



*Capitol Update*  
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### **A Short Break for Legislators to Gear-Up for Upcoming Deadlines**

Minnesota legislators took a break for Easter and Passover before coming back to face some difficult spending decisions. Lawmakers returned Tuesday and the pace picked up quickly as they faced a Thursday deadline for all finance bills to have made their rounds through the finance divisions. Internal deadlines give legislative finance committees less than a week after that to put the finishing touches on spending bills before sending them to the House and Senate floors for votes.

Tuesday April 7 was the second committee deadline for the Legislature. With the passage of this deadline bills must be through all non-tax and finance committees in order to be considered alive. Because of this, all policy committees are now done with their work for the year. Also, we now have a better idea what bills are alive and what bills are dead.

### **Now Starts the Budget Work**

Minnesota's Constitution requires the Legislature to adjourn no later than May 18. It is still unclear whether or not the Democrats, who control both the House and the Senate, and Republican Governor Tim Pawlenty can reach agreement on a new state budget. If not, the Governor would have to call a special session before the state budget expires on June 30.

With deadlines for policy committees behind us, the work on passing a balanced budget will now become the main focus of the Legislature. The most recent budget forecast projects a \$6.4 billion deficit for the next two year period. With the help of the federal stimulus money that shortfall has been reduced to \$4.6 billion. The Legislature is required to pass a balanced budget before they adjourn. This can be done through spending cuts, revenue increases, or most likely, a combination of both.

Governor Pawlenty continues to promote a budget that includes no new tax increases and large cuts to the health and human services programs. Because of strings that are attached to the federal stimulus money, he is no longer recommending eligibility cuts for Medical Assistance (MA) or MinnesotaCare. He is still recommending a 3 percent payment cut to all providers, elimination of most of the optional benefits for adults enrolled in MA, and elimination of the Health Care Access Fund. The Governor's recommendations total more than \$1 billion in cuts to the health and human services programs over the next two years.

The Senate Democrats have released an outline of their budget recommendations that includes a 7 percent across the board cut to all program areas (including K-12 education) and \$2 billion in new revenues. They argue that this is the fairest approach so that no one program takes the brunt of the cuts. The size of a 7 percent cut to the HHS area totals \$719 million in cuts. When stimulus money is added the 7 percent cut is offset to a 5.9 percent cut, totaling \$606 million in cuts.

The House Democrats most recently released their budget ideas. Their outline protects K-12 education from cuts, cuts health and human services programs between 4 and 15 percent, protects the Health Care Access Fund, shifts nearly \$1 billion into the next biennium, and recommends \$1.5 billion in new revenues. The targets for cuts to the HHS areas total \$489 million in cuts, or just less than 5 percent.

The task immediately before legislators is to begin passing omnibus budget bills out of committee. With cuts ranging from \$500 million to over \$1 billion needed, the challenges that face them are great.

Also of interest to physicians is that fact that both the House and the Senate are considering modifying the Governor's recommendation to cut MA physician payments by 3 percent. The Governor recommends cutting payments for all outpatient providers. Sen. Berglin and Rep. Huntley are recommending cutting every provider 3 percent except for office visits and preventive services provided by primary care providers. This is an acknowledgement that primary care physicians are under-reimbursed for their services.

Following is an update on the status of a number of policy bills.

### **Provider Tax Increase**

The House Tax Committee heard [HF2315](#) (Huntley) on Thursday which would increase the 2 percent provider tax to 3 percent. The MMA, Mayo Clinic, Minnesota Medical Group Managers Association, Psychologists and many others testified against the measure. The committee laid the measure over for inclusion in the tax bill. A similar bill was introduced later in the day in the Senate. SF2076 is authored by Senator Linda Berglin.

Legislators are looking to any and all potential sources of new revenue as they try to close the budget gap. The provider tax is appealing to them because a 1 percent increase in the provider tax would raise about \$250 million a year.

[Email](#) your legislators to let them know that raising the provider tax is a step in the wrong direction, since it will only increase health care costs further.

### **Safe Patient Handling**

[SF 594/HF921](#) (Higgins/Fritz) requires all clinics that have to physically move patients to have a plan in place by July 1, 2010, to minimize manual lifting of patients by January 1, 2012. The bill does not require clinics to purchase lifts, but it does require the plan to assess the risk to patients and employees and purchase appropriate equipment needed to reduce risks.

