

Minnesota Legislature

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2011 Regular &
1st Special Session Wrapup
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Chapter 12 – Community Paramedic

This measure represents the first CP legislation passed in the United States. It places the title “Emergency Medical Technician – Community Paramedic” or “EMT-CP” in permanent statute.

-Establishes a minimum of two years full-time (or equivalent) experience to be eligible to enroll in the course;

-CPs may only function through an ambulance service and under the license of the service’s medical director;

-Training program instructors, and their qualifications, are described;

-Certification, regulation and disciplinary action is under the auspices of the EMSRB;

-The Commissioner of Human Services, in consultation with a variety of healthcare providers, is to determine the services to be offered and create a fee schedule. This determination is to be forwarded to specific legislative committees by 12/1/2012. The new law mandates that Medical Assistance and other state programs reimburse for CP services once the legislature approves DHS’s recommendations.

-Requires an evaluation of the effects of CPs on the cost and quality of care and requires MA, MN CARE and other state program participants to provide required information by

12/1/2014. (HF 262/SF 119*). It is worth noting that the intent of this legislation has been repeatedly mischaracterized. First, the CP bill has been titled as adding Community Paramedics to the definition of “Community Health Workers”. The Community Health Worker language was in the initial draft of our bill, but was totally eliminated after the first draft. Remember this legislation was drafted and re-drafted no less than 19 times. Second, it has never been our intention for CPs to compete with home healthcare agencies, members of the nursing profession or other current health care providers. The concept is to enhance the quality of care and fill gaps in the current system – not undermine it.

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-We are working with Senator Rosen and the Governor's Office to set up a mock bill signing so those folks who were involved in securing passage of the legislation can have a photo op.

Chapter 23 – Hannah's Law

Enhances CPR training requirements for child care center staff. Previously, only one trained staff person needed to be present at the facility when children were present.

-This new law requires all child care center teachers and assistant teachers to successfully complete CPR training, including CPR for infants and children;

-Mandates at least one staff person during field trips and when transporting infants/children to have the above training. (HF 235*/SF 381)

Chapter 33 – Public Safety Sole Source Purchasing

This law increases from 10 to 15 years certificates of indebtedness or capital notes to acquire new or used public safety equipment.

-Authorizes local governments acquiring by lease or purchase,

public safety equipment for fire departments to use sole-source acquisition used equipment if no other source is available. (This is similar to the language that the MAA secured several years ago to allow purchases through the co-op.) (HF 1139*/SF 921)

Chapter 37 – Omnibus Public Safety & Courts Appropriations

Vetoed 5/24/2011

Chapter 38 – Omnibus Tax Bill

Vetoed 5/24/2011

Chapter 40 – Omnibus State Government Appropriations

Vetoed 5/24/2011

Chapter 41 – Omnibus Health & Human Services Appropriations

Vetoed 5/24/2011

Chapter 49 – Omnibus Transportation Appropriations

Vetoed 5/24/2011

Chapter 51 – Hospital Moratorium Exception

The new law amended the current hospital moratorium, by permitting expansion of from 20 to 50 beds the number of approved beds at the Prairie Care facility in Maple Grove. (HF1018/SF 742*)

Chapter 71 – Ambulance Revenue Recapture

This may be one of the most misrepresented pieces of legislation to pass in 2011. The bill **did not** expand Revenue Recapture to non-government-based ambulance services. They are already eligible. Rather, it was a technical change that eliminates superfluous language. All Recapture claims will now go directly to the state, rather than being processed by some counties, then forwarded to the state for final collection. The new law reflects what the current state practice is. A number of counties did not want to be involved in the Recapture process, thus limiting options for non-government services. With the passage of this law, all 'Recapture' claims will go directly to the Minnesota Department of Revenue for processing. (HF 258*/SF 217)

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Chapter 75 – Donated Equipment Liability Immunity

Allows tort immunity for a municipality that donates public safety equipment to another agency, unless there is fraud or misrepresentation as to the condition of the equipment. The broad definition would include virtually everything that would be utilized in response to an emergency situation. (HF 695*/SF 735)

Chapter 80 – Anatomical Gift Program

Allows a voluntary \$2 gift be donated to promote and educate the public on organ and tissue donation when one renews their vehicle or driver registration. (HF 808*/SF 892)

Chapter 101 – The “Its Ronald McDonald’s Fault” Bill

This legislation would have held harmless purveyors of Big Macs, Double Range Burgers, Arby’s 2 pounders, etc. from civil lawsuits if consumers became obese, saw significant weight gain or experienced other calorie-related health problems from

eating their products. It was termed the “Personal Responsibility in Food Consumption Act”.

