

## **One Month to Go with Session**

With a little over a month left to go in the 2010 session, the pace of activity at the Capitol is unusually slow. At this point of a "typical" session, the legislature is deep into the budget process, there are multiple conference committees meeting on different aspects of the budget, and negotiations are occurring between the Governor and legislative leaders.

This year, however, the Legislature has already completed a large portion of their work this session. Before the Easter/Passover break, legislators passed, and the Governor signed, a tax bill, a bonding bill, a GAMC compromise, and a budget bill that covers 12 of the state's spending areas reducing the \$994 million state deficit by \$312 million.

Nonetheless, with the DFL and Republican state conventions the last two weekends of April, little work will occur in St. Paul until after they are completed. Upon their return from party conventions, legislators will have a little over two weeks to act on the K-12 Education and Health & Human Services spending bills and implement any changes from the federal health care reform law. Per the state constitution, the Legislature must adjourn on Monday, May 17th.

## **Federal Reform Implications for Minnesota and its GAMC Program**

One thing that has slowed to pace related to the Health and Human Services budget is a lack of clarity of how much federal money Minnesota will receive from the recently passed federal health reform bill. As legislators struggle to come up with a budget-balancing bill, they are trying to understand how Minnesota might benefit from an early opt-in program that is part of the federal health reform. The federal reform bill allows states to expand Medicaid (in Minnesota called Medical Assistance) to coverage adults without children earning up to 133% of the federal poverty level if the state allocates 50% of the money.

Several Senate and House committees heard from the Department of Human Services officials in trying to sort through the federal law. Brian Osberg, the State Medicaid Director, said that DHS is still awaiting clarity from CMS as to who the rules will be with this new expansion. Minnesota will be barred from imposing an asset test for new enrollees, something which Minnesota currently requires for persons applying for GAMC. This would cost the state \$10-15 million. Another issue is the benefit set. Medical Assistance includes long-term care and GAMC does not. It is also not clear how GAMC recipients fit into the MA definition of "medically frail."

States who are eligible for early expansion can begin providing MA as of April 1, 2010 and must submit a state plan amendment by June 30, 2010. Obviously, there are timing issues in trying to determine what changes Minnesota would have to make to take advantage of the early opt-in and the how Minnesota would pay for the costs since state matching funds are required. In addition, DHS is trying to implement the new GAMC compromise proposal.

### **Should GAMC Compromise Proposal Be Scrapped?**

With new federal money potentially available, many legislators have begun talking about using that money to replace the reformed GAMC program that just passed the Legislature last month. The House HHS Finance Committee heard testimony from the Minnesota Medical Association, Minnesota Hospital Association and a number of hospitals who are eligible to create the newly designated Coordinated Care Delivery Systems (CCDS) for Minnesota's newly retooled General Assistance Medical Care program. All expressed concern about the financial risk of being responsible for coordinating the care of these patients in a program that is significantly underfunded. June 1 has been set as the date for GAMC recipients to start enrolling in the newly restructured program.

At the time the GAMC compromise was passed, federal health reform proposal had not been adopted. All of the testifiers expressed support for the state to move ahead with the early expansion of the Medical Assistance program to cover these individuals that is part of the federal health reform bill. Part of problem in moving in this direction is that the state would have to come up with state matching funds. The other significant issue is that Governor and Republicans believe the GAMC compromise provides major reform in health care delivery where federal health care bill does not.

### **Health Care Access Fund Possible Solution to Federal Match Requirement?**

#### **[HF 3713](#)**

Minnesota would qualify for \$1.136 billion in new federal payments over three years under a plan released on Wednesday by Representatives Tom Huntley (DFL-Duluth), Paul Thissen (DFL-Minneapolis) and Erin Murphy (DFL-St. Paul). The dollars would be available if Minnesota takes advantage of an early opt-in provision in the federal health care bill that will extend Medical Assistance coverage to GAMC recipients. The reported cost to early enrollment, according to a March Minnesota Management and Budget analysis could be as high as \$881 million in the next biennium.

Through a new way of accounting the funds the legislators are proposing to address the state match by not using the federal money to fill the Health Care Access Fund forecasted deficit, and instead using the federal money to expand care. This new fiscal note would reduce the general fund cost over the next three years to \$65 million, which would draw down the \$1.136 billion of new federal funds. Lawmakers would still need to develop a solution to the HCAF deficit prior to the end of next legislative session.

Gov. Pawlenty's spokesman Brian McClung responded that the DFL plan to tap the Health Care Access fund for that money won't work, because the fund already has a projected deficit. "That's like asking somebody to transfer money from their checking account to their savings account when they've already overdrawn on their checking account. There's no money to transfer."

Efforts to maximize new federal funds will be a major focus of the Legislature over the next four weeks.

### **Peer Grouping, [HF 3056/SF 2815](#)**

This bill modifies the timelines for the release of the peer grouping data that was authorized in the 2008 health reform act. The bill changes release dates to comply with contract the Health Department has with Mathematica to analyze the peer grouping information. The bill requires that prior to the Commissioner releasing any data she must assure that it is reliable and valid so that it is useful to purchasers and providers. The bill also repeals a provision that would prohibit providers who fall in the bottom 10% of this data from participating in our public safety net programs. The bill passed on the 129-2 in the House. It is still awaiting action in a Senate committee.

### **Mandatory Reporting –Pregnant Women [SF 2695](#)**

The bill that amends the current law, that requires a provider to report a pregnant women who they suspect are abusing chemicals, including marijuana and alcohol, during their pregnancy. The bill would not require the mandatory reporting if the physician or knew or had reason to know that the pregnant woman was receiving prenatal services.

When the mandatory reporting law was expanded a few years ago to include use of alcohol physician groups testified that they were worried that it may result in pregnant women not getting care because of fear of being reported to authorities. The city of Minneapolis public health clinics have testified this year that they have experienced a “chilling” effect from accessing prenatal services due to the reporting requirement.

### **NASPER Funding [SF 3201](#)**

In 2007 Minnesota passed legislation to develop an electronic registry to track patients' use of narcotic drugs. The National All Schedule Prescription Electronic Registry (NASPER) is designed to help physicians and pharmacists to track patients who may be “doctor shopping” in order to get narcotics for illicit use. The Board of Pharmacy received a federal grant to develop the registry and it is about to go live soon. The federal grant has run dry and the state is now looking to find \$350,000 annual funding to run NASPER. Earlier this year a bill was introduced that would have established a state version of the DEA and would have required all prescribers to register and pay a fee to the Board of Pharmacy to fund this. That proposal was strongly opposed by organized medicine and the pharmacy associations.

The current version of SF 3201 would assess the licensing boards for professionals who prescribe or dispense controlled substances, the boards of medicine, pharmacy, dentistry, nursing, optometry, and podiatry, to fund NASPER. If this bill passes it may result in a small increase in license fees if the licensing boards do not have surplus funds to pay this assessment.