, MS, a professor and director of the Lillehei Heart Institute at the U of M Medical School, and senior author of the study. "It is important to note that our findings do not imply causation. Thus, more research is needed to assess potential causal relationships between factor XI inhibition and adverse cardiovascular events." MM

Three private equity healthcare strategies to maximize profits—and a legislative bill to promote transparency

Private equity buyouts of physician practices follow predictable patterns. Unfortunately, so do the results.

BY HUNTER CANTRELL, BSC; DAVID J. SATIN, MD

The days of physician-owned practices have been waning for decades. Some have turned to private equity (PE) investment firms as sources of ongoing capital for their practices—even after they retire from medical practice. PE firms are not interested just in physician practices though. In the past 20 years, these firms have demonstrated a growing interest in the full spectrum of healthcare entities from hospitals to nursing homes. PE healthcare acquisitions have grown from $5 billion in 2001 to $100 billion in 2019.[1]

In this article, we use recently published data to detail three problematic PE strategies used in healthcare: (1) changing management to cut costs, (2) generating revenue through real estate, and (3) creating geographic monopolies to increase prices.[2,3,4] In response to concerns about worsening outcomes and quality of care when PE takes over a medical service, we offer policy solutions, including a bill introduced in the Minnesota Legislature in 2024. We conclude that legislative action alongside other safeguards are needed to restore a trusting patient-physician relationship.

Background

PE firms are financial investment companies whose expressed purpose is to maximize returns for their investors. In market economies, bringing such expertise to industries can help streamline production and reduce waste.[2] But healthcare markets are distinct economies by nature of the vital goods and services they provide. Despite the high costs of U.S. healthcare, maximizing profits has been a more central feature of the pharmaceutical and health insurance industries than of the physician-patient relationship. PE has discovered that physician practices, nursing homes, and even hospitals are leaving money on the table. They are just beginning to pry open this financial opportunity. PE's infusion of capital and business acumen is not a problem in principle. Yet in practice, the data tell a disturbing story. The volume of medical literature about PE spiked in the last five years, coinciding with this increasingly common phenomenon in healthcare management (Figure 1).

FIGURE 1

PubMed search results for the phrase "private equity" from 1979 to 2023 (2024 total pending)

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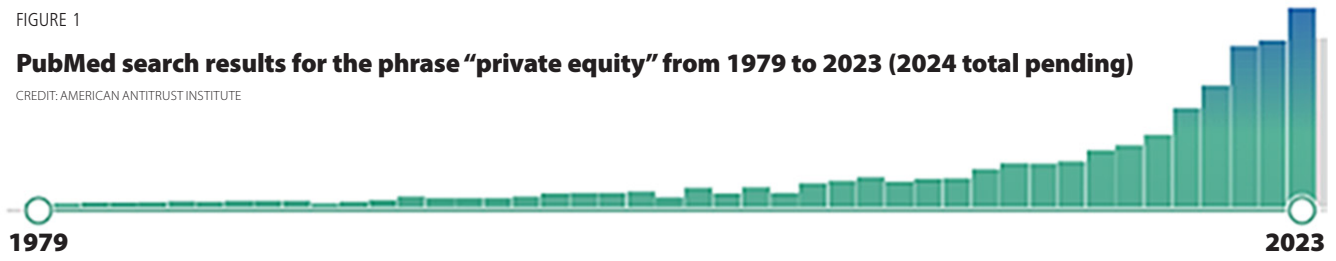

In this article, we use recently published data on trends in worsening health outcomes and higher costs among PE-owned medical service entities to detail three PE profit-maximization strategies.

Strategy 1: Changing management to cut costs

Over 30 states have some form of prohibition against the corporate practice of medicine. Such protections come in the form of state statutes or case law that prohibit nonphysicians from dictating the practice of medicine.[6] Minnesota's prohibition on the corporate practice of medicine comes from two State Supreme Court decisions in conjunction with a patchwork of state statutes that do not fully cover contemporary circumstances. Whether PE control of the clinical aspects of medical practices is prohibited by case or statutory law, PE firms can often bypass these protections. PE firms entice physician-practice owners with exorbitant purchase prices; in exchange, the practice retains a management entity owned by the PE firm, also called a management services organization.[6] The management entity controls the practice's "nonclinical" assets including financial, human resources, billing, payor negotiations of physician fee schedules, clinical operations, and administration.

Their goal is to increase profits paid to shareholders in the form of dividends, as quickly and as much as possible. They do so initially by cutting services, safety, and staffing, including long-term reductions in physician and other staff salaries.[1,7] These cuts may be accompanied by upselling treatments with marginal benefits, adding costs that may not be in the best interests of patients.[1,8,11]

Although physicians have a fiduciary responsibility to their patients, PE firms do not. PE firms can exert pressure on clinicians to set aside principles of patient-centered care if doing so is more profitable for the firm. Clinicians and administrators may face incentives against less profitable services, longer appointments, or seeing patients on lower-reimbursing public healthcare programs.[1] The results can be devastating:

- PE-run nursing homes cut staff and routinely provide substandard care, resulting in an estimated 20,000 additional deaths over 12 years.[9]
- PE-run nursing homes were associated with 10% increased mortality.[9]
- PE-owned facilities were found to cut frontline nursing assistants by 3% and their hours by 1.7%.[9]

PE firms can exert pressure on clinicians to set aside principles of patient-centered care if doing so is more profitable for the firm. Clinicians and administrators may face incentives against less profitable services, longer appointments, or seeing patients on lower-reimbursing public healthcare programs.[1] The results can be devastating.

Perhaps to compensate for staff reductions, patients in PE-owned facilities are given more antipsychotic medications.[10]

PE-run hospitals are associated with 25% more adverse health events, including 27% more falls, 37.7% more central line infections, and twice as many surgical site infections.[7]

The negative effects of PE operational control are not restricted to quality but impose financial burdens on patients and the system. In a 2024 study of 578 physician practices in dermatology, ophthalmology, and gastroenterology, PE takeovers were tied to an average increase of $71 per medical claim and a 9% increase in lengthy, more costly, patient visits.[11]

Strategy 2: Generating revenue through real estate

When PE firms acquire nursing homes, hospitals, or other healthcare facilities, they often place the land and buildings in one or more limited liability corporations (LLCs) and the operations component in a different LLC.[12] This conceals PE ownership and management of facilities. It shields firms from economic liability and government oversight.[12] The adverse patient outcomes data presented above is one reason PE firms might want to obfuscate this relationship. But there is another, more practical purpose for separating assets from operations: profiting from real estate on which the medical facility sits.

Real estate investment trusts (REITs) are becoming popular in the PE healthcare space. They recognize not only the outsized land value of healthcare facilities but also their negotiating power. PE firms often acquire hospitals and facilities through leveraged buyouts. They finance debt worth between 50% and 70% of the facility's asset value to generate immediate

PE firms generate profit by acquiring properties such as hospitals and leasing the real estate back to the healthcare facility tenant (aka a "sale-leaseback") increasing rent an average of 75% after buyout.[10,11]

revenue for shareholders.[2,5,13] They may cut services, safety, and staff, leaving governments to use taxpayer funds to preserve the essential services still provided by the over-leveraged healthcare facilities.[6,14] The risk of facility closure is no accident. PE firms often control medical services for just five to 10 years before leaving these services saddled with debt and facing financial insolvency.[2,5] A final REIT strategy is to own portfolios of income-producing healthcare real estate.[2,3] They generate profit by acquiring properties such as hospitals and leasing the real estate back to the healthcare facility tenant (aka a "sale-leaseback") increasing rent an average of 75% after buyout.[10,11]

A specific example, combining several of the real estate strategies above, is the still-unfolding story of Steward Health Care, LLC. For many years, Steward was run by the PE firm Cerebus Capital Management.[15,16] Steward hospitals' management, staff, and patients initially welcomed the influx of essential capital from Cerebus. Nevertheless, their financial situation quickly worsened when Cerebus sold most of the hospitals' real estate to REIT firm Medical Properties Trust (MPT). As expected, the rent base of the facilities involved in these sale-leaseback agreements were in all cases far higher than their assessed property values.[15,16] As part of Steward's bankruptcy proceedings, the state of Massachusetts agreed to provide $30 million through Medicaid to maintain the operation of six of eight hospitals during the transition to new ownership.[16,17] The remaining two hospitals closed. No buyer could be found to take over MPT's property leases that were four to eight times above market value.[15,16] The PE strategy of generating revenue by leveraging the real estate value of facilities is not unique to healthcare acquisitions. A similar phenomenon recently led, in part, to the Chapter 11 bankruptcy of the restaurant chain Red Lobster.[18]

FIGURE 2

Cumulative number of private equity acquisition deals of physician practices by specialty, 2012–2021

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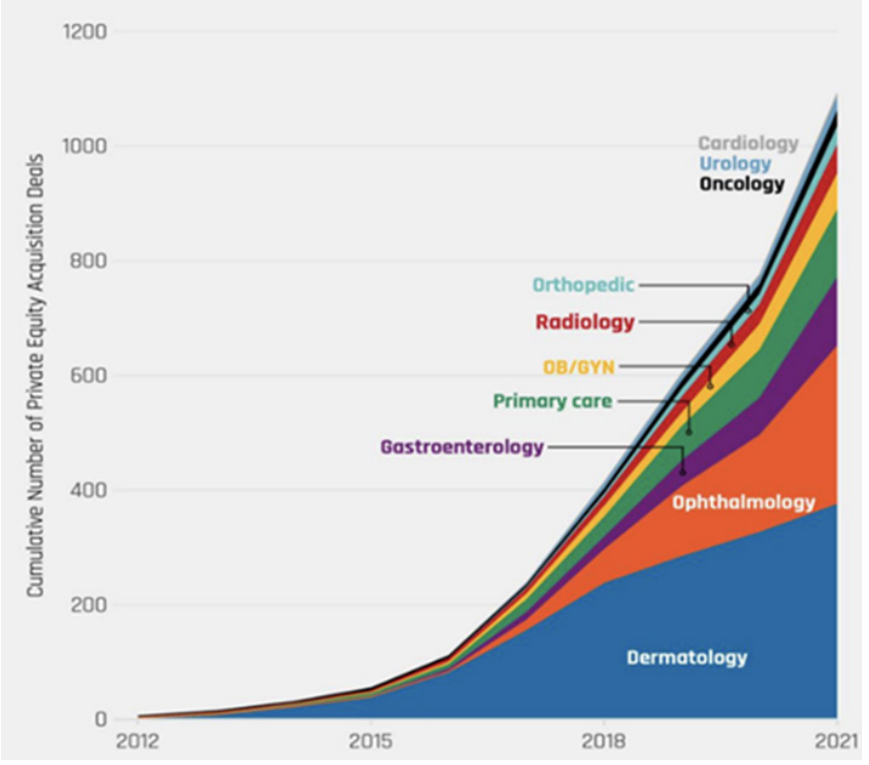

Strategy 3: Creating geographic monopolies to increase prices

Another strategy for profit maximization is the creation of monopolies across multiple specialties, primarily but not exclusively targeting the highest profit subspecialties (Figure 2). In addition to acquiring real estate assets, PE firms across the nation purchase substantial operating and managerial interests in physician practices and physician staffing companies (Figure 3). Sufficient local market capture allows for increasing prices and decreasing quality because no competition for medical services exists.[1,4] Greater practice specialty consolidation is directly related to increases in patient costs[1,2] (Figure 4).

