Minnesota Department of **Human Services**

Memo

DATE: April 5, 2005

TO: The Honorable Linda Berglin, Chair
Health and Family Security Budget Division

FROM: Amy Dellwo
Legislative Liaison
Continuing Care Administration (296- 1368)

SUBJECT: Responses to question asked at the April 5, 2005 hearing on the SF 1607

Question: Regarding the ICF/MR closures, how many of them closed due to occupancy issues?

In current FY 05- two of the 10 closed due to occupancy issues. Two more will be closing due to low occupancy in the next three months.

- In FY 04- one of the six closed due to occupancy issues.
- In FY 03- one of the 13 closed due to occupancy issues.

Question: What were the results of the discussion with Mr. Waller regarding options for CareCo?

Senator Berglin asked the department to meet with Mr. Waller to see if any other solutions were available. The following three areas were discussed:

1. Conversion to waivered services: This involves follow up with Dakota County on the possibility of converting to a waiver site for two (four- bed) waiver sites under the same roof since this is possible given the structural design of the existing building. Mr. Waller agreed to discuss this again with Mr. Kruse at Dakota County, but indicated that Dakota county has not shown interest in pursuing this option. Also, Mr. Waller is not certain that this would be the best solution for his facility or the residents.

2. Legislation: This involves seeking legislative relief knowing it is not cost neutral and is the current course of action.

3. Closure: Mr. Waller voiced that he felt closure as an ICFMR MR by provider choice with appropriate notification to all involved was the probable course of action if new funding is not made available.

Question: How does the department treat ICF/MR conversions to the waiver programs?

A conversion means the provision of home and community-based services to a person discharged from an ICF/MR directly into those services resulting in decertification of an ICF/MR bed under Minnesota Statutes, section 252.28 subdivision 4.

ICF/MR costs include the rate for the ICF/MR as well as the day service, either DT&H, Services During the Day or Retirement.

The MR/RC rate for the conversion is based on set amounts. Often, but not always the conversion rate is less that the ICF/MR rate. The reduction of funding for ICF/MR and increase in MR/RC waiver activity is anticipated in the forecast and this type of movement is anticipated in the MA forecast.

In the discussion regarding SF 1607, Mr. Waller testified that he felt that Dakota County was not interested in moving the current ICF/MR beds to waiver beds.

For further clarification please contact Barb Nelson via 651-582-1969 or email at Barbara.A.Nelson@state.mn.us

A bill for an act

relating to insurance; creating a statewide health insurance pool for school district employees; appropriating money; amending Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 5; 297I.05, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 62A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [62A.662] [SCHOOL EMPLOYEE INSURANCE PLAN.]

Subdivision 1. [DEFINITIONS.] For purposes of this section:

(1) "eligible employee" means a person who is insurance eligible under a collective bargaining agreement or under the personnel policy of an eligible employer; and

(2) "eligible employer" means a school district as defined in section 120A.05; a service cooperative as defined in section 123A.21; an intermediate district as defined in section 136D.01; a cooperative center for vocational education as defined in section 123A.22; a regional management information center as defined in section 123A.23; an education unit organized under section 471.59; or a charter school organized under section 124D.10.

Subd. 2. [CREATION OF BOARD.] (a) The Minnesota School Employee Insurance Board is created as a public corporation subject to the provisions of chapter 317A, except as otherwise provided in this section. As provided in section 15.082, the state is not liable for obligations of this public corporation.

(b) The board shall create and administer the Minnesota School Employee Insurance Pool as described in this section.

(c) If the board does not offer coverage by December 15, 2008, the board expires and this section expires on that date.

Subd. 3. [BOARD OF DIRECTORS.] (a) The School Employee Insurance Board consists of:

(1) seven members representing exclusive representatives of eligible employees, appointed by exclusive representatives, as provided in paragraph (b); and

(2) seven members, appointed by the Minnesota School Boards Association, to represent the interest of eligible employers.

(b) The seven members of the board who represent statewide affiliates of exclusive representatives of eligible employees are appointed as follows: four members appointed by Education Minnesota and one member each appointed by the Service Employees International Union, the Minnesota School Employees Association, and American Federation of State, County, and Municipal Employees.

(c) Appointing authorities must make their initial appointments no later than August 1, 2005, by filing a notice of the appointment with the commissioner of commerce. Notices of subsequent appointments must be filed with the board. An entity entitled to appoint a board member may replace the board member at any time.

(d) Board members are eligible for compensation and expense reimbursement under section 15.0575, subdivision 3.

(e) The board must arrange for one or more methods of dispute resolution so as to minimize the possibility of deadlocks.

(f) The board shall establish governance requirements, including staggered terms, term limits, quorum, a plan of operation, and audit provisions.

Subd. 4. [DESIGN AND NATURE OF PLAN.] (a) Health coverage offered through the Minnesota School Employee Insurance Pool shall be made available by the board to all eligible employees of eligible employers, as defined in subdivision 1.

(b) The board must offer more than one health plan and may establish more than one tier of premium rates for any specific plan. Plans and premium rates may vary across geographic regions established by the board. The health plans must comply with chapters 62A, 62J, 62M, and 62Q, and must provide the optimal combination of coverage, cost, choice, and stability in the judgment of the board. All health plans offered must be approved by the commissioner of commerce.

(c) The board must include claims reserves, stabilization reserves, reinsurance, and other features that, in the judgment of the board, will result in long-term stability and solvency of the health plans offered.

(d) The board may determine whether the health plans should be fully insured through a health carrier licensed in this state, self-insured, or a combination of those two alternatives.

(e) The health plans must include disease management and consumer education, including wellness programs and measures encouraging the wise use of health coverage, to the extent determined to be appropriate by the board. The health plans must use the quality and performance measurements established for use by the state for its employee and public assistance programs.

(f) The board must confer with the service cooperatives and make a recommendation to the legislature on how health insurance reserves currently held by the service cooperatives will be dispensed.

(g) Upon request of the board, health plans that are providing or have provided coverage to employees of eligible employers within two years prior to the effective date of this section, shall provide to the board at no charge nonidentifiable aggregate claims data for that coverage. The information must include data relating to employee group benefit sets, demographics, and claims experience. Notwithstanding section 13.203, Minnesota service cooperatives must also comply with this paragraph.

Subd. 5. [MCHA MEMBERSHIP AND ASSESSMENTS.] The board is a

contributing member of the Minnesota Comprehensive Health Association and must pay assessments made by the association on its premium revenues, as provided in section 62E.11, subdivision 5, paragraph (b).

Subd. 6. [PREMIUM TAX OBLIGATIONS.] The board must pay taxes on premiums as provided in section 297I.05, subdivision 5, paragraph (c).

Subd. 7. [REPORT.] The board shall report to the legislature by January 15, 2007, on a final design for the pool that complies with subdivision 4 and on governance requirements for the board, including staggered terms, term limits, quorum, and a plan of operation and audit provisions. The report must include any legislative changes necessary to ensure conformance with chapters 62A, 62J, 62M, and 62Q.

Subd. 8. [PERIODIC EVALUATION.] (a) Beginning January 15, 2008, and for the next two years, the board must submit an annual report to the commissioner of commerce and the legislature, in compliance with sections 3.195 and 3.197, summarizing and evaluating the performance of the pool during the previous year of operation.

(b) Beginning in 2011 and in each odd-numbered year thereafter, the board must submit to the legislature a biennial report summarizing and evaluating the performance of the pool during the preceding two fiscal years.

Sec. 2. Minnesota Statutes 2004, section 62E.02, subdivision 23, is amended to read:

Subd. 23. [CONTRIBUTING MEMBER.] "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; ~~and~~ joint self-insurance plans regulated under chapter

62H; and the Minnesota School Employee Insurance Board created under section 62A.662. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization ~~or~~, a community integrated service network, or the Minnesota School Employee Insurance Board shall be considered to be accident and health insurance premiums.

Sec. 3. Minnesota Statutes 2004, section 62E.10, subdivision 1, is amended to read:

Subdivision 1. [CREATION; TAX EXEMPTION.] There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; the Minnesota School Employee Insurance Board created under section 62A.662; health maintenance organizations; and community integrated service networks licensed or authorized to do business in this state. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

Sec. 4. Minnesota Statutes 2004, section 62E.11, subdivision 5, is amended to read:

Subd. 5. [ALLOCATION OF LOSSES.] (a) Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the

association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance, MinnesotaCare, or general assistance medical care services according to chapters 256, 256B, and 256D shall be excluded when determining a contributing member's total premium.

(b) In making the allocation of losses provided in paragraph (a), the association's assessment against the Minnesota School Employee Insurance Board must equal the product of (1) the percentage of premiums assessed against other association members; (2) .3885; and (3) premiums received by the Minnesota School Employee Insurance Board. For purposes of this calculation, premiums of the board used must be net of rate credits and retroactive rate refunds on the same basis as the premiums of other association members.

Sec. 5. Minnesota Statutes 2004, section 297I.05, subdivision 5, is amended to read:

Subd. 5. [HEALTH MAINTENANCE ORGANIZATIONS, NONPROFIT HEALTH SERVICE PLAN CORPORATIONS, ~~AND~~ COMMUNITY INTEGRATED SERVICE NETWORKS, AND THE MINNESOTA SCHOOL EMPLOYEE INSURANCE BOARD.] (a) Health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations are exempt from the tax imposed under this section for premiums received in calendar years 2001 to 2003.

(b) For calendar years after 2003, a tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums received in the calendar year.

(c) A tax is imposed on the Minnesota School Employee Insurance Board under section 62A.662. The rate of tax is equal to .36 percent of gross premiums less return premiums received

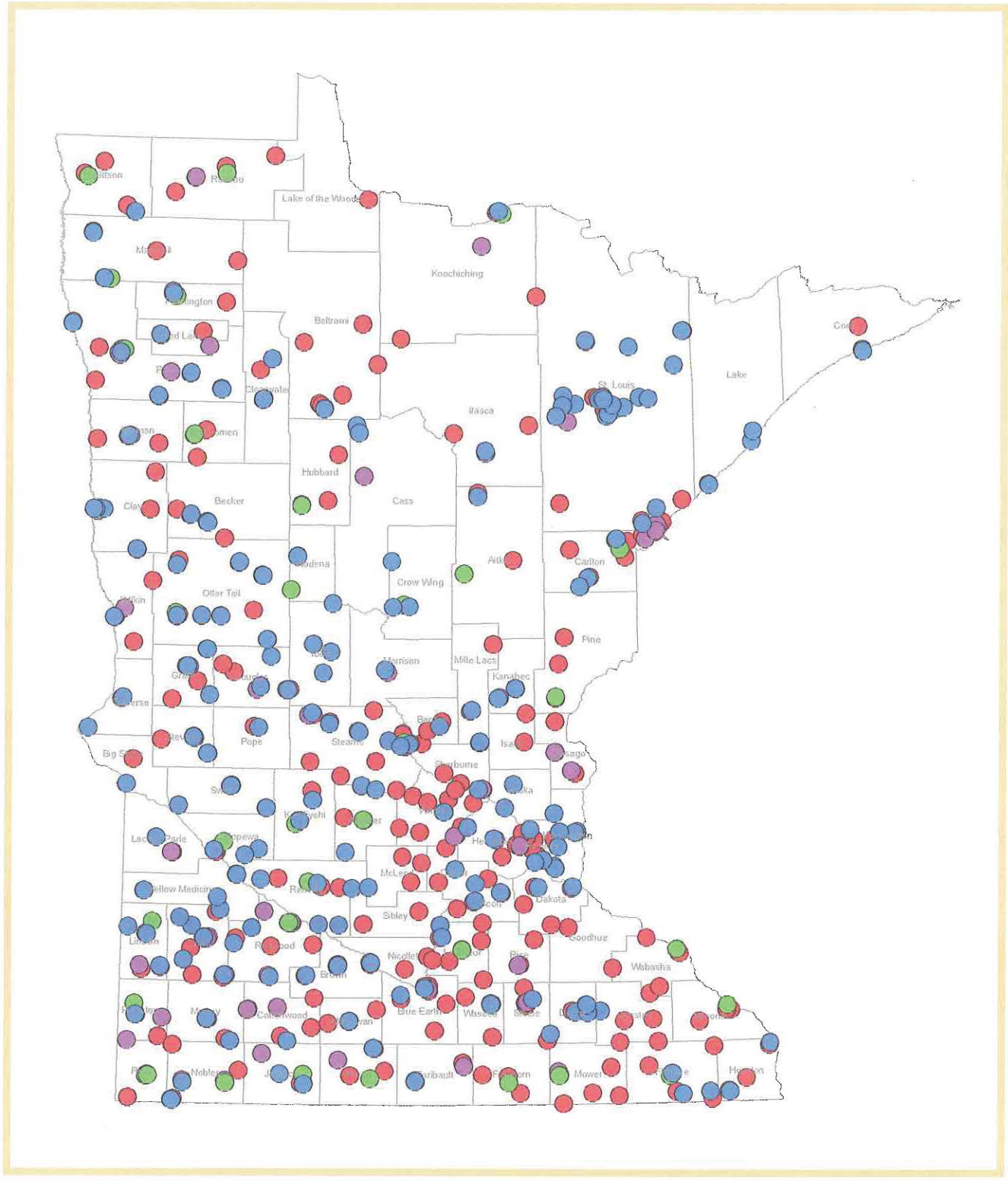
in the calendar year.

(d) In approving the premium rates as required in sections 62L.08, subdivision 8, and 62A.65, subdivision 3, the commissioners of health and commerce shall ensure that any exemption from tax as described in paragraph (a) is reflected in the premium rate.

~~(d)~~ (e) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, ~~and~~ nonprofit health service plan corporations , and the Minnesota School Employee Insurance Board in the health care access fund. Refunds of overpayments of tax imposed by this subdivision must be paid from the health care access fund. There is annually appropriated from the health care access fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 6. [APPROPRIATION; LOAN.]

$..... is appropriated from the general fund to the commissioner of commerce as a loan for start-up costs to the Minnesota School Employee Insurance Board. The Minnesota School Employee Insurance Board must repay the loan to the general fund in ten equal installments paid at the end of each fiscal year, beginning with the 2008 fiscal year.



N

Legend

- County Boundary
- Schools
- Government Agencies
- Counties
- Cities

Service Cooperative Groups Minnesota, March 2005

Map created on 3/18/2005 by Healthcare Informatics. Data source, Marketing

healthcare informatics

STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

Why is it important?

School districts are finding it impossible to continue to offer reasonable health insurance coverage to employees. Double-digit increases in health insurance costs will continue without reforming the system, and will only expand this problem.

Statewide health insurance for school employees, HF 517 and SF 1459, is smart public policy that will bring about reform and efficiency in how school districts offer health insurance coverage to employees. It will:

- Save millions of dollars, while providing a long-term, locally-controlled solution to the health insurance crisis confronting school districts;
- Curtail the skyrocketing growth in health-insurance premiums; and
- Allow school districts to continue to offer cost-effective, quality health care coverage to employees.

Statewide Health Insurance for School Employees is supported by AFSCME, AFL-CIO, MSEA and SEIU.

Contact Jan Alswager, manager of government relations, at 651-292-4890 or jan.alswager@educationminnesota.org for more information.

An organization of 70,000 educators doing what it takes to help students succeed.

41 Sherburne Avenue, St. Paul, MN 55103-2196
651-227-9541 | 800-652-9073 | FAX 651-292-4802
www.educationminnesota.org

Education Minnesota is an affiliate of the American Federation of Teachers, National Education Association and AFL-CIO.

