Capitol Update
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2008 Legislature Adjourns Sunday May 18
The Legislature and Governor reached agreement on the final budget bills just in time to complete their work and go home at 11:48 p.m. on Sunday May 18 just prior to the midnight deadline. They are scheduled to return January 6, 2009.

From all accounts the MAO had a very good session, considering what could have been: despite facing a state budget deficit of $935 million and early versions of health care reform that many believed were reminiscent of failed efforts of the passed.

A quick review of Academy priorities shows success in many areas. We defeated efforts to add prior authorization for additional services for public program enrollees (including stopping legislative language to adopt non-coverage for portions of the Oregon priority list), successfully avoided scope of practice issues, and helped defeat efforts that could have negatively impacted surgery centers including a proposal to establish a technology assessment as part of health care reform. Although health care reform does not include medical liability reform, it makes significant progress to address access, cost and quality issues. It is also notable that increases in access are not all attributed to public coverage; rather many will be in private coverage through tax credits and HSAs.

Much of the credit for our success this year is owed to those otlaryngologists that are developing relationships with legislators and getting involved in the process.

Global Budget Deal Reached
After on-again and off-again negotiating sessions throughout Saturday night, the Governor and legislative leaders reached an agreement on how to address the projected budget shortfall.

Negotiations were intertwined with the discussions on balancing the state budget, property tax relief, K-12 funding and health care reform. An agreement in each of these areas was reached throughout the night with the Tax Conference Committee meeting at 4 a.m. Sunday to announce their agreement and the Supplemental Budget Conference Committee meeting at 5 a.m. to make their announcement.

The overall agreement to address the $935 million shortfall includes $355 million in spending cuts, $109 million in tax revenues from changing a loophole for foreign operating corporations, accounting shifts raising $30 million, and $500 million from the state's $653 million in budget reserve funds. The budget packet also includes a 3.9% property tax cap for three years (something very important to the Governor) and $60 million in local government aid and $25 million in direct property tax refunds (something very important to the DFL Legislature). The property tax issue was one of the major hold-ups in reaching a deal. Finally, several bonding projects were part of the deal including the Central Corridor light rail project, improvements to the Minnesota Veterans Home and the new Lake Vermilion State Park.

The health and human services budget received the largest cut – a $229 million reduction during the next year and a half. Higher education took a $21 million hit. K-12 education received a one-time increase of $51 in per

pupil funding for a total of $43 million and nursing homes received a cost-of-living increase for direct care workers. Here is a summary of the key provisions of the health and human services budget changes:

- *Health Care Access Fund (HCAF)*—The bill includes a one-time transfer of $50 million from the HCAF to the General Fund on June 30, 2009. This transfer will be repaid using the projected savings accrued in the state health care programs as a result of cost saving measures in the Health Reform bill. Once the savings are projected to reach $50 million, that amount will be transferred from the General Fund back to the HCAF. This "loan" from the HCAF is significantly better than the earlier recommendations to transfer $250 million from the HCAF and a proposal to use an ongoing $48 million each year to offset other General Fund spending on health care programs.

- *Interpreter Services Quality Initiative*—The bill establishes a voluntary roster and requires the development of a plan for a registry and certification process for health care interpreter services. It does not address the issue of how interpreter services should be paid, but it does start the process of ensuring minimum quality standards for interpreter services.

- *Hospital Reductions*—The bill delays the scheduled hospital inpatient rebasing by 24 months beginning Jan. 1, 2009. This saves the state $9.7 million in FY 09 and $73.4 million in FY10-11. It reduces inpatient hospital rates, affecting fee-for-service care for Medical Assistance (MA) and General Assistance Medical Care (GAMC), by 3.46% in FY 2009. In FY2010, the cut drops to 1.9 percent. In FY2011, the rate cut will change again to 1.79 percent and will permanently remain at that level. This saves the state $8.3 million in FY 09 and $16.7 million in FY 10-11. In addition, the bill proposes a permanent 3-percent rate reduction for outpatient MA and GAMC fee-for-service care, starting in fiscal year 2009. The final bill does not include provision that would have eliminated disproportionate share payments for hospitals as was proposed in earlier versions of the bill.

- *HMOs*—The bill increases managed care withholds used by the Department of Human Services from 5% to 8%. This saves the state $13.6 million FY08-09 and $43.4 million FY10-11. It also reduces the administrative costs for health plans that participate in MA, GAMC, and MinnesotaCare to 7% of their premiums. This saves the state $2.9 million in FY08-09 and $16 million in FY10-11. It does not include provisions from earlier versions to assess $50 million from health plan reserves.

- Also notable is those things once proposed to help balance the budget but not included in the final agreement including a 3 percent cut to state program enrollee outpatient physician services, new prior authorization requirements for services and procedures based on Oregon's priority list, and a $5 licensing fee increase for all professional licenses.

Health Care Reform

Late Saturday night an agreement was announced on health care reform that was acceptable to the Governor and the Legislature. The bill begins to change payment systems to reward physicians for care coordination for those with chronic and complex conditions through the promotion of the health care home model. It rewards the provision of quality care through the development of pay for performance methodology that is valid, transparent, and standardized. It funds statewide health improvement grants to fight tobacco use and obesity.

It is estimated that the bill will expand coverage for 12,000 Minnesotans—7,000 will receive coverage under public programs and 5,000 through new incentives for private coverage. It includes a provision to require the Commissioner of Health to convene a work group to make recommendations on the design of an essential benefit set that includes coverage for a broad range of services and technologies that are to be determined to be clinically and cost effective by January 2010.