Sufficient local market capture by PE firms allows for increasing prices and decreasing quality because no competition for medical services exists.[1,4] Greater practice specialty consolidation is directly related to increases in patient costs.[1,2]

FIGURE 3

Metropolitan statistical areas with greater than 30% (gray) and 50% (red) of market share of one or more physician specialties possessed or managed by private equity[2]

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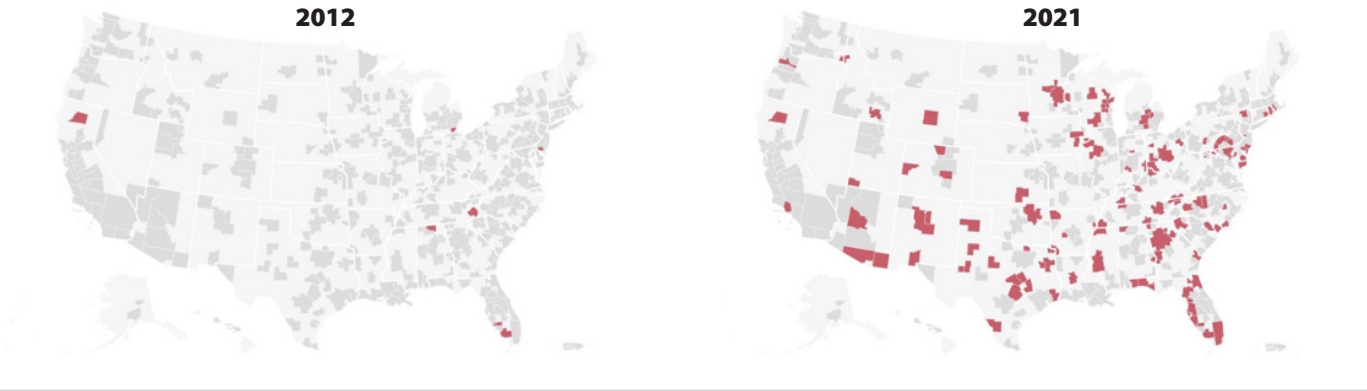

Geographic market consolidation of specialties enables greater leverage to pursue strategies 1 and 2.[2,4,5,8]

Although physicians are bound by their professional standards, PE is held to a business standard. This difference in standards of conduct crosses all three domains of incentives described by behavioral economists: financial, social, and moral. For example, while PE is free to advertise within a wide legal standard, physicians can have their medical licenses suspended or revoked for unprofessional advertising.[19] PE can exploit this gap between medical and business ethics—between unprofessional and illegal. PE can pursue business practices that are normally considered socially forbidden for physicians. PE can exploit loopholes in the current regulatory infrastructure, leading to increased costs for patients through functional monopolies.[1]

Proposed legislative action

Co-author Hunter Cantrell worked with legislators to introduce a bill in the Minnesota State House and Senate (Hanson-Mann) in 2024. It aims to address some of the loopholes that allow PE to engage in what economists call "rent-seeking" practices—economic activities that extract money without adding value. In this case, rent-seeking also has the potential to harm patients and clinicians.[20] The Hanson-Mann bill received much attention and an informational hearing in the

FIGURE 4

Physician prices for 10 specialties, 2012–2021[2]

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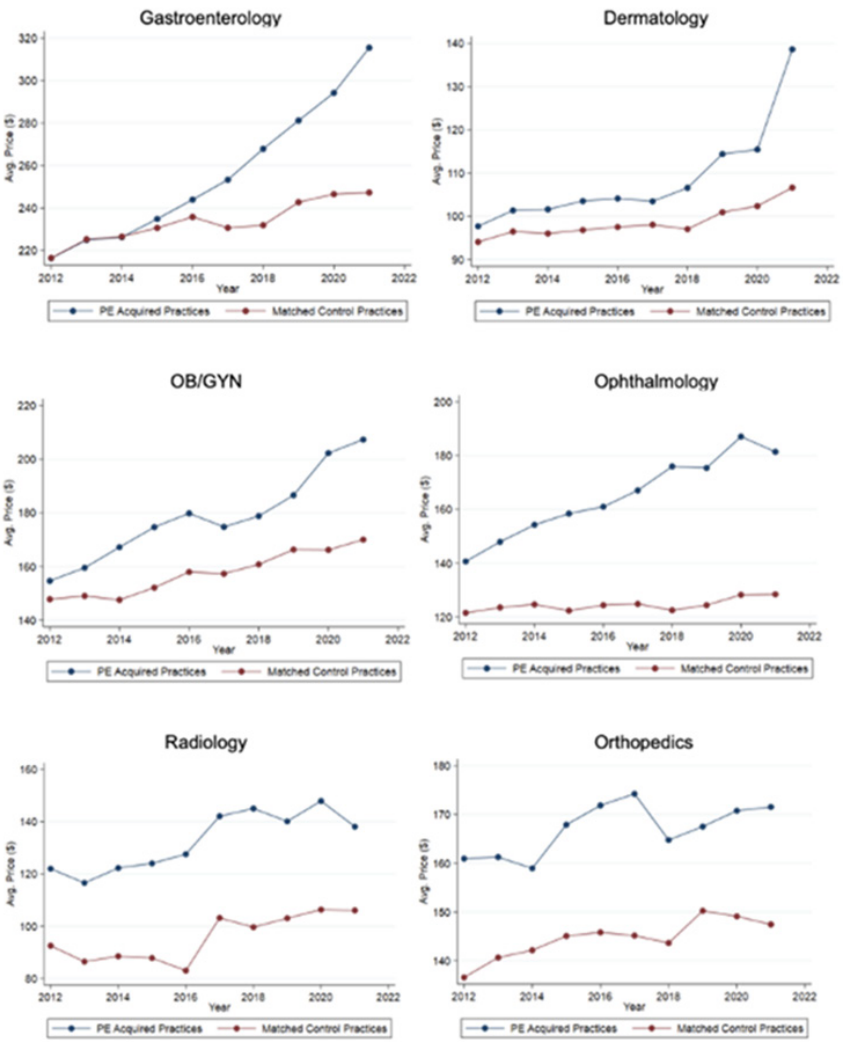

House Commerce Committee but did not pass into law. It would have imposed an open-ended moratorium on PE firms' and REITs' initiating or expanding operational or managerial control of any medical service entity in the state. A pause in further market consolidation of medical services would allow government regulators time to evaluate how these companies ought to engage in healthcare commerce. We believe that a track record of shuttering facilities and concerning patient-outcome data merit further evaluation. The Minnesota Academy of Family Physicians has recently endorsed this legislative action.[21]

Our research and discussions with government regulators find that PE acquisition data is neither systematic nor complete. Apart from occasional media coverage and institutional research, it is difficult to know how and when private equity companies acquire clinical practices, nursing homes, hospitals, and other facilities. In 2023, reporting requirements and oversight authority were given to the Minnesota attorney general for medical services sales or mergers with greater than $80 million in annual revenue.[21] The attorney general must determine if these transactions are in the public interest. Similarly, there are federal reporting requirements for oversight of healthcare mergers and acquisitions. Yet, PE firms can exploit loopholes in the system to complete "stealth acquisitions," bypassing antitrust regulations because federal laws do not consider aggregate management and portfolio holdings in assessing total healthcare merger entity value.[1,22] We propose expanding these reporting requirements to all PE acquisitions of healthcare entities, regardless of financial magnitude, and enshrining a well-defined safeguard against the corporate practice of medicine in statute. This serves as a mechanism for data collection and transparency.

Conclusions

PE acquisition of healthcare practices and facilities is associated with worse patient outcomes. They maximize profits by changing management to cut costs, generating revenue through real estate, and creating monopolies. Financial, social, and moral gaps between medical and business cultures allow for the exploitation of financial opportunities. We propose legislative action to gather further data, safeguard patients, and restore a trusting patient-physician relationship. MM

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First, do no (ADMINISTRATIVE) harm

Can growing recognition of the damage caused by administrator-clinician disconnects be a first step toward healing the rift?

BY MARY HOFF

An insurance company's insistence on prior authorization for admission to skilled nursing lengthens a patient's hospital stay.

A healthcare system turns a patient away because they haven't paid their medical bills.

A primary care physician, fed up with paperwork, quits to take a job with a drug company, leaving patients and employer in the lurch.

As diverse as these incidents are, they have one thing in common: They're all examples of administrative harm—physical, psychological, or other injury caused or aggravated by decisions made by healthcare administrators, policymakers, and the like.

Most likely you have an example of your own, whether as a clinician, a patient, an administrator, or another participant in the U.S. healthcare system.

"My impression is that this is something that a lot of people have experienced, are frustrated or angry about, but have not necessarily had a name for," says Walter O'Donnell, MD, assistant professor of medicine at Harvard Medical School and clinical director emeritus of the Division of Pulmonary and Critical Care at Massachusetts General Hospital.

A doctor for decades, O'Donnell in recent years has noticed a growing disconnect between decisions made by administrators and what's best for patients. In 2022, he published a paper in the *New England Journal of Medicine* on the trend he was observing, giving it a name and calling out the dramatic lack of oversight of administrative practices relative to clinical ones.

"I'd seen enough, and I was pissed off, and I tried to move from just ranting to trying to put it into words," he says.

"The defining feature of administrative harm is that it results from an administrative action or failure that is recognizable as topdown, unilateral, and business-oriented," O'Donnell says. As he wrote recently in *The American Journal of Medicine* ("Another Physician Bites the Dust"), "Administrative harm in the case of a patient or a clinician, or both, stems from

an administratively driven intervention or a failure in the 5 S's: staff, space, stuff, systems, and team spirit—that support clinical work."

Quiet epidemic

The phenomenon is not new; it's entirely possible that Hippocrates himself was hobbled to some extent by the system in which he (literally) operated. It was formally alluded to at least as early as 2011, when Huan Chang, MD, MPH, and Matthew Liang, MD, MPH, called out a "quiet epidemic" of "management malpractice" in a paper in *JAMA*.

"The world, at times, seems to have gone mad with senseless (at least from a clinical point of view) administrative rules," they wrote. "It is clear that something has to change to facilitate patient care and address physicians' helplessness to perform our jobs to the best of our ability."

What is new is the degree to which administrative harm appears to be permeating—and adversely impacting—healthcare today. In a study published earlier this year in *JAMA Internal Medicine*, University of Colorado professor of medicine Marisha Burden, MD, MBA, and colleagues conducted a mixed-methods study that included a survey and focus groups with 41 physicians, administrators, and other stakeholders from 32 different organizations. They found that more than eight in 10 of the 32 participants who responded to the survey had encountered some form of administrative harm.

"Clinicians and organizations face this problem, no matter what they do or where they work. The way clinicians and other healthcare workers work and the decisions that shape their work are very important. If organizational decision-makers don't get these things right, then this can lead to harms that impact the workforce, ultimately patients, and organizational bottom line."

MARISHA BURDEN, MD, MBA, professor, University of Colorado

"Clinicians and organizations face this problem, no matter what they do or where they work," Burden says. "The way clinicians and other healthcare workers work and the decisions that shape their work are very important. If organizational decision-makers don't get these things right, then this can lead to harms that impact the workforce, ultimately patients, and organizational bottom line."

"I think it is a big problem, and I think it's becoming a bigger problem with time," says Dhruv Khullar, MD, MPP, associate professor of health policy and economics at Weill Cornell Medicine and director of the Physicians Foundation Center for the Study of Physician Practice and Leadership. "We're increasingly seeing some of the effects, both in terms of patient frustration and mistrust in the healthcare system and in terms of physician turnover and physician burnout."

What's behind this unsettling trend? And, more importantly, what can be and is being done to mitigate it?

"The defining feature of administrative harm is that it results from an administrative action or failure that is recognizable as topdown, unilateral, and business-oriented. Administrative harm in the case of a patient or a clinician, or both, stems from an administratively driven intervention or a failure in the 5 S's: staff, space, stuff, systems, and team spirit—that support clinical work."

WALTER O'DONNELL, MD, assistant professor of medicine at Harvard Medical School and clinical director emeritus of the Division of Pulmonary and Critical Care at Massachusetts General Hospital

Convergence of causes

Administrative harm seems rarely, if ever, to be due to a deliberate lack of care or concern. Rather, it emerges when things such as the bottom line, the need to follow regulations, the need to ensure patient safety, or the need to avoid lawsuits drive decisions without sufficient attention to downstream consequences and without feedback loops needed to raise the alarm when things do go awry as a result.