One could argue that it is an issue of personal responsibility for one to determine their appropriate daily calorie intake. [NOTE: This doesn’t really apply to the EMS provider community except that our ambulance crews are noticing more gravitationally challenged patients, but it cried out for inclusion in this report]. (HF 264*/SF 160). I didn’t read the Governor’s veto message, but it was.....

Vetoed 5/27/2011

Chapter 112 – Technical Tax Changes

Governor Dayton signed this legislation which deals primarily with federal tax conformity. It is worth noting that our Revenue Recapture language was also included in this legislation. Consequently, our technical language passed twice. (HF 1219*/SF 869)

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Other Issues of Interest

A number of legislative initiatives failed to secure passage during both the Regular and subsequent Special Session – which in some cases was a good thing.

-In what can best be called a "challenging" session, we need to include any all good news that we can come up with. What can be characterized as a major victory for us was preventing any reimbursement changes to the No Fault Auto Insurance law. During previous sessions, there has been a significant effort to make dramatic changes in this insurance statute. Due to the political make up of the legislature, there was a big push to make numerous changes in No Fault. Granted, there are a number of technical changes that would be appropriate to the statute, however, there was considerable effort also invested in eliminating the mandatory minimum \$20,000 medical coverage. Although this may seem like a relatively small amount of money, it results in millions of dollars a year to hospital EDs and ambulance services. We worked hard to preserve the \$20,000 benefit and it paid off as we succeeded in blocking the repeal. It is worth noting that this also represents a significant amount of revenue to many fire departments and 1st Responder squads.

-Although the EMS provider community did not have a position on either one of these two issues, both of them failed: (1) SF 393/HF 42) Would have allowed **special license plates** for retired firefighters; and, (2) HF 922/SF 532) Would have allowed the use of red lights and

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sirens on what are termed “**collector**” **emergency vehicles** during parades, exhibitions or demonstrations.

-MN ACEP, the MAA and other EMS providers pushed for enactment of **caps on non-economic losses** for patients who sued any physicians who rendered care in a hospital emergency department. It became clear during the first hearing of the bill that support had eroded. There was also little enthusiasm for the bill among the provider community as well. The legislation was withdrawn.

-Repeal of the **Primary Seat Belt Law** was brought forward as an amendment to the Omnibus Public Safety Finance bill on the House floor. It was a complete surprise. Not even the chair of the committee knew of the planned effort. Repeal of the Primary Law, and making it a secondary offense, passed the House by a significant margin. We worked very hard to convince the Senate to **not** accept the repeal amendment. Working with the Seat Belt Coalition and a cadre of other concerned organizations, we were successful in retaining the current law and preventing the repeal. The potential for repeal continued, however, as there were other legislative vehicles to which the repeal could have been amended. In fact, we continued to work with the other groups to assure that it would not appear in

one of the special session initiatives. The defeat of this repeal attempt was a **major** victory for public safety and **continued** funding for Emergency Medical Service providers, 1st Responders and fire departments throughout the state. In addition, remember that 10% of these funds are used by the 12 District Offices of the State Patrol to fund educational materials on seat belt usage and vehicle safety.

-Although all but one of the major appropriations bills were vetoed, we were successful in protecting virtual all critical EMS-related programmatic funding. However, with the vetoes, we had to start all over again. We will discuss the specifics in the next section under the Special Session synopsis.

-On the downside, ambulance services (and STS providers) will see a 4.5% reduction in reimbursements under MA and other state programs. We had several options for eliminating the cuts, but were not successful in getting their inclusion in the final bill. The cuts will be to both fee-for-service and PMAP rates. The FFS cuts will take effect on 10/1/11; the PMAP cuts take effect 1/1/12. We will continue trying to restore the cuts, as funding allows. One area of interest to consider in the future is that a majority of the FFS population will be moving

to PMAP automatically. In the future, providers will be working more closely with the health plan on ambulance and STS issues.