Statewide Health Insurance for School Employees

HF 517 & SF 1459

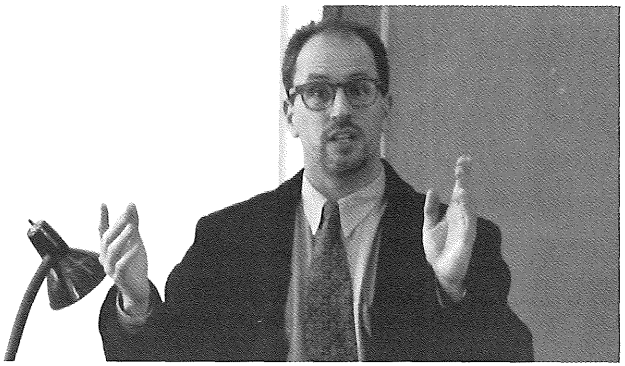
Smart public policy that will:

- Reform health insurance coverage for school employees
- Provide more efficient use of tax dollars

What is the problem?

- School districts and their employees are confronted with double-digit increases in health care coverage.
- Runaway costs are consuming school districts' revenues and employees' incomes.
- School districts and employees are being forced to reduce or even eliminate insurance coverage.
- Without the necessary reforms in this bill, all of these problems will continue to get worse.

HF 517 & SF 1459



STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

What is it?

HF 517 and SF 1459 are bills designed to create a statewide health insurance program for all school district employees and their families. The legislation is built on the state's own feasibility study that established the viability of the concept and estimated cost savings of approximately $223 million over the first six years of implementation.

The authors are Rep. Greg Davids (R-Preston) and Sen. Don Betzold (D-Fridley).

STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

What does the legislation do?

In short, the statewide health-insurance legislation would:

- Establish a risk pool of about 200,000 individuals, which would reform the current approach to health care coverage for school employees and generate significant cost savings. This will:
    - o Spread the costs of catastrophic claims across a much larger population;
    - o Reduce the likelihood of spikes in insurance premiums.
- Create a labor-management committee, with equal representation between labor and management, to develop and oversee all aspects of the program. This will:
    - o Provide continued local control through district and union negotiations. Individual school districts and the union will still determine which plan to offer, how much the district will contribute toward the premiums, and who is eligible for insurance.

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1459-2E **Complete Date:** 04/11/05

Chief Author: BETZOLD, DON

Title: SCHOOL EMPLOYEE INSURANCE BOARD

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agencies: Commerce (04/11/05) Education Department (04/11/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund		538	537		
Commerce		538	537		
Revenues					
General Fund				108	108
Commerce				108	108
Net Cost <Savings>					
General Fund		538	537	(108)	(108)
Commerce		538	537	(108)	(108)
Total Cost <Savings> to the State		538	537	(108)	(108)

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50		
Commerce		0.50	0.50		
Total FTE		0.50	0.50		

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 04/11/05 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S1459-2E **Complete Date:** 04/11/05

Chief Author: BETZOLD, DON

Title: SCHOOL EMPLOYEE INSURANCE BOARD

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Commerce

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		538	537		
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		538	537		
Revenues					
General Fund				108	108
Net Cost <Savings>					
General Fund		538	537	(108)	(108)
Total Cost <Savings> to the State		538	537	(108)	(108)

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50		
Total FTE		0.50	0.50		

Bill Description

Senate File 1459-2E proposes the following:

1) Creates a statewide health insurance pool for school district employees.
2) Creates a 14 member board to create and administer the Minnesota School Employee Insurance Pool. Board members are eligible for compensation and expense reimbursements.
3) The board must provide to the legislature by January 1, 2007:
   a) The final plan designs (including benefits, claim and stabilization reserves, reinsurance, and whether the plan will be self-insured or fully insured through a health carrier.
   b) Review the current group benefits experience of school districts to determine new coverage and premiums, necessary legislative changes, and governance requirements for the board.
4) Beginning January 1, 2008, the board must report to the Legislature and the Department of Commerce. The report must summarize and evaluate the performance of insurance the pool during the preceding year.
5) The Board will receive an appropriation.
6) The Board must repay the appropriation in 10 equal installments, beginning in FY 2008.

Assumptions

1) The Department of Commerce and the Board will require extensive actuarial services to set up the insurance pool.
2) The Department of Commerce will incur expenses to conduct the study.

Expenditure and/or Revenue Formula

	FY 2006	FY 2007	FY 2008	FY 2009
Expenditure - Actuarial Services	$500,000	$500,000		
Expenditure - Board Member Expenses	$12,500	$12,500		
Expenditure - Department Support Staff	$25,000	$25,000		
Total Annual Expenditure:	**$537,500**	**$537,500**		
Revenue - Loan Repayment			$107,500	$107,500

Long-Term Fiscal Considerations

None.

Local Government Costs

Individual school districts could see cost reductions or increases, depending on the type of plan the districts currently have.

References/Sources

John Gross
john.gross@state.mn.us
651-297-2319

Study: State Wide Health Insurance Pool for School District Employees and Retirees
January 23, 2004

Agency Contact Name: John Gross 651-297-2319
FN Coord Signature: MICHAEL F. BLACIK
Date: 04/08/05 Phone: 297-2117

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 04/11/05 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S1459-2E **Complete Date:** 04/11/05

Chief Author: BETZOLD, DON

Title: SCHOOL EMPLOYEE INSURANCE BOARD

Agency Name: Education Department

Fiscal Impact	Yes	No
State		X
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

Senate File 1459 creates a permissive statewide health insurance pool for school district employees, creates the Minnesota School Employee Insurance Board of 14 members as defined in the bill, requires a plan to be designed and made available to all employees of eligible employers, and provides other requirements regarding the establishment of the statewide insurance pool.

Assumptions

All state costs associated with this bill will be identified and included in the Department of Commerce fiscal note.

The Minnesota Department of Education (MDE) does not have expertise in the area of establishing and creation of insurance pools and related requirements.

MDE does not have information regarding the number of school districts and employees that would participate in this insurance pool.

Expenditure and/or Revenue Formula

No appropriation is provided in the bill.

Long-Term Fiscal Considerations

The change would be permanent.

Local Government Costs

MDE does not any data as to the fiscal impact that this bill would have on the local school districts. Depending upon the eventual disposition of service cooperative reserves, member school districts may be affected.

References/Sources

Agency Contact Name: Bulger, John 651-582-8781
FN Coord Signature: AUDREY BOMSTAD
Date: 04/08/05 Phone: 582-8793

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: LISA MUELLER
Date: 04/11/05 Phone: 296-6661

Senate Counsel, Research, and Fiscal Analysis

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DIRECTOR

Senate

State of Minnesota

S.F. No. 1459 - School Employee Health Insurance Pool (Second Engrossment)

Author: Senator Don Betzold

Prepared by: Christopher B. Stang, Senate Counsel (651/296-0539)
Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 8, 2005

Section 1 establishes the school employee insurance plan.

Subdivision 1 defines the terms "eligible employee" and "eligible employer." An eligible employer is a school district or a related entity listed in the definition.

Subdivision 2 creates a board to create and administer the health insurance pool. The board would be a public corporation subject to chapter 317A, except as otherwise provided. The state is not liable for the obligations of the corporation. The board expires if coverage is not offered by December 15, 2008.

Subdivision 3 provides that the board has 14 members: seven appointed by school employee unions and seven appointed by the Minnesota School Boards Association. Requires that initial appointments to the board be made by August 1, 2005. Provides that board members are eligible for reimbursement of expenses on the same basis as members of other state-related boards. Requires the board to establish governance requirements.

Subdivision 4 requires that the health coverage be available to all eligible employees of eligible employers. Requires the board to offer more than one health plan and allows the board to establish more than one tier of premium rates for a plan. Permits geographic variations. Requires plans to comply with specified health insurance laws and provide the optimal combination of coverage, cost, choice, and stability. The plans offered must be approved by the Commissioner of Commerce. Requires claims reserves, stabilization reserves, reinsurance, and other features to achieve stability and solvency. Permits the board

to decide whether the health plans should be fully insured, self-insured, or some combination. Requires the health plans to include disease management and consumer education, including wellness programs, and measures to encourage wise use of health coverage. Requires the board to confer with the service cooperatives and make recommendations to the Legislature on how health insurance reserves held by the cooperatives will be dispersed. Requires health plans providing coverage to employees of eligible employers within two years prior to the effective date of this section to provide to the board, on request, specified aggregate claims data.

Subdivision 5 requires the board to be a contributing member of the Minnesota Comprehensive Health Association (MCHA) and pay assessments according to section 4.

Subdivision 6 requires the board to pay a premium tax as specified in section 5.

Subdivision 7 requires the board to report to the Legislature by January 15, 2007, on final design for the pool. Legislative changes needed to ensure conformance with specified health insurance laws must be included in the report.

Subdivision 8 requires periodic reporting by the board to the Legislature summarizing and evaluating performance of the pool.

Section 2 adds the board as a contributing member under MCHA.

Section 3 is a conforming change.

Section 4 sets the board's allocation of MCHA losses pursuant to a specified formula intended to hold MCHA harmless.

Section 5 creates a premium tax of .36 percent for the board in order to hold the premium tax base harmless.

Section 6 provides an appropriation of an unspecified amount from the general fund as a loan for start-up costs. Requires that the loan be repaid to the general fund over ten years beginning in the 2008 fiscal year.

CBS:KC:ph

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1459: A bill for an act relating to insurance; creating a statewide health insurance pool for school district employees; appropriating money; amending Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 5; 297I.05, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 62A.

Reports the same back with the recommendation that the bill be amended as follows:

Page 2, after line 36, insert:

"(b) If an eligible employer provides health coverage or money to purchase health coverage to eligible employees, the coverage must be provided or purchased only through the health plans offered by the board."

Page 3, line 1, delete "(b)" and insert "(c)"

Page 3, line 9, delete "(c)" and insert "(d)"

Page 3, line 13, delete "(d)" and insert "(e)"

Page 3, line 16, delete "(e)" and insert "(f)"

Page 3, line 23, delete "(f)" and insert "(g)"

Page 3, line 27, delete "(g)" and insert "(h)"

Page 3, after line 35, insert:

"(i) Effective July 1, 2005, no contract entered into between an eligible employer and an eligible employee or the exclusive representative of an eligible employee shall contain provisions that establish cash payment in lieu of health insurance to an eligible employee if the employee is not receiving such payment on or before June 30, 2005. Nothing in this section shall prevent any eligible employee who otherwise qualifies for payment of cash in lieu of insurance on June 30, 2005, to continue to receive this payment."

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin

(Division Chair)

April 12, 2005

(Date of Division action)

Senators Kubly, Rosen, Koering, Senjem and Lourey introduced--

S.F. No. 1567: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for rural pharmacy preservation; establishing a rural pharmacy grant program; modifying the rural loan forgiveness program; appropriating money; amending Minnesota Statutes 2004, section 144.1501, subdivisions 1, 2, 3; proposing coding for new law in Minnesota Statutes, chapter 144.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [144.1476] [RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For the purposes of this section, the following definitions apply.

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license

issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. [GRANTS AUTHORIZED; ELIGIBILITY.] (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what pharmacy services are needed and desired by the community. The assessment must include interviews with or surveys of area and local health professionals, local community leaders, and public officials;

(2) an assessment of the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes; and

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. [FUNDING.] Notwithstanding section 214.06, subdivision 1, any revenue collected by the Board of Pharmacy in excess of the board's expenditures shall be credited to a rural pharmacy grant account. Money in the account is appropriated to

the commissioner of health to issue grants under this section. No more than ten percent of the money appropriated may be used to pay for administrative expenses.

Subd. 4. [CONSIDERATION OF GRANTS.] In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues including two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

Subd. 5. [ALLOCATION OF GRANTS.] (a) The commissioner shall establish a deadline for receiving applications and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year. Each relevant community board has 30 days in which to review and comment to the commissioner on eligible applications.

(b) Any grant awarded must not exceed $50,000 a year and may not exceed a one-year term.

(c) Applicants may apply to the program each year they are eligible.

(d) Project grants may not be used to retire debt incurred with respect to any capitol expenditure made prior to the date

on which the project is initiated.

Subd. 6. [EVALUATION.] The grant program shall be evaluated annually in reports by the recipients of the grants. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a recipient or the commissioner.

Sec. 2. Minnesota Statutes 2004, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered

nurses for advanced practice as nurse practitioners.

(i) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(j) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(j)~~ (k) "Physician assistant" means a person registered under chapter 147A.

~~(k)~~ (l) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(l)~~ (m) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 3. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas or underserved urban communities, for midlevel practitioners agreeing to practice in designated rural areas, ~~and~~ for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions, and for pharmacists who agree to practice in designated rural areas. Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 4. Minnesota Statutes 2004, section 144.1501, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY.] (a) To be eligible to participate in the loan forgiveness program, an individual must:

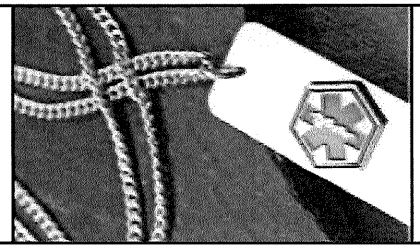
(1) be a medical resident or a licensed pharmacist or be enrolled in a midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 5. [APPROPRIATION.]

$200,000 in fiscal year 2006 and $200,000 in fiscal year 2007 are appropriated from the health occupations licensing account in the special revenue fund to the commissioner of health for purposes of Minnesota Statutes, section 144.1476. This is a onetime appropriation.



RURAL PHARMACY PRESERVATION ACT

ACCESS TO PHARMACISTS in rural Minnesota is nearing a crisis point. Pharmacies and pharmacists not only provide drug therapy and health care guidance regarding medications to patients coming into their pharmacy, they also serve local nursing homes, hospitals and other entities by providing medication reviews for patients, and ordering and delivering medications.

Rural pharmacy is fragile in today's environment due to increasing costs of doing business and continuous cuts to pharmacy reimbursement in both the public and private sectors. The result is many rural Minnesotans are loosing access to medications and the knowledge of a pharmacist. Incorporation of a rural pharmacy planning and transition grant program and rural loan forgiveness provides support to initiatives that preserve access to Pharmacy services for rural Minnesotans and assists rural communities in attracting pharmacists.

- A study of 126 rural communities with only one community pharmacy in Minnesota revealed that the 216,000 patients within these community's limits, would have to travel, on average, 22 miles to a neighboring community to receive medications. Not having access to a pharmacists or a pharmacy is also an issue for rural primary care clinics, health systems and rural communities.

- Minnesota loses 38 pharmacies per year: 10-12 of those community pharmacies are not replaced. From July 2004 to February 2005, Minnesota lost 22 pharmacies.

MAINTAINING LOCAL ACCESS TO MEDICATIONS AND THE KNOWLEDGE OF A PHARMACIST

- Through the grant program hospitals, clinics, pharmacies and communities can collaborate and explore options to maintain local access to medications and the skills of a pharmacist. This grant program for pharmacy is needed to keep up with and reverse pharmacy closures and loss of pharmacists in rural areas.

- The grant program will be funded by excess licensure fees paid by pharmacists, pharmacies and wholesalers and collected by the Board of Pharmacy. Since the Board's budget has remained at a fixed rate and the fees brought in from licensures have increased, excess revenues have been swept into the state's special revenue fund. The excess fees will be dedicated to the grant program, which will be administered by the Minnesota Department of Health. The initiative will help pharmacy sustain pharmacy.

- In addition, rural pharmacist loan forgiveness is another incentive to attract new graduates to the rural areas that are in need of a pharmacist. The current rural loan-forgiveness program, funded by the provider tax and wholesale drug distributor tax incurred by pharmacies, encourages students graduating from the health care professions to practice in rural areas. However, this program currently does not include pharmacists. With the growing pharmacist shortage in rural areas it is necessary to add pharmacists into the program.

MINNESOTA PHARMACISTS ASSOCIATION • 1935 West County Road B-2, Suite 450 • Roseville, MN 55113

651-697-1771 Metro • 800-451-8349 MN • Fax: 651-697-1776 • Liz@mpha.org • Abbie@mpha.org

March 22, 2005

Dear Legislator,

Please accept this written testimony in support of Senate File 1567, the Rural Pharmacy Preservation Act. Thank you for this opportunity.

