What’s in Store for the 2015 Legislative Session

Speaker: Mary Krinkie
Date: Friday, Jan. 9
Time: 2:30 – 3:15 p.m.
Mary Krinkie makes politics and the formation of public policy her vocation and her avocation. For more than a decade, she has been the vice president of government relations at the Minnesota Hospital Association, directing MHA’s policy and advocacy efforts. Mary is the MHA staff person our government officials see at the capitol and the one who provides us with the most up-to-date information during the session and then helps us make sense of what happened after the session is over.
Political landscape & Election review

- Governor Dayton (DFL) comfortably re-elected. And Yet...
- MN House majority party status changed.
  - Was 73 DFLers, 61 Rs. Now is 72 Republicans and 62 DFL.
  - Republicans did not lose any incumbents or any of the seats previously held by a Republican.
  - There are 26 new legislators in total, 15 from open seats and 11 from Republican candidates defeating DFL incumbents.
  - Of the 11 new Republicans, 10 are from outside of the metropolitan area.
- Voter turnout drops in non-Presidential election years. Minnesota’s voter turnout in 2014 was 50%, compared to a 76% participation rate in 2012.
- No state senators were up for re-election. 39 DFL and 28 Rs.
The Affordable Care Act... Getting past the sound bites

The Good News:
- Minnesota’s uninsured rate drops 40%.
- 180,500 uninsured Minnesotans newly covered.
  - Dropping the state’s uninsured rate from 8.2% to 4.9%. (Second lowest level in the nation!)
- HHS reports ACA will save hospitals $5.7 billion this year in uncompensated care.
  - $4.2 billion in the 26 Medicaid expansion states.
  - $1.5 billion in the non-expansion states.

MNsure Update (Year 1)

- MNsure numbers as of 11/5/14:
  - 369,118 total enrollment
  - 233,194 Medicaid
  - Hospital Presumptive Eligibility (HPE) implemented 7/1/14
  - 80,111 MinnesotaCare
  - 55,813 Qualified Health Plan

- Renewed legislative (House) criticism. Proposals to:
  - Eliminate “active” purchaser
  - Change MNsure Board composition
  - Others
AND NOW, the rest of the story...

- More people in Medicaid is NOT a big windfall for hospitals.
  - Current budget neutral rebasing process, DHS calculates that MA rates will be set at minus 38% off of 2012 costs.
- Charity care expenses are down. But, bad debt expenses are up, due to high deductibles. In 2013, MN had the highest average deductibles in the U.S.
  - Minnesota’s average deductible was $4,061.
  - U.S. average deductible was $2,763.
- Don’t forget... $155 billion in Medicare cuts to hospitals to help pay for the ACA.

MN Hospital Financial Picture

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<th>Hospital Operating Margins 2013</th>
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Reform of MN’s Inpatient Medicaid Payment System

**2014 Legislation:** Minnesota redesigned its Minnesota Health Care Program (MHCP) fee-for-service inpatient prospective payment system.

- **DRG services:** DHS plans to adopt the All Patient Refined Diagnostic Related Groups (APR-DRG) patient classification model, subject to budget neutrality.

- **CAH services:** DHS plans to develop cost-based rates, subject to budget neutrality.

- **DRG-Exempt Services:** For inpatient LTAC and rehabilitation providers, DHS plans to evaluate current rates based on a comparison to estimated cost, subject to budget neutrality.

- Kept the 2011 language providing up to a 5% MA payment refund if readmissions targets were met. (Payments of 4% made on Dec. 16, 2014, covering the period of July 1, 2013 to October 31, 2014.)

- Restored a 10% rate cut passed in 2011 on November 1, 2014, instead of July 1, 2015, to further mitigate payment swings.

Implementation Timeline

- May 2014: New inpatient payment framework approved by legislature

- November 1, 2014: Proposed new DRG system effective date based on current legislation; claims will continue to be paid on an interim basis under current system rates and methodologies

- January – May 2015: Possible development of legislative changes

- March 2015: Legislative report showing impact

- October 1, 2015: ICD-10 conversion (per federal requirement)

**Through June, 2016:** DHS Commissioner has authority to adjust rates to protect key services; like pediatric, behavioral health, low volume services, transplants. +5%/-5% “banding” provision in effect.
$556 million projected surplus for the current biennium. $183 million of the surplus will be transferred to the budget reserve, leaving a $373 million balance.

Projected surplus for state fiscal years 2016-17 is $664 million, bringing the total projected surplus to $1.037 billion.

Gov. Dayton will use this forecast to finalize his budget, which will be released on January 27, 2015.

February Forecast will be used to set the 2016-17 budget, which begins on July 1, 2015.

13.9 percent projected increase in spending for health and human services. Most Medical Assistance provider payments are flat, so cost increases are driven by enrollment and/or utilization experience.

