



## Minnesota Academy of Otolaryngology

*Capitol Update*  
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The Legislature has moved into the final days before the constitutionally-required adjournment date Monday, May 18. Unfortunately, the Governor and legislative leaders have not yet reached agreement on budget items. In order to avoid a special session, a global agreement with the Governor would need to be reached by the end of this week to allow sufficient time to process bills and complete their work on time. While this seems unlikely right now, it is still entirely possible. Stay tuned.

### **First Omnibus HHS Bill Passes**

The biggest news this week is that the House and Senate completed work on their Health and Human Services Omnibus bill conference report early Sunday morning after a full week of work concluded with a 20-hour sprint to the finish.

This bill passed both bodies this afternoon but the Governor is expected to veto the bill immediately because the reductions are substantially than he proposed. Nevertheless, the contents of the bill are still important as this will become the base for the second bill.

Following is a summary of relevant provisions:

### **Article 4, Department of Health**

#### **Health Information Technology**

- Requires the uniform standards to be updated on an ongoing basis and an annual report to the legislature.
- Requires the electronic health record to be a “qualified electronic health record— makes other changes to conform with federal law.
- Authorizes the commissioner to collect certain data.
- Establishes a loan account.

#### **E-Prescribing**

- Requires “backward compatible” and NCPDP SCRIPT
- Requires the use of E-Prescribing by January 1, 2011.

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

Requires the Commissioner of Health in consultation with the Administrative Uniformity Committee at the Department of Health to develop, by July 1, 2009 or in six weeks from adoption of this section, a uniform prior authorization and formulary exception form. All group purchasers must accept this form (including part D) or by phone. An electronic system must be in place by January 1, 2011. Effective January 1, 2011, the uniform drug authorization must

be accessible by health care providers, and accepted and processed by group purchasers, electronically through a secure Internet site.

### **Medication Therapy Management**

Requires a Pharmacy Benefit Manager that provides prescription drug services must make available medication therapy management services for enrollees taking four or more prescriptions to treat or prevent two or more chronic conditions. Defines medication therapy management duties—including identifying drug interactions, communication essential information to the patient’s primary care providers and education the patient.

## **Article 5, Health Care**

### **Outreach Grants**

Adds outreach, targeting geographic areas with high rates of families with un-enrolled children and racial and ethnic minorities with health disparities.

### **School District Enrollment and MA Billing**

- Requires public and charter schools to comply with state health care program outreach requirements.
- Requires districts to have the applications available, maintains current law requirement that schools designate an enrollment specialist, and requires districts to have a link on their web site on how to obtain an application and enrollment assistance.
- Allows the commissioner to use an interim rate and then a settle up payment.
- Establishes an open enrollment process for MnCare that is tied to the public education system.
- Establishes a “fast lane” process that would blend MNCare and Free and Reduced lunch applications.

### **Urgent Dental Care Services**

- Authorizes pilots to reduce the total costs to the state dental services provided to persons through emergency rooms.
- Establishes a subcommittee to the health services policy committee to advise the commissioner on criteria for critical access, coverage, delivery models, and services to be added or eliminated. And study of critical access dental providers.
- Defines the services that will be eligible for dental coverage for non-pregnant adults.

### **Health Services Policy Committee**

Adds study of reimbursement based on patient-centered decision making, high cost specialty services where there is a high variation in utilization across physicians, and best practice policies to minimize C Sections including standards and guidelines for health care providers and health care facilities.

### **Non-Payment for Certain Hospital Acquired Conditions.**

Adopts non-payment language for the federal nonpayment for never events including hospital acquired infections and medical errors, however, adds additional conditions for non-payment for both hospitals and physicians.

**Early Hearing Detection**

Increases the newborn screening fee to provide funding for early hearing services to families identified through the universal newborn hearing screening.

**Payment Reform**

Requires the commissioner by January 1, 2011, to establish performance thresholds for providers included in the provider peer grouping system developed by MDH. Effective January 1, 2012, any provider with a combined cost and quality scores below the threshold shall be prohibited from enrolling as a vendor in state health care programs.

**Colorectal Screening**

Extends MA coverage to participants who have been screened by the demonstration project and who needs treatment. Allows State-only funded MA to be paid for individuals screened by the demonstration project. Adds an expiration date that coincides with a colorectal cancer prevention demo project—December 31, 2010.

**Anesthesiology Payment Limits**

Limits the reimbursement for anesthesiology services provided to physicians for the medical direction of CRNA's shall be the same as the rate paid to CRNA under medical direction.

**Pharmacy Rate**

Reduces the pharmacy rate from AWP minus 14% to AWP minus 15%. Adds PA's to list of eligible providers.

**Prior Authorization of Diagnostic Imaging**

Effective January 1, 2010, requires prior authorization for outpatient CT, MRI, MRA, PET, cardiac imaging and ultrasound diagnosis imaging. Exempts prior authorization for ER, inpatient hospitalization, or concurrent or on the same day as an urgent care facility visit. Allows DHS to contract with a private entity and must be based on evidence based medical literature. Exempts, Medicare and PMAP.

**Eligibility Increases**

Incorporates a number of eligibility increases for children under 275% of FPG, and also allows children and families to buy MnCare without restrictions under 200%.

**Asthma Demonstration Project**

Establishes a pilot with at maximum of 200 American Indian Children in first class cities to include HEPA filters, and other furniture, bedding and equipment to reduce toxins.

**Claims and Utilization Data**

Requires a report by December 15, 2009 to allow for the release of summary data on claims and utilization for Minnesota Government Programs to the U of M and Mayo and other institutions to conduct an analysis of health care outcomes and treatment effectiveness.

**Administration of Publicly Funded Healthcare.**

Requires DHS to study the alignment of services to families and children and report by September 15, 2010.

**COBRA Premium State Subsidy.**

Pays 35% of the COBRA until December 31, 2010 for people who elect COBRA and are eligible for state government programs.

**Pilot for Intensive Medication Program**

Requires the commissioner to establish a pilot project for an intensive medication program for patients with chronic conditions and a high number of medications.

**Managed Care Contracts**

Health plans objected to proposals to recapture monies in their reserves but legislators were unwilling to let them off the hook from experiencing cuts like other constituencies in the health care arena. This provision creates a new withhold for health plans and also extends the withhold to county based purchasing. Withhold is 3.5% from January 1, 2010 to December 31, 2010. Effective for January 1, 2011, through December 4%, for calendar year 2012 and 2013 withhold 4.5% and for 2014 goes back down to 3%.

**Specialty Provider Payment Ratable Reduction (MA, GAMC, MNCARE)**

Effective July 1, 2009, physician and professional services will have a 5% ratable reduction for fee for service, and January 1, 2010 for health plans (PMAP). Certain primary care outpatient services provided by primary care physicians are excluded from the cut (procedure codes 99201 to 99215 and codes 99381 to 99412). PT, OT, Chiropractic and other basic care services are reduced by 3% for FFS and for October 2, 2009 for PMAP.

**C-Section –Blended Rate**

Effective October 1, 2009, requires a single rate for the following DRG's 371, 372, and 373, consistent in the increase of vaginal deliveries and reduction in C-Sections, such that the reduction in C Sections is less than or equal to one standard deviation below the average in the frequency of cesarean births for Minnesota health plan program clients at hospitals performing greater than 50 deliveries per year. Also establishes blended rate for professional services. Eliminates prior authorization.