A big contributor is the rise in compartmentalization of administrative and clinical functions—what O'Donnell calls the "adminiverse" and the "cliniverse"—as physicians shifted from private practice to an employer-employee model.

"I think it is a big problem, and I think it's becoming a bigger problem with time. We're increasingly seeing some of the effects, both in terms of patient frustration and mistrust in the healthcare system and in terms of physician turnover and physician burnout."

DHRUV KHULLAR, MD, MPP, associate professor of health policy and economics at Weill Cornell Medicine and director of the Physicians Foundation Center for the Study of Physician Practice and Leadership.

"Healthcare providers have really lost the ability to determine what healthcare looks like," says Matt Hoffman, MD, a family medicine physician with Allina Health. "And we've lost it to healthcare administrators. We've lost it to people that don't care for patients, that have never cared for patients, that don't really understand what's important for patients. And often these people are making decisions based on purely financial reasons, and short-term financial reasons often, and not really looking at what is best for our patients."

Increasing complexities of the insurance and regulatory worlds factor in, too. Lawmakers pass laws intended to protect patients without sufficient understanding of the needs and constraints frontline workers face. Administrators assess regulations and produce CYA paperwork and procedures—sometimes putting an adult-size diaper on a newborn-size problem in an effort to ensure sufficient coverage. Prior authorization requirements impede needed care.

Sometimes, a simple lack of big-picture thinking can be the culprit. Unnecessary meetings and training requirements insufficiently aligned with individual needs suck time away from patients. Overengineered systems become obstacle courses rather than conduits to better care. Standardized protocols intended to boost efficiency and save money do a disservice to patients and staff alike.

Particularly significant seems to be the infusion of generic business practices into healthcare with the rise in for-profit systems, use of consultants, and increased size of healthcare companies.

Ryan Armbruster, MHA, oversees the Master of Healthcare Administration executive program in the Division of Health Policy and Management at the University of Minnesota. He points out that this has brought numerous benefits—increased availability of advanced care, increased capacity, diversity of services, and more. But "once you bring formal administration and processes to medicine, it comes along with all of the other unintended, probably, consequences of doing so," he says.

"We thought we could make healthcare more efficient by adopting practices from the manufacturing sector, like Lean and Six Sigma," says Armbruster. "And that's true, we can apply those processes to healthcare. But they have to be adapted to the unique human nature of healthcare services. Healthcare is not a product being manufactured on an assembly line, like cars. It's a service provided to people, not a physical good being produced."

For Hoffman, that manifests itself in recent trends toward heaping mounds of nonmedical tasks onto physicians' already-brimming plates. "A huge source of administrative harm for me and my colleagues is the amount of nonpatient work that we're expected to do," he says. "When I have to look at things like medication refills or messages from patients or phone calls or messages from other healthcare providers, all the time I spend doing that, I'm not able to actually be in the room caring with patients. And it's important, but a lot of that work doesn't need to be done by us."

The bottom line? "We've made some really poor design decisions in how we operate our healthcare system," Armbruster explains. "And we didn't correct those mistakes in time. Instead, the problems continued to build and build, until they became substantial and significant issues."

"Healthcare providers have really lost the ability to determine what healthcare looks like. And we've lost it to healthcare administrators. We've lost it to people that don't care for patients, that have never cared for patients, that don't really understand what's important for patients. And often these people are making decisions based on purely financial reasons, and short-term financial reasons often, and not really looking at what is best for our patients."

MATT HOFFMAN, MD, a family medicine physician with Allina Health

What to do?

The first step in reducing administrative harm, Burden says, is to recognize and define the problem. Armbruster encourages doing so in a way that focuses on solutions rather than shame and blame.

"This is a shared problem that we've all contributed to, maybe knowingly or unknowingly, and we all hold the responsibility for addressing and solving it," he says. "I see this all over in healthcare: It's

the payers, it's the insurance company, it's the government. Yes, the system doesn't work really well because there are all those players, but we have to invite people to a conversation about how we work collaboratively to fix some of these things."

Administrators can help reduce administrative harm by thoroughly thinking through proposed policies and procedures—along the entire chain of impact—while formulating them, with an eye to avoiding adverse unintended consequences to staff and patients. "Every time a new policy is introduced, either within a hospital or clinic, or from a state or federal government, one of the things that people should be thinking about is, Is this going to increase or decrease administrative harms?" Khullar says.

One way to help that happen is to include representatives of those impacted by decisions—patients, physicians, and families—in making administrative decisions. "Healthcare really needs to be focused on patient care," Hoffman says. "And to do that, you need to empower people that actually take care of patients and know what patients need. So, you need to incorporate those doctors and nurse practitioners and PAs. You need to incorporate them in the design of a health system and the bigger decisions that need to be made in healthcare."

Those in administrative or clinical leadership roles can help mitigate harm by calling a time out, as is common practice in operating rooms. "If you're making a high-risk decision," Burden suggests, "you need to take a pause and consider, What information do I need to make this decision? Do I have it? What are the likely outcomes? What are the balancing measures? Are there any negative consequences that may happen, and what can be done to mitigate them? Have the potential impacts been fully considered? The time out should include thinking through the impact on patient care, the healthcare workforce, and the financial and operational outcomes, and thinking about both short and long-term outcomes."

That can require a new paradigm for administrators trained in typical MBA practices, Armbruster notes. In a 2021 commentary in *BMJ Leader*, he and colleagues call for leaders to "shift their gaze away from industrial healthcare and embrace bold experiments to shift policy and change to the culture needed to achieve careful and kind care."

"We thought we could make healthcare more efficient by adopting practices from the manufacturing sector, like Lean and Six Sigma. And that's true, we can apply those processes to healthcare. But they have to be adapted to the unique human nature of healthcare services. Healthcare is not a product being manufactured on an assembly line, like cars. It's a service provided to people, not a physical good being produced."

RYAN ARMBRUSTER, MHA, oversees the Master of Healthcare Administration executive program in the Division of Health Policy and Management at the University of Minnesota

Measure and report

In addition to prevention is the need to be vigilant for signs of administrative harm and, when detected, both mitigate the harm and learn from the experience. Chang and Liang recommended adoption of systems to document incidences of damage caused by administrative decisions so patterns become clear and can be corrected.

O'Donnell underscores the importance of identifying what went wrong and calls for "regular clinical-administrative M&M conferences" as a way to debrief and reduce the likelihood of future occurrences.

Khullar urges clinicians to note instances and propose ways to reduce administrative harm. "Let's have a process through which we can raise these issues with leadership, with the goal of making things both more efficient and more professionally satisfying," he says.

For Hoffman, belonging to the labor union Doctors Council is an important element of being able to be speak up and be heard. "Across the country, there's so much interest from the provider point of view in unionizing, because otherwise you don't really have a great avenue to have some control back and where these decisions are made," he says. "If you really want to make a change, it has to be from the bottom up. It has to be from healthcare workers and patients saying that we're not going to take this anymore."

O'Donnell calls for a bidirectional rating system like that Uber uses to give drivers and riders a chance to provide feedback on each other. "We get scored on so many things as clinicians," he says. "I think we should have that same accountability for and transparency for administrators."

Equally important is ensuring that those in the trenches are comfortable reporting incidences of administrative harm. That means creating a culture where clinicians feel safe bringing concerns to light and ensuring those who point out problems are not penalized for doing so.

"A lack of psychological safety can perpetuate administrative harm because the workforce may not feel safe enough to tell organizational leaders, I think this decision is causing harm. This inhibits organizational learning and better decision-making," Burden says.

Patient feedback is important, too, says University of California San Francisco

Patient and Family Advisory Council member Gina Symczak. "The patient voice should be a mandatory part of decisions for all hospital departments," she says.

Khullar also looks to technology as at least a partial fix. Although electronic health records in some cases seem to add to rather than detract from the problem, artificial intelligence and other advances could reverse that trend. "These aren't yet proven strategies to reduce administrative burdens, but you could envision a future in which AI helps alleviate some of the things that humans don't need to be doing and allows clinicians to focus on the interaction with the patient and providing what only people can provide to other people," he says.

What can administrators do?

Solicit clinicians' and patients' insights on proposed policy changes.

Create a system for tracking administrative harm.

Create safe lines of communication with clinicians.

Include administrative harm in patient surveys.

Be thoughtful about what aspects of conventional business practice need to be moderated in a healthcare setting.

What can clinicians do?

Recognize the constraints administrators work within. Avoid the temptation to point fingers, and focus on solutions instead.

Call it out. Increasing visibility is a critical step in reducing administrative harm.

File a safety report if you don't have another mechanism for bringing an incident to light.

Initiate and participate in efforts to identify and reduce administrative harm.

Signs of hope

There are some signs that elements of the administrative ecosystem are beginning to look at decisions with an eye to costs as well as benefits.

In 2021 the Texas Legislature passed a law exempting some physicians from some prior authorization requirements, a commonly cited cause of administrative harm, and a number of other states appear to be following suit. The Centers for Medicare and Medicaid Services' Patients over Paperwork initiative and the AMA's Physician Well-Being Program are two other examples of efforts to reduce sources of harm.

Over the past decade, the MMA has worked diligently to reduce the burden of prior authorization by insurers and pharmacy benefit managers. In 2020, the MMA advocated on behalf of legislation that shortened the time insurers have to make prior authorization decisions. The legislation also required that if a prior authorization request was to be denied it had to be done by physicians with the same or similar specialties as the treating physician. During the 2024 legislative session, the MMA supported additional legislation that eases the hardship of prior authorization and limits its use.

Khullar also points to the Getting Rid of Stupid Stuff program that invited employees of Hawaii Pacific Health to call out EHR documentation practices in need of change. Among other things, that initiative eliminated a single EHR click that was unnecessarily taking up 1,700 staff hours per month. A similar EHR improvement program carried out at M Health Fairview in 2019 and 2022 not only is saving physicians countless clicks, it also has improved patient care.

A 2024 article in *Health Affairs* points out that recent U.S. Supreme Court actions are providing more latitude for hospitals to "prioritize fixing the occasionally inefficient workflows that resulted from what we might now regard as overly conservative views of what compliance required." And the AMA's 2024 Reducing Regulatory Burden Playbook offers advice for reducing overinterpretation of regulations that leads to administrative heavy-handedness.

Continuing the conversation is important, too. In 2023 O'Donnell offered a continuing medical education conference at Harvard Medical School on the topic "Administrative Harm, Professionalism and Teamwork in Medicine" that was attended by more than 150 participants. He's planning a second conference in April 2025.

With increased attention, it's clearly time to roll up some sleeves and get to work for the good of all involved—from individual patients to entire healthcare systems. Key to success, Armbruster says, will be to get beyond finger pointing to cultivate a collaborative commitment to reduce administrative harm.

"I do see evidence out there in the industry that we can get to a better place," he says. "We got ourselves into this problem because we've been too separate. We need to come together and solve these problems together." MM

Mary Hoff is a Stillwater-based science writer and editor with special interest in the environment, natural resources, and health.

"The patient voice should be a mandatory part of decisions for all hospital departments."

UCSF Patient and Family Advisory Council member **GINA SYMCZAK**

Funding Change

MMA Foundation grants go to physicians focused on good work in their communities

BY ANDY STEINER

Creating portable kits to help unhoused IV drug users heal wounds. Educating neighbors about healthy ways to approach death and dying. Expanding access to emergency obstetrics care in rural towns and cities.

To many, these significant community-based projects might seem almost insurmountable, but, despite the odds, three Minnesota physicians chose to jump in head first and make a difference. And thanks to financial support from the Minnesota Medical Association Foundation's microgrants program, these activists were able to make positive change in their communities.

"The microgrant program was established to give physician advocates the kickstart needed to take on pressing issues in their communities," says Kristen Gloege, MMA Foundation chief executive officer. Most grant awards average around $5,000—"small, but impactful enough to help move projects from a physician's dream to reality," she says.

