

## **2009 Minnesota Legislative Session Health and Human Services Wrap-up**

After five months of debates, political posturing and limited dialogue, the Governor and Legislature failed to reach a final deal that balanced the state's \$6.4 billion budget deficit. One week before the legislature adjourned, Governor Tim Pawlenty convened a press conference and announced that he would sign all DFL budget bills, thus declining to call a special session. As an alternative, the Governor is issuing a series of line-item vetoes along with a combination of accounting shifts and unallotments to health care, higher education and local aid, to balance the budget. An unallotment is an act of not funding a legislatively mandated budget proposal. The executive branch reserves the seldom used right to unallot when revenue projections fall short of spending commitments.

Historically, unallotment has been used very infrequently. The Governor is expected to authorize deeper unallotment cuts than any Governor has made in the past, generating speculation that there may yet be a special session to prioritize the cuts in a way the Governor cannot do on his own.

In lieu of using the final days of session to work together on a compromise proposal, the Legislature responded to the Governor's veto by passing a third tax bill minutes before adjournment which the Governor subsequently vetoed.

Through line-item vetoes, Pawlenty cut hundreds of millions of dollars out of the Legislature's budget bills. The largest vetoed item was a \$381 million provision for General Assistance Medical Care (GAMC), a move that kicks 30,000 of the poorest Minnesotans off the state funded program. Although former GAMC enrollees can qualify for coverage under MinnesotaCare, there is some skepticism regarding their ability to effectively make the transition. GAMC enrollees often have physical or mental disabilities and will inevitably seek medical care in emergency rooms. The impact on hospitals and other providers could be significant. For example, if GAMC enrollees do not successfully make the transition to MinnesotaCare, varying estimates project that Hennepin County Medical Center alone will need to absorb between \$40 million and \$108 million in increased uncompensated care expenses from this line item veto.

### **HF 1362 Omnibus Health and Human Services Bill**

The Health and Human Services Omnibus Bill approved by the Legislature authorized a reduction of \$489 million in the next biennium to the Health and Human Services Budget. This cut is in addition to the \$381 million additional savings resulting from the Governor's GAMC line item veto. One time money increasing the federal match under Medicaid by 50 percent helped avoid even deeper cuts, but this increased match will only last for the next two fiscal years.

The 2009 budget calls on all entities receiving state funding to make deep concessions, many of which will result in jobs lost, increased access problems and potentially lives lost. Rebasement for both hospitals and nursing homes was delayed as money saving measures.

A 5 percent rate reduction for physician specialists was included in the bill as were rate reductions for long term care facilities, inpatient hospital care services, a three percent cut for basic care services and cuts in funding for dental care reimbursement.

The physician rate cuts generated significant conversation as legislators continued to learn over the session just how little they actually know about how health insurance companies spend taxpayer dollars.

The House Health and Human Services Omnibus bill included a prohibition on health plans passing all rate cuts along to health care providers. Introduced by Rep. Paul Thissen (DFL-Minneapolis), this proposal was prompted largely by sense of fairness desired by House conferees. Members of the legislature have become increasingly aware that previous legislatures allocated funding increases to health plans contracted by the state to manage public programs. However, health care providers have not received an increase in their reimbursement under public programs since 2000. The Department of Human Services spoke out against requiring health plans to absorb a portion of the aforementioned physician rate cuts because such a course of action would threaten the Department's ability to ensure that reimbursement rates for public programs remained actuarially sound.

Health plans and the Department, however, were unable to give legislators a salient answer of how they spent the funding from revenue increases in previous years. This discrepancy resulted in many legislators, such as Thissen and Rep. Erin Murphy (DFL-St. Paul), calling for a more transparent system where legislators have a better sense of how the Department of Human Services and health insurance companies are spending taxpayer dollars. Murphy and Thissen worked with the Minnesota Medical Association (MMA) and Minnesota Medical Group Management Association (MMGMA) to pass legislation requiring health plans to report to the legislature annually on how these taxpayer dollars are being spent.

As the House and Senate crafted the HHS budget, there were two sticking points that threatened to halt negotiations, both of which were Senate proposals. One section allowing the state to impose a \$48 million assessment on health plan reserves was removed after House conferees questioned the legality of such a move. As an alternative, the conference committee authorized a shift that delays payments to health plans for funding public programs.

Language authorizing standalone birthing centers was also debated at length, and the final compromise calls for developing licensure standards for birthing standards and a cap on facility payment rates after October 1, 2009. The cap will result in a fixed rate of \$3,528 paid to managed care and county-based purchasing plans for cesarean sections "without complicating diagnosis;" "vaginal delivery with complicating diagnosis;" and "vaginal delivery without complicating diagnoses."