Article 1: Public Health

- The bill provides $47 million in FY10-11 for competitive grants to community health boards to reduce obesity and the use of tobacco. It requires a local match of 10% to receive a grant and it requires the Commissioner of Health to report on a sustainable funding source for the future for these grants other than the HCAF.

- The grants must be based on scientific and community input and occur in community, school, worksite and health care settings.

Article 2: Health Care Homes/ Workforce Shortage

- The bill defines "personal clinician" as a physician, advanced practice nurse (APN), physician assistant (PA), or "other health care provider as determined by the commissioner of health."
- The commissioners of Health and Human Services shall develop and implement standards for certification on health care homes by July 1, 2009. The focus initially must be on patients with chronic conditions. The standards must emphasize primary care.
- A personal clinician or a primary care clinic may be certified as a health care home. If a clinic is certified, all of the primary care clinicians in the clinic must meet the criteria of a health care home.
- If initial savings from the health care home do not accrue, then the Commissioner of Human Services "may make recommendations to the legislature on reallocating costs within the health care system."
- The health care home model must be evaluated three and five years after implementation to determine if it is meeting the expected goals.
- The bill directs the care coordination fees paid as part of the health care home to vary based on the complexity of the care provided.
- The Commissioner of Health is directed to study changes needed in health professional licensing to ensure full utilization of APNs, PAs, and other professionals in the health care home and primary delivery system.

Article 3: Increasing Access: Continuity of Care

- The bill provides seamless coverage between MA and MinnesotaCare for children. A child whose family income rises above the MA limits may remain eligible for MA for two additional months and is deemed automatically eligible for MinnesotaCare until renewal.
- It raises the income cap for parents who are eligible for MinnesotaCare from $50,000 to $57,500.
- It increases eligibility for adults without kids from 215% to 250% FPL.
- It allows enrollees who fail to submit renewal forms to remain eligible for an additional month.
- It requires the Department of Human Services to use data from the free and reduced school lunch program for the purposes of identifying children eligible for medical assistance.
- It increases an incentive program for organizations who assist those enrolling in public programs from $20-$25 per enrollee.
- It includes a report on automation and coordination for state health care programs.

Article 4: Health Insurance Purchasing and Affordability Reform

- The bill includes standards for interoperable electronic health records and electronic prescribing.
- It Includes payment reform to provide financial incentives for providers to reduce health care cost, improve quality and provide more transparency in price. Reforms include standardized quality incentives, care coordination incentives, and a peer grouping system that arrays providers based on cost of care and quality of care.
- It directs the Commissioner of Health to establish definitions for baskets of care for at least seven baskets. It specifically directs the commissioner to consider developing baskets for coronary artery and heart disease, diabetes, asthma, and depression. If a providers chooses to bill for these baskets of care then that provider is required to use a single price for all private payers for these baskets.
- It requires employers with 11 or more employees to establish Section 125 Plans unless the employer acts to opt-out of this requirement. These 125 Plans are designed so employees may purchase individual or employer-based health coverage with pretax dollars. It provides grants for companies to establish 125 Plans.

- The bill also includes a new tax credit of up to 20% of the premium cost to help individuals purchase coverage through the private market.
- It establishes a work group to make recommendations on the design of an essential benefit set that includes coverage for a broad range of services and technologies that are to be determined to be clinically and cost effective with a report to the Legislature by January 2010.
- It creates a Health Care Reform Review Council, consisting of 14 members, of which the MMA names two physicians. This council is to periodically review the progress of implementation of the reforms in this bill.
- It requires the Commissioner of Health to make recommendations on a "community benefit standard" to be required of nonprofit health plans.
- It requires the Commissioner of Health to develop a plan for a health care affordability program for families with incomes of 300% FPG.

Graduated Drivers License

Although not an MAO legislative priority, the legislature adopted changes for teenage drivers designed to address the fact the Minnesota has the highest rate of teen driving deaths in the country. They strengthened the "Graduated Drivers License." Under the bill that passed, teenagers are limited from driving between 12 midnight and 5 a.m unless for work or school functions for the first six months after they obtain their license. They are also limited from having more than one other, non-family member in the vehicle. For the second six months they can have no more than three other non-family members in the vehicle. In the 47 other states that have similar laws, they have seen a reduction in teen accidents. The bill is on the Governor's desk waiting for a signature.

Two other driver and passenger safety provisions did not pass, updating the child restraint laws (booster seats) and primary seatbelt. Legislation passed the Senate but not the House to require children up to age nine to use booster seats when riding in a motor vehicle, consistent with the recommendations of the National Highway Traffic Safety Administration. There were also efforts once again to change our seat belt law to make it a primary offense to not wear a seat belt. This provision passed the Senate and nearly passed the House.

Retiring Legislators

Following another contentious session 12 House members announced their retirement. Eight are Republicans and four are Democrats. One of those retiring is running for Congress (Rep. Paulsen). Since the Senate is not up for election this year, there were no Senators making any retirement announcements. Here are the 12 retiring members.

- Rep. John Berns (R-Wayzata)
- Rep. Chris DeLaForest (R-Andover)
- Rep. Brad Finstad (R-Comfrey)
- Rep. Bud Heidgerken (R-Freeport)
- Rep. Scott Kranz (DFL – Blaine)
- Rep. Frank Moe (DFL – Bemidji)
- Rep. Aaron Peterson (DFL – Appleton)
- Rep. Dennis Ozment (R-Long Prairie)
- Rep. Erik Paulsen (R-Eden Prairie)
- Rep. Connie Ruth (R-Owatonna)
- Rep. Kathy Tingelstad (R-Andover)
- Rep. Neva Walker (DFL-Minneapolis)