"The MMA Foundation is committed to empowering physicians with microgrants to foster innovative, community-specific solutions that advance optimal health," Gloege says. "By providing these targeted resources, we enable MMA members to effectively address unique local challenges, leading to improved health outcomes and a stronger, more resilient community."

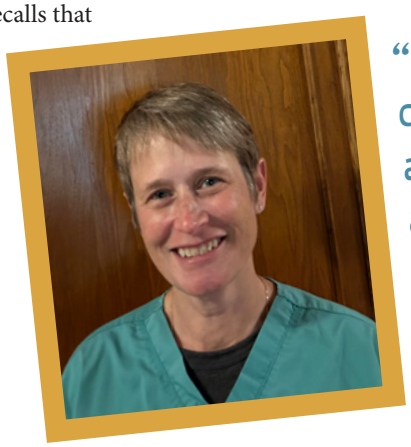
For recipients, the program feels like a needed public acknowledgement of their concerns, and provides key financial support of unique projects designed to improve life for members of their communities. It's just the kind of important work the MMA Foundation wants to support. "This foundation grant program aligns with the MMA's mission to be the leading voice of medicine," she says, "making Minnesota the healthiest state and the best place to practice, one locally led initiative at a time."

Minnesota Medicine talked to three grant recipients and learned more about their projects and the positive change they inspired.

Tools for healing

M. DAISY BRAATEN, MD

It was happening way too often. A few years ago, M. Daisy Braaten, MD, a faculty member at Duluth Family Medicine who also spent a half day a week at the city's Chum shelter providing medical care to unhoused Duluthians, recalls that she and her colleagues started seeing patients with infected skin wounds that would not heal.



"We were getting lots of urgent-care types of visits from patients with serious and persistent mental illness and substance use disorder who had infected wounds," Braaten says, adding that drug use is "incredibly prevalent," in the Chum shelter, with at least 30% of people actively using. "Many of the wounds were related to injectable drug use and may have been worse and harder to heal due to Xylazine," a veterinary sedative also known as tranq. "There seems to be more wounds and worse wounds associated with it," she says.

While Braaten and other healthcare workers at Chum could help their patients clean, sterilize and dress their wounds, they had no guarantee that those patients, many of whom didn't feel comfortable seeking traditional medical care, would return for the important follow-up care needed for their wounds to heal completely. "We were seeing a lot of people who had a real mistrust of the health system," she says.

But these wounds are serious and could even be life-threatening. Braaten knew of Twin Cities nonprofits that had assembled portable wound-care kits for people with similar injuries. She wanted to do the same thing for people in Duluth and rural Itasca County.

In 2022 Braaten was awarded a $3,500 MMA Foundation microgrant to fund the creation of 500 portable wound-care kits, gallon-sized Ziploc bags filled with gauze pads, sterile saline, gloves and other dressing supplies, as well as information sheets about local providers who provide low-barrier care. The kits were distributed by residents, students, and community health workers at Chum, and by outreach workers at needle-exchange programs and encampments.

The kit distribution, "was a way of meeting the community with a concrete need as well as building opportunities to connect and have conversations," Braaten says. "It helped us build bridges."

One example of the kits' bridge-building was a woman who, Braaten says, "was very skittish." She had a large, dangerously infected wound on her forearm. Says Braaten, "It went through all the skin layers, through fat and muscle. Because of her mistrust and feeling discriminated against in emergency settings, she didn't have the faith to make a connection at a traditional wound-care site."

When the woman was given a wound-care kit at Chum, it turned out to be, Braaten says, "a lifeline to her and a little bit of trust-building. We'd suggest, 'Why don't you come to our primary care clinic? We'll get extra supplies ordered for you.'"

Because of the trusting relationship she'd been able to build with Braaten and her colleagues, the woman continued to return for treatment with the Harm Reduction Sisters, a partner program that provides safer injection and smoking supplies, Narcan, and nonmedical HIV case management to people in northern Minnesota.

"She went to see the Harm Reduction Sisters weekly and had them support her in dressing her own wounds," Braaten said. Eventually, her wounds, "improved quite a bit."

This turn of events is exactly what Braaten was hoping for when she applied for the MMA Foundation microgrant. "It was a way of meeting a community with a concrete need as well as building opportunities to connect and have conversations," she says. With a little bit of effort and a relatively small amount of money, Braaten and her colleagues saw positive change for a community that continues to struggle. "When things look bad," she says, "it helps to feel like you're doing something."

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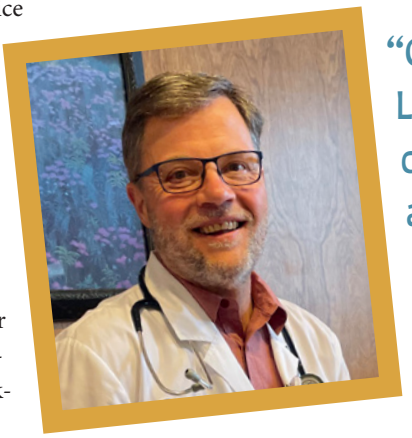
A community's focus on 'dying well'

TIM EBEL, MD

Since he was a child, Tim Ebel, MD, has had a deeper understanding of death than many people.

"At a very early age, the veil was lifted for me," he says. "My oldest brother was killed in a car accident when I was about 6 years old. I was given a dose of empathy." As his clinical practice developed, Ebel realized that he wanted to focus his professional life on helping other people find their way to a good death. "I decided that I'm in a position to make the effort and spend the time to partner with people who have serious illnesses or are making their final journey," he says.



To help people in their end-of-life journeys, Ebel, a hospitalist and medical director of Quiet Oaks Hospice House outside of St. Cloud, created the Trajectory and Legacy Project Initiative, a community program designed to improve resident health by normalizing discussions around end-of-life care and death.

The project developed a number of programs, including hosting a "Death Café," where St. Cloud residents gathered to talk about end-of-life decision-making; conducting a series of interviews with healthcare workers about their experiences with end-of-life care; supporting an "end-of-life" simulation lab for nursing students at the College of St. Benedict and St. John's University and supporting a resident physician medical precepting program at Quiet Oaks Hospice House.

"Our mission for the Trajectory and Legacy Project is to help the people of central Minnesota die well by becoming a guiding force to bring about a cultural change around end-of-life care, death, and dying," Ebel says. "It is an initiative designed to improve community health by providing education and working first and foremost to normalize discussions about end-of-life care and death for individuals and their families in our community."

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The term "normalization" is key to what the Trajectory and Legacy program is about, Ebel says. Too often people in Western cultures want to deny the reality of death, actively removing themselves from it and working against all hope to extend life. When that happens, Ebel believes, people miss out on the transformative beauty of a good death.

"We've turned death over to the professionals," Ebel says. "I would like to see something like the Lamaze movement of the '70s where we take death back like we took back childbirth."

In 2023, the MMA Foundation supported the Trajectory and Legacy Project with an $8,000 grant. Ebel says he's particularly pleased with the project's comprehensive approach to shifting community attitudes around death: "We need to model and teach our next generation that this is how we treat our ill and dying. We are honoring their humanity."

Modeling new ways of approaching death and dying extends even to Ebel's family. Recently, his 95-year-old mother fell gravely ill. Some of Ebel's siblings struggled to get on board with the idea that their ailing matriarch was ready for hospice care. "It was an interesting experience for me," Ebel says.

Some days later, Ebel's mother died. At the graveside, he asked the funeral director to lower the casket into the ground and allow mourners to throw dirt into the grave. This request came as a surprise, Ebel recalls, but after some hesitation, many joined in the ritual. It was a profoundly moving experience, he says.

"It took seven minutes to lower the casket into the ground. There was this prolonged period of silence. If I were to use a word to describe the silence I would say it was 'liturgical.' It was a crisp, still silence. I thought, Wow! This is what death is all about: Ashes to ashes, to dust you shall return."

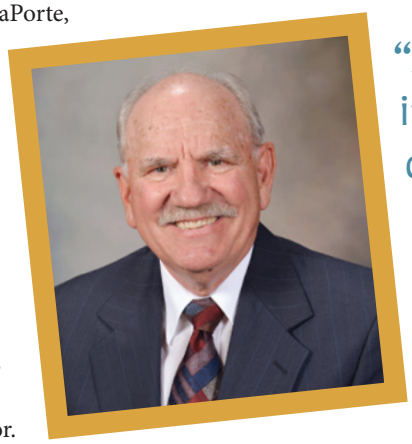
Supporting rural births

VINCE LAPORTE, MD

Vince LaPorte, MD, teaches an ALSO course to medical professionals with limited opportunities to attend to childbirth. "I tell every class I teach, Pay attention! If you do this work the way we teach you, you will save lives."

Since he moved to Marshall to practice family medicine in 1976, Vince LaPorte, MD, has been an outspoken advocate for rural physicians and the communities they serve. In his 30-year career practicing family medicine in the southwestern Minnesota town, LaPorte has learned firsthand what medical providers need to serve their patients and improve the lives of their neighbors.

One important way to serve a community is to offer high-quality obstetrics care, an essential service that fewer rural hospitals and physicians now feel qualified to provide. Many years ago, LaPorte, who has delivered more babies than he can count, attended an Advanced Life Support in Obstetrics (ALSO) course at the University of Minnesota.



LaPorte found the course, which teaches medical professionals how to efficiently handle obstetric emergencies, so essential that he signed up to become an ALSO instructor. Since then he's been teaching the course to physicians and nurses in Greater Minnesota hospitals with a low birth census. The skills taught in the ALSO course are key for healthcare providers who attend fewer births but need to be prepared for all situations, LaPorte says, calling it a "fire drill" on obstetric emergences: "I tell every class I teach, Pay attention! If you do this work the way we teach you, you will save lives."

For the last two years, the MMA Foundation has provided year-over-year grants totaling $7,000 to support LaPorte's work through MediSota, a rural nonprofit healthcare consortium. These grants helped train 78 rural clinicians in ALSO and funded the purchase of specialized mannequins needed to more effectively teach the course.

LaPorte knows more than anyone just how important having these kinds of training opportunities can be for a rural physician. When he was a young doctor, opportunities for knowledge building were rare, and he recalls having to take matters into his own hands.

"I didn't get enough training," LaPorte says. "The opportunities weren't always there." But he was eager to expand his skills and he kept an eye out for opportunities: "I even went to Sioux Falls for two weeks on my own vacation time to learn how to do ultrasounds."

While LaPorte is now retired from his medical practice, his approach to life is far from retiring. While other physicians may feel adrift in their post-career years, casting around for meaningful projects to occupy their time, he's doubled down on significant goals. And he doesn't plan on slowing down anytime soon.

"As I get to the end of my career, it's important to me that I've done everything I can to make healthcare safer and more effective for everyone in my community," LaPorte says. "So, every time I have a chance to reach others, I take advantage of the opportunity to create skills and build momentum to get things done." MM

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Andy Steiner is a Twin Cities freelance writer and editor.

Finding common ground—is that still a thing?

Newly elected to Congress, MMA member Kelly Morrison will soon find if it's possible to reach across the aisle.

PHOTO BY RICH RYAN

Kelly Morrison, MD

MMA member and former state senator Kelly Morrison, MD, won her bid to represent Minnesota's 3rd Congressional District. Morrison, an OB-GYN, has been active in politics for the past five years. She is the first physician elected to Congress to represent Minnesota since Rep. Walter Judd in 1942.

Morrison served in the Minnesota Legislature since 2019—two terms in the Minnesota House before being elected to the State Senate in 2022. She announced her candidacy for Congress in November 2023 and resigned her Senate seat last summer.

Most recently in the 2024 legislative session, Morrison authored legislation severely limiting the use of prior authorization. In her time, she has also championed other MMA priorities, including legislation increasing access to reproductive healthcare; supporting physician mental health and well-being; and ensuring reimbursement for telehealth services.