The Senate bill has passed the Senate floor and the bill passed out of the HHS policy committee and the Commerce Committee. To ensure that bill moves forward the language of the bill is now also included in HF 1760. The Department of Labor and Industry, which enforces OSHA laws, has raised concerns with the penalties in the bill. We have worked with the House author to limit these penalties and clarify that the plan does not require the purchase of expensive lifts.

### **Cost Savings Provisions**

This morning Senator Berlin added a number of additional provisions to bills for possible inclusion in her Omnibus spending bill. One provision requires prior authorization for diagnostic imaging by contracting with a private entity (perhaps ICSI) to incorporate a technology assessment process that is based on evidence-based medical guidelines. The provision excludes hospital emergency room, inpatient hospitalization, and urgent care visits. Patients enrolled in PMAP, Medicare, and MinnesotaCare are also excluded.

Another provision added for consideration would prohibit providers who are identified via peer grouping as low-quality, high-cost from participating as a provider for state health care programs. While the provision is intended to put some teeth into quality and cost measures adopted as part of

health care reform, some providers may actually see this as an opportunity to become exempted from serving public program patients.

The final provision added this morning of interest is another payment reform demonstration project implementing a value-based purchasing system for patients with two or more complex or chronic health conditions, including coronary artery and heart disease or diabetes. This appears similar to the baskets of care provisions passed into law last year.

### **Patient Centered Decision Making**

A bill to requiring patient-centered decision making as a condition of reimbursement remains alive in both the House and Senate. This bill (HF1140/[SF696](#)) requires an interaction or “coaching” for certain surgical procedures—or no payment would be made for the procedure. Rep. Huntley indicated that this bill is “a work in progress” and that he wants to get it to committee to get a fiscal note that shows savings. MMA and the Minnesota Hospital Association expressed questions regarding the details of the process and documentation necessary and Rep. Huntley indicated that he would work on all the concerns prior to including the provision in the finance bill.

The bill requires all patients to have “patient centered decision making” prior to getting reimbursed for any of the following procedures: abnormal uterine bleeding; benign prostate enlargement, chronic back pain; early stages of breast and prostate cancers; gastro esophageal reflux disease; hemorrhoids, spinal stenosis; TMJ, ulcerative colitis; urinary incontinence; uterine fibroids; or varicose veins for all government programs effective January 1, 2010. The list, with any additions, will be published in the State Register. This process involves direct interaction with the patient to assist the patient in arriving at an informed objective decision regarding the procedure, and may be conducted by a health care provider or through the electronic use of decision aids.

In an effort to expand the fiscal savings, the Senate finance committee added an amendment it to include more conditions, including: bypass surgery for coronary disease; angioplasty for stable coronary artery disease; or total hip replacement. The format for the certification would be developed by the Administrative Uniformity Committee, on which the MMA is a member.

### **Uniform Prior Authorization and Formulary Exemption**

This bill, initiated by St. Mary’s Duluth Clinic, requires the commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, to develop a uniform prior authorization and formulary exception form that allows health care providers to request exceptions from group purchaser formularies, including Part D plans, using a uniform form, within six weeks from the enactment date or July 1, 2009, whichever is later. Effective January 1, 2011, the uniform prior authorization and formulary exception form must be accessible by health care providers, and accepted and processed by group purchasers, electronically through a secure Internet site. Electronic transmissions from providers would be required by January 1, 2011.

The House also passed a similar version of this bill and is working with the Council on Health Plans to come up with a form that can be implemented this spring.

### **Scope of Practice Provisions in Omnibus Licensing Bill**

A number of health licensing bills met deadline. House bills are part of an omnibus licensing bill ([HF 535](#)) which includes mostly bills that are not controversial, except for certain dental provisions which remain contentious. Several of these bills are moving as separate bills in the Senate.

The advance practice nurse prescribing bill was not included in the House omnibus licensing bill as there has been no agreement with the advance practice nurses, MMA and the Minnesota Psychiatric Society. The bill did not meet deadline in either body and may be dead for the year.