Cost Drivers of the 13.9% H&HS Projected Increase

Projected $1.55 Billion growth from 2014-15 to 2016-17

- 90% of this growth is a result of increased spending for MA, which is expected to grow $1.4 billion, due primarily to 16% higher average biennial enrollment.
  - Elderly and disabled basic care will increase by $456 million from the current biennium to the next. This change is due to a growth in average payments (15 percent from FY 2015 to FY 2017), and a steady growth in enrollment over time.
  - LTC waivers are also expected to grow by $409 million from FY 2014-15 to FY 2016-17 as increased demand for long term care services continues.
  - Non-health care spending is expected to grow $118 million (4.4 percent) from FY 2014-15 to FY 2016-17. The biggest driver of this change is MFIP child care assistance, which is forecasted to increase by $56 million (38 percent) in the next biennium.
Legislation to Oppose

Protect Minnesota’s health care delivery system’s ability to provide nation-leading patient care and innovative care models of the future, which requires flexibility in staffing without unnecessary and burdensome government mandated nurse staffing quotas or onerous staffing data reporting requirements.

- Nurse staffing should continue to be driven by patient needs. Staffing should be adjusted according to changes in the number of patients, the severity of illness and the available skills of staff. Health care professionals, not the government, are in the best position to determine appropriate staffing.
- A mandated ratio will likely pull nurses from other health care settings and raise overall health care costs for everyone.
  - Example: Nursing home R.N. salary differential.

How does the MNA respond? (Possibilities)

1. Current law requires MDH to release its study on the correlation between nurse staffing levels and patient outcomes. (January 15, 2015.) MNA could pursue a data reporting requirement and a second MDH study. Additional data mandate could include: LPN/RN distinction and/or shift level staffing by unit.
2. Scale back a ratio bill. Ratios in ICUs only.
3. Proceed with a ratio bill. May not be able to get a hearing in 2015 in the Senate H&HS Policy Committee, alternatively push for a hearing in a Labor Committee.
4. Violence in the work place bill. Rep. Joe Atkins has said he will introduce “felony offense” legislation. Is it for just RNs, or any hospital worker injured on the job?
2015 Session Priorities
Policy Initiatives

- Support budget appropriations that position state public programs to more appropriately reflect the actual costs of providing the care. (The 2014 “rebasing” legislation needs to be evaluated and adjusted in either 2015 or 2016.)
- Advance mental health reforms, including increased expenditures, designed to improve access to and funding of mental health services across the care continuum.
- Secure provider access to all-payer, all-patient or all-provider data for purposes that advance the Triple Aim through legislation expanding access to the state’s All-Payer Claims Database.
- Promote policy reforms designed to improve the number, education and experience of Minnesota’s health care workforce; including proposed interstate provider compacts for physicians and nurses. Support efforts to promote greater adoption of tele-health.
- Pursue increased investment in Minnesota’s infectious disease preparedness and response capacity and coordination. Support state funding for hospital Ebola training and personal protective equipment supplies.

Mental health reforms

- MHA will not act unilaterally or in a vacuum. Numerous stakeholders and constituencies.
  - DHS “Year of Mental Health” proposals. Waiting for Governor’s budget to be released.
  - Mental Health Legislative Network
  - Mental Health Workforce Shortage work group
  - Offenders with Mental Illness work group
  - DHS detox services recommendations
  - DHS intensive community services rates work group
### Possible mental health legislation: Capacity & access

- Increase capacity of children’s residential or psychiatric residential treatment facilities (PRTFs).
- Rebase/increase reimbursement rates for mental health services
  - Community-based, outpatient services possibly with quality incentives
  - May target rate increases to intensive services, crisis teams, services delivered in jails
- Increase number of Behavioral Health Homes
- Grant funding or other support to create/expand access to Mental Health Urgent Care services
- Enhance telephonic crisis services
  - Develop uniform standards or protocols for crisis lines, as well as text/mobile
  - Consolidate crisis lines into single, uniform number

### Possible mental health legislation: Telehealth

- Require commercial plans to reimburse for telepsych, teletherapy.
- Allow telepsych services delivered at patient’s home
- Support funding for “last mile”
- Expand/finance telepsych
- Adopt Interstate Physician Licensure Compact
Possible mental health legislation: Transportation

- Develop pilot/demonstration project for protected mental health transportation
  - Not ambulance; not law enforcement
  - Regulatory relief to ease existing restrictions (MnDoT)
  - Grant/start-up funding
  - Incentives for vehicle donations/repurposing from state patrol, city/county law enforcement

Ebola ---Changed Perspectives

- Focus on emergency preparedness and first responders. Training and PPE resources.
- Emergency Care Coalition created and working on more sustainable funding.
- On-going MHA efforts to bring better coordination to infectious disease preparedness.

- Could advance:
  - mandatory flu vaccinations
  - interstate nurse and physician compact legislation
  - support for tele-health availability
Navigating the legislative process and the Capitol!
Discussion with Senator Tom Bakk, 12/30/2014:

- Forecast is solid, but limited new spending. Possible inflation increase for nursing homes.
- Concerned about physician shortages, particularly in rural MN.
- Caucus priorities include workforce development, partnering with our state colleges.
- A transportation bill.
- Hospitals are key to economic development in communities throughout MN!