My name is Doug Thomas. I live and work in Henderson, Minnesota and co-chair the Henderson Chamber of Commerce and chair its retail subcommittee. Eighteen months ago, our local pharmacy closed after being purchased some three years earlier by a neighboring pharmacy from LeSueur. Of course, the reason for closing was stated to be lack of revenues and heavier regulation of the pharmacy industry. The business had been in continuous operation for seventy years and was a thriving cornerstone in our small, but growing community sixty miles SW of Minneapolis.

As a result of the closing, twenty local community investors bought the business, completely restored the store, including the classic soda fountain, and re-opened the store without the pharmacy. Henderson's Main Street is a national historic preservation district so the corner drug store is key to preservation efforts. We then set about to recruit a pharmacist. With a terrific facility, strong community support (born out in a community survey), and promising population growth (33% in the past ten years), we thought our chances were quite good. Not so. The deck is stacked against young pharmacists who want to live and work in rural Minnesota, let alone own their own pharmacy. I spent a good deal of time investigating the issues surrounding this situation and found that:

1) Pharmacy graduates are strapped with excessive student debt and few options for repayment exist other than finding the highest paying job, nearly always in a metro area.

2) Very few national chains have any interest in smaller communities, no matter how established the business.

3) Large companies offer incentives to new pharmacists that blatantly discriminate against rural pharmacies.

4) There is a serious lack of state support for rural pharmacy recruitment and retention.

The Rural Pharmacy Preservation Act, administered by the Minnesota Department of Health, can play an important part in restoring service to many areas of Minnesota. If we think hospitals and clinics are important to rural areas, we must also support their small town counterparts, rural pharmacies.

Although we in Henderson are involved in historic preservation, this is not a nostalgic issue. We are all about being creative and innovative about a new kind of partnering around the pharmacy and health care industry. Through extensive recruiting efforts, we recently signed on with Sibley Medical Center to bring medical clinic services to our community and are in hopes of building a medical arts facility to bring dental, chiropractic and possibly pharmacy services in an integrated fashion to our community. Without further support for new pharmacists, we stand little chance, even as close to the metro area as we are, of being successful in our recruiting efforts.

We ask for your support for this tremendous need in rural Minnesota and communities like Henderson that are working hard to maintain economic and health care integrity. Please vote for S.F. 1567. Thank you very much.

Sincerely,

Doug Thomas
Henderson Chamber of Commerce
25899 335th Ave.
Henderson, Minn. 56044

Tyler Healthcare Center
Avera Health

240 Willow Street
P.O. Box 280
Tyler, MN 56178
(507) 247-5521
Fax (507) 247-5972

March 22, 2005

Dear Legislative Committee,

As a Critical Access Hospital located in Southwest Minnesota, Tyler Healthcare Center was very fortunate to receive funding through the Rural Hospital Planning and Transition Grant Program last year. We were identified as one of many rural communities that would likely be facing a critical pharmacy shortage because our local pharmacist was nearing retirement and had been unable to sell his retail pharmacy. Additionally, he had been the sole hospital pharmacist providing about 2 hours per day of hospital pharmacy coverage for many years.

The Rural Hospital Planning and Transition funding allowed us to 1) address critical needs with respect to the delivery of pharmacy services within our organization and in the community, and 2) establish a rural pharmacy residency practice partnership with the University of Minnesota. This program allowed us to establish a full time pharmacy residency position at our hospital. The pharmacy resident has worked to improve the delivery of pharmacy services in the inpatient and outpatient settings, provide support to existing medical staff with respect to medication use issues and participate in THC quality assurance activities.

With the success of the collaboration with the pharmacy residency program and recognition of the level of service improvement that has been generated by establishing a full-time equivalent pharmacist position in the organization, THC has decided to move from relying on a part-time contract arrangement with our local pharmacist and has hired the current pharmacy resident as a full-time staff pharmacist at the completion of her post-graduate educational experience (June '05). In addition, we plan to continue our relationship with the University of Minnesota Pharmaceutical Residency program and recruit another pharmacy practice resident for 2005-06, thus establishing two full-time pharmacist positions within the organization.

While the full scope of pharmacy services at THC continues to develop and mature, much has been learned from this experience already. We believe that this is a "Model that Works". We urge you to support any programs such as rural practice partnerships, loan forgiveness programs and other programs that could increase the number of pharmacists willing to work in rural communities.

From many perspectives, the results of the initiatives made possible from the Rural Hospital Planning and Transition Grant program have been highly positive and have allowed THC to establish a sustainable approach to pharmacy services after a period when the ability to do so was in question. Not only has the availability of pharmacist-staff been stabilized and increased, the ability for pharmacists to contribute to the overall medication use process at THC has expanded. This has allowed for a greater collaborative approach across multiple health disciplines, improving the medication use experience for patients receiving inpatient, outpatient and long-term care from THC.

Thank you for your continued support of rural healthcare services.

Sincerely,

Rhonda Wiering

Rhonda Wiering, RN, BC, LNHA
Patient Care Director

MRHA
MN Rural Health Association
316 Woodshire Drive
Mankato, MN 56001
507.625.2003
507.625.1216 - fax

March 11, 2005

Dear Legislator:

The Minnesota Rural Health Association is pleased to provide this letter of support on behalf of the Rural Pharmacy Preservation Act (HF 1642/SF 1567). The Rural Pharmacy Preservation Act will:

- Utilize excess Board of Pharmacy licensure fees to fund Rural Pharmacy Planning and Transition Grants to rural communities, rural pharmacies or health systems operating in rural communities to plan, establish, keep in operation or operate a health system which will preserve access to prescription medications and the skills of a pharmacist; and

- Include pharmacists who are willing to practice in designated rural areas in Minnesota's Health Professional Education Loan Forgiveness Program. Pharmacists were not included in this program during the last legislative session; recent pharmacy graduates, who may incur $80,000 or more in student loan debt, are often attracted to urban pharmacy positions where employers offer to pay back a large portion of the new pharmacist's student loans. Pharmacies and hospitals in small rural communities lack the financial resources to compete with these offers.

Pharmacists practicing in Minnesota's isolated rural towns are oftentimes one of the few healthcare providers in those towns, if not the entire county. Residents of rural Minnesota communities tend to be older, poorer and have more medical needs than their urban counterparts; ironically, these Minnesotans are also less likely to have private health insurance coverage – and thus less access to healthcare services – than their urban counterparts. As a regular provider of first-contact care in rural communities, the pharmacist serves as a pivotal and excellent source of information for rural patients regarding cost-effective self-treatment as well as appropriate referrals to higher levels of care within the healthcare system. Pharmacies also tend to be open for more hours of business than physician offices or clinics, providing patients and the healthcare system with a cost-effective, convenient source of drop-in care.

.../2

In addition, many rural communities rely upon their local pharmacists to conduct monthly reviews of the medications being given to every patient in a nursing home or long-term care facility, as required by the federal Centers for Medicare and Medicaid Services (CMS). The most isolated rural communities, such as Grand Marais, further rely on their local community pharmacist to provide pharmacy services to patients in the local hospital.

Over the last 2½ years, approximately 90 Minnesota community pharmacies have closed, 42% of these being in rural communities. Data from the University of Minnesota's Pharmacy Rural Education, Practice and Policy (PREPP) Institute indicate that the average age of pharmacists currently practicing in Minnesota's rural communities is 50 years old. Many of these pharmacists are looking to retire within 5-10 years, at the same time that fewer and fewer pharmacy program graduates are selecting rural communities in which to practice. The Rural Pharmacy Preservation Act aims to reverse these trends and preserve vital pharmacist services in rural communities by assisting communities in attracting and retaining these highly trained healthcare professionals in the face of stiff salary competition for pharmacists from Minnesota's urban centers.

Please vote in support of this important rural healthcare issue. Thank you.

Sincerely,

Ray Christensen, MD
President, Minnesota Rural Health Association

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
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JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1567 - Rural Pharmacy Grant Program

Author: Senator Gary W. Kubly

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 21, 2005

S.F. No. 1567 creates a rural pharmacy planning and transition grant program and extends the loan forgiveness program to pharmacists who agree to practice in a designated rural area.

Section 1 (144.1476) establishes the rural pharmacy grant program.

Subdivision 1 defines the following terms: "eligible rural community," "health care provider," "pharmacist," and "pharmacy."

Subdivision 2 requires the Commissioner of Health to establish a program to award grants to eligible rural communities or health care providers for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist. The applicant for a grant is required to develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. The strategic plan must consist of a needs assessment to determine what pharmacy services are needed and desired by the community, the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes, and an implementation plan. A grant may be used to implement transition projects to modify the type and extent of pharmacy services provided that reflects the needs of the community, to develop pharmacy practices that integrate pharmacy and existing health care provider facilities, or to establish a pharmacy provider cooperative or initiative that maintains local access to prescription medications and the skills of a pharmacist

Subdivision 3 states that any excess revenue collected by the Board of Pharmacy must be credited to a rural pharmacy grant account. Money in the account is appropriated to the

commissioner to issue grants under this program. No more than ten percent of the money appropriated may be used to pay for administrative expenses.

Subdivision 4 states that the commissioner shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues to determine which applicants should receive grants under this program. The committee shall take into account improving or maintaining access to prescription medications and the skills of a pharmacist; changes in service populations; the extent pharmacy needs are not being met by other providers in the area; the financial condition of the applicant; the integration of pharmacy services into existing health care providers; and community support.

Subdivision 5 requires the commissioner to establish an application deadline and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year. Each relevant community board has 30 days in which to review and comment to the commissioner on eligible applications. Each grant awarded may not exceed $50,000 a year and may not exceed a one-year term. Applicants may apply each year they are eligible. A grant may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Subdivision 6 requires the grantees to submit annual evaluations. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the evaluation if requested by a grantee or the commissioner.

Sections 2 to 4 (144.1501) expand the loan forgiveness program to permit a licensed pharmacist who agrees to practice in a designated rural area to participate in the loan forgiveness program.

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1567-0 **Complete Date:** 03/31/05

Chief Author: KUBLY, GARY

Title: RURAL PHARMACY PRESERVATION

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agencies: Health Dept (03/31/05) Pharmacy Board (03/30/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
Misc Special Revenue Fund		200	200		
Health Dept		200	200		
Revenues					
Misc Special Revenue Fund		200	200		
Health Dept		200	200		
Net Cost <Savings>					
Misc Special Revenue Fund		0	0		
Health Dept		0	0		
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/31/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1567-0 **Complete Date:** 03/31/05

Chief Author: KUBLY, GARY

Title: RURAL PHARMACY PRESERVATION

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Health Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Misc Special Revenue Fund		200	200		
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Misc Special Revenue Fund		200	200		
Revenues					
Misc Special Revenue Fund		200	200		
Net Cost <Savings>					
Misc Special Revenue Fund		0	0		
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

This bill:

Section 1 establishes Rural Pharmacy Planning and Transition Grant Program. The program would be administered by the Commissioner of Health. Section 1, subd. 3, provides that revenue collected by the board of pharmacy in excess of its expenditures be credited to a rural pharmacy grant account and appropriated to the commissioner of health for the program.

Sections 2, 3 and 4 add pharmacists who agree to practice in designated rural areas to the health professions loan forgiveness program established at M.S. 144.1501.

Section 5 provides an appropriation of $200,000 each year in 2006 and 2007 from the health occupations licensing account in the State Government Special Revenue Fund for the Rural Pharmacy Planning and Transition Grant Program.

Assumptions

Section 1 MDH assumes that .1 FTE (208 hours) will be needed for administration and evaluation of the Rural Pharmacy Planning and Transition Grant Program. MDH administrative costs are capped at 10% of the appropriation. An average of 7-8 grants/year, with an average award of $25,000 (some larger, some smaller) is assumed. Regarding the ongoing appropriation to the program of excess board of pharmacy revenues, MDH contacted the board, and was informed the board does not have an estimate of these revenues. Therefore, no appropriation figures are included beyond FY 2007.

Sections 2, 3 and 4. Seeing no appropriation in the bill for additional loan forgiveness funds, MDH assumes the bill effect is to provide pharmacists a share of the loan forgiveness program's existing appropriation. Current state staff administering the loan forgiveness program can absorb adding this profession to the existing program.

Expenditure and/or Revenue Formula

Expenditures	**FY2006**	**FY2007**	**FY2008**	**FY2009**
Grants (approx. 8 /year @ $25,000 avg.)	$180,000	$180,000		
Operations Support (per sec. 1, subd. 3)	20,000	20,000		
	$200,000	$200,000		

Long-Term Fiscal Considerations

None

Local Government Costs

None

References/Sources

Mark Schoenbaum, Minnesota Department of Health
David Holmstrom, Board of Pharmacy (Board of Pharmacy is also submitting a fiscal note)

Agency Contact Name: Mark Schoenbaum (651-282-3859)
FN Coord Signature: MARGARET KELLY
Date: 03/31/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/31/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1567-0 **Complete Date:** 03/30/05

Chief Author: KUBLY, GARY

Title: RURAL PHARMACY PRESERVATION

Agency Name: Pharmacy Board

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

HF 1642-0 and SF 1567-0 - Rural Pharmacy Preservations

This bill has two functions:

1. To establish a rural pharmacy grant program that allows rural communities to apply for a grant to either establish a new pharmacy in rural areas or to preserve an existing pharmacy in rural areas. This grant program would be established through the Dept. of Health.
2. To establish and fund an education loan forgiveness program for pharmacy students agreeing to practice in designated rural areas. This forgiveness program would be established through the Dept. of Health.

Assumptions

It is assumed by the Board of Pharmacy that the Dept. of Health would appoint an individual from the Board of Pharmacy to serve as a member of the committee under the Dept. of Health which will review grant applications and establish the grants program.

Section 1, subd 3 - Funding

- Under this section the bill states, "Any revenue collected by the Board of Pharmacy in excess of the board's expenditures shall be credited to a rural pharmacy grant account."
- The Dept. of Health may keep no more than 10% of money appropriated to cover administrative expenses.

Section 5 – Appropriations

- Under this section the bill states, "$200,000 in FY 2006 and $200,000 in FY 2007 are appropriated from the health occupations licensing account in the special revenue fund to the commissioner of health for purposes of Minnesota Statutes, section 144.1476."

It is assumed by the Board of Pharmacy regarding the grant program that:

1. The funding information that is stated under section 1, subd 3 needs to be clarified. The Board of Pharmacy receives a direct appropriation to cover the costs of administering the board, an open appropriation to cover the cost of the state-wide indirect costs and also pays for items indirectly such as the cost of the Health Professional Services Program (HPSP), legal services from the Attorney General's Office (AGO) and costs associated with the Administrative Services Unit (ASU). The board would need to make sure that all these costs are covered before any funds could be appropriated to this grant program.
2. Currently the Board of Pharmacy is collecting approximately $150,000 of excess revenue each year.
3. The Board of Pharmacy suggests the language that states, "Any revenue collected by the Board of Pharmacy in excess of the board's expenditures shall be credited to the rural pharmacy grant account" be modified. The board suggests a portion of the excess revenues collected by the board continue to be deposited in the state government special revenue fund in order to cover any unexpected expenditures from the HPSP, ASU or AGO due to contested case activity or other such events. The Board of Pharmacy suggests the language in subd. 3 be modified to read, "80 percent of the excess revenue collected by the Board of Pharmacy be credited to the rural pharmacy grant program." That would leave the board with 20 percent to be used to cover unanticipated costs.

It is assumed by the Board of Pharmacy regarding the loan forgiveness program that:

1. The Board of Pharmacy assumes that the loan forgiveness program is just adding Pharmacists to the same scope as all the other professions already in the program and that the program will be funded in the same manner as in the past.
2. Funding will continue to be appropriated to an account under the Dept of Health.
3. The Board assumes that this program would be funded in the same manner as the current loan forgiveness program that other professions are in and that funding for the loan forgiveness for pharmacists would not be taken from the health occupations licensing account or from annual fee revenue in excess of expenditures as is the case with the grant program.
4. The Board of Pharmacy assumes that there will be no costs allocated to the board.