Also included in the bill was a provision authorizing a rate cut for anesthesiologists when medically directing nurse anesthetists; however, the rate reduction was scaled back considerably from the original proposal. The Senate budget originally called for a 100% rate cut for anesthesiologists when medically directing nurse anesthetists. This draconian proposal

effectively penalized anesthesiologists and nurse anesthetists for working together and sparked an outcry from the physician community. Many doctors contacted their elected officials on behalf of anesthesiologists in part because of the disastrous precedent that such a proposal would have set.

Nurse anesthetists also received a rate reduction in the bill when performing anesthesiology services independently. Their rate was reduced to the same level an anesthesiologist currently receives when performing the same services independently.

### **No Provider Tax Increase . . . For Now**

The silver lining in the 2009 legislative session may be the legislative proposals that *didn't* become law. Such was the case with proposals involving the Health Care Access Fund and the Provider Tax.

The Governor struck first with his initial budget proposal that recommended merging the entire Health Care Access Fund into the General Fund under the guise of having government operate more efficiently. This proposal would have only made it easier for policymakers to raid monies raised by the two percent Provider Tax for purposes that have nothing to do with providing access to affordable health coverage to low income Minnesotans. DFL members balked at this proposal which was ultimately unsuccessful.

Not to be outdone, DFL members began toying with the concept of increasing the Provider Tax. Rep. Tom Huntley (DFL-Duluth) and Sen. Linda Berglin introduced legislation that officially put the proposal of a provider tax increase on the table. Senate Tax Committee Chair Tom Bakk (DFL-Virginia) subsequently added language to the Senate Omnibus Tax bill to serve as a placeholder for a provider tax hike at Berglin's request. Part of the rationale behind this effort was to find a tax increase that Governor Pawlenty would agree to. Advocates representing providers quickly learned that in order to successfully thwart an increase in the tax under the present budget implications, new arguments were needed.

Former Minnesota Senator and current associate administrator at Noran Neurological Clinic, Phil Riveness, who serves on MMGMA's Government Relations Committee, developed a document that reminded legislators that the Provider Tax and the Surgical Center Tax are each imposed on a health care provider's gross revenue – except for revenues from Medicare, Medical Assistance and MinnesotaCare patients. Riveness' argument pointed out that a one percent increase would be the equivalent of a 10 to 20 percent corporate tax increase.

Advocates for physicians and other health care providers were ultimately successful in defeating this proposal. Proposed Provider Tax hikes are sure to resurface, particularly in light of the Minnesota Hospital Association's (MHA) recent endorsement of an increase. In addition, future Provider Tax hikes may also be a further complication and consequence of the GAMC cut. GAMC was funded from the General Fund. If GAMC enrollees do successfully transition to MinnesotaCare which is funded by the Health Care Access Fund, the increased drain on the Health Care Access Fund may prompt an increase in the Provider Tax.

The full implications of the health and human services cuts are still unclear for providers and patients. Will increases in uncompensated care force hospitals to close programs from which the

state currently benefits? Will the dramatic rate cuts create health care access problems for low income Minnesotans? Will a special session be necessary if it is clear the aforementioned cuts are simply unsustainable? These are unfortunate questions indicative of the current economic climate, and may need to be revisited by policymakers before the Legislature reconvenes in February of 2010.

## **Sidebar**

In addition to the budget, there were several other legislative proposals debated in 2009:

### **Health Reform**

Health reform advocates labeled the 2008 Session the Landmark Health Reform Session. While Single Payer System supporters were not rewarded with a system like the one introduced by Senator John Marty, most of the health reform agenda in 2008 was enacted. New initiatives were launched to create a health care system that now includes health care homes; a quality incentive payment system to providers; reimbursement for providing a basket of care; data collection by the Minnesota Department of Health (MDH) to place providers in peer groups (a concept some label as tiering); mandatory use of electronic patient records, electronic prescribing, and electronic claims processing; uniform administrative procedures for the health plans and providers; and an essential benefit set.

MDH, for its part, continued during the session to host meetings for providers, health plans, and other stakeholders to inform them about ongoing efforts to implement health reform. For more information on the ongoing implementation of the health reform bill, visit <http://www.health.state.mn.us/healthreform/>.

### **Medical Record Copying**

The demand for medical records copies increases each year and adds to medical practice overhead costs. The current allowable charge of \$.75 per page plus maximum charges for employee retrieval time does not cover the costs of the time of the employee making the copies and the costs of the copying itself. Because of the current costs, it was shocking when Senator Mary Olson (DFL-Bemidji) introduced S.F. 857.

