

**First Round of Budget Cuts Moves to Governor Before Passover/Easter Break
(HF 1671 / SF3223)**

The conference committee report for [HF 1671](#) passed both the Senate and House floors on Monday March 29, just prior to the Legislature beginning its Passover/Easter break. This bill is the first of three bills designed to close the state's \$994 million budget deficit. The bill includes net reductions in spending of \$313 million in FYs 2010-2011 and \$413 million in FYs 2012-2013. It is on its way to the Governor for his signature.

The supplemental budget bill includes reductions in agency budgets for higher education, economic development, natural resources, agriculture, veterans, public safety, energy, transportation and the legislative, judicial, and executive branches of government. It is round one of the House and Senate's budget strategy. The E-12 Education bill and Health and Human Services will be considered after the Passover/Easter Break which began Monday evening. Legislators will return for work on April 6th.

The HHS finance chairs are getting the details regarding what federal match might be available to soften the proposed cuts. The HHS target assumes that there will be at least \$408 million in extra federal matching funding for Medical Assistance (MA). With this additional federal money they will be expected to still cut and additional \$155 million.

At issue is whether the new money from the federal health care reform bill—that includes a provision for Minnesota to adopt immediate expansion of MA for adults without children earning up to 133% of federal poverty level—will and can be used to “fix” the GAMC bill that was just signed, and to what extent it can reduce other proposed reductions by the Governor. Recall that the Governor's budget proposed sharp reductions for physician payments, hospital payments, and Medical Education and Research (MERC) funding. The HHS budget bills are expected to be released to the public on Tuesday April 6th.

GAMC Signed By Governor ([Chapter 200](#))

The compromise bill for a stripped down GAMC bill passed both bodies and was signed by Governor Pawlenty on March 26th. On final passage, the bills had only 12 no votes in both the House and Senate. All of those no votes came from Democrats who believed that this bill left very little leverage for legislative leaders to negotiate a better bill with the Governor using the new federal match for this population included in the Health Care Reform Bill.

Highlights of the proposal include:

- It preserves GAMC in its current form until June 1 with provider payments cut by 63 percent.
- Beginning June 1 the program would operate through a “coordinated care delivery systems” (CCDS). The 17 hospitals representing about 70% GAMC caseload and providing geographic access would be eligible to be CCDS.
- The CCDS are required to coordinate and provide all necessary care for a set fee.
- Outpatient/physician services other than those provided by staff physicians of CCDS are not covered unless they contract with a CCDS.
- From June 1 to November 30, 2010, hospitals that are not a CCDS will share a \$20 million uncompensated care pool to pay for GAMC patients who need medical services. After November 30, 2010, services are available only through a CCDS.
- Beginning December 1, 2010, other hospitals may join but the pool of money is limited.
- Effective June 1, 2010, a prescription drug pool will reimburse pharmacies and other providers for prescription drugs. Prescription drug costs will continue to be covered outside of a CCDS will be required to pay in the aggregate 20% of the state’s appropriation for the prescription drug pool. Each CCDS assessment must be in proportion to the system’s share of total funding provided by the state for CCDS.
- It provides rapid Access to psychiatric consultation for low-income populations.
- It establishes a process to make recommendations on appropriate drugs and doses of ADD/ADHD and psychotropic medication for children and adolescents with the goal of reducing the use of medication. The commission will track utilization and other practices and beginning July 1, 2011, may require psychiatric consultations and prior authorization if a provider prescribes an atypical does or medication. Also provides some financial penalties.

BMP Adopts Lyme Position; Legislation Pulled ([SF 1631 / HF 2597](#))

Legislation to limit the Board of Medical Practice (BMP) authority to discipline physicians related to the treatment of Lyme disease has been pull from consideration by the authors because of action taken by the BMP at its March 13 Board meeting. At that meeting the BMP agreed to a voluntary moratorium on action related to the treatment of chronic Lyme disease, for a period of no more than 5 years. While this is not an ideal situation, this is a much better outcome than the passage of legislation that would have created a very bad precedent for the Legislature telling the BMP how to act.

The resolution adopted by the BMP follows:

1. Whereas: The science regarding the presumptive diagnosis “chronic Lyme disease” and the long term prescription and administration of antibiotic therapy for its treatment is unsettled.
2. Whereas: The Minnesota Board of Medical Practice has never investigated, disciplined, or taken any other action against any practitioner solely on that basis.

3. Whereas: The Minnesota Board of Medical Practice has never received any complaints solely on that basis.

4. Whereas: Patients, some physicians, and the public are seeking guidance on this issue.

Therefore, in the interest of allowing time for science to resolve this issue:

1. The Minnesota Board of Medical Practice voluntarily will engage in a moratorium for a time period not to exceed five years, or the time at which double-blind, peer reviewed studies have resolved the issues, whichever is first, on the investigation, disciplining, or issuance of Corrective Action Agreements based solely on long term prescription or administration of antibiotic therapy for “chronic Lyme disease,” except in the event of a complaint lodged by a patient or by a conservator, parent or guardian on the patient’s behalf for this specific use of antibiotic therapy.

2. Will publicize this voluntary action on its website.

3. Will educate its staff, medical coordinators, and members regarding this voluntary action.

4. Will diligently seek the results of double-blind, peer reviewed scientific studies that address this issue.

5. At the end of the five year period, in the absence of such scientific studies which bring a conclusion to the issue of the legitimacy of this diagnosis and treatment, the Board will reexamine this issue based on evidence available at the time.

Health Plan Contracting Bill Passes the Senate ([SF 2700 / HF 3042](#))

Legislation to address a number of health plan contracting problems that have been identified by clinics has passed the Senate floor and is awaiting final action by the House. The legislation was developed by the Minnesota Medical Group Management Association (MMGMA), the organizations representing medical clinics.

The bill requires health plans to provide to physicians and other providers the methodology the plan uses when calculating tiered networks. The must also let the provider know what tier they are in prior to the effective date of the tiered plan. Health plans must also let providers know what their fee schedule is and what, if any additional fees the plan may pay.

The bill also limits the time period that plans can go back to recoup payments or adjust claims. Health plan contracts cannot allow this period to be any longer than 12 months.

Finally, the bill allows clinics to collect patient co-payments, deductibles, or co-insurance prior to the time of service. This would most likely be for non-emergent, scheduled procedures. The bill states that if the claim is later adjusted and it is determined that the patient overpaid, the clinic must return the overpayment amount within 30 of receiving the adjusted claim.

Federal SGR Cut Not Delayed Again

Once again Congress has gone on recess without stopping the scheduled 21.5% Medicare physician payment cut. According to law, beginning April 1, 2010, physician payments will be cut by 21.5% because of the flawed Sustainable Growth Rate (SGR) formula.

On Friday March 26, legislation to delay the cut until October 1, 2010 was objected to by a member of the Senate, so the bill did not go forward to stop the cut. Congress is now in recess until the week after Easter.

Similar to what happened last month, CMS has instructed its contractors to hold claims containing services paid under the Medicare physician fee schedule (including anesthesia services) for the first 10 business days of April. This hold will only affect claims with dates of service April 1, 2010, and forward. The hope is that Congress will act as soon as they return to delay the cut. Work continues to find a permanent solution to this problem so we don't have to play these delay games year after year.