Expenditure and/or Revenue Formula

The grant program would not cost the board directly but indirectly - $400,000 would be transferred from the health

occupations licensing account to fund the program initially and an unidentified amount each year after FY 2007. This would reduce health occupations licensing account accumulative surplus. If the surplus is reduced and if high costs are incurred because of an unanticipated contested case, the board would then need to make a decision to possibly increase fees to cover those unanticipated costs.

Long-Term Fiscal Considerations

Future adjustment of fees for the Board of Pharmacy to stay in compliance with M.S. 16A.1285, Sub 2 would impact the source of funding for the proposed rural pharmacy grant program.

Local Government Costs

References/Sources

FN Coord Signature: JULI VANGSNESS
Date: 03/30/05 Phone: 617-2120

EBO Comments

The health licensing boards incur both direct expenditures (salaries) and indirect expenditures (Attorney General). Minnesota Statutes 214.06, Subdivision 1 requires that health-licensing boards collect fees that closely as possible equal anticipated direct and indirect expenditures during the fiscal biennium. HF 1642 Section 1, Subdivision 3 needs to clarify that expenditures include both direct and indirect expenditures.

Minnesota Statutes 214.06, Subdivision 1 also states that fees collected by the health licensing boards be credited to the health occupations licensing account in the state government special revenue fund. A purpose of the consolidated health licensing account is to pool the non-dedicated revenue from fees collected by the boards in order to cover unanticipated costs the boards incur from contested cases.

Two considerations need to be considered when deciding to statutorily dedicate excess revenue collected by the Board of Pharmacy:

1. The statutory requirement stated above that health-licensing boards collect fees that closely as possible equal anticipated direct and indirect expenditures during the fiscal biennium.
2. Future fee adjustments will impact the funding source of the grant program.

EBO Signature: DOUG GREEN
Date: 03/30/05 Phone: 286-5618

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 1567 as follows:

Page 2, delete lines 33 to 36

Page 3, delete lines 1 to 3

Page 3, line 4, delete "4" and insert "3"

Page 3, line 8, delete "including" insert ", including, but not limited to,"

Page 3, after line 23, insert:

"The commissioner may also take into account other relevant factors."

Page 3, line 24, delete "5" and insert "4"

Page 3, line 29, delete everything after the period

Page 3, delete line 30

Page 4, delete lines 2 to 6 and insert:

"Subd. 6. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues."

Page 6, line 16, after the first "the" insert "state government"

Page 6, delete line 18

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1567: A bill for an act relating to health; providing for rural pharmacy preservation; establishing a rural pharmacy grant program; modifying the rural loan forgiveness program; appropriating money; amending Minnesota Statutes 2004, section 144.1501, subdivisions 1, 2, 3; proposing coding for new law in Minnesota Statutes, chapter 144.

Reports the same back with the recommendation that the bill be amended as follows:

Page 2, delete lines 33 to 36

Page 3, delete lines 1 to 3

Page 3, line 4, delete "4" and insert "3"

Page 3, line 8, delete "including" and insert ", including, but not limited to,"

Page 3, after line 23, insert:

"The commissioner may also take into account other relevant factors."

Page 3, line 24, delete "5" and insert "4"

Page 3, line 29, delete everything after the period

Page 3, delete line 30

Page 4, delete lines 2 to 6 and insert:

"Subd. 5. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues."

Page 6, line 16, after the first "the" insert "state government"

Page 6, delete line 18

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin
(Division Chair)

April 12, 2005
(Date of Division action)

A bill for an act

relating to health; establishing the Health Information Technology and Infrastructure Advisory Committee; modifying hospital and clinic grant programs; eliminating community health center program; amending Minnesota Statutes 2004, sections 144.147, subdivision 2; 144.148, subdivision 1; 144.1483; 145.9268; proposing coding for new law in Minnesota Statutes, chapter 62J; repealing Minnesota Statutes 2004, section 144.1486.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [62J.495] [HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ADVISORY COMMITTEE.]

Subdivision 1. [ESTABLISHMENT; MEMBERS; DUTIES.] (a) The commissioner shall establish a Health Information Technology and Infrastructure Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for administrative data exchange, clinical support programs, and maintenance of the security and confidentiality of individual patient data; and

(3) other related issues as requested by the commissioner.

(b) The members of the Health Information Technology and

Infrastructure Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the Health Information Technology and Infrastructure Advisory Committee.

Subd. 2. [ANNUAL REPORT.] The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

Subd. 3. [EXPIRATION.] Notwithstanding section 15.059, this section expires June 30, 2009.

Sec. 2. Minnesota Statutes 2004, section 144.147, subdivision 2, is amended to read:

Subd. 2. [GRANTS AUTHORIZED.] The commissioner shall establish a program of grants to assist eligible rural hospitals. The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b).

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what health services are needed and desired by the community. The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings;

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes; and

(3) an implementation plan.

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, an electronic health records system, or a rural health care system or to cover expenses associated with being designated as a critical access hospital for the Medicare rural hospital flexibility program. Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals. The commissioner shall give priority to grant applications for projects involving electronic health records systems.

Sec. 3. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 10,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital, including establishing an electronic health records system. The commissioner shall give priority to grant applications for projects involving electronic health records systems.

Sec. 4. Minnesota Statutes 2004, section 144.1483, is amended to read:

144.1483 [RURAL HEALTH INITIATIVES.]

The commissioner of health, through the Office of Rural Health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the Higher Education Services Office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

~~(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;~~

~~(3)~~ develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

~~(4)~~ (3) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

~~(5)~~ (4) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

~~(6)~~ (5) study and recommend changes in the regulation of

health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

~~(7)~~ (6) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

~~(8)~~ (7) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

~~(9)~~ (8) coordinate the development of a statewide plan for emergency medical services, in cooperation with the Emergency Medical Services Advisory Council;

~~(10)~~ (9) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or

health professional shortage area designation is subsequently withdrawn; and

~~(11)~~ (10) carry out other activities necessary to address rural health problems.

Sec. 5. Minnesota Statutes 2004, section 145.9268, is amended to read:

145.9268 [COMMUNITY CLINIC GRANTS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "eligible community clinic" means:

(1) a nonprofit clinic that ~~provides~~ is established to provide health services ~~under conditions as defined in Minnesota Rules, part 9505.0255,~~ to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay;

(2) a governmental entity or an Indian tribal government or Indian health service unit that provides services and utilizes a sliding fee scale or other procedure as described under clause (1); ~~or~~

(3) a consortium of clinics comprised of entities under clause (1) or (2); or

(4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

Subd. 2. [GRANTS AUTHORIZED.] The commissioner of health shall award grants to eligible community clinics to plan, establish, or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state,

and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the problem or problems the grant funds will be used to address; ~~and~~

(3) a description of achievable objectives, a workplan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(4) a process for documenting and evaluating results of the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the ~~priority level~~ eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which

uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations. ~~In addition, the commissioner shall give priority, in declining order, to grant applications for projects that:~~ In addition, the commissioner shall give priority to grant applications for projects involving electronic health records systems.

Subd. 3a. [AWARDING GRANTS.] (a) The commissioner may award grants for activities to:

(1) provide a direct offset to expenses incurred for services provided to the clinic's target population;

(2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;

(3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;

(4) provide improvements for care delivery, such as increased translation and interpretation services; ~~or~~

(5) build a new clinic or expand an existing facility; or

(6) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

~~(e)~~ (b) A grant awarded to an eligible community clinic may not exceed $300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed $300,000 per clinic included in the consortium. The

commissioner has discretion over the number of grants awarded.

Subd. 4. [EVALUATION AND REPORT.] The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on ~~priority areas for grants set under subdivision 3~~ the needs of community clinics and provide any recommendations for adding or changing ~~priority areas~~ eligible activities.

Sec. 6. [REPEALER.]

Minnesota Statutes 2004, section 144.1486, is repealed.

APPENDIX
Repealed Minnesota Statutes for S0836-1

144.1486 RURAL COMMUNITY HEALTH CENTERS.

Subdivision 1. **Community health center.** "Community health center" means a community owned and operated primary and preventive health care practice that meets the unique, essential health care needs of a specified population.

Subd. 2. **Program goals.** The Minnesota community health center program shall increase health care access for residents of rural Minnesota by creating new community health centers in areas where they are needed and maintaining essential rural health care services. The program is not intended to duplicate the work of current health care providers.

Subd. 3. **Grants.** The commissioner shall provide grants to communities for planning, establishing, and operating community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self-sufficient and qualify for other supplemental funding and enhanced reimbursement. The commissioner shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification.

Subd. 4. **Eligibility requirements.** In order to qualify for community health center program funding, a project must:

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area. "Rural" means an area of the state outside the seven-county Twin Cities metropolitan area and outside of the Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas;

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental or tribal entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental or tribal entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax-exempt status within six months of accepting community health center grant funds; and

(3) for an application for an operating expense grant, demonstrate that expenses exceed revenues or demonstrate other extreme need that cannot be met from other sources.

Subd. 5. **Review process, rating criteria, and point allocation.** (a) The commissioner shall establish grant application guidelines and procedures that allow the commissioner to assess relative need and the applicant's ability to plan and manage a health care project. Program documentation must communicate program objectives, philosophy, expectations, and other conditions of funding to potential applicants.

The commissioner shall establish an impartial review process to objectively evaluate grant applications. Proposals must be categorized, ranked, and funded using a 100-point rating scale. Fifty-two points shall be assigned to relative need and 48 points to project merit.

(b) The scoring of relative need must be based on proposed service area factors, including but not limited to:

(1) population below 200 percent of poverty;

(2) geographic barriers based on average travel time and distance to the next nearest source of primary care that is

accessible to Medicaid and Medicare recipients and uninsured low-income individuals;

(3) a shortage of primary care health professionals, based on the ratio of the population in the service area to the number of full-time equivalent primary care physicians in the service area; and

(4) other community health issues including a high unemployment rate, high percentage of uninsured population, high growth rate of minority and special populations, high teenage pregnancy rate, high morbidity rates due to specific diseases, late entry into prenatal care, high percentage geriatric population, high infant mortality rate, high percentage of low birth weight, cultural and language barriers, high percentage minority population, excessive average travel time and distance to next nearest source of subsidized primary care.

(c) Project merit shall be determined based on expected benefit from the project, organizational capability to develop and manage the project, and probability of success, including but not limited to the following factors:

(1) proposed scope of health services;

(2) clinical management plan;

(3) governance;

(4) financial and administrative management; and

(5) community support, integration, collaboration, resources, and innovation.

The commissioner may elect not to award any of the community health center grants if applications fail to meet criteria or lack merit. The commissioner's decision on an application is final.

Subd. 6. **Eligible expenditures.** Grant recipients may use grant funds for the following types of expenditures:

(1) salaries and benefits for employees, to the extent they are involved in project planning and implementation;

(2) purchase, repair, and maintenance of necessary medical and dental equipment and furnishings;

(3) purchase of office, medical, and dental supplies;

(4) in-state travel to obtain training or improve coordination;

(5) initial operating expenses of community health centers;

(6) programs or plans to improve the coordination, effectiveness, or efficiency of the primary health care delivery system;

(7) facilities;

(8) necessary consultant fees; and

(9) reimbursement to rural-based primary care practitioners for equipment, supplies, and furnishings that are transferred to community health centers. Up to 65 percent of the grant funds may be used to reimburse owners of rural practices for the reasonable market value of usable facilities, equipment, furnishings, supplies, and other resources that the community health center chooses to purchase.

Grant funds shall not be used to reimburse applicants for preexisting debt amortization, entertainment, and lobbying expenses.

Subd. 7. **Special consideration.** The commissioner, through the Office of Rural Health, shall make special efforts to identify areas of the state where need is the greatest, notify representatives of those areas about grant opportunities, and encourage them to submit applications.

Subd. 8. **Requirements.** The commissioner shall develop a list of requirements for community health centers and a tracking and reporting system to assess benefits realized from the program to ensure that projects are on schedule and effectively utilizing state funds.

The commissioner shall require community health centers established or supported through the grant program to:

(1) provide ongoing active local governance to the community health center and pursue community support, integration, collaboration, and resources;

(2) offer primary care services responsive to community needs and maintain compliance with requirements of all cognizant regulatory authorities, health center funders, or health care payers;

(3) maintain policies and procedures that ensure that no person will be denied services because of inability to pay; and

(4) submit brief quarterly activity reports and utilization data to the commissioner.

Subd. 9. **Precautions.** The commissioner may withhold, delay, or cancel grant funding if a grant recipient does not comply with program requirements and objectives.

Subd. 10. **Technical assistance.** The commissioner may provide, contract for, or provide supplemental funding for technical assistance to community health centers in the areas of clinical operations, medical practice management, community development, and program management.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 836 - Modifies Hospital and Clinic Grant (First Engrossment)

Author: Senator Michelle L. Fischbach

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 4, 2005

S.F. No. 836 modifies the hospital and community health clinic grant programs.

Section 1 (62J.495, subdivision 1) requires the commissioner to establish a health information technology and infrastructure advisory committee to advise the commissioner on:

(1) assessing the use of health information technology by the state, health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure; and

(3) other related issues.

Subdivision 2 requires the commissioner to prepare and issue an annual report no later than January 30 of each year outlining progress in implementing a statewide health information infrastructure and recommending future projects.

Subdivision 3 sunsets the committee on June 30, 2009.

Section 2 (144.147, subdivision 2) authorizes the Commissioner of Health to award a grant under the rural hospital planning and transition grant program to an eligible hospital for the purpose of establishing an electronic health records system.

Section 3 (144.148, subdivision 1) expands the definition of an eligible project under the rural hospital capital improvement grant program to include the establishment of an electronic health records system.

Section 4 (144.1483) deletes reference to the rural community health centers under Minnesota Statutes, section 144.1486 (which is being repealed).

Section 5 (144.9268) combines statutorily the rural community health center grant program with the community clinic grants. Adds to the list of possible grant activities establishing, updating, or improving an electronic health records system and building a new clinic or expanding an existing facility.

Section 6 repeals section 144.1486 (rural community health centers).

KC:ph

Fiscal Note – 2005-06 Session

Bill #: S0836-1A **Complete Date:** 03/22/05

Chief Author: FISCHBACH, MICHELLE

Title: MODIFY HOSPITAL & CLINIC GRANT PRGMS

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Health Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Care Access Fund		79	79	79	79
Less Agency Can Absorb					
Health Care Access Fund		79	79	79	79
Net Expenditures					
Health Care Access Fund		0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund		0	0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

Bill Description

Section 1 establishes a Health Information Technology and Infrastructure Advisory Committee to advise the commissioner of health on assessment of health information technology by state, licensed providers and facilities, and local public health agencies; recommendations for implementing a statewide interoperable health information infrastructure, and other related matters. The commissioner is instructed to issue an annual report by January 30 of each year outlining progress to date in implementing a statewide infrastructure and recommending future projects. The committee sunsets on June 30, 2009.

Sections 2 and 3 modify Minnesota Statutes 2004, § 144.147, Section 1, subd. 2(b) and Section 2, subd.1 (c) to include electronic health records system as an eligible project under the rural hospital grant program set forth therein, and furthermore, to give priority to these projects in grant applications.

Section 4 modifies Minnesota Statutes 2004, § 144.1483, by eliminating Section 2 language pertaining to the rural community health center program.

Section 5 modifies Minnesota Statutes 2004, § 145.9268, subd. 1 and subd. 2 to include rural community health centers as eligible for grant awards under the community clinic grant program. It also instructs the commissioner to give priority to grant applications for electronic medical records system projects.

In summary, Sections 4 and 5 of the bill effectively combine the language and appropriations of the rural community health center grant program and the community clinic grant program into one grant program.

Assumptions

Section 1

The Health Information Technology and Infrastructure Advisory Committee was established in session law in 2004, and the bill would establish it in statute. The department has been absorbing the costs of supporting the committee since it began in 2004, and will continue to do so. Estimate assumes 1.0 FTE RAS Sr. at step 7 who will support the work of the committee.