### **False Claims Act**

[SF82](#) (Latz) and [HF8](#) (Simon) establish penalties for entities that make a false claim to the state for payment. Health care providers are already subject to federal false claims law that applies to Medicaid and Medicare, but this bill creates a new course of action here in the state with layered penalties and provisions that opponents say incentivize whistle blowing to such an extent that whistleblowers may not alert their organizations to correct the problem first. The Minnesota Medical Association, Minnesota Hospital Association and groups representing nursing homes have been very involved opposing the bill. They are particularly concerned that with the transition to electronic billing, a health care provider could be subject to millions in penalties (and legal expenses to defend themselves) for a mistakenly miscoded procedure or data point, even if the error is a few cents off, but repeated frequently due to electronic systems.

The bill met the House deadline and is included in the Senate State Government Finance Omnibus bill. The Senate version appears to have stalled but with its inclusion in the House omnibus bill, it may still be on track.

### **Mandatory Prescription Pads**

[SF1709/HF1947](#) (Ortman/Lesch) establishes a single, uniform, state approved, tamper-proof prescription pad for all prescribers from a single vendor for all prescriptions written in the state. While tamper-proof prescriptions are currently required for Medicaid and Medicare; this extends to the privately insured as well. A vendor for tamper-proof pads is advocating for passage of this bill and spoke to the need for additional security features in order to decrease drug diversion and theft of prescription pads.

The bill originally required the state to provide prescribing pads free of charge to providers but due to a fiscal note, the bill was amended to allow the Board of Pharmacy to charge prescribers for the state-mandated pads. While this bill met the policy deadlines in both bodies, it failed a vote to continue in Senate Health Finance committee and should be dead for the year. Legislators expressed concerns raised by the MMA about the increased cost of the new pads and how the bill would impact the e-prescribing mandate effective January 2011. The bill would have required prescribers to use the new pads June 2010, just six months before prescribers are required to transition to all electronic prescribing. The bill should be dead for the year.

### **Non-Payment for Hospital Acquired Infections**

[SF460/HF802](#) (Berglin) prohibits reimbursement for hospital acquired infections in an attempt to be consistent with new Medicare provisions. The bill, however, goes further prohibiting reimbursement for any cost of care related to certain events – including physician services. It is unclear whether a physician whose services did not cause the adverse event would be able to be reimbursed.

This provision is expected to be included in the Senate HHS Omnibus Finance bill as there are small savings projected. DHS however, has indicated there may be no way to determine which physician's services are related to the events.

### **Medical Records**

A bill to limit the amount that can be charged to patients and their attorneys for copying and printing medical records is no longer advancing. The bill, [SF857](#) (Olson, M., Brainerd) would have lowered the

cap on copying fees from just over \$1.00 per page (\$.75 adjusted for inflation) to \$.05 or the cost to copy the material – whichever was *less*.

The bill was heard in the Senate data Privacy Subcommittee and deleted after objections from hospitals and providers. The author and opponents reached an agreement that the issue related to the cost duplicating records should be examined over the interim particularly related to the user-friendliness of electronic medical records.

### **Get Engaged!**

Whether determining eligibility for state programs, prior authorization requirements, the provider tax, or countless other items, the actions of the legislature significantly impact your practice and ability to care for patients. It is critical, therefore, that you get involved for yourself and weigh in with legislators on topics that are important to you.

There are two ways we're making it easy for MAO members to get engaged.

**Capitol Rounds.** Imagine your own, personalized, Day at the Capitol. Capitol Rounds involves coming to the capitol yourself, either on your own or along with colleagues from your area. You can meet with a legislator in their office and see the capitol. Capitol Rounds only occur when the legislature is in session.

**In District Meetings.** Can't make it to the capitol? Meet with your legislator in your home community. Typically these are small group events in a coffee shop, at a restaurant, in your home or in a clinic office. Legislators love to meet their constituents. Legislators are in Saint Paul usually Monday through Thursday during the legislative session, however, so if you live outside the metro area these meetings are scheduled on a weekend. Once the legislature adjourns, legislators tend to have much more flexible availability.

Please contact myself at [snoznesky@mnmed.org](mailto:snoznesky@mnmed.org) or Dennis Gerhardstein at [dgerhardstein@mnmed.org](mailto:dgerhardstein@mnmed.org) and we will coordinate all the details!

### **Committee Schedules for This Week**

Check <http://www.leg.state.mn.us/leg/sched.asp> for the most up-to-date information.