-We were also unsuccessful in removing the current law which requires a 5% reduction in hospital ED utilization under MA and other state programs for each one of the next 5 years from the previous session. However, we are currently working on some ideas for the next session to mitigate the implications. As I understand it, a key aspect of this law may be problematic because the ED utilization reductions will be tracked in **aggregate** – not by specific hospital. How this tracking will be done should be challenging.

The bills passed during the special session also either protected what we secured during the regular session or failed to include some of our other attempts to amend policy issues such as the ED utilization piece, mentioned above.

First Special Session

We are referring to this most recent gathering as the “First Special Session” because there could be a ‘second’. Considerable debate continues over the need (desire?) for another special session to deal with the issue of a new

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Viking's Stadium. In addition, as more and more details are emerging from the HHS bill, there may be some unintended complications, at least in some people's minds.

As we have related previously, this special session was somewhat unique. After the Governor and legislative leadership agreed to a "compromise", after 20 days, to bring the state shutdown to an end, there were some procedural shortcuts agreed to. Bills had either a House File number of a Senate File number, but not both. Also, the rules were suspended so that committee hearings would be dispensed with; all bills would be brought up on the respective floors; and, no amendments would be accepted. Several floor speeches were offered and nobody seemed very happy with the situation. In any case, the impasse ended and the engine of Minnesota state government resumed chugging along.

Chapter 1 – Omnibus Public Safety/ Judiciary

-\$604,000 each year is appropriated to the Hazmat and Chemical Assessment Teams;

-The Fire Safety Account had some of its funds transferred to the General Fund; \$4,227,000 the first year and \$4,228,000 the second.

-PSAPs were funded in the amount of \$13,664,000 each year of the biennium.

-The **Medical Resource Communications Centers** (MRCCs) were fully funded in the amount of \$683,000 for each year. These dollars are evenly divided between the Metro East and Metro West programs.

-The ARMER backbone operating cost center received \$8,300,000 the first year, and \$8,650,000 the second. In addition, a total of \$2 million was allocated for the biennium for ARMER improvements.

-Inmates of correctional facilities will be responsible for 'at least a \$5 co-pay per visit to a health care provider';

-There is also language that we are still trying to interpret. It requires that all county boards shall pay no more than the MA rate for all medical costs. For providers with a contract, this may result in a reduction of reimbursement. However, for providers which have historically not be reimbursed, this could have a positive effect. We are continuing to research this policy change to determine if it is good, bad or both – depending on the provider. (Special Session SF 1*)

Chapter 3 – Omnibus Transportation

-\$308,000 is appropriated for

each year of the biennium for the **Public Safety Officer Survivor Benefits Program**. In addition to law enforcement personnel and others, 1st Responders and all ambulance personnel – regardless of employer – are eligible for this benefit. A number of years ago, we were successful in assuring that all ambulance personnel were treated equally, whether they worked for a public or non-public ambulance service. In addition, we were successful in including 1st responder squads, but they must be registered with the EMSRB and recognized by the local unit of government. (Special Session HF 2*)

Chapter 7 – Taxes

-Language is included which states that "good or services purchased by a town as inputs to goods and services that are generally provided by a private business engaged in the same activity" could be taxable. **Ambulance and other public services** are exempt.

-Clarification that any leased vehicle of an ambulance service that is "equipped and specifically intended for emergency response or for providing ambulance services" is exempt from tax. This makes it clear that leased QRVs and ambulances are exempt if they carry emergency equipment. We secured this exemption several years ago, but the Revenue Department felt the

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language was unclear. This also makes the tax law consistent with the vehicle registration provisions currently in statute. (Special Session HF 20*)

Chapter 9 – Health & Human Services Finance

This legislation was, by far, the most controversial initiative enacted during the special session. Unfortunately, several weeks of intense work drafting some significant ‘reform’ legislation was not included in the final bill.

A major success was the agreement to pursue early Medicaid enrollment, which the Minnesota Hospital Association estimates will have a **positive** financial benefit to hospitals of approximately **\$608 million for the biennium**. From an ambulance perspective, this should help those services with higher amounts of uncompensated care. Early expansion allows more individuals to enroll in MA, which should benefit all providers.