Sections 2-5

No fiscal impact.

Expenditure and/or Revenue Formula

EXPENDITURES	SFY06	SFY07	SFY08	SFY09
Salary – RAS Sr	51,469	51,469	51,469	51,469
Salary – Fringe 29%	14,926	14,926	14,926	14,926
Subtotal Sal & Fringe	66,395	66,395	66,395	66,395
Supplies & Exp:				
Indirect Cost 19.4%	12,881	12,881	12,881	12,881
TOTAL EXPENSES	79,276	79,276	79,276	79,276

Long-Term Fiscal Considerations

None

Local Government Costs

None

References/Sources

Mark Schoenbaum, MDH Office of Rural Health & Primary Care

Agency Contact Name: Mark Schoenbaum (651-282-3859)
FN Coord Signature: MARGARET KELLY
Date: 03/09/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/22/05 Phone: 282-5065

Policy Position

Minnesota Department of Health SF 836

Electronic Health Records and Rural Health Care Grants

M.S.144.148, M.S. 144.147, M.S. 144.1486, M.S.145.9268

Electronic Health Records and Rural Health Care Grants

As part of its initiative to speed the implementation of electronic health records and technology throughout the health care system, MDH is proposing a straightforward statutory change in several current programs to accentuate the department's commitment to health information technology projects.

What does the legislation do?

The department administers several grant programs that support rural hospital planning, and capital improvements, and community and rural clinic projects. The legislation adds specific language to these programs clarifying that electronic health records projects are eligible activities for state grant support. This legislation will encourage and support the transition to electronic health records.

The legislation adds Electronic Health Records language to the following existing grant programs:

Hospitals:

- Rural Hospital Capital Improvement Grant Program (M.S.144.148)
- Rural Hospital Planning and Transition Grant Program (M.S. 144.147)

Clinics:

- Rural Community Health Center (M.S. 144.1486) and
- Community Clinic Grant Programs (M.S.145.9268)

The legislation combines the two clinic programs cited above into one section of statute in order to better support the capacity of rural and urban clinics in:

- Serving rural or low-income populations
- Reducing uncompensated care burdens or
- Providing for improved quality of care.

The programs are similar enough in objectives, structure and function that combining them can retain the fundamental nature of each, improve the operation of the programs, and make the application process clearer and simpler for the safety net clinics supported by the programs.

Moved is backed by stakeholders

The Minnesota Hospital Association supports the hospital program changes. The Minnesota Primary Care Association and the Neighborhood Health Care Network support the clinic program changes. No opponents or controversies are known or expected.

Supports the department's goals

Adding Electronic Health Records language to these programs supports these department goals:

- E-Health Initiative
- Stewarding resources and fostering best business practices
- MDH priority to reduce health care gaps in rural communities.

MINNESOTA MDH DEPARTMENT OF HEALTH

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St. Paul, MN 55164-0882
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MDH staff contact: Mark Schoenbaum
651-282-3859

Minnesota Rural Hospital Planning and Transition Grant Program

What is the Rural Hospital Planning and Transition Grant Program?

The Rural Hospital Planning and Transition Grant Program is a state administered program that helps small rural hospitals plan for preserving access to health services or to respond to changing conditions. Hospitals have used transition grants to prepare strategic plans, implement new uses for hospital space and develop community services.

What is the history of the Rural Hospital Planning and Transition Grant Program?

The Rural Hospital Planning and Transition Grant Program was enacted by the Minnesota State Legislature in 1990 to assist small hospitals and their communities in developing strategic plans for preserving access to health services, and implementing transition projects to modify the type and extent of services provided. It was modeled after the federal Rural Hospital Planning and Transition Grant Program that ended in 1996.

Year	Eligible Hospitals	Applications Received	Total Request	Hospitals Funded	Program Budget
1991	25	11	$371,722	4	$100,000
1992	77	21	$613,660	9	$250,000
1993	64	26	$865,786	11	$235,000
1994	51	9		7	$211,765
1995	73	18	$592,000	9	$250,000
1996	73	15	$521,076	8	$238,750
1997	78	20	$818,146	11	$250,000
1998	78	20	$651,411	8	$250,000
1999	80	21	$860,545	13	$250,000
2000	81	24	$890,625	12	$250,000
2001	80	28	$954,339	12	$250,000
2002	80	23	$882,035	11	$250,000
2003	82	17	$726,838	12	$300,000
2004	82	22	$802,497	15	$300,000

How do hospitals spend the grant funds?

The Rural Hospital Planning and Transition Grant program is intended to assist hospitals as they develop alternatives to inpatient acute care in an effort to remain viable health care providers. The majority of funding has been spent on consulting, personnel and equipment expenses for strategic planning, clinic expansion and relocation, emergency and ambulance services, and recruitment projects.

Why are Planning and Transition Grants important to the State of Minnesota?

These grants help to preserve and improve access to health care in rural areas. With the use of these funds, small hospitals (fewer than 50 beds) that are in designated rural areas or in communities with populations less than 5,000 are able to continue providing needed, quality health services in their communities.

Who administers the Rural Hospital Planning and Transition Grant Program?

The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Rural Hospital Planning and Transition Grant Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Rural Hospital Planning and Transition Grant Program?

Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Rural Hospital Capital Improvement Grant Program

What is the Rural Hospital Capital Improvement Grant Program?

The Rural Hospital Capital Improvement Grant Program provides funding to assist small, rural hospitals to maintain or update their buildings and equipment when other options are limited or unavailable. Minnesota has 80 rural hospitals with 50 or fewer licensed beds. Many of these hospitals were built with federal Hill Burton funds in the 1950s and 60s. Though essential to maintaining health care access in their communities, their modest revenues have made it difficult for many to update their buildings or modernize their medical equipment to keep pace with changes in technology.

What is the history of the Rural Hospital Capital Improvement Grant Program?

The Minnesota legislature enacted the Rural Hospital Capital Improvement Program in 1997. In its first two years the program made awards to five remote, financially fragile hospitals to renovate their facilities. For FY 2000, the legislature expanded eligibility criteria for the program, making all small rural hospitals eligible.

Fiscal Year	Eligible Hospitals	Applications Received	Total Request	Grants Approved	Program Budget
1998-99	5	5	$7.5 million	5	$7.5 million (for biennium)
2000	81	48	$11 million	22	$2.8 million
2001	81	44	$9.5 million	24	$2.8 million
2002	81	50	$16.8 million	24	$4.6 million
2003	81	48	$ 8.9 million *	26	$2.6 million
2004	80	43	$4.9 million *	22	$1.8 million

* maximum request amount reduced as a result of declining budget.

How do hospitals spend the grant funds?

Capital Improvement Grants have been awarded to help cover expenses in the following categories:

- Building/facility upgrades: (for example, roofs, boilers, room renovations, building additions and repairs, HVAC, fire protection system, heliport etc.)
- Technological improvements and equipment upgrades (for example, mammography, radiology, information technology, cardiac ultrasound, teleradiology etc.)

The 2001 legislature set the maximum award amount at $500,000; awards have varied from $15,000 to help build a new helicopter-landing pad to $500,000 for major facility enhancement and updates. The attached tables provide detail about grant recipients, amounts and projects.

Why are Capital Improvement Grants important to the State of Minnesota?

Two-thirds of Minnesota's small rural hospitals were built in the 1960's or earlier and are being used to accommodate new and changing community health care needs. According to a survey conducted in 2000 by the MDH, 70% of Minnesota's small rural hospitals are classified as "struggling" or "distressed" regarding the status of capital investments in their facilities and equipment as they try to keep pace with burgeoning infrastructure needs and advances in medical technology. The capital investment needs of these hospitals cannot be fully supported by operating profits. They face significant barriers to borrowing for their capital improvement needs, such as low operating margins and lack of cash. Hospitals report that grant awards have been necessary for projects to move forward. Grants help these struggling hospitals meet their capital improvement needs so that they can continue to provide critical health care services in their communities. Sixty hospitals in Minnesota have been recipients of Rural Hospital Capital Improvement Grants, benefiting local communities throughout the entire state.

Who administers the Rural Hospital Capital Improvement Program?

The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Rural Hospital Capital Improvement Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Rural Hospital Capital Improvement Program?

Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Community Clinic Grant Program

What is the Community Clinic Grant Program?
A Community Clinic Grant Program provides funding to support the capacity of rural and urban community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. Eligible clinics include those that provide physician directed primary care services and utilize a sliding fee schedule for uninsured and underinsured patients or a consortium of clinics providing these services. Eligible applicants also include Indian tribal governments or Indian Health Service units.

What is the history of the Community Clinic Grant Program?
The Minnesota legislature enacted the Community Clinic Grant Program in 2001. The program is funded under intergovernmental transfers and has experienced significant budget reductions since the first year. The maximum request amount was reduced to $100,000 in year two and then, again, reduced to $45,000 to accommodate the decreasing budget.

Fiscal Year	Applications Received	Total Request	Grants Approved	Outstate Awards	Program Budget
2002	27	$6,293,752	22	8	$3,039,300
2003	27	$2,569,613 *	21	11	$1,009,907
2004	20	$896,604 *	9	3	$317,000

* maximum request amount reduced as a result of declining budget.

How do clinics spend the grant funds?
Community Clinic Grants have been awarded to help cover expenses in the following categories:

- Provide a direct offset to expenses incurred for services provided to the clinic's target population: (e.g. clinical salaries.)
- Establish, update, or improve information, data collection, or billing systems (e.g. billing software, computer hardware.)
- Procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic (e.g. exam tables, medical equipment, dental equipment.)
- Provide improvements for care delivery, such as increased translation and interpretation services.
- Other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve (e.g. clinical staff training, multilingual patient information brochures.)

Awards have varied from $10,000 to offset uncompensated care to $437,300 to establish a 12-facility shared management information system. The attached tables provide detail about grant recipients, amounts and projects.

Why are Community Clinic Grants important to the State of Minnesota? Community Clinic grants improve the ability of the state's safety net primary care providers to provide quality, responsive services to uninsured and underinsured patients.

Who administers the Community Clinic Program?
The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Community Clinic Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Community Clinic Program?
Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Community Health Center Grant Program

What is the Community Health Center Grant Program?
The Community Health Center Grant Program provides funding to rural communities and clinics for planning, establishing and operating community health centers. Eligible applicants include Nonprofit, governmental or tribal entities located in a rural shortage area outside the Twin Cities, Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester or La Crosse urbanized areas. Grantees must provide local governance to the clinic, offer primary care services responsive to the community needs, and maintain policies and procedures that ensure that no person will be denied services because of inability to pay.

What is the history of the Community Health Center Grant Program?
The Minnesota legislature enacted the Community Health Center Grant Program in 1995. The program is funded under intergovernmental transfers and has experienced significant budget reductions since the first year. The maximum request amount was reduced to $100,000 in year two and then, again, reduced to $45,000 to accommodate the decreasing budget.

Fiscal Year	Applications Received	Total Request	Grants Approved	Total Awards	Program Budget
1995	6	$412,250	5	$337,250	$337,250
1996	5	$206,899	5	$185,000	$250,000
1997	3	$250,000	3	$250,000	$250,000
1998	9	$533,149	5	$250,000	$250,000
1999	6	$291,688	6	$250,000	$250,000
2000	7	$287,381	7	$250,000	$250,000
2001	8	$511,826	8	$250,000	$250,000
2002	9	$1,939,152	4	$250,000	$250,000
2003	10	$871,497	7	$250,000	$250,000
2004	10	$513,888	6	$250,000	$250,000

How do clinics spend the grant funds?
Community Clinic Grants have been awarded to help cover expenses in the following categories:

- Provide a direct offset to expenses incurred for services provided to the clinic's target population: (e.g. clinical salaries.)
- Establish, update, or improve information, data collection, or billing systems (e.g. billing software, computer hardware.)
- Procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic (e.g. exam tables, medical equipment, dental equipment.)
- Provide improvements for care delivery, such as increased translation and interpretation services.
- Other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve (e.g. clinical staff training, multilingual patient information brochures.)

Awards have varied from $10,000 to offset uncompensated care to $437,300 to establish a 12-facility shared management information system. The attached tables provide detail about grant recipients, amounts and projects.

Why are Community Health Center Grants important to the State of Minnesota? Community Health Center grants have provided support for rural Minnesota's smallest and most isolated communities to secure and maintain access to basic health care services.

Who administers the Community Health Center Program?
The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Community Clinic Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Community Clinic Program?
Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 836: A bill for an act relating to health; establishing the Health Information Technology and Infrastructure Advisory Committee; modifying hospital and clinic grant programs; eliminating community health center program; amending Minnesota Statutes 2004, sections 144.147, subdivision 2; 144.148, subdivision 1; 144.1483; 145.9268; proposing coding for new law in Minnesota Statutes, chapter 62J; repealing Minnesota Statutes 2004, section 144.1486.

Reports the same back with the recommendation that the bill do pass and be referred to the full committee.

Linda Berglin
(Division Chair)

April 12, 2005
(Date of Division action)

Senators Dille, Berglin, Foley, Lourey and Nienow introduced--

S.F. No. 1445: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; requiring information about postpartum depression to be given to mothers and their families; proposing coding for new law in Minnesota Statutes 2004, chapter 145.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [145.906] [POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.]

(a) The commissioner of health shall work with health care facilities and licensed health care professionals in the state to develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must provide education to women and their families about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources, including a hotline to be determined by the commissioner.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1445 - Postpartum Depression Information

Author: Senator Steve Dille

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 11, 2005

S.F. No. 1445 amends the chapter of law relating to public health provisions by adding a new section of law, which requires the Commissioner of Health to work with health care facilities and licensed health care professionals to develop policies and procedures to comply with this section.

Paragraph (b) requires physicians, traditional midwives, and other licensed health care professionals providing prenatal care to provide education to women and their families about postpartum depressions.

Paragraph (c) requires hospitals and other health care facilities to provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including a hotline to be determined by the commissioner.

JW:rdr

Fiscal Note – 2005-06 Session

Bill #: S1445-0 **Complete Date:** 04/07/05

Chief Author: DILLE, STEVE

Title: POSTPARTUM DEPRESSION EDUC & INFO

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Health Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

SF 1445 requires the Commissioner of Health work with health care facilities and licensed health care professionals in developing policies and procedures related to providing education to pregnant or postpartum women and their families about postpartum depression.

The bill requires physicians, midwives and other licensed health care professionals providing prenatal care to provide education to women and their families about postpartum depression. It also requires hospitals and other health care facilities to provide new mothers, fathers and other family members, as appropriate, with written information about postpartum depression.

Assumptions

- The Department would convene a work group to develop policies and procedures related to this bill.
- The Department would work with existing professional organizations to inform the identified groups listed in this legislation of the developed policies and procedures and responsibilities under this law.
- The Department would work with interested parties to identify existing postpartum depression information or if none are determined to be appropriate, to produce a fact sheet that includes pertinent information.
- Information would be made available in a format for downloading and printing from the Department's website for professionals and health care facilities.
- That the Department in the second year would work to make postpartum depression information available in other languages.
- All information would reference a national toll-free suicide hotline number.

Expenditure and/or Revenue Formula

The costs associated with convening a work group, working with professional organizations to notify professionals and health care facilities of the law, and providing web-based access to informational materials to professionals and health care facilities would be minimal and could be absorbed by the Department.

Long-Term Fiscal Considerations

N/A

Local Government Costs

N/A

References/Sources

Agency Contact Name: Janet Olstad (651-281-9884)
FN Coord Signature: MARGARET KELLY
Date: 04/06/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/07/05 Phone: 282-5065

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 1445 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [145.906] [POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.]

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources."

Amend the title accordingly

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1445: A bill for an act relating to health; requiring information about postpartum depression to be given to mothers and their families; proposing coding for new law in Minnesota Statutes 2004, chapter 145.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. [145.906] [POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.]

