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S.F. No. 378 - Caregiver Support (The A-4 Delete-Everything Amendment)

Author: Senator Sheila Kiscaden

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 16, 2005

S.F. No. 378 modifies the ability of employees to use personal sick leave to care for family members. It establishes an Internet-based caregiver support program. It establishes a home care tax credit.

Section 1 (181.9413) allows employees to use personal sick leave to care for a spouse, sibling, parent, grandparent, or stepparent. Current law limits use of this benefit to the care of sick or injured children.

Section 2 (256B.0911, subdivision 3) requires county long-term care consultation teams to certify that applicants for a home care tax credit satisfy certain requirements. The teams must certify that the care qualifies as personal care assistance services, is needed and provided daily, is appropriate, and has been given a score using the caregiver burden scale under section 4.

Section 3 (256B.0917, subdivision 6a) requires the Minnesota Board on Aging to implement an Internet-based caregiver support program. The program is designed to provide needed support to caregivers to plan, purchase, coordinate, monitor, and evaluate the care outcomes of family members they are assisting. Program components are outlined in the bill.

Section 4 (256B.0917, subdivision 6b) assigns duties to the Department of Human Services (DHS) with respect to the home care tax credit. The department must develop a scale to score applicants for the credit. The scale must measure the volume and types

of care provided and other aspects of care determined to be pertinent by DHS. Each caregiver applying for a tax credit must obtain a score from DHS, and DHS must limit approvals under this section in order to keep the expenditure for tax credits within the limit of appropriations for that purpose. A timetable for accepting and approving applications is established. DHS is exempt from the Administrative Procedure Act for the purposes of this section.

Section 5 (290.0676) establishes the home care tax credit.

> **Subdivisions 1 to 4** define terms. A "service recipient" of a caregiver must be at least 65, must be closely related to the caregiver, must not reside in a licensed or registered setting, and must be determined eligible for nursing home placement.
>
> **Subdivision 5** establishes the credit of $200 per month, up to $2,400 per year.
>
> **Subdivision 6** sets a variety of limits on the credit. Income guidelines are established. Eligibility is limited to persons approved by DHS. The credit is reduced to $100 during any month in which the qualifying person receives more than four hours per day of publicly funded home care services.
>
> **Subdivision 7** makes the tax credit refundable.
>
> **Subdivision 8** establishes annual caregiver training requirements.

Section 6 requires DHS to convene a work group to study the possible integration into the home health care delivery system of the delivery of home health care services using interactive technologies. Study requirements and work group membership are outlined. A report is due by January 15, 2006.

Section 7 appropriates a blank amount for added long-term care consultation team services, $950,000 for the Internet-based caregiver support program, and $4,800,000 for the tax credit.

DG:rdr

Senators Kiscaden, Nienow, Higgins and Lourey introduced--
S.F. No. 378: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; providing support to caregivers; appropriating money; amending Minnesota Statutes 2004, sections 181.9413; 256B.0917, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 290.

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

Section 1. Minnesota Statutes 2004, section 181.9413, is amended to read:

181.9413 [SICK ~~OR-INJURED-CHILD-CARE~~ LEAVE BENEFITS; USE TO CARE FOR CERTAIN RELATIVES.]

(a) An employee may use personal sick leave benefits provided by the employer for absences due to an illness of or injury to the employee's child, parent, grandparent, or stepparent for such reasonable periods as the employee's attendance ~~with-the-child~~ may be necessary, on the same terms upon which the employee is able to use sick leave benefits for the employee's own illness or injury. This section applies only to personal sick leave benefits payable to the employee from the employer's general assets.

(b) For purposes of this section, "personal sick leave benefits" means time accrued and available to an employee to be used as a result of absence from work due to personal illness or injury, but does not include short-term or long-term disability or other salary continuation benefits.

[EFFECTIVE DATE.] This section is effective August 1, 2005,

and applies to sick leave on or after that date.

Sec. 2. Minnesota Statutes 2004, section 256B.0917, subdivision 6, is amended to read:

Subd. 6. [CAREGIVER SUPPORT AND RESPITE CARE PROJECTS.] (a) The commissioner shall establish up to ~~36~~ 50 projects to expand the respite care network in the state and to support caregivers in their responsibilities for care. The purpose of each project shall be to:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite workers to clients and care receivers and assure the health and safety of the client; and

(3) provide training for caregivers and ensure that support groups are available in the community.

(b) The caregiver support and respite care funds shall be available to the four to six local long-term care strategy projects designated in subdivisions 1 to 5.

(c) The commissioner shall publish a notice in the State Register to solicit proposals from public or private nonprofit agencies for the projects not included in the four to six local long-term care strategy projects defined in subdivision 2. A county agency may, alone or in combination with other county agencies, apply for caregiver support and respite care project funds. A public or nonprofit agency within a designated SAIL project area may apply for project funds if the agency has a letter of agreement with the county or counties in which services will be developed, stating the intention of the county or counties to coordinate their activities with the agency requesting a grant.

(d) The commissioner shall select grantees based on the following criteria:

(1) the ability of the proposal to demonstrate need in the area served, as evidenced by a community needs assessment or other demographic data;

(2) the ability of the proposal to clearly describe how the

project will achieve the purpose defined in paragraph (b);

(3) the ability of the proposal to reach underserved populations;

(4) the ability of the proposal to demonstrate community commitment to the project, as evidenced by letters of support and cooperation as well as formation of a community task force;

(5) the ability of the proposal to clearly describe the process for recruiting, training, and retraining volunteers; and

(6) the inclusion in the proposal of the plan to promote the project in the community, including outreach to persons needing the services.

(e) Funds for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) train caregivers;

(4) ensure the development of support groups for caregivers;

(5) advertise the availability of the caregiver support and respite care project; and

(6) purchase equipment to maintain a system of assigning workers to clients.

(f) Project funds may not be used to supplant existing funding sources.

Sec. 3. [290.0676] [MINNESOTA HOME CARE CREDIT.]

Subdivision 1. [CREDIT ALLOWED.] (a) An individual is allowed a credit against the tax imposed by this chapter, equal to $200 for