Morrison spoke with *Minnesota Medicine* about her initial plans in Congress. The interview has been edited for clarity and brevity.

First, congratulations. And second, you picked a tough time to be a Democrat, after a convincing win by Republicans for the presidency and a Republican majority in the House. Any thoughts about what will be in store for you and other Democratic representatives?

I think that it's important first of all to understand that while Donald Trump did win the presidential election and Republicans won majorities in the Senate and the House, they are very narrow majorities, and he won the presidency by less than 1.5% of the popular vote. So we remain a pretty divided country in many ways, in spite of the Republican trifecta.

I'm a lifelong Democrat, but I grew up in a Republican family who valued independent thought and debate. So I know that, number one, good ideas can come from both sides of the aisle, and number two, that Republicans are good people. I'm related to many who I love and respect, and you just come back again and again to the truth that we have more in common than we don't. And at this moment where we are apparently so divided by politics, we've got to find the issues that bring us together and focus on those.

That's been one of my missions in the state Legislature, and that will continue to be one of my missions in Congress, even from my position in the minority. I think that Speaker Mike Johnson will have such a tight governing majority that they're going to have to work with Democrats to get legislation passed. I came back from two weeks of new member orientation, and I'm working hard to meet my fellow

Republican freshmen as well as my new Democratic colleagues to figure out the things that we have in common and areas that we can work on together. And I'm certain there are many of those.

To what extent will your occupation as a physician inform your service in Congress?

Well, it certainly has informed my service in the state Legislature, and I think my professional background was one of the big reasons that I ran for office in the first place. I'm sure it will continue to. I ran in the wake of Trump's first election. I was really concerned about the divisiveness. As an OB-GYN, I was concerned about the implications for reproductive healthcare across the country and in Minnesota, but I'd also been worried for years about the creeping skepticism about science and expertise in our culture and in our politics. So, I think I ran really primarily for three reasons. One, because I love Minnesota and its people. I'm a little bit of a Minnesota chauvinist, and I wanted to work to protect what's wonderful about it and work to improve in the areas where we fall short. I really wanted to work to try to heal our divides, to be a bridge-builder and a consensus-builder. Of course, as a physician I wanted to be a voice for science and evidence-based policymaking. And those three values continue to animate me, and I will certainly bring that ethic to Congress.

It was a surprise how similar campaigning felt like to doctoring to me. The act of door knocking, for example, where you go to someone's door, knock on the door, they answer, you introduce yourself, and then you basically listen, you listen to what's on people's minds, you listen to what's bothering them, what's hurting them, and then you trade ideas and come up with a treatment plan or potential solution. So there's surprising overlap, and I do think that there are ways in which our training as physicians is really useful in the political arena. We don't tend to be flamethrowers. We tend to be listeners. We tend to gather information and try to make decisions based on the best available information, and we tend to stay calm in crises.

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So there are ways in which our training, I think, prepares us well for this arena, in ways that may surprise some people.

As long as you bring up the subject, how do we improve public perception of science, reduce skepticism, and improve public perception of public health institutions in particular?

That is a huge challenge before us. And one of the challenges that public health always faces is that when it's done well, we're not very aware of it. If it's done poorly, or we have a crisis, then it comes into the spotlight. So I think that it's going to have to be an endeavor that we come at from several different perspectives. One is we've got to find a way to combat the myths and disinformation that continues to flood social media and our fragmented media, where we're not all being delivered the same information and facts. It's hard to have a conversation where we all come at it starting with very different information.

And I think that we need good public storytellers who are trusted voices. We're going to have to use social media and meet people where they are. We're going to have to invest in public health campaigns. I have real concerns about some of the proposed nominees that President-elect Trump has put forth in terms of our public health organizations and Department of Health and Human Services. We've got a big task before us, because the next pandemic will come. We have all kinds of different public health challenges. You know, our declining vaccination rates, the effects of environmental insults and climate change on public health is something that people don't always put together. And I think increasingly we're going to have to explain that to the public and help them prepare and adapt. We've got big challenges in front of us. There's no question. But what isn't going to work is calling people names, talking down to people, and disrespecting people. People want to be heard and people want to be respected, and we've got to meet people where they are.

You mentioned the alarm over some of Trump's nominations for health positions. I'm thinking especially of Robert F. Kennedy Jr. to head the Department of Health and Human Services. I think you have mentioned that not only did you have some concerns, but also perhaps saw an opportunity for constructive change there. So could you talk about that—on the one hand, the concerns, on the other hand, what you might see as opportunities for improvements?

Well, I do have concerns about putting people in charge of big organizations that have no experience running large organizations. That's a gamble. Doesn't mean that they're going to fail, but it is a gamble. That is a particular skill set. You know, in the case of Robert Kennedy, he has, in my view, earned money and even I'd use the word grifted off misinformation and has sown a lot of distrust of our public health institutions, has introduced a lot of doubt and fear into parents about vaccinations for their children, and that's really dangerous.

On the flip side, he has a lot of people's ears, and if he is willing to engage con-

structively with public health experts and is willing to have his mind changed about some things, there would be a huge opportunity for him to reach a lot of people who trust him and believe in him. You know, it's a little bit of the celebrity culture that we're living in, of who can be the purveyors of facts and information that help people make good choices to keep themselves and their families safe.

What do you think the chances are for significant overhaul or additions to our medical system, such as a public option addition to the Affordable Care Act? And the reason I ask is I get the sense, especially given what's been in the news the last couple of days [the murder of Brian Thompson, chief executive of UnitedHealthcare], that there's a lot of frustration and anger on the part of doctors, patients, pretty much everyone except insurance companies.

Yeah. I mean, the events of the last couple of days are really horrifying. Violence is never the solution to a problem, and my heart breaks for Brian Thompson and his family. I think there is a real acknowledgement among many, if not most, Americans that the American healthcare system is broken. It's not working for most people. It's not working for most doctors, certainly, but most importantly, I think that the frustration and the medical debt and the unnecessary pain and suffering and death that is happening in our system is pushing people to a place where they're really going to start to demand change.

I think that one interesting development, and I think we saw some of this in these elections, is this is not a partisan issue. There is widespread frustration among American people regardless of their political affiliation about the way our system is failing people. And so I think there's this growing acknowledgement that we need to move towards some kind of a universal system. How we get there is the challenge and the conundrum. But there are real solutions out there. We just need to start taking steps toward trying some things. And there are a lot of different things. You mentioned strengthening the Affordable Care Act. People have talked about lowering the age of Medicare, a public option Medicare buy-in. I mean, these are things that we can try that could create some competition to make it more accessible and affordable and also to get better outcomes, which is ultimately what we all want. We're spending an absurd amount of money, and some people are becoming kind of unimaginably wealthy on the backs of Americans' health. And I think most of us don't think that's right.

It's very exciting that Sen. Amy Klobuchar was intimately involved in the reform to allow Medicare to negotiate that list of 10 drugs. That will save our healthcare system and individual Americans a lot of money. We need to continue to expand that list.

What are some of the medical issues that you are most excited about working on in Congress?

I worked a lot in the prescription drug space in the Legislature and passed the bipartisan Drug Price Transparency Act with Sen. Julie Rosen, a Republican who has since retired, that established and empowers the Prescription Drug Affordability Board to set upper payment limits on certain high-priced drugs. I was involved in helping create the Alex Smith insulin emergency fund. So I think we've kind of exhausted most of what is possible on the state level.

I would love to continue to engage in that area on the federal level, because that's where real change can be made. It's very exciting that Sen. Amy Klobuchar was intimately involved in the reform to allow Medicare to negotiate that list of 10 drugs. That will save our healthcare system and individual Americans a lot of money. We need to continue to expand that list.

I also was involved in reforming the prior authorization process here in Minnesota, and there's big opportunity on the federal level. The numbers are becoming more publicized than they used to be—the high denial rate and then the use of AI to deny treatment and medications for patients is pretty upsetting. One of the reforms that we passed in Minnesota was to ensure that prior authorization denials were made only by a physician with some background in the area for which the treatment or the medication was being prescribed—that we don't have someone with no medical training making a denial based on some checklist that's in front of them. We need to have someone who has expertise in the area, who understands the nuance of why a treatment or a medication might be being prescribed. Prior authorization is obviously a big headache for providers, but it also denies, delays, and then sometimes prevents people from getting the care that they need. So there's opportunity at the federal level there.

Prior authorization is obviously a big headache for providers, but it also denies, delays, and then sometimes prevents people from getting the care that they need. So there's opportunity at the federal level there.

Of course, my passion is maternal and child health, and we have a worsening maternal morbidity and mortality crisis in the country, made worse by the Dobbs decision. I helped lead the effort to protect and expand access to abortion care and other reproductive healthcare here in Minnesota. I was hoping to be part of that

effort at the federal level. That's obviously not going to happen in the next four years. But as the only prochoice OB-GYN in Congress, I have a unique voice in standing against any attempt to restrict women's access to healthcare, and I certainly am prepared to use that voice. But we need to make sure that we are supporting our maternal morbidity and mortality review committees across the country. There have been some disturbing reports in Georgia and Idaho and in Texas, I believe, too, of just shutting them down and not studying maternal deaths. And that's really problematic, particularly in the wake of the Dobbs decision in those states that have banned access to abortion care. We need to understand what the impact of that is if we're going to be able to make the best-informed policy that helps people to live healthy lives and have safe and healthy pregnancies.

You had mentioned Medicare. Low payment rates by Medicare and Medicaid threaten the viability of many physicians' clinics.

They sure do.

Will Congress be able to address that?

I hope so. I think that, again, is going to cost money, but the system right now is just not keeping up, and it's going to lead to some physicians' stopping taking Medicare and doing only out-of-pocket kind of care. And that, of course, leads to just caring for wealthier patients, which will just increase the disparities that we already have. So we've got to make sure that Medicare is viable. We've got to make sure that *Medicaid* is viable too. I'm really concerned about the Department of Government Efficiency and where they're going to find the trillions of dollars in savings. I'm concerned about Medicaid and that conversation, because America's children, we don't invest in them nearly to the degree that we invest in older people, and obviously they are our future. So we need to make sure that they have access to the care that they need so that they can live up to their potential and live their best lives.

As the only prochoice OB-GYN in Congress, I have a unique voice in standing against any attempt to restrict women's access to healthcare, and I certainly am prepared to use that voice.

You know, one last thing that I thought of is telehealth, which I worked on with MMA's help to enshrine the pandemic changes, so that we could continue using telehealth, including audio only. [Audio only was extended until July 1.] There was concern that that could worsen disparities. And so part of our compromise was to have a study of the impacts, and the impacts were published in the *Star Tribune* not that long ago, and it had the impact that we hoped and thought that it would, that it in fact decreased disparities. It increased access for people where there just aren't many options for getting to the doctor, and particularly the mental health space, whether it's an urban or a rural desert. To be able to use audio only is another option that was particularly helpful to people who don't have shelter, for example, and veterans who really wanted privacy. We found that they were much more likely to seek care when they could have privacy of either a telehealth visit or an audio-only visit to address some of their mental health challenges. There's still an opportunity to enshrine those changes at the federal level so that we can continue to offer that care to patients.

Explain to me: This has to be reauthorized in order to receive coverage for telehealth visits?

We did in Minnesota, but at the federal level, it is pending. There's a sunset, if we don't reauthorize it.

I wanted to ask one last thing, because I'm always baffled by how people pull this off. How do you manage to be both a physician and a representative? That's a tough, tough chore.

It is, it is. And, you know, I stopped operating and taking call when I got into politics. I think that would have been really challenging. So I was just in the clinic. But I've been on a leave since I started to run for Congress. We're in conversations to figure out if and how I can continue to practice. It obviously would have to be on a very part-time basis if I did, but with all of the travel back and forth, it may be challenging.

But I just finished my CME, so I'm still board certified! MM

Interview by Greg Breining, editor of *Minnesota Medicine*.