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources."

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin
(Division Chair)

April 12, 2005
(Date of Division action)

A bill for an act

relating to health; modifying certain critical access hospital provisions; requiring a report; amending Minnesota Statutes 2004, sections 144.147, subdivision 1; 144.148, subdivision 1; 144.551, subdivision 1; 144.562, subdivision 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.147, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~10,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

Sec. 2. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the

federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~10,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Sec. 3. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read:

Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.] (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order

reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves

adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of

the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County; ~~or~~

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; or

(19) a critical access hospital established under section 144.1483, clause (10), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law.

Sec. 4. Minnesota Statutes 2004, section 144.562, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (10), and section 1820 of the

federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home, eligible hospitals are allowed a total of ~~1,460~~ 2,000 days of swing bed use per year~~, provided that no more than ten hospital beds are used as swing beds at any one time~~. Critical access hospitals that have an attached nursing home are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home, the commissioner of health ~~must~~ may approve swing bed use beyond ~~1,460~~ 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

Sec. 5. [REPORT TO THE LEGISLATURE ON SWING BED USAGE.]

The commissioner of health shall review swing bed and related data reported under Minnesota Statutes, sections 144.562, subdivision 3, paragraph (f); 144.564; and 144.698. The commissioner shall report and make any appropriate recommendations to the legislature by January 31, 2007, on:

(1) the use of swing bed days by all hospitals and by

critical access hospitals;

(2) occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds; and

(3) information provided by rural providers on the use of swing beds and the adequacy of rural services across the continuum of care.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1266 - Modifying Certain Critical Access Hospital Provisions (The First Engrossment)

Author: Senator Julie Rosen

Prepared by: David Giel, Senate Research (296-7178)

Date: April 8, 2005

S.F. No. 1266 modifies the definition of "eligible rural hospital" for the purposes of several grant programs; establishes a hospital construction moratorium exception for Critical Access Hospitals (CAHs) that delicensed beds in response to a 1997 federal law; and expands the amount of swing bed care that can be provided in a CAH.

Section 1 (144.147, subdivision 1) modifies the definition of "eligible rural hospital" in the Rural Hospital Planning and Transition Grant Program to include hospitals located in communities with a population of less than 15,000 persons. The current limit is 10,000.

Section 2 (144.148, subdivision 1) makes the same change for the Rural Hospital Capital Improvement Grant Program.

Section 3 (144.551, subdivision 1) establishes an exception to the hospital construction moratorium for any CAH that delicensed beds since the enactment of the federal Balanced Budget Act of 1997, as long as CAHs that add beds do not exceed the CAH bed limit set in federal law.

Section 4 (144.562, subdivision 2) allows CAHs without attached nursing homes to provide up to 2,000 days annually of swing bed care. The current limit is 1,460 days. The limit on using no more than 10 beds as swing beds at any one time is removed. CAHs that have attached nursing homes are allowed swing bed use up to the limits in federal law. The Minnesota Department of Health (MDH) may approve bed usage beyond 2,000 days if the CAH determines there are no skilled nursing facility beds within 25 miles that are willing to admit the patient. CAHs must maintain documentation that they have contacted facilities within this radius. In addition, CAHs that reach 2,000 days of use may admit six additional swing bed patients without MDH approval. Health care

systems may allocate their total limit of swing bed days among hospitals within the system, provided that no CAH without an attached nursing home exceeds 2,000 days per year.

Section 5 requires MDH to study swing bed issues and report to the Legislature in 2007.

DG:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1266-1E **Complete Date:** 04/11/05

Chief Author: ROSEN, JULIE

Title: CRITICAL ACCESS HOSPITALS PROVISIONS

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agencies: Health Dept (04/11/05) Human Services Dept (04/11/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/11/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1266-1E **Complete Date:** 04/11/05

Chief Author: ROSEN, JULIE

Title: CRITICAL ACCESS HOSPITALS PROVISIONS

Agency Name: Health Dept

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

This bill:
Sections 1 and 2 modify Minnesota Statutes § 144.147, Section 1, subd. 1 and Section 2, subd. 1 and changes the definition of eligible rural hospital from a community with a population of less than 10,000 to a community with a population of not less than 15,000.

1. Section 3 modifies Minnesota Statutes § 144.551, sub. 1(a)(19) to allow those Critical Access Hospitals that reduced their number of licensed beds to 15 between 1998 and 2003 in order to comply with provisions of the Balanced Budget Act of 1997, Public Law 105-33, to raise their bed limit to 25 in conformity with eligibility under current federal law.
2. Section 4 modifies Minnesotan Statutes § 144.562 related to swing bed licensing and usage. This section:
    a. Provides full swing bed conformity with federal law for Critical Access Hospitals with attached nursing homes.
        i. Once these hospitals reach 2,000 swing bed days in a year, it requires that they document contacts with nursing homes to determine if there are available nursing home beds.
    b. Raises the annual limit on swing bed days for all other hospitals from 1,460 to 2,000 days.
    c. Provides exceptions for 6 cases each year for hospitals subject to the 2,000 annual day limit.
    d. Allows a health care system to allocate its swing bed days among its system hospitals, provided that no hospital without an attached nursing home may exceed 2,000 swing bed days per year.
3. Section 5 requires a report to the legislature in January, 2007, on the use of swing bed days, occupancy rates in nursing homes with 25 miles of swing bed hospitals, and related information and recommendations.

Assumptions

Sections 1 – 4 are policy changes with no MDH cost.

Expenditure and/or Revenue Formula

Regarding the study required in section 5, MDH has analyzed the report called for in section 5 of the bill. MDH already receives much of the data cited in section 5 through the department's Health Care Cost Information System hospital reporting system and through the MDH Licensing and Certification section. The department also has existing reporting responsibilities regarding swing beds, and we have concluded the report required in the bill will require minimal additional effort, which the department can absorb.

Long-Term Fiscal Considerations

none

Local Government Costs

References/Sources

Mark Schoenbaum, MDH Office of Rural Health & Primary Care

Agency Contact Name: Mark Schoenbaum (651-282-3859)
FN Coord Signature: MARGARET KELLY
Date: 04/08/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/11/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1266-1E **Complete Date:** 04/11/05

Chief Author: ROSEN, JULIE

Title: CRITICAL ACCESS HOSPITALS PROVISIONS

Agency Name: Human Services Dept

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Narrative: SF 1266-1E

Bill Description
This bill impacts the department of health and revises the eligibility requirements of the Rural Hospital Grant Program. It also provides modifications to the hospital construction moratorium and swing bed license requirements in order to adapt to changes in federal law.

Assumptions
This bill as amended does not affect the departments critical access hospital payments and therefore has no impact on the department of human services.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Paul Olson 296-5620
FN Coord Signature: STEVE BARTA
Date: 04/08/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KATIE BURNS
Date: 04/11/05 Phone: 296-7289

Policy Position

Minnesota Department of Health March, 2005

Create Conformity with Federal Law for Critical Access Hospitals

M.S. 144.562, M.S. 144.147. M.S. 144.148, M.S. 144.551

Problem statement

Recent changes were made to federal law and the regulations applicable to rural Minnesota's 61 Critical Access Hospitals. These changes resulted in two major inconsistencies with state statutes; the definitions of a rural hospital and the limit on swing beds. Hospital swing beds provide patients brief transitional care at the hospital following their acute care stay. The 2003 federal legislation also changed these bed limits upward. However, Minnesota law retains the earlier 10 bed limit, instead of the federal 25 bed limit.

In addition, several Critical Access Hospitals reduced their number of licensed beds between 1998 and 2003 to comply with the limit of 15 beds provided in the 1997 federal law creating the Critical Access Hospital option. In 2003, federal legislation raised the bed limit for Critical Access Hospitals to 25. However, Minnesota's hospital construction moratorium prohibits these hospitals from adjusting to this federal change.

How does this legislation address the problem?

The following amendments will bring state law into conformity with new federal regulations. This will allow Critical Access Hospitals to provide all the services established under federal law for rural communities:

- Amend M.S. 144.562 to exempt Critical Access Hospitals from the daily limit of 10 swing beds and the annual limit of 1,460 swing bed days. Critical Access Hospitals could then use any of their 25 beds for swing bed patients.

- Amend the definition of rural hospitals in M.S. 144.147 and 144.148 to retain eligibility for current and prospective Critical Access Hospitals.

- Amend M.S. 144.551 to allow Critical Access Hospitals a moratorium exception to increase up to the 25 beds allowed under federal law.

Move backed by stakeholders

The Minnesota Hospital Association already supports the initiative. The support of the Minnesota Rural Health Association is expected. There are no known opponents.

Consequences if this legislation does not pass:

- If the more restrictive state limit on swing bed use is not revised, recovering patients could be unnecessarily transferred to nursing homes even though Critical Access Hospitals could provide the needed care.
- One hospital would lose its status as a Critical Access Hospital, if the state definition of a rural hospital is not revised to include it. Yet other hospitals—in similar circumstances—would continue operating as Critical Access Hospitals.
- Patients could be forced to travel farther for hospital services than necessary, if Critical Access Hospitals are updated.

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ATTACHMENT "C"

04/12/05 [COUNSEL] DG SCS1266A-4

Senator ..... moves to amend S.F. No. 1266 as follows:

Page 4, line 19, strike "operated by a hospital" and insert "within or among hospitals"

Page 5, after line 18, insert:

"**[EFFECTIVE DATE.]** This section is effective the day following final enactment."

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1266: A bill for an act relating to health; modifying certain critical access hospital provisions; requiring a report; amending Minnesota Statutes 2004, sections 144.147, subdivision 1; 144.148, subdivision 1; 144.551, subdivision 1; 144.562, subdivision 2.

Reports the same back with the recommendation that the bill be amended as follows:

Page 4, line 19, strike "operated by a hospital" and insert "within or among hospitals"

Page 5, after line 18, insert:

"**[EFFECTIVE DATE.]** This section is effective the day following final enactment."

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda J. Berglin
(Division Chair)

April 12, 2005.....
(Date of Division action)

A bill for an act

relating to health; requiring disclosure of employers of applicants for publicly funded health programs; proposing coding for new law in Minnesota Statutes, chapter 62J.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [62J.85] [EMPLOYER DISCLOSURE FOR PUBLIC ASSISTANCE HEALTH CARE PROGRAMS.]

Subdivision 1. [INFORMATION REQUIRED UNDER PUBLIC ASSISTANCE HEALTH CARE PROGRAMS.] Any applicant applying for health care benefits under medical assistance, general assistance medical care, or MinnesotaCare must identify the employer or employers of the applicant. In the event the applicant is not employed, the applicant shall identify the employer or employers of any adult who is responsible for providing all or some of the applicant's health care support.

Subd. 2. [REPORT.] (a) On or before January 1 of each year, beginning January 1, 2006, for the previous fiscal year, the commissioner shall submit to the legislature a report identifying all employers who employ 25 or more public assistance health care program recipients as identified under subdivision 1. In determining whether the 25-employee threshold is met, the commissioner shall include all public assistance health care program recipients employed by the employer and its subsidiaries at all locations within the state. The report

shall include the following information:

(1) the name and address of the employer and, as appropriate, the names and addresses of its subsidiaries that employ public assistance health care program recipients;

(2) the number of recipients who are employees of the employer;

(3) the number of recipients who are spouses or dependents of employees of the employer;

(4) the cost to the state of providing health care benefits for these employers' employees and enrolled dependents.

(b) The report shall not include the name of any individual public assistance health care program recipient and shall comply with privacy standards according to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

(c) The commissioner shall make the report available to the public on the Department of Human Services Web site, and shall provide a copy of the report to any member of the public upon request.

ATTACHMENT "D"

Senator ..... moves to amend S.F. No. 828 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [62J.85] [EMPLOYER DISCLOSURE FOR THE MINNESOTA HEALTH CARE PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Minnesota health care program" means the prescription drug program under section 256.955, medical assistance under chapter 256B, general assistance medical care under section 256D.03, subdivision 3, and MinnesotaCare under chapter 256L.

Subd. 2. [REPORT.] (a) On or before January 1 of each year, beginning January 1, 2007, for the previous fiscal year, the commissioner shall submit to the legislature a report identifying all employers that employ 50 or more employees who are Minnesota health care program recipients. In determining whether the 50-employee threshold is met, the commissioner shall include all employees employed by an employer and its subsidiaries at all locations within the state. The report shall include the following information:

(1) the name of the employer and, as appropriate, the names of its subsidiaries that employ Minnesota health care program recipients;

(2) the number of Minnesota health care program recipients who are employees of the employer;

(3) the number of Minnesota health care program recipients who are spouses or dependents of employees of the employer; and

(4) the cost to the state of providing health care benefits for these employers' employees and enrolled dependents.

(b) In preparing and publishing the report, the commissioner shall take reasonable precautions to protect the identity of Minnesota health care program recipients:

(1) the report shall include only nonindividually identifiable summary data as defined in section 13.02, subdivision 19;

(2) the commissioner shall employ generally accepted

statistical and scientific principles and methods for rendering information as not individually identifiable. ~~The commissioner must determine that there is an insignificant risk that information in the report could be used, alone or in combination with other reasonably available information, to identify any Minnesota health care program recipient~~; and

(3) the commissioner shall comply with all other applicable privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and its corresponding regulations, Code of Federal Regulations, title 45, sections 160, 162, and 164; Minnesota Statutes, chapter 13; section 144.335; and any other applicable state and federal law.

(c) The commissioner shall make the report available to the public on the Department of Human Services' Web site, and shall provide a copy of the report to any member of the public upon request."

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 828 - Public Disclosure of Employers with Enrollees in Public Assistance Programs (A-4 Amendment)

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 11, 2005

S.F. No. 828 requires the Commissioner of Human Services to report to the Legislature the identity of employers that employ a total of 100 or more employees of which 25 or more employees are public assistance health care program recipients.

Subdivision 1 defines "commissioner" and "Minnesota health care program."

Subdivision 2 requires the Commissioner of Human Services to submit to the Legislature on or before January 1 of each year, beginning January 1, 2007, a report identifying all employers that employ 50 or more employees who are Minnesota health care program recipients. The report must include the name of the employer, names of its subsidiaries that employ Minnesota health care program beneficiaries, the total number of its employees and dependents who are enrolled in each Minnesota health care program, and the total cost to the state of providing public health care benefits for the employees and enrolled dependents of each named employer. The report must not include the name of any individual recipient. The Commissioner must make the report available to the public on the Department's Web site and must provide a copy to any member of the public who requests a copy.

KC:ph

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0828-1E **Complete Date:**

Chief Author: LOUREY, BECKY

Title: EMPLOYER DISC;PUB ASSIST HEALTH CARE

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		650	0	0	0
Health Care Access Fund		424	327	327	327
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		650	0	0	0
Health Care Access Fund		424	327	327	327
Revenues					
Health Care Access Fund		170	131	131	131
Net Cost <Savings>					
General Fund		650	0	0	0
Health Care Access Fund		254	196	196	196
Total Cost <Savings> to the State		904	196	196	196

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund		5.50	5.25	5.25	5.25
Total FTE		5.50	5.25	5.25	5.25

Narrative: SF 828-1E

Bill Description

Subdivision 1: Requires any applicant applying for medical assistance (MA), general assistance medical care (GAMC), or MinnesotaCare to identify his or her employer(s). If the applicant is not employed, he or she must identify the employer(s) of any adult who is responsible for providing all or some of the applicant's health care support.

Susbdivision 2: Requires the commissioner of human services to report to annually report to the legislature all employers who employ 25 or more public assistance health care program recipients. The 25 or more employee threshold is determined based on all public assistance employees employed by the employer and its subsidiaries at all locations within the state. The report is to include:

- The name and address of the employer and the names and addresses of its subsidiaries that employ health care program recipients;
- The number of recipients who are employed by the employer;
- The number of recipients who are spouses or dependents of employees of the employer; and
- The cost to the state of providing health care benefits for these employees and their enrolled dependents.

