



Minnesota Academy of Otolaryngology

Capitol Update

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The result of the 2009 legislative session is highly unusual. The drama leading to the end did not disappoint even the most casual political watchers. Most years the legislature and Governor come to agreement on a global budget deal at the very last minute. Lobbyists and legislators were on standby nearly 24 hours a day the final weekend but following a failed attempt to override two of the Governor's vetoes, the political posturing on both sides resulted in no final budget agreement when all was said and done.

As a reminder, the February Forecast predicted a \$6.4 billion state budget deficit, offset by approximately \$1.8 billion in federal stimulus money for a net deficit of \$4.6 billion. Although legislators started working on a plan to close the gap early in session, details on the federal stimulus were slow to emerge and with the worsening economic situation, the budget became a moving target. With the end of session quickly approaching and the end of the Fiscal Year (June 30) also not long off, the flash point between legislative leaders and the Governor was whether to raise revenue in order to balance the budget as required by the state constitution.

Leading into the last few days of session, the Legislature had passed all their major spending bills to the Governor anticipating vetoes of the bills because no agreement had been reached on the tax bill. The Governor surprised everyone when he signed most of the bills into law including only a handful of line-item vetoes. DFL leaders were visibly flustered and had to scramble to determine their next move. Because the tax bill was not completed, there remained a nearly \$3 billion budget gap as well.

In the end the DFL was unable to put a package of cuts and new revenue together that the Governor would sign. The result is that the budget is not balanced as constitutionally required; therefore the Governor will "unallot" in order to balance the budget. This means the Governor may cancel state appropriations for programs, reduce payments further and even eliminate programs entirely in order to balance the budget until the legislature reconvenes in 2010. He has said he will not call them back into special session so there will not be an opportunity to restore any cuts he makes as part of the unallotment process until next session.

Health care overall did not fare well in the signed HHS budget bill or in anticipation of unallotment. Payments to hospitals, pharmacists, physicians and virtually all other health care providers were reduced in the omnibus finance bill signed by the Governor. Only primary care providers were spared cuts. Additionally, the Governor issued a line-item veto of 2011 funding for the General Assistance Medical Care (GAMC) program for low-income adults. In addition to the lives impacted by the cut, hospitals are reeling at the loss of reimbursement for services provided under this program.

Despite the potential devastating effects as a result of the lack of resolution on the budget, the MAO had relatively positive session. We successfully avoided any concerning scope of practice issues and successfully fought both increases in the provider tax and misuse of its revenue. Unfortunately the cut to reimbursement will be painful. The potential impact of eligibility and hospital cuts on surgery and clinics affiliated with hospitals could also be very difficult.

Eligibility Mostly Protected As a result of the strings attached to the federal stimulus funds, the signed HHS budget does not cut eligibility or benefits for children on state health care programs. The Governor did eliminate the General Assistance Medical Care (GAMC) in 2011 (approximately 30,000 lives) as a line-item veto. GAMC is a state-only funded program for single adults at the lowest income level.

Rate Cuts for Nearly All Providers As part of budget reductions, there will be a 5 percent reduction to reimbursement for specialty physician services provided to enrollees of state health care programs (MinnesotaCare, GAMC and Medical Assistance). All other health care providers were cut including hospitals, pharmacists, personal care attendants, nursing homes, rehabilitative services and chiropractors as part of reductions to help balance of the state budget.

In an attempt to recognize already-low payment for primary care, the cut does not apply to office or other outpatient visits billed by physicians, advanced practice nurses, physician assistants in the following primary care practices: general practice, general internal medicine, general pediatrics, geriatrics, family medicine and family planning.

They also passed a one-month delay in payment from June 2011 to July 2012 order to shift expenses from services from this biennium into the next.

No Provider Tax Increase As the budget situation looked more and more grim; there were rumblings of efforts to increase the provider tax despite an existing surplus in the Health Care Access Fund. Physician organizations including the MN-AAP expressed frustration over previous misuse of revenue from the provider tax and successfully opposed an increase in the tax on physician services.

Additionally, the Governor's proposal to eliminate the Health Care Access Fund and transfer all revenue to the General Fund was refused by the legislature. Maintaining a separate fund for the revenue raised by the provider tax remains critical to maintaining transparency over the use of these funds.