Generally, the hospitals will experience significant reductions in MA and other state program reimbursements. Remember that the reduction of \$1 in state spending on reimbursement actually results in a loss of \$2 because of the loss of the federal

match. It should be understood that this legislation is very complicated, with a number of new proposals included in the final product.. Consequently, it will take some additional time to completely understand the implications for all state hospitals and other health care providers.

The following is a broad overview on what was included in the bill, however, it is not a comprehensive synopsis. As referenced above, we are still working with other organizations in an effort to fully comprehend what the Governor signed into law.

Because there are a variety of audiences reading this session wrapup, I have separated the EMS-specific provisions from the rest of the overview, although there are some obvious overlaps.

Non EMS Specific

-MERC funding fared better in the special session legislation, as the amount of money transferred from the tobacco tax revenue fund was reduced from the original \$8.5 million per year to \$3.9 million;

-The biennial exercise of delaying hospital rebasing was finally resolved. Effective 1/1/2013, hospital reimbursement rebasing was eliminated.

-On top of the 5% annual hospital ED utilization decrease (in current law), hospital readmissions within 30 days were targeted. The Commissioner of Human Services is charged with determining the formula which will determine reimbursement holdbacks;

-The ratable reduction for inpatient hospital admissions occurring between September 1, 2011 and June 30, 2015 is set at 10% for the state payer population.

-Providers **will be able to seek payment** from enrollees for services not covered under MA if a review was conducted and the individual signed forms which indicated they understood their liability;

-Limits MA payment for Medicare crossover claims to MA payment rate. (Certain mental health treatments and other services are excluded);

-There are reduced payments to physicians of 3% for services provided between September 1, 2011 and June 30, 2013. The reduction to **outpatient hospital fees** is 5%.

-The MN CARE Provider Tax, currently at 2%, is **repealed** January 1, 2020. If the balance in the Health Care Access Fund hits certain thresholds, the tax must be reduced;

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-The **Healthy Minnesota Contribution Program** was created for MN CARE participants who are adults with no children and a gross family income over 200% of the federal poverty level. Based on a sliding scale, they will receive a monthly amount to purchase health insurance on the private market. The amount ranges between \$125 and \$357 per person and should affect about 3500 enrollees. This amount has to be increased by 20% for participants denied coverage in the private market, so that they may participate in MCHA;

-Eliminates MA coverage for legal noncitizens and limits coverage under emergency MA programs;

-Chiropractors saw no reduction in MA and other state program reimbursements and are also allowed 24 visits without prior approval, up from the current 12 visits;

-MN CARE residency requirements are aligned with MA criteria;

-The 7 County Metro Area will undergo a two-year competitive bid pilot project for the nonelderly, nondisabled in MA and MN CARE;

-There will be a demonstration project on complementary and alternative medicine. However, it is limited to academic and

research institutions in conjunction with FQHCs and similar programs.

-An RFP is to be issued for a vendor to identify Medicaid fraud. The vendor must be identified no later than January 31, 2012;

-The law establishes new requirements under managed care plan's performance targets for ED utilization rates (by 10% each year from the previous year's rate until it is reduced by 25% of 2011 rate), hospitalization admission rates (by 5% each year from the previous year's rate until it is reduced by 25% of 2011 rates) and readmission rates (by 5% each year from the previous year's rate until it is reduced by 25% of 2011 rate);

-DHS will not consider prior authorization requests when a recipient has third-party coverage, unless the provider has made efforts to obtain from third party.

EMS Specific Provisions

-The ongoing concerns with data collected by the EMSRB was addressed by the following language: *"By October 1, 2011, the board must convene a working group composed of six members, three of which must be appointed by the board and three*

of which must be appointed by the Minnesota Ambulance Association, to redesign the board's policies related to collection of data from licenses. [emphasis added]...The working group must report its findings and recommendations to the board no later than July 1, 2012."