S.F. 857 would have reduced the per page cost to \$.05 per page with a maximum of \$10 for transmitting an electronic record. Retrieval fees would have remained the same and capped at a one time fee, even if separate provider entities were retrieving records. Due to the strong opposition of MMGMA and other provider groups S.F. 857 was removed from consideration for the 2009 session and will be considered in the interim by interested legislators and willing stakeholder groups.

### **No-Fault Auto**

Senator Linda Scheid introduces legislation on No-Fault automobile insurance each session. In previous sessions she has attempted to pass legislation that would move No-Fault automobile insurance into the managed care arena by forcing injured insureds to use provider networks organized by the automobile insurance carriers. This session she introduced S.F. 1310 which was a scaled "reform" bill.

S.F. 1310 included provisions that limited medical benefits to the lower amount actually paid or incurred on behalf of the claimant; increased the weekly disability and income loss benefit; increased the allowable funeral and burial expense; directed the court in a cause of action for negligence to deduct the value of basic or optional economic loss benefits paid; limited noneconomic damages unless the amounts actually paid exceed \$4,000; and prohibited balance billing by providers if the payer determined the charges were not medically necessary or exceeded usual and customary rates.

Early and strong opposition to this measure by the MMGMA, trial lawyers and other provider groups prevented the more onerous proposals in this bill from moving forward.

### **Nurse Scope of Practice**

No legislative session is complete without a scope of practice debate, and one of the more visible debates involved primary physicians, anesthesiologists and nurses. Legislation was introduced that would have authorized multiple changes to the practice requirements for advanced practice nurses, including authorization for advance practice nurses to prescribe drugs. Additionally, the bill would have authorized nurse anesthetists to prescribe and administer drugs and therapeutic devices without any type of collaborative arrangement with a physician.

The bill was initially touted as a proposal resulting from the Health Care Workforce Shortage Study recommendations facilitated by the Minnesota Department of Health. This however, was an inaccurate characterization as the legislation did not reflect the Department's recommendations. This legislative effort was unsuccessful, but it is clear that advocates for expanding nurses' scope of practice will return in 2010.

### **Single Standardized System for Electronic Data Interchange**

Another bill passed in 2009 authorizes the Commissioner of Health, in consultation with the Minnesota Administrative Uniformity Committee, to study the feasibility of a single standardized system for simplifying health care administrative transactions through electronic interchange. The study requires recommendations be made on the feasibility of and barriers to establishing a single, standardized system for all group purchasers for health care administrative transactions; the identification of a range of potential technologies to accomplish a single standardized system; the relationship of technologies to the current e-prescribing statute; and an analysis of the readiness of providers and group purchasers to implement appropriate technologies in compliance with current state and federal laws and standards.

### **Workers Compensation**

During the summer of 2008, Commissioner of Labor and Industry, Steve Sviggum, appointed three work groups and one subgroup to look at the Workers Compensation system to develop recommendations for system changes that would result in a major legislative effort in the 2009 Session. With the members representing labor, business, health care, and rehabilitation, the groups worked all summer into the early winter of 2009 to develop an acceptable framework for a major workers compensation legislative initiative.

Throughout their deliberations, it became apparent that the WCAC would not adopt any major legislative agenda for 2009. The 2010 Session could be another story, however, as continued pressure on the state to save money increases.

### **Language Interpreter Services**

For years, MMGMA and MMA have worked to educate legislators on the fact that medical groups are paying very substantial costs each year for language interpreter services for non-English speaking patients. Medicare and Medical Assistance provide some reimbursement, but with interpreter costs running \$60 to \$100 per hour, medical groups are burdened with rising and unsustainable overhead for these services.

In the 2009 Session, Representative Maria Ruud (DFL-Minnetonka) introduced H.F. 1211 which provided for reimbursement to be phased in with increments of one third added each year beginning July 1, 2009. The bill also provided for the Commissioner of Health to establish an Interpreter Services Work Group to study interpreter services in medical and dental facilities with a report back to the legislature by January 15, 2010. A companion bill, S.F. 1693, was introduced in the Senate by Senator Linda Higgins. Given the budget deficit and large fiscal estimates by the Department of Human Services, neither bill was able to move forward in 2009.

### **False Claims Act**

Introduced by Rep. Steve Simon (DFL-St. Louis Park) and Sen. Ron Latz (DFL-Golden Valley), the False Claims Act is legislation aimed at recovering state funds from those who knowingly submit false bills to the government. The bill as initially introduced would not have allowed the ability to cure a previously submitted false claim that was newly discovered without penalty. In addition, the bill included a look back provision which would have given the new law immediate enforceability on previously submitted claims. The final compromise that passed the House and Senate included a “right to cure” provision and the look back provision was removed.