Quality Reporting Standardization Maintained Minnesota's health plans attempted a broad exemption from the pay for performance and quality reporting standards passed into law last year as part of health care reform. Last year's provision prohibits plans from requiring physicians to report on quality measures beyond a uniform, evidence-based set of measures. We defeated their attempt.

Health Plan Transparency Increased Additionally, an important provision passed into law will shed light onto the reimbursement practices of health plans administering public programs (called PMAP). Minnesota Health Plans have received 8 to 10 percent increases in payments each year in capitated payments to provide coverage to these populations but anecdotal evidence suggests those payments are not being passed along to providers. The Department of Human Services will be required to report information on the money trail.

Standardized, Electronic Prior Auth and Formulary Exception Forms A number of items passed this year to help simplify the paperwork in your clinic including developing a standardized form for prior auth and formulary exceptions to be used by the state and all health plans. This provision brought to Rep. Tom Huntley by physicians from SMDC requires the administrative uniformity committee to develop a standard form to be used by all health plans in order to save clinics valuable time and money.

Non-Payment for Adverse Events and Errors Public Programs will no longer reimburse physicians for services that caused a medical error or hospital-acquired infection which is reportable to the state. Medicare already prohibits payment for hospital services when there is such an event, but Medicare is silent on physician services. This provision, however, carried no fiscal savings because the Department of Human Services testified that they have no way to link physician services to hospital-based reportable events in their billing system.

CME Required on Use of X-Ray machines A last minute proposal was defeated that would have dictated topics for CME in statute. The Department of Health reported that x-ray errors were all together too common, so one legislator's solution was to propose all physicians have at least one hour of CME on x-ray use each day.

Only once before has a CME topic been specified in statute but the provision was repealed because it was ineffective at accomplishing its stated goal.

Patient-Centered Decision Making Mandate Fails Another provision once included in the HHS omnibus bill would have required patients to complete active participation in a patient-centered decision making process in order for a surgeon to be reimbursed for a number of procedures including abnormal uterine bleeding; benign prostate enlargement; chronic back pain; early stage of breast and prostate cancers; gastroesophageal reflux disease; hemorrhoids; spinal stenosis; temporomandibular joint dysfunction; ulcerative colitis; urinary incontinence; uterine fibroids; or varicose veins; and bypass surgery for coronary disease; angioplasty for stable coronary artery disease; or total hip replacement.

As a result of the concerns we raised, the language was amended to become a study. The DHS Health Services Advisory Committee will study patient-centered decision making and whether payment should be contingent upon participation. The committee must evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs and present their findings early next session. Depending on the findings of the committee, the issue may be back next year.

Standardized Tamper-Proof Rx Pads A company that prints tamper-proof prescription pads brought legislation to require all prescribers in Minnesota to use a single vendor for all prescription pads. The pitch was that uniformity and standard, sequential numbering of scripts would be an added safety precaution against theft of Rx pads. The bill as amended by legislators would have required prescribers to purchase these pads. Physicians raised concerns because the additional cost of the pads was not known. Further, the provision sent mixed messages to prescribers who will be required to prescribe electronically in 2011.

Imaging Prior Authorization The high cost of diagnostic imaging continues to raise eyebrows at the capitol. This session as legislators worked to find ways to save money on public health care program benefits they discussed prior authorization for diagnostic imaging for Fee for Service enrollees in Medical Assistance. Although we were not able to defeat the proposal entirely, the language was amended to allow the use of decision-making tools to satisfy the requirement, much in the same way providers are already required to use the tool by health plans in Minnesota. The provision applies to CT, MRI, MRA, PET, cardiac imaging and ultrasound diagnostic imaging and will not apply to diagnostic imaging services performed as part of a hospital emergency room visit, inpatient hospitalization, or if concurrent with or on the same day as an urgent care facility visit.

Physician Assistant Licensure and Supervision As a result of a new law, physician assistant regulation will change from “registration” to “licensure”. Additionally, physicians will now be allowed to supervise up to five PAs. Current law only allowed for supervision of two PAs by each physician. We did not oppose this change.