-There was a provision in law that allowed the EMSRB to use noncompliance with data requests as grounds for revocation of an ambulance license. This was eliminated from the law;

-Non emergency medical transportation is to be placed under a single administrative structure for fee for service MA patients. The implications for **nonemergency ambulance service** is unclear, but we will be working with DHS on this matter;

-There were changes in definition of care eligible for reimbursement under the definition of "emergency medical care" (for MA);

-Effective for services provided on or after September 1, 2011, **ambulance service rates** are reduced by **4.5%**. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, must reflect this reduction;

-Effective for services provided

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on or after January 1, 2012, Medical Assistance payment for an enrollee's cost sharing associated with Medicare part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare. There are certain exceptions to this requirement;

-There is a \$3.50 co-payment for nonemergency visits to a hospital-based emergency room. However, this copayment **may be increased to \$20** upon federal approval;

-By January 15, 2012, the Commissioner of Human Services is required to present recommendations to the legislature on reducing hospitalization rates for state healthcare program enrollees **who are children with high-cost medical conditions;**

-The Comprehensive Advanced Life Support Program (CALs) was fully funded. This required an **additional** appropriation to the base, to compensate for the legislative drafting error in the previous session. It now appears to have been restored to the original base amount of **\$408,000**. This program was moved from the EMSRB to the MDH in the previous session;

-The **EMSRB's** operational budget request appears to have been fully funded. There was, however, a previously agreed to

reduction of \$704,000 for each year of the biennium as the **Health Professional Services Program** was transferred to the Board of Dentistry;

-The base funding for the 8 Regional Systems of **\$585,000** for each year of the biennium was retained., as was the continued dedication of **90% of the seat belt fines;**

-Cooper/Sams, the volunteer ambulance recruitment/retention program, will continue to receive **\$700,000 each year**. Of this amount, \$89,000 will continue to be allocated to the EMSRB to administer the program;

-Reimbursement for training costs for volunteer ambulance personnel in the amount of **\$361,000** each year of the biennium was not reduced;

[NOTE: One of the issues that arises virtually every year is the EMSRB's budget. The way the budget is set up, in the appropriations bill, is confusing. Under the heading of **Emergency Medical Services Regulatory Board**, the budget columns list \$2,742,000 for each year of the biennium. However, as is delineated later in the budget document, **\$1,096,000 (per year)** is for EMS Board Operations. As currently organized in the budget bill, it is not clear that the difference in the amounts (between

\$2,742,000 and \$1,096,000) represents the **various grant programs**. The seat belt allocations are not addressed in this at all. Consequently, it appears that the EMSRB has a larger budget than it does.

Closing Notes

As indicated previously, this synopsis is not complete. We don't have the staff to review the legislation in detail. Much of it was done by Buck McAlpin and I working as the sun came over the horizon, along with some invaluable input from a few others. Thanks to everyone who helped out this session.

It should be noted that when you see a star (*) next to either a HF or SF, it indicates that this is the bill that was enrolled and sent to the Governor.

Another **very** important aspect to these bills is that the appropriations are **not pro-rated**. **All of the grant programs will be fully funded for the biennium as if these bills became effective on July 1st.**

During the previous legislative session, the Minnesota Ambulance Association worked very hard to secure passage of the law that would make volunteer ambulance and fire personnel eligible for MN CARE health insurance, if you did not have access to health insurance.

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The program was to begin this past April. In early April, we met with the Department of Human Services to figure out how to set up the plan. At that time, we were told that because of issues with the session (possible state shutdown), Governor Dayton had decided to delay implementation until this coming fall. During the Special Session MN CARE was eliminated about 8 years from now. We will try to figure out how to proceed or if the program will still be initiated.

Chapter 10 – State Government Finance

-Creates a Sunset Advisory Commission, consisting of 12 members including four Representatives, four Senators and four individuals appointed by the Governor. Appointments are to be made before September 1, 2011. All state agencies are to be reviewed for effectiveness and virtually every aspect of their operations to determine their value. The group is charged with recommending whether or not to sunset each state agency based in order of their identified group number (1 through 6). The initial group (#1) includes all health-related licensing boards listed in 214.01. Because the EMSRB is not technically included in this list, it appears that the EMSRB may be the only state agency not included in the law.

-Establishes a state employee “gain sharing system”, whereby a state employee who helps reduce the cost of state government will receive a one-time “bonus compensation”. There are additional incentive programs for state employees/agencies to reduce the cost of government.

-There is a provision that precludes contractors or other third parties from receiving damages as a result of the state shutdown under most circumstances.