The report shall not include the names of the recipients or their dependents and shall comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy standards.
The report shall be made available to the public on the DHS web site and a copy of the report provided to any member of the public upon request.

Assumptions

There are no program impacts.

This proposal will cause a 2 month delay in HealthMatch. The complex design of the innovative HealthMatch system is near completion and programming has begun. Due to the intricacies of programming a new system, any change prior to system completion requires substantial analysis and design rework, in addition to programming the actual changes. This effort delays the HealthMatch implementation date and results in costs of $889,000 per month of delay. Currently, for each month of delay to the project, the associated vendor cost for maintaining staff on the project is $600,000. Concurrent state staff costs per month are $289,000. These numbers reflect 100% of the cost; state budget costs are less when adjusted for federal participation.

Once HealthMatch is completely built and implemented, the cost for making requested changes will be significantly lower. Legislation with effective dates of August 1, 2006, or upon HealthMatch implementation, whichever is later, will not incur the state staff and associated vendor costs caused by implementation delay, although they will, as with current systems, require investments of time for analysis and design.

See attached spreadsheet.

Expenditure and/or Revenue Formula

SF 828-1E: Employer disclosure
HCEA admin + systems costs

ADMINISTRATIVE COSTS

	FY2006	FY2007	FY2008	FY2009
MinnesotaCare FTE 5 minutes per application or renewal	5	5	5	5
Direct staff cost At average $53,000	265,000	265,000	265,000	265,000
FTE to produce report	.50	.25	.25	.25

Develop Data warehouse report, reporting conventions and procedures, publish report, etc.				
Direct staff cost At average $70.,000	35,000	17,500	17,500	17,500
Indirect staff cost At average $22,500 first year, $8500 thereafter	123,750	44,625	44,625	44,625
Total staff cost	423,750	327,125	327,125	327,125
Federal reimbursement offset--40%	169,500	130,850	130,850	130,850
State share--60%	254,250	196,275	196,275	196,275
SYSTEMS COSTS				
MMIS Costs	70,400	0	0	0
MMIS Costs, state share (35%)	24,640			
MAXIS Costs--	5,200	0	0	0
MAXIS Costs, state share (55%)	2,860			
HealthMatch costs--total	1,778,000	0	0	0
HealthMatch costs, state share (35%)	622,300	0	0	0

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Senator Berglin introduced--

S.F. No. 1979: Referred to the Committee on Finance.

A bill for an act

relating to human services; creating a hospital disproportionate population adjustment; designating certified public expenditures; increasing the surcharges on criminal and traffic offenders; amending Minnesota Statutes 2004, sections 256.969, by adding a subdivision; 357.021, subdivisions 6, 7; proposing coding for new law in Minnesota Statutes, chapter 256B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256.969, is amended by adding a subdivision to read:

Subd. 9c. [ADDITIONAL DISPROPORTIONATE POPULATION ADJUSTMENTS.] (a) The adjustment under this subdivision shall be paid in addition to all other disproportionate population adjustments provided by law to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with more than 250 medical assistance admissions in 2002. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate in excess of 20 percent, the adjustment must be determined by multiplying the total of the operating and property payment rates by 30 percent; and

(2) for a hospital with a medical assistance inpatient utilization rate less than or equal to 20 percent, the adjustment must be determined by multiplying the total of the operating and property payment rates by nine percent.

(b) The federal share of the adjustments under paragraph

(a), clause (1), and the adjustments under paragraph (a), clause (2), shall be paid annually on July 1 for services to be rendered in the fiscal year beginning on that day, based on services rendered in the previous calendar year.

Sec. 2. [256B.199] [CERTIFIED PUBLIC EXPENDITURES.]

Subdivision 1. [EXPENDITURES TO BE CERTIFIED.] The following expenditures shall be certified by the nonstate entities listed annually on July 1 as the nonfederal share of the adjustments under section 256.969, subdivision 9c, paragraph (a), clause (1):

(1) Hennepin County, $9,514,284;

(2) Ramsey County, $3,220,921;

(3) University of Minnesota, $4,716,921;

(4) Douglas County, $174,407; and

(5) Rice County Hospital District, $126,928.

Subd. 2. [ADJUSTMENTS PERMITTED.] (a) The commissioner may adjust the certified amounts under subdivision 1 and the payments under section 256.969, subdivision 9c, paragraph (a), clause (1), based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and hospital-specific limitations on disproportionate share payments. Any adjustments must be made on a proportional basis. The commissioner may make these adjustments only after consultation with the nonstate entities identified in subdivision 1.

(b) The ratio of disproportionate population adjustments specified in section 256.969, subdivision 9c, paragraph (a), clause (1), to the certification amounts specified in subdivision 1 shall not be reduced. The commissioner may adjust payments under section 256.969, subdivision 9c, paragraph (a), clause (1), and certification amounts under subdivision 1 in order to access the maximum disproportionate population adjustments available under federal law.

(c) Each nonstate entity listed in paragraph (a) shall report and certify expenditures eligible to be certified as public expenditures for the purposes of this subdivision in a

manner prescribed by the commissioner.

Sec. 3. Minnesota Statutes 2004, section 357.021, subdivision 6, is amended to read:

Subd. 6. [SURCHARGES ON CRIMINAL AND TRAFFIC OFFENDERS.] (a) The court shall impose and the court administrator shall collect a ~~$60~~ $70 surcharge on every person convicted of any felony, gross misdemeanor, misdemeanor, or petty misdemeanor offense, other than a violation of a law or ordinance relating to vehicle parking, for which there shall be a $3 surcharge. In the Second Judicial District, the court shall impose, and the court administrator shall collect, an additional $1 surcharge on every person convicted of any felony, gross misdemeanor, or petty misdemeanor offense, other than a violation of a law or ordinance relating to vehicle parking, if the Ramsey County Board of Commissioners authorizes the $1 surcharge. The surcharge shall be imposed whether or not the person is sentenced to imprisonment or the sentence is stayed.

(b) If the court fails to impose a surcharge as required by this subdivision, the court administrator shall show the imposition of the surcharge, collect the surcharge and correct the record.

(c) The court may not waive payment of the surcharge required under this subdivision. Upon a showing of indigency or undue hardship upon the convicted person or the convicted person's immediate family, the sentencing court may authorize payment of the surcharge in installments.

(d) The court administrator or other entity collecting a surcharge shall forward it to the commissioner of finance.

(e) If the convicted person is sentenced to imprisonment and has not paid the surcharge before the term of imprisonment begins, the chief executive officer of the correctional facility in which the convicted person is incarcerated shall collect the surcharge from any earnings the inmate accrues from work performed in the facility or while on conditional release. The chief executive officer shall forward the amount collected to the commissioner of finance.

Sec. 4. Minnesota Statutes 2004, section 357.021, subdivision 7, is amended to read:

Subd. 7. [DISBURSEMENT OF SURCHARGES BY COMMISSIONER OF FINANCE.] (a) Except as provided in paragraphs (b), (c), and (d), the commissioner of finance shall disburse surcharges received under subdivision 6 and section 97A.065, subdivision 2, as follows:

(1) one percent shall be credited to the game and fish fund to provide peace officer training for employees of the Department of Natural Resources who are licensed under sections 626.84 to 626.863, and who possess peace officer authority for the purpose of enforcing game and fish laws;

(2) 39 percent shall be credited to the peace officers training account in the special revenue fund; and

(3) 60 percent shall be credited to the general fund.

(b) The commissioner of finance shall credit $3 of each surcharge received under subdivision 6 and section 97A.065, subdivision 2, to the general fund.

(c) In addition to any amounts credited under paragraph (a), the commissioner of finance shall credit ~~$32~~ $42 of each surcharge received under subdivision 6 and section 97A.065, subdivision 2, and the $3 parking surcharge, to the general fund.

(d) If the Ramsey County Board of Commissioners authorizes imposition of the additional $1 surcharge provided for in subdivision 6, paragraph (a), the court administrator in the Second Judicial District shall withhold $1 from each surcharge collected under subdivision 6. The court administrator must use the withheld funds solely to fund the petty misdemeanor diversion program administered by the Ramsey County Violations Bureau. The court administrator must transfer any unencumbered portion of the funds received under this subdivision to the commissioner of finance for distribution according to paragraphs (a) to (c).

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1979 - Hospital Payment Additions; Criminal and Traffic Offender Surcharge Increase (The A-4 Delete-Everything Amendment)

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)

Date: April 11, 2005

S.F. No. 1979 authorizes additional Medical Assistance (MA) payments to certain hospitals, to be financed through a combination of nonstate expenditures certified for these purposes and a $10 increase in the surcharge on criminal and traffic offenders.

Section 1 (256.969, subdivision 9) adds three new disproportionate population adjustments for hospitals that are located in Minnesota, do not qualify for the "small rural" payment adjustment, and satisfy certain other criteria, as follows:

- hospitals in which MA represents more than 19 percent of total patient days receive a 13 percent rate increase;
- hospitals in specified cities outside the seven-county metropolitan area in which MA represents less than 19 percent of total patient days receive a ten percent rate increase; and
- hospitals not located in one of the specified cities and in which MA represents less than 19 percent of total patient days receive a five percent increase.

These rate increases are paid annually in a lump sum on July 1. The adjustments paid on July 1, 2005, are paid at double the rates specified.

Section 2 (256B.199) authorizes certain expenditures by nonstate entities to be certified as the state and federal share of the payments in section 1. These expenditures include $9.5 million from

Hennepin County, $5.1 million from Ramsey County, and unspecified amounts from the University of Minnesota and Gillette Children's Hospital. The Commissioner of Human Services is authorized to adjust the payments under section 1 and the amount of expenditures certified under this section to comply with federal law, to access the maximum amount of federal matching funds, and to maintain budget neutrality.

Section 3 (357.021, subdivision 6) increases the surcharge on criminal and traffic offenders to $70 from the current $60 and specifies that this increase is in addition to any other increase in this surcharge enacted by the 2005 Legislature.

Section 4 (357.021, subdivision 7) credits the additional $10 surcharge to the general fund.

Section 5 appropriates the additional revenue expected from the surcharge increase from the general fund to the Commissioner of Human Services for the purposes of section 1.

DG:rdr

Name	City	Base Yr % MA Days
GILLETTE CHILDRENS HOSPITAL	ST PAUL	59.60%
CHILDRENS HEALTH CARE MINNEAPOLIS	MINNEAPOLIS	54.30%
CHILDRENS HEALTH CARE ST PAUL	ST PAUL	47.04%
HENNEPIN COUNTY MEDICAL CENTER	MINNEAPOLIS	38.56%
REGIONS HOSPITAL	ST PAUL	24.54%
KINDRED HOSPITAL - MINNESOTA	GOLDEN VALLEY	24.51%
FAIRVIEW UNIVERSITY MEDICAL CENTER	MINNEAPOLIS	21.29%
NORTH COUNTRY REGIONAL HOSPITAL	BEMIDJI	19.62%
HEALTHEAST BETHESDA HOSPITAL	ST PAUL	17.95%
TRI-COUNTY HOSPITAL	WADENA	17.78%
ST MARYS REGIONAL HEALTH CENTER	DETROIT LAKES	17.64%
MILLER-DWAN MEDICAL CENTER	DULUTH	17.42%
CAMBRIDGE MEMORIAL HOSPITAL	CAMBRIDGE	17.36%
DEER RIVER HEALTHCARE CENTER	DEER RIVER	17.25%
MINNESOTA VALLEY MEMORIAL HOSPITAL	LESUEUR	16.84%
MILLE LACS HOSPITAL & HOME	ONAMIA	16.61%
UNIVERSITY MEDICAL CENTER - MESABI	HIBBING	16.60%
WEINER MEMORIAL MEDICAL CENTER	MARSHALL	16.29%
RICE COUNTY DIST ONE HOSPITAL	FARIBAULT	15.69%
PAYNESVILLE AREA HEALTH CARE SYSTEM	PAYNESVILLE	14.72%
ST MARYS MEDICAL CENTER	DULUTH	14.41%
OLMSTED MEDICAL CENTER	ROCHESTER	14.16%
GLACIAL RIDGE HOSPITAL	GLENWOOD	13.65%
ST CLOUD HOSPITAL	ST CLOUD	13.02%
NORTH MEMORIAL HEALTH CARE	ROBBINSDALE	13.00%
FIRST CARE MEDICAL SERVICES	FOSSTON	12.49%
MERCY HOSPITAL & HEALTH CARE CENTER	MOOSE LAKE	12.03%
HEALTHEAST ST JOSEPHS HOSPITAL	ST PAUL	11.92%
CUYUNA REGIONAL MEDICAL CENTER	CROSBY	11.91%
ST FRANCIS MEDICAL CENTER	BRECKENRIDGE	11.76%
UNITY HOSPITAL	FRIDLEY	11.76%
ST JOSEPHS MEDICAL CENTER	BRAINERD	11.49%
NORTH VALLEY HEALTH CENTER	WARREN	11.43%
OWATONNA HOSPITAL	OWATONNA	11.28%
WORTHINGTON REGIONAL HOSPITAL	WORTHINGTON	11.19%
GREATER STAPLES HOSP & CARE CENTER	STAPLES	11.14%
BUFFALO HOSPITAL HEALTHSPAN	BUFFALO	11.13%
MERCY HOSPITAL	COON RAPIDS	11.11%
UNITED HOSPITAL INC	ST PAUL	10.85%
WINDOM AREA HOSPITAL	WINDOM	10.72%
FAIRVIEW NORTHLAND REGIONAL HOSP	PRINCETON	10.53%
NORTHWEST MEDICAL CENTER	THIEF RIVER FALLS	10.51%
MONTICELLO BIG LAKE COMMUNITY HOSP	MONTICELLO	10.41%
FALLS MEMORIAL HOSPITAL	INTERNATL FALLS	9.89%
CLEARWATER COUNTY MEMORIAL HOSPITAL	BAGLEY	9.81%
VIRGINIA REGIONAL MEDICAL CENTER	VIRGINIA	9.81%
LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	9.61%