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PHOTO BY RICH RYAN

Medicaid payment increase tops MMA list for legislative session

The MMA's advocacy team will have its work cut out for itself during the upcoming legislative session. In an environment of tightening purse strings, the MMA will be advocating for several high-priced improvements in medicine.

In November, the MMA Board of Trustees approved five legislative priorities for the upcoming legislative session.

1 **Increasing Medical Assistance** (MA), Minnesota's Medicaid program, and MinnesotaCare payments leads the list. Currently, MA reimburses at a rate of between 60 and 70% of Medicare, and only 30% of commercial payers. The MMA is proposing a way to maximize federal matching funds to pay for this increase through an assessment on managed care organizations. If the plan receives federal approval, it will limit the cost to the state's general fund.

2 A second priority is **prohibiting formulary changes during a contract year** by health plans and pharmacy benefit managers. Patients often choose their insurance based on whether a plan covers their medications. Unexpected changes in a drug formulary can not only increase out-of-pocket costs but also compromise patient health if the changes keep a patient from accessing their medications. The proposal also requires payers to use a real-time benefit tool that informs prescribers what is covered and what is not. Similar to the MA payment increases, this legislative priority will have a large price tag.

3 The third priority involves **funding the POLST** (Provider Orders for Life-Sustaining Treat-

ment) registry that was recommended by the Minnesota Department of Health. This recommendation followed legislation promoted by the MMA two years ago directing a study of the issue. Proposed legislation would develop the education needed to begin the phased-in implementation of the registry.

4 The fourth priority is focused on the continued effort to **address physician wellness**. In addition to removing administrative burdens that lead to burnout, the MMA will pursue funding for the Breaking Barriers in Health-Seeking campaign started through a health department grant. This campaign is designed to reduce stigma related to seeking care and make it easier for physicians to get help when they need it.

5 The fifth priority is **continuing coverage for audio-only telehealth services**. When the telehealth law first passed, the Legislature put a sunset on audio-only coverage to ensure it was meeting the needs of patients. That sunset is currently scheduled for June 30, 2025. A recent state study shows that telehealth, including audio-only services, has been a useful tool for both patients and providers across Minnesota.

"We certainly have our work cut out for us," says Dave Renner, the MMA's director of advocacy. "These are all important priorities, but they all come with a price tag. Whether legislators will be willing to find funding sources for these topics remains to be seen."

The MMA advocacy team will also keep an eye on these other topics during the session: private equity in healthcare; scope of practice; reinsurance; the public option; licensure for International Medical Graduates; and physician-aid-in-dying.

The Legislature convenes January 14. MM

PHOTO BY RICH RYAN

Physicians' Day at the Capitol set for February 19

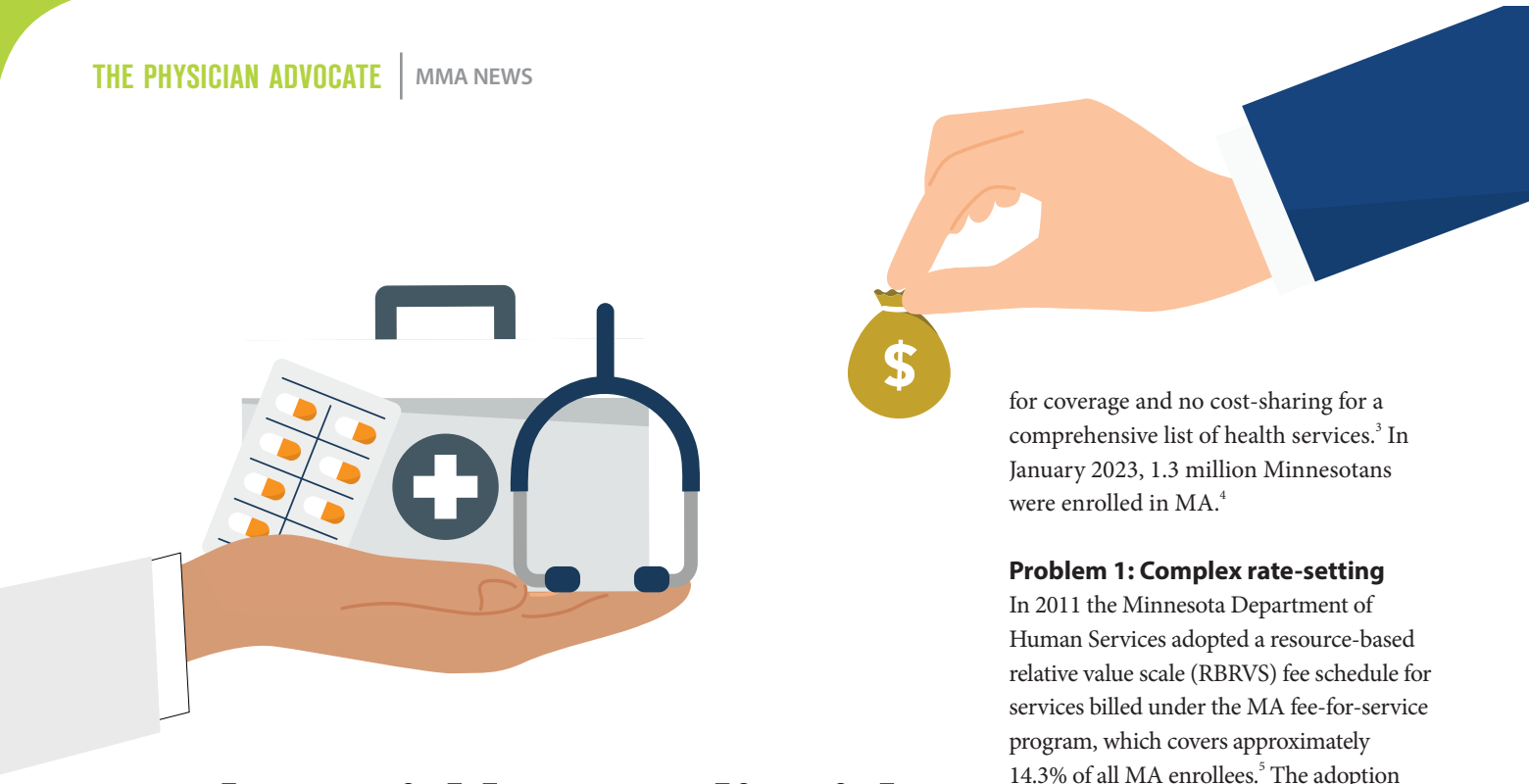
PHYSICIANS' DAY AT THE CAPITOL

Physicians and physicians-in-training from across the state will gather again at the state Capitol February 19 to advocate on behalf of medicine.

The annual get-together will include a presentation from a key lawmaker and most importantly, scheduled meetings with your individual legislators.

"This is organized medicine's chance to really make a difference at the Capitol," says MMA President Edwin Bogonko, MD, MBA. "Physicians need to meet with representatives and senators to make sure they understand how the legislation they are considering will affect our patients and how we practice medicine in Minnesota."

The MMA is partnering with several specialty societies to promote the event. For more information and to register visit: www.mnmed.org/2025PDAC.



Underpaid by Medicaid

MMA is fighting for increased Medical Assistance (Medicaid) payment for outpatient physician services. Here's why.

BY ADRIAN UPHOFF, MPH, MPP

Through a Minnesota Legislature–commissioned study, the Minnesota Department of Human Services has concluded what physicians have known for far too long—Medical Assistance (MA) payments need to be increased because they are too low to cover the costs of care and preserve access.

Specifically, the study, conducted by Burns & Associates and released in a two-part series, concluded that the current MA rate-setting methodology for outpatient physician services is inappropriately complex and yields rates that are unacceptably low.[1] The study recommended that the Legislature simplify the methodology and increase rates to Medicare levels. The MMA agrees and has made the passage of Burns' recommendations a top legislative priority in 2025.

"Medical Assistance is a crucial program that ensures low-income Minnesotans get the healthcare they need," said MMA President Edwin Bogonko. "Outpatient physician payments have been underfunded for nearly a quarter century and it is time the Legislature raise these rates. Our patients deserve that."

Any proposal to increase payment rates, however, will come with a significant price tag, which the Minnesota Legislature may not be eager to pay. Yet, the state's longstanding failure to invest in Medicaid payment rates threatens to undermine access to care and the financial viability of many medical practices. Stakeholders have floated various financing options, each with their own purported winners and losers. The MMA has favored a tax on managed-care organizations (MCOs) that would generate enough federal match funds to pay the MCOs back through higher MA rates. While other states such as California and West Virginia have successfully implemented MCO taxes, the taxes are not without controversy.

MA: Minnesota's Medicaid program

MA is Minnesota's version of Medicaid, a joint federal-state program that provides health insurance to low-income individuals.

To be eligible for MA, individuals must meet income requirements that vary by age, pregnancy status, and family size.[2] People enrolled in MA pay no premium for coverage and no cost-sharing for a comprehensive list of health services.[3] In January 2023, 1.3 million Minnesotans were enrolled in MA.[4]

Problem 1: Complex rate-setting

In 2011 the Minnesota Department of Human Services adopted a resource-based relative value scale (RBRVS) fee schedule for services billed under the MA fee-for-service program, which covers approximately 14.3% of all MA enrollees.[5] The adoption of RBRVS by Human Services moved Minnesota away from an archaic payment methodology based on historic payments and, instead, to one more aligned with methodologies used by most other payers.

Under RBRVS, every healthcare service is assigned a Common Procedural Terminology (CPT) billing code, and each CPT code is assigned relative value units (RVUs) that indicate how labor- and capital-intensive the service is relative to others. CPT codes and their respective RVUs are standardized across all payers who use RBRVS. What varies are the conversion factors (i.e., dollar multipliers) that payers apply to RVUs to calculate the dollar amount paid to physicians.

Unlike Medicare, which uses a single conversion factor ($33.29 in 2024), the Minnesota MA fee schedule uses three conversion factors—$25.40 for obstetrical and gynecological services, $27.50 for mental health services, and $24.79 for all other service codes.

The complexity does not end there. Since 2011, the Minnesota Legislature has passed dozens of adjustments to the fee schedule based on specific services and provider types that do not apply uniformly across CPT codes or categories.

Burns criticizes this complexity: "The overall effect of these rate adjustments makes it virtually impossible for providers to know what payment they should receive for the services that they have rendered."[6]

To correct for this complexity, Burns makes two recommendations to the Legislature. First, adopt a single conversion factor. Second, remove the dozens of adjustments passed since 2011 that do not apply uniformly across all CPT codes.

To be clear, these recommendations are limited to MA fee-for-service. Approximately 85.7% of MA enrollees are covered by MA managed care, referred to as the Prepaid Medical Assistance Program.[7] Enrollees in the prepaid program are assigned to one of nine managed-care organizations that manage MA benefits. Under the program, the Department of Human Services pays MCOs a flat per-member-per-month fee to the MCO for every MA enrollee assigned to them. The MCO is then responsible for paying for all of the enrollees' covered healthcare services during the coverage period.

Minnesota has historically preferred the Prepaid Medical Assistance Program model with its flat per-member-per-month payments for at least two reasons. First, per-member-per-month payments are more predictable than variable fee-for-service payments. This facilitates state budgeting. Second, per-member-per-month payments may incentivize MCOs to improve the health of their MA enrollees. Healthier patients need fewer healthcare services and thus cost less to MCOs to cover. The difference between per-member-per-month revenue and enrollee health service expenditures translates to net revenue or net loss for MCOs.

Most MCOs reimburse physicians on a fee-for-service basis using the RBRVS payment methodology. Unfortunately, there is very little transparency on payment levels used by MCOs for their Prepaid Medical Assistance Program plans.

Burns does not discuss the current Prepaid Medical Assistance Program rate-setting methodology or offer recommendations on how to simplify it.

Problem 2: Low rates

MA pays significantly lower rates for outpatient physician services than Medicare and commercial payers.

"Medical Assistance is a crucial program that ensures low-income Minnesotans get the healthcare they need. Outpatient physician payments have been underfunded for nearly a quarter century and it is time the Legislature raise these rates. Our patients deserve that."

EDWIN BOGONKO, MD, MBA
MMA PRESIDENT

Using publicly available data for 2021, for example, MA fee-for-service paid physicians an average of $90 for a 25-minute office visit with an established patient. That was 70% of the average Medicare payment and 33% of the average commercial payment. Across all services that are not categorized as OB/GYN or mental health services, the average MA fee-for-service payment ranged from 65% to 74% of the average Medicare payment and 29% to 33% of the average commercial payment.

Comparative rates look different for OB/GYN and mental health services. For example, in 2021 MA fee-for-service paid physicians an average of $20 for a pap smear. That was 100% of the average Medicare payment and 80% of the average commercial payment. The MMA does not have comparative data for other OB/GYN codes. In 2021 MA fee-for-service paid physicians an average of $145 for a psychiatric diagnostic evaluation. That was 82% of the average Medicare payment and 60% of the average commercial payment. The MMA has comparative data for only one other mental health code: a 45-minute psychotherapy session. For that code, MA fee-for-service paid physicians an average of $86, which was 84% of the average Medicare payment and 51% of the average commercial payment.

In sum, MA fee-for-service pays physicians about 70 cents on the dollar compared to Medicare and about 30 cents on the dollar compared to commercial health plans for most outpatient services. Payments for certain OB/GYN and mental health services pay closer to 100% of Medicare rates, because of the service-specific edits adopted by the Legislature over the years. Compared to the payment levels of other states' Medicaid fee-for-service programs, Minnesota's ranks 30th.[8]

Burns recommends a single MA fee-for-service conversion factor that applies to all CPT codes, set at 100% of the Medicare conversion factor to address both the lack of transparency and the low rates in the current system. If the recommendation is adopted, MA fee-for-service would become the fifth-highest paying Medicaid fee-for-service program in the country.[8] The MMA agrees with this recommendation. The rate increase is reasonable and would provide much-needed relief to physicians who care for patients on MA fee-for-service.

Burns does not discuss if and how payments under the Prepaid Medical Assistance Program should be adjusted. According to the best available data, MA fee-for-service pays professionals approximately 90% of what the Prepaid Medical Assistance Program pays for outpatient services.

Low MA payments have imposed a greater financial burden on physicians over time as a greater share of their patients have become covered by MA. Between 2011 and 2024, the percentage of Minnesotans on MA has doubled from 12% to 24%.[9]

Paying for the solutions

Burns' recommendations come at a cost. The Department of Human Services estimates that it would cost between $120 million and $175 million per year to increase payments for outpatient professional services to Medicare levels. Given budget constraints and competing bills vying for limited funds, future legislation will have a better chance of passing if it includes a new revenue stream to finance MA payment reform.

The MMA is developing an alternative funding mechanism for MA payment reform that does not rely on the Health Care Access Fund (that is, provider tax revenue) or the unpredictability of general fund dollars. One promising option is a managed-care assessment similar to one passed by other states.[9] Under such a financing approach, the state imposes two taxes on each MCO—one fixed dollar tax per Medicaid enrollee, and one fixed dollar tax per commercial enrollee.

When the state uses the MCO tax revenue to pay for increased Medicaid payments, the federal government provides matching funds. Effectively, the MCOs recoup all or most of their MCO tax burden for Medicaid enrollees through higher Medicaid managed-care payments, and the state recoups its expenditures on increased Medicaid managed-care payments through federal matching funds. To comply with federal rules on Medicaid match funds, the MCO tax must be designed in a way that does not allow MCOs to entirely recoup their tax burden on commercial enrollment. The MMA is committed to minimizing that margin as much as federal rules allow.

To preserve access to care for patients served by MA, the MMA Board of Trustees has authorized staff to develop this financing proposal for consideration by the Legislature in 2025. Physicians concerned about MA payment rates are urged to contact their legislators in support of reform. MM

Adrian Uphoff, MPH, MPP, is the MMA health policy analyst.

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A lost voice

After the Wright County Medical Society recently closed, Minnesota's county medical societies are down to two

BY SUZY FRISCH

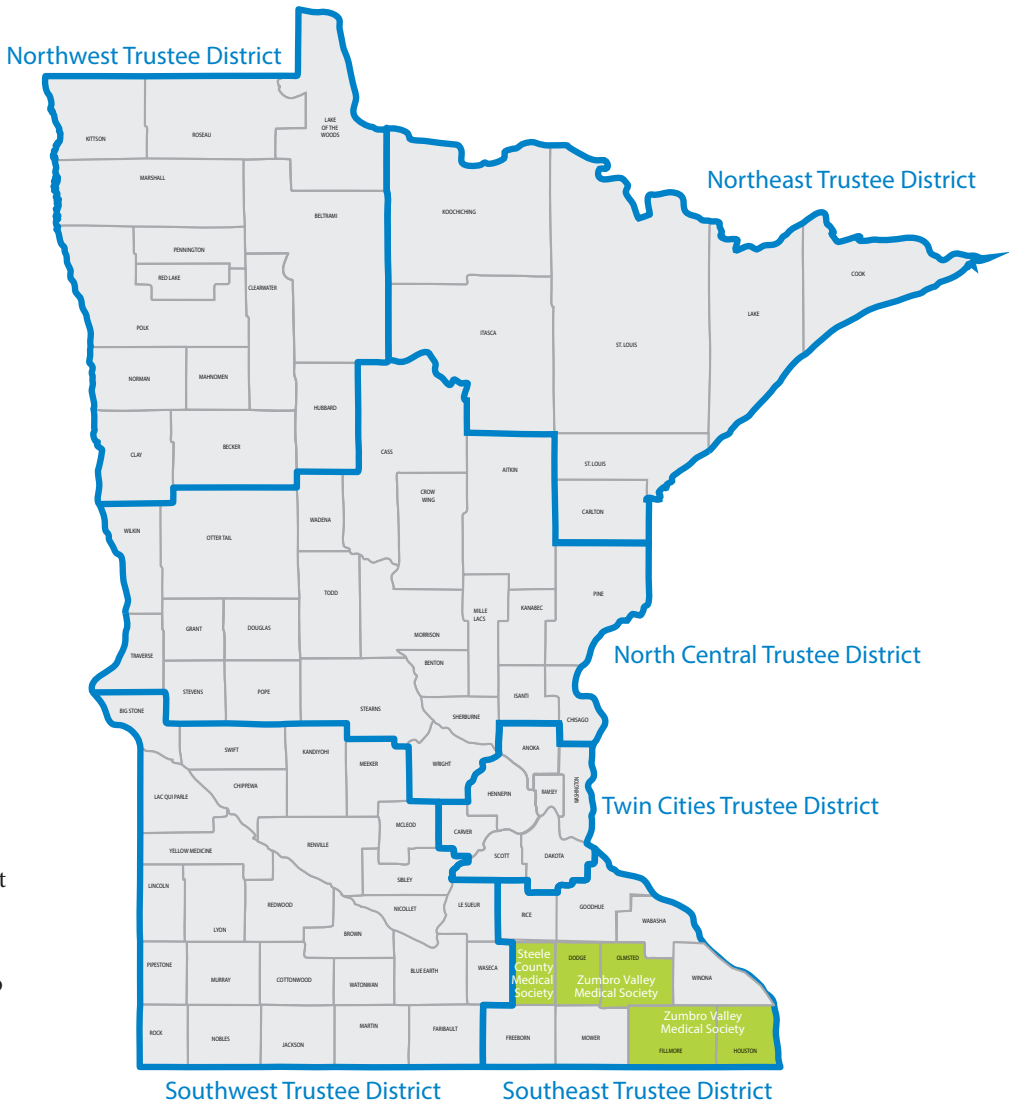
From the earliest days of his career as a family medicine physician, Robert Milligan, MD, got involved in county and statewide medical societies. It helped him learn the ropes as a rural physician, meet fellow doctors from across Minnesota, and gain a voice with lawmakers on issues that mattered to him and his peers and patients.

Milligan began his career and medical society involvement in Marshall in the early 1980s, and he continued participating three years later when he moved to Buffalo. He immediately joined the Wright County Medical Society and the Minnesota Medical Association, enabling Milligan to build a network of practitioners to call for consultations.

The MMA used to have more than 30 component medical societies across the state, including the ones Milligan joined in Yellow Medicine and Wright counties. Now with the closing in Wright County, just two are left: the Steele County and Zumbro Valley medical societies.

Participation was robust in Wright County for years, primarily because the Buffalo Clinic funded its physicians' memberships. When the society held meetings, more than two dozen doctors would attend. The gatherings provided opportunities for physicians to build camaraderie while discussing the state's healthcare landscape and current issues in medicine, Milligan says.

He and many others championed various changes throughout the years to legislators. Often, area lawmakers would attend Wright County meetings and hear from physicians about their top concerns. And then Milligan and others also would attend the MMA's annual House of Delegates meeting to share issues Wright County physicians faced.



Milligan stayed engaged throughout his career, often serving as president of the Wright County Medical Society or treasurer-secretary. "The primary things were those friendships. I could go and talk to any physician in town, whether from our clinic or a competing clinic," Milligan says. That might mean covering for a doctor living in a rural area during bad weather or calling another physician to dissect a case. "It was those kinds of friendships that the county society fostered. It was partly personal and partly professional, and we got to know each other and what our skills were."

When a rare genetic nerve disease prompted Milligan to retire, he still stayed involved with the MMA and the Wright County Medical Society. Others' participation dwindled over the years, especially as the Buffalo Clinic, now known as Stellis Health, stopped funding memberships.

Milligan is sad to see the county-based medical society gone, knowing how much it benefited him as a physician and community member. "I learned skills from talking to other physicians, and I got to have a voice from talking with our local legislators," he says. "I got a lot out of those relationships." MM

News Briefs

MMA challenges policies reducing same-day services pay

In a letter sent late in October, the MMA requested that Blue Cross Blue Shield of Minnesota (BCBS MN) reconsider three of its publicly posted reimbursement policies that reduce physician payment for same-day services.

Specifically, BCBS MN reduces payment for evaluation and management (E/M) services by 20% to 50%, depending on product line (commercial, Medicaid, Medicare), when appended with modifier 25. The Common Procedural Terminology (CPT®) coding guidelines require that providers append modifier 25 to an E/M service to "indicate that a patient's condition required a significant, separately identifiable E/M service above and beyond that associated with another procedure or service by the same physician… on the same date."

The MMA's request follows a lengthy dialogue between the MMA and BCBS MN on the policies. The two first met in November 2023 after several MMA members flagged the policies. At that meeting, the chief medical officer at BCBS MN shared his belief that other Minnesota health plans had similar policies, and thus BCBS MN was within community standards. The MMA tabled the conversation to corroborate BCBS MN's claim.

Since then, MMA staff have concluded that, based on publicly available information confirmed by health plan representatives, BCBS MN is the only health plan with modifier 25 payment reduction policies that apply in all cases that a modifier 25 is used. Three health plans have no modifier 25 payment reduction policies whatsoever. Three other health plans have modifier 25 payment reduction policies that apply only when the E/M service is billed with a same-day preventive service (that is, CPT codes 99381-99387, 99391-99397).

At a follow-up meeting on October 28, 2024, BCBS MN acknowledged the MMA's findings but argued that, since same-day services afford physicians overhead- and pre/post-op synergies, the cost to provide care is less, and thus reimbursement should be less.

The MMA agreed that there are synergies and overhead efficiencies generated when services are provided at the time of a patient visit. However, the MMA noted that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) regularly screens all CPT codes that are billed with E/M codes more than 50% of the time and then reduces the relative value units (RVUs) of those codes to prevent duplicate valuation of practice expenses and pre-/post-visit physician work. Therefore, the policies of BCBS MN to further, and arbitrarily, reduce payment for these services is inappropriate and redundant.