ST LUKES HOSPITAL	DULUTH	9.22%
ST FRANCIS REGIONAL MEDICAL CTR	SHAKOPEE	9.19%
CHIPPEWA COUNTY-MONTEVIDEO HOSPITAL	MONTEVIDEO	8.95%
MAYO PSYCHIATRY & PSYCHOLOGY	ROCHESTER	8.95%
PIPESTONE COUNTY MEDICAL CENTER	PIPESTONE	8.93%
COMMUNITY MEMORIAL HOSPITAL	WINONA	8.88%
RICE MEMORIAL HOSPITAL	WILLMAR	8.80%
ST GABRIELS HOSPITAL	LITTLE FALLS	8.75%
MADELIA COMMUNITY HOSPITAL	MADELIA	8.61%
WASECA AREA MEMORIAL HOSPITAL	WASECA	8.59%
HUTCHINSON AREA HEALTH CARE	HUTCHINSON	8.50%
ELY BLOOMENSON COMMUNITY HOSPITAL	ELY	8.38%
AUSTIN MEDICAL CENTER	AUSTIN	8.34%
COMMUNITY MEMORIAL HOSPITAL	CLOQUET	8.20%
NAEVE HOSPITAL ASSOCIATION	ALBERT LEA	8.18%
RIVERVIEW HEALTHCARE ASSN	CROOKSTON	8.11%
MEEKER COUNTY MEMORIAL HOSPITAL	LITCHFIELD	7.98%
LAKEWOOD HEALTH CENTER	BAUDETTE	7.95%
ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	7.93%
LAKE REGION HOSPITAL	FERGUS FALLS	7.93%
CENTRACARE HEALTH SERV OF LONG PRAI	LONG PRAIRIE	7.82%
PERHAM MEMORIAL HOSPITAL & HOME	PERHAM	7.82%
ORTONVILLE AREA HEALTH SERVICES	ORTONVILLE	7.60%
ELEAH MEDICAL CENTER	ELBOW LAKE	7.52%
HOLY TRINITY HOSPITAL	GRACEVILLE	7.28%
NORTHFIELD CITY HOSPITAL	NORTHFIELD	7.23%
RENVILLE COUNTY HOSPITAL	OLIVIA	7.18%
LAKE CITY MED CTR - MAYO HEALTH SYS	LAKE CITY	7.16%
IMMANUEL ST JOSEPHS HOSPITAL	MANKATO	6.91%
PHILLIPS EYE INSTITUTE	MINNEAPOLIS	6.90%
HEALTHEAST ST JOHNS HOSPITAL	MAPLEWOOD	6.71%
NEW ULM MEDICAL CENTER	NEW ULM	6.56%
COOK COMMUNITY HOSPITAL C & NC UNIT	COOK	6.37%
ST JAMES HEALTH SERVICES - HOSPITAL	ST JAMES	6.30%
KANABEC HOSPITAL	MORA	6.22%
HENDRICKS COMMUNITY HOSPITAL	HENDRICKS	6.14%
LUVERNE COMMUNITY HOSPITAL	LUVERNE	6.01%
RIVERWOOD HEALTHCARE CENTER	AITKIN	6.01%
SIOUX VALLEY CANBY CAMPUS	CANBY	5.97%
FAIRMONT COMMUNITY HOSPITAL	FAIRMONT	5.96%
ST MICHAELS HOSPITAL	SAUK CENTRE	5.91%
DOUGLAS COUNTY HOSPITAL	ALEXANDRIA	5.81%
FAIRVIEW RIDGES HOSPITAL	BURNSVILLE	5.65%
BRIDGES MEDICAL SERVICES	ADA	5.49%
ST JOSEPHS HOSPITAL	PARK RAPIDS	5.29%
ROCHESTER METHODIST HOSPITAL	ROCHESTER	5.17%
GRANITE FALLS MUNICIPAL HOSPITAL	GRANITE FALLS	5.15%
COOK COUNTY NORTH SHORE HOSPITAL	GRAND MARAIS	5.07%
GLENCOE REGIONAL HEALTH SERVICES	GLENCOE	5.01%
ROSEAU AREA HOSPITAL & HOMES	ROSEAU	4.88%
REGINA MEDICAL CENTER	HASTINGS	4.81%
REDWOOD FALLS HOSPITAL	REDWOOD FALLS	4.73%

TRACY AREA MEDICAL SERVICES	TRACY	4.68%
UNITED HOSPITAL	BLUE EARTH	4.68%
MINNEWASKA DISTRICT HOSPITAL	STARBUCK	4.62%
WHEATON COMMUNITY HOSPITAL	WHEATON	4.57%
ST MARYS HOSPITAL	ROCHESTER	4.49%
FAIRVIEW LAKES REGIONAL HEALTH CARE	WYOMING	4.46%
GRANDITASCA CLINIC & HOSPITAL	GRAND RAPIDS	4.45%
ST ELIZABETH HOSPITAL	WABASHA	4.31%
NORTHERN ITASCA HEALTH CARE CENTER	BIGFORK	4.11%
SIBLEY MEDICAL CENTER	ARLINGTON	4.11%
JOHNSON MEMORIAL HEALTH SERVICES	DAWSON	4.07%
RIDGEVIEW MEDICAL CENTER	WACONIA	4.01%
TYLER HEALTHCARE CENTER	TYLER	3.98%
MELROSE AREA HOSPITAL - CENTRACARE	MELROSE	3.73%
SPRINGFIELD MED CTR - MAYO HEALTH	SPRINGFIELD	3.68%
MADISON HOSPITAL	MADISON	3.59%
SWIFT COUNTY BENSON HOSPITAL	BENSON	3.57%
APPLETON MUNICIPAL HOSPITAL	APPLETON	3.37%
CANNON FALLS COMMUNITY HOSPITAL	CANNON FALLS	3.28%
LAKESIDE MEDICAL CENTER	PINE CITY	3.23%
FAIRVIEW SOUTHDALE HOSPITAL	MINNEAPOLIS	3.12%
JACKSON MEDICAL CENTER	JACKSON	3.11%
METHODIST HOSPITAL	ST LOUIS PARK	3.04%
ST PETER COMM HOSP & HLTH CARE CTR	ST PETER	3.00%
STEVENS COMMUNITY MEDICAL CENTER	MORRIS	2.98%
FAIRVIEW RED WING HOSPITAL	RED WING	2.78%
LAKEVIEW MEMORIAL HOSPITAL	TWO HARBORS	2.68%
PINE MEDICAL CENTER	SANDSTONE	2.51%
QUEEN OF PEACE HOSPITAL	NEW PRAGUE	2.23%
WHITE COMMUNITY HOSPITAL	AURORA	2.19%
KITTSON MEMORIAL HOSPITAL	HALLOCK	2.09%
ALBANY AREA HOSPITAL	ALBANY	1.95%
DIVINE PROVIDENCE HEALTH CENTER INC	IVANHOE	1.75%
WESTBROOK HEALTH CENTER	WESTBROOK	1.31%
MURRAY COUNTY MEMORIAL HOSPITAL	SLAYTON	1.28%
SLEEPY EYE MUNICIPAL HOSPITAL	SLEEPY EYE	0.83%
MAHNOMEN HEALTH CENTER	MAHNOMEN	0.82%
HEALTHEAST WOODWINDS HOSPITAL	WOODBURY	0.00%

Recommendations for Distribution of New Disproportionate Population Adjustment (DPA) Dollars

Based on Principle #1
Recommendation #1: MHA recommends that hospitals with greater than 19% Medicaid days in the base year receive a 13% add-on.
(8 hospitals fall into this category)

Based on Principle #2
Recommendation #2: MHA recommends hospitals located in small urban areas in Greater Minnesota with more than 250 Medicaid admissions in the base year receive a 10% add-on.
(17 hospitals fall into this category)

Based on Principle #3
Recommendation #3: MHA recommends that hospitals with more than 250 Medicaid admissions, and that have less than 19% Medicaid days in the base year, and are not located in small urban areas in Greater Minnesota, receive a 5% add-on.
(12 hospitals fall into this category)

Minnesota Department Of Human Services
Medicaid Management Information System (MMIS)

5%
10%
13%

City	PROVIDER NAME	TOTAL PAYMENTS LESS DPA	Supplemental DPA pmts FFY06 ($24M) at 5%,10%, & 13%
Detroit Lakes	ST MARYS REGIONAL HEALTH	536,759.04	$ 53,676
Golden Valley	KINDRED HOSPITAL - MINNES	596,800.00	$ 77,584
Rochester	OLMSTED MEDICAL CENTER	709,088.32	$ 70,909
Willmar	RICE MEMORIAL HOSPITAL	846,184.46	$ 84,618
Woodbury	HEALTHEAST WOODWINDS HOSPITA	966,519.00	$ 48,326
Hutchinson	HUTCHINSON AREA HEALTH CA	968,730.04	$ 96,873
Alexandria	DOUGLAS COUNTY HOSPITAL	1,162,714.02	$ 116,271
Austin	AUSTIN MEDICAL CENTER	1,291,041.88	$ 129,104
Cambridge	CAMBRIDGE MEMORIAL HOSPIT	1,456,574.02	$ 145,657
Brainerd	ST JOSEPHS MEDICAL CENTER	1,458,966.45	$ 145,897
Burnsville	FAIRVIEW RIDGES HOSPITAL	1,480,291.28	$ 74,015
Hibbing	UNIVERSITY MEDICAL CENTER	1,919,589.11	$ 191,959
Mankato	IMMANUEL-ST JOSEPHS HOSPI	2,006,102.11	$ 200,610
St. Louis Park	METHODIST HOSPITAL	2,104,266.24	$ 105,213
Maplewood	HEALTHEAST ST JOHNS HOSPI	2,270,072.51	$ 113,504
Rochester	MAYO PSYCHIATRY & PSYCHOL	2,447,333.38	$ 244,733
Edina	FAIRVIEW SOUTHDALE HOSPIT	2,840,187.48	$ 142,009
Fridley	UNITY HOSPITAL	3,033,902.27	$ 151,695
St. Paul	HEALTHEAST BETHESDA HOSPI	3,423,228.09	$ 171,161
Rochester	ROCHESTER METHODIST HOSPI	3,550,948.15	$ 355,095
D ı	MILLER-DWAN MEDICAL CENTE	3,612,922.94	$ 361,292
Bemidji	NORTH COUNTRY REGIONAL HO	3,714,070.23	$ 482,829
Duluth	ST LUKES HOSPITAL	3,999,760.42	$ 399,976
St. Paul	GILLETTE CHILDRENS HOSPIT	4,605,873.18	$ 598,764
St. Paul	HEALTHEAST ST JOSEPHS HOS	5,288,478.52	$ 264,424
Coon Rapids	MERCY HOSPITAL	5,704,042.22	$ 285,202
Duluth	ST MARY'S MEDICAL CENTER	6,824,460.29	$ 682,446
St. Paul	CHILDRENS HEALTH CARE ST	8,052,606.35	$ 1,046,839
St. Cloud	ST CLOUD HOSPITAL	8,889,898.51	$ 888,990
St. Paul	UNITED HOSPITAL INC	9,233,475.23	$ 461,674
Robbinsdale	NORTH MEMORIAL HEALTH CAR	9,244,895.72	$ 462,245
Rochester	ST MARYS HOSPITAL	10,554,725.57	$ 1,055,473
Minneapolis	ABBOTT NORTHWESTERN HOSPI	13,117,034.06	$ 655,852
St. Paul	REGIONS HOSPITAL	16,866,936.61	$ 2,192,702
Minneapolis	CHILDRENS HEALTH CARE MIN	20,692,126.65	$ 2,689,976
Minneapolis	FAIRVIEW UNIVERSITY MEDIC	31,446,138.70	$ 4,087,998
Minneapolis	HENNEPIN COUNTY MEDICAL C	34,683,826.67	$ 4,508,897
			$ 23,844,489

ATTACHMENT "E"

Senator ..... moves to amend S.F. No. 1979 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 256.969, subdivision 9, is amended to read:

Subd. 9. [DISPROPORTIONATE NUMBERS OF LOW-INCOME PATIENTS SERVED.] (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the

adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class; ~~and~~

(3) for a hospital that had medical assistance

fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995;

(4) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 19 percent of total patient days during the base year, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payments due under this subdivision equal to 13 percent of the total of the operating and payment rates;

(5) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Hutchinson, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, and St. Cloud; and

(6) for a hospital located in Minnesota but not located in

a specified urban area under clause (5) and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision equal to five percent of the total of the operating and property payment rates.

The adjustments under clauses (4), (5), and (6) shall be paid annually on July 1 for services to be rendered in the fiscal year beginning on that day, based on services rendered in the previous calendar year. The adjustments paid on July 1, 2005, shall be paid at 200 percent of the rate specified in clauses (4), (5), and (6).

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in ~~clause~~ clauses (3), (4), (5), and (6).

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Sec. 2. [256B.199] [CERTIFIED PUBLIC EXPENDITURES EFFECTIVE JULY 1, 2005.]

Subdivision 1. [PAYMENTS FROM GOVERNMENTAL ENTITIES.] The following expenditures shall be certified by the nonstate entities listed annually on July 1 for payment as the state and federal share under section 256.969, subdivision 9, paragraph (b), clauses (4), (5), and (6):

(1) Hennepin County, $9,500,000;

(2) Ramsey County, $5,100,000;

7.8 million

(3) University of Minnesota, $.....; and

(4) Gillette Children's Hospital $.....

Subd. 2. [ADJUSTMENTS PERMITTED.] (a) The commissioner may adjust the payments under section 256.969, subdivision 9, paragraph (b), clauses (4), (5), and (6), based on changes in certified public expenditures under subdivision 1 and total federal disproportionate share payment limits. The commissioner may ratably increase the payments under section 256.969, subdivision 9, paragraph (b), clauses (4), (5), and (6), based on the availability of certified public expenditures under subdivision 1. Any adjustments must be made on a proportional basis. The commissioner may make these adjustments only after consultation with the nonstate entities identified in subdivision 1.

(b) The ratio of disproportionate population adjustments specified in section 256.969, subdivision 9, paragraph (b), clauses (4), (5), and (6), to the certification amounts specified in subdivision 1 shall not be reduced. The commissioner may adjust payments under section 256.969, subdivision 9, paragraph (b), clauses (4), (5), and (6), and payments under subdivision 1 in order to access the maximum disproportionate population adjustments available under federal law.

Sec. 3. Minnesota Statutes 2004, section 357.021, subdivision 6, is amended to read:

Subd. 6. [SURCHARGES ON CRIMINAL AND TRAFFIC OFFENDERS.] (a) The court shall impose and the court administrator shall collect a ~~$60~~ $70 surcharge on every person convicted of any felony, gross misdemeanor, misdemeanor, or petty misdemeanor offense, other than a violation of a law or ordinance relating to vehicle parking, for which there shall be a $3 surcharge. In the Second Judicial District, the court shall impose, and the court administrator shall collect, an additional $1 surcharge on every person convicted of any felony, gross misdemeanor, or petty misdemeanor offense, other than a violation of a law or ordinance relating to vehicle parking, if the Ramsey County

Board of Commissioners authorizes the $1 surcharge. The surcharge shall be imposed whether or not the person is sentenced to imprisonment or the sentence is stayed.

(b) If the court fails to impose a surcharge as required by this subdivision, the court administrator shall show the imposition of the surcharge, collect the surcharge and correct the record.

(c) The court may not waive payment of the surcharge required under this subdivision. Upon a showing of indigency or undue hardship upon the convicted person or the convicted person's immediate family, the sentencing court may authorize payment of the surcharge in installments.

(d) The court administrator or other entity collecting a surcharge shall forward it to the commissioner of finance.

(e) If the convicted person is sentenced to imprisonment and has not paid the surcharge before the term of imprisonment begins, the chief executive officer of the correctional facility in which the convicted person is incarcerated shall collect the surcharge from any earnings the inmate accrues from work performed in the facility or while on conditional release. The chief executive officer shall forward the amount collected to the commissioner of finance.

(f) The $10 surcharge increase in paragraph (a) is in addition to any other increase in this surcharge enacted by the 2005 legislature.

Sec. 4. Minnesota Statutes 2004, section 357.021, subdivision 7, is amended to read:

Subd. 7. [DISBURSEMENT OF SURCHARGES BY COMMISSIONER OF FINANCE.] (a) Except as provided in paragraphs (b), (c), and (d), the commissioner of finance shall disburse surcharges received under subdivision 6 and section 97A.065, subdivision 2, as follows:

(1) one percent shall be credited to the game and fish fund to provide peace officer training for employees of the Department of Natural Resources who are licensed under sections 626.84 to 626.863, and who possess peace officer authority for

the purpose of enforcing game and fish laws;

(2) 39 percent shall be credited to the peace officers training account in the special revenue fund; and

(3) 60 percent shall be credited to the general fund.

(b) The commissioner of finance shall credit $3 of each surcharge received under subdivision 6 and section 97A.065, subdivision 2, to the general fund.

(c) In addition to any amounts credited under paragraph (a), the commissioner of finance shall credit ~~$32~~ $42 of each surcharge received under subdivision 6 and section 97A.065, subdivision 2, and the $3 parking surcharge, to the general fund.

(d) If the Ramsey County Board of Commissioners authorizes imposition of the additional $1 surcharge provided for in subdivision 6, paragraph (a), the court administrator in the Second Judicial District shall withhold $1 from each surcharge collected under subdivision 6. The court administrator must use the withheld funds solely to fund the petty misdemeanor diversion program administered by the Ramsey County Violations Bureau. The court administrator must transfer any unencumbered portion of the funds received under this subdivision to the commissioner of finance for distribution according to paragraphs (a) to (c).

Sec. 5. [APPROPRIATION.]

$4,900,000 in fiscal year 2006 and $6,500,000 in fiscal year 2007 is appropriated from the general fund to the commissioner of human services for the purposes of section 1."