"The rationale provided by Blue Cross Blue Shield for their payment reduction policy does not hold up to scrutiny," said MMA President Edwin Bogonko, MD, MBA. "The policy is harmful to physicians and duplicates reductions that have already been accounted for by the RUC."

The MMA will update its members on the response from BCBS MN.

MMA workshop explores racism in medicine

In November, the MMA hosted a 90-minute virtual workshop Reckoning with Racism in Medicine.

There is an increasing need to promote anti-racism in medicine in Minnesota. Discrimination in the workplace is associated with negative implications relating to career advancement and satisfaction, physical and mental health, well-being, and burnout. Efforts to create inclusive and equitable environments must acknowledge the harmful effects of racism, microaggressions, and implicit bias.

The interactive workshop featured video stories from physicians of color about their experiences studying and practicing medicine in Minnesota. The workshop was created to inspire understanding, compassion, and the motivation to work toward an anti-racist culture of medicine in Minnesota.

MMA launches online resource for exploring healthcare careers

The MMA has launched a new website to support the healthcare career aspirations of students from across the state.

The website (www.HealthcareCareersMN.org) includes information about pathway programs and other resources that provide mentorship, training, exposure, and inspiration to students interested in healthcare careers in Minnesota. The website is geared toward elementary, middle school, and high school students in the state as well as their families and guardians, school guidance counselors, and STEM teachers.

"We want this website to become a trusted, dynamic, and go-to resource to support elementary, middle, and high school students interested in pursuing careers in healthcare," says Verna Thornton, MD, co-chair of the MMA's Barriers to Workforce Diversification in Physician Education, Training, and Licensing Task Force, which was created in 2021 to develop recommendations to reduce or eliminate the policies, practices, and structures in medical education, residency training, and licensure that perpetuate racism or otherwise limit Minnesota physician workforce diversification.

"Students, parents, guardians, school guidance counselors, and teachers can all use this online resource to see what's out there in terms of training, internships, mentorships for aspiring physicians, nurses, and other healthcare fields," says Kacey Justesen, MD, the other cochair of the MMA's Barriers to Workforce Diversification in Physician Education, Training, and Licensing Task Force.

The website was developed and launched with partial funding from UCare.

Task force on harm reduction meets

The Task Force on Holistic and Effective Responses to Illicit Drug Use met for the first time in late September. The group is tasked with reviewing and analyzing data on approaches to addressing illicit drug use in Minnesota.

At the meeting, Kurt DeVine, MD, and Ryan Kelly, MD, who are serving as the MMA's representatives, were selected to serve as cochairs of the task force.

The task force was formed following legislation passed in 2024. The Office of Addiction and Recovery was directed to administer the task force. By February 15 the task force must submit a report on its recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over public safety, health, and human services. MM

FROM THE CEO

Advocating for you at the Capitol

The 2025 legislative session begins January 14, and the MMA is prepared to advance its strategic goals with five specific legislative priorities.

This session we are focusing on the following:

- Limiting formulary changes by health plans and pharmacy benefit managers during a patient's insurance contract year;
- Preserving audio-only telehealth coverage and parity, which is currently set to sunset June 30, 2025;
- Normalizing care-seeking by physicians and other health professionals with a public education campaign;
- Seeking implementation funding for an electronic POLST registry; and
- Increasing Medical Assistance (MA) and MinnesotaCare payment rates.

The Legislature's failure—for more than 20 years—to invest in adequate MA and MinnesotaCare payment rates is a serious challenge for many medical groups. Although Minnesota has invested in expanding MA and MinnesotaCare eligibility, the state has largely ignored the need to ensure that those delivering care—physicians and other healthcare professionals—are fairly compensated to care for more and more public program enrollees. A recent study commissioned by the Legislature agreed and called for an increase in physician MA and MinnesotaCare payment rates to Medicare levels (see the essay "Underpaid by Medicaid" for additional background).

With a 67-67 tie in the Minnesota House of Representatives, the political dynamics of the Legislature are certain to be a challenge, especially when it comes to budget negotiations. Although specific costs are pending, it will likely take more than $150 million in new state spending to achieve Medicare-equivalent increases in MA and MinnesotaCare payment rates. Unfortunately, the commissioned study failed to identify a financing mechanism and, as such, it is unclear if there is any legislative interest in following through on the recommendations.

The MMA Board of Trustees, however, is not content to wait. Instead, the board has agreed that it is up to the MMA to put a proposal on the legislative table that addresses the unsustainable payment rates. The MMA has retained an expert in Medicaid financing to help it develop both an innovative and feasible financing proposal. Specifically, the MMA will propose an assessment on managed care organizations based on their enrollment, with higher rates applied to MA and MinnesotaCare enrollees relative to commercial enrollees. The assessment revenue can then be matched with federal funds and returned to health plans via higher capitation rates that, in turn, will be used for higher physician payment rates.

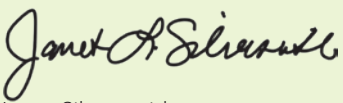
This type of financing proposal has been successfully adopted by California and West Virginia. Both successfully obtained waiver approval for their assessments from the Centers for Medicare and Medicaid Services (CMS). Minnesota has used financing mechanisms similar to this for more targeted aims, such as graduate medical education.

As is true with any new financing plan, this proposal will face scrutiny both at the Legislature and by CMS. The MMA is working with local health plans to address potential concerns and is optimistic that the use of the financial mechanism by both red and blue states will make its support by CMS that much more likely.

Another financing option the Legislature might consider is the Health Care Access Fund, which is largely financed by the provider tax. The MMA does not support increasing the current provider tax for this purpose, particularly given the Legislature's historic tendency to raid the fund for nonhealthcare purposes.

The Board of Trustees recognizes the importance of adequate MA and MinnesotaCare payment rates for physician groups. Thanks to the MMA's investment in putting a proposal out for legislative consideration, physicians have a greater chance of seeing real progress than they have in decades.

You can show your support for this proposal by attending the February 19 Physicians' Day at the Capitol. We look forward to seeing you there! MM



Janet Silversmith
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VIEWPOINT

We are committed to health equity

Kimberly Tjaden, MD
MMA board chair

Shortly after Election Day, the MMA sent out an email encouraging its members to attend an AMA-organized webinar to discuss insights into how to challenge harmful narratives regarding health equity and reshape how we think about health.

This is standard practice. We market events like this, on topics we've identified as priorities, quite regularly.

The following morning, we received an email from a member who wrote that the MMA, by promoting this webinar, was "buying a ticket on the DEI train engineered/driven by the Woke." The email went on to suggest that the American people had spoken on November 5 and implied that the MMA should abandon its health equity efforts.

It's not the first time we received this type of feedback. Earlier this year, after we marketed a webinar on racism in medicine, we received an email from a nonmember informing us that there is "no racism in medicine, and please do not invent this [sic] divisive topics."

Although these are only two voices out there, it does reinforce what we strongly believe—health equity is an issue in Minnesota that needs to be addressed.

Minnesota is a very healthy state. However, there are large disparities in healthcare and health outcomes in marginalized communities. This must continue to be studied and solutions advanced in order to make all Minnesotans healthy.

The MMA is committed to advancing health equity and confronting systemic racism. In pursuit of our mission to make Minnesota the healthiest state and best place to practice, this commitment is strategically embedded in our organization, with "improved health equity" as a key outcome in our strategic map. Our work to improve health equity is based off three primary areas of focus:

1. Diversifying the physician workforce,
2. Addressing social drivers of health, and
3. Changing the culture of medicine.

That said, we will continue facilitating live conversations for physicians and physicians-in-training to discuss topics that relate to inclusion in healthcare. We will continue to hold dialogues on topics such as anti-racism, implicit bias, and microaggressions, cultural humility, racism in medicine, and allyship. We will continue to offer live training and private workshops that allow participants to examine implicit bias in healthcare settings, understand how it contributes to health disparities, and learn practical strategies for mitigating the effects. We will continue to convene health equity leaders and professionals quarterly to exchange expertise, network with their peers, and discuss issues and priorities. We will continue to offer intercultural development resources to members who have diversity, inclusion, and health equity goals. We will continue to support our members from marginalized communities, including our LGBTQ section, making sure their voices are heard and their well-being is protected.

We will continue to be champions of health equity in medicine in this state. Changes in political leadership will not change our commitment.

We want the MMA to represent all voices in medicine in Minnesota. And, yes, that also includes those voices who may not agree with our leadership's direction. We want all Minnesotans to have the opportunity to live a healthy life. MM

We will continue to support our members from marginalized communities, including our LGBTQ section, making sure their voice is heard, and their well-being is protected.

We will continue to be champions of health equity in medicine in this state. Changes in political leadership will not change our commitment.

CLARA ZAMORANO, MD

Clara Zamorano, MD, is an intensivist at Abbott Northwestern Hospital, where she has practiced critical care medicine since 2011. Her patients are critically ill adults with a variety of conditions including multiorgan failure, sepsis, respiratory failure, heart failure, stroke, or intracranial hemorrhage. She is boarded in internal medicine, critical care medicine, and neurocritical care. She is the system intensivist medical director and system inpatient sepsis medical director for Allina Health. She has been an MMA member since 2005.

Clara Zamorano with son Sebastian, daughter Melania, and husband Colin Monette.

Where did you grow up, do your undergraduate and grad work, medical degree?

Clara Zamorano with daughter Melania and son Sebastian.

I was born in Mexico City, but moved to Columbia Heights, Minn., when I was 7. We arrived in the middle of winter, and I still remember the shock of seeing snow for the first time! I went to Carleton College in Northfield, where I was a biology major, graduating magna cum laude in 2000. Bill Clinton was the speaker at graduation. I went to Medical School at the University of Minnesota and then completed Internal Medicine residency at Hennepin County Medical Center. I did an extra year as chief resident, and then stayed at HCMC for another two years to complete a critical care fellowship.

Tell us about your family.

I am the second of four siblings. My father is a retired engineer from Mexico City and my mother is a retired Chinese medicine practitioner of German and Irish heritage. My sisters work in the legal field and my brother is also an engineer. I live in Minneapolis with my husband, who is a musician. We have two lovely children in elementary school.

Hobbies or side gigs?

I have many hobbies. I have enjoyed wheel-throwing pottery since my high school days. I continued pottery throughout college and even medical school and now take part in community ed classes at a local park. I also play soccer in a women's league and take inspiration from my teammates who continue to play soccer into their 50s. Women can remain active as we age!

My other favorite hobby is working in my vegetable garden, particularly growing root vegetables. I have won six blue ribbons at the Minnesota State Fair for my carrots.

Why did you decide to become a physician?

I have wanted to be a doctor ever since I can remember. My cousin was a female neurosurgeon in Mexico and always had exciting and interesting stories of her experiences. That exposure made me want to follow in her footsteps. As an adult, I became aware of what a feat it was for her to be one of the few female neurosurgeons in Mexico during the early 1980s. I have been in awe of her strength of will ever since. I thought I would become a surgeon like her, but my path led me to critical care medicine. I found throughout my training that I had the ability to stay calm in the midst of chaos and thus was suited for the ICU.

What was the greatest lesson of your medical education?

That our impact on patients can be extremely powerful, both in positive ways and in negative ways.

What's the greatest challenge facing medicine today?

One of the challenges facing medicine today relates to the barriers to care created by our complex insurance system, including prior authorization, medication shortages, and need for referrals. So many patients are unable to receive needed care because they cannot navigate the system and wind up sicker and in the ICU.

How do you keep life balanced?

I am still trying to figure this out! One thing that has helped me is scheduling time for the things I love doing that feed my soul and committing to not letting work or other things interfere with that scheduled time.

If you weren't a physician—?

If I was not a physician, I would be a potter. If not a potter, I would run a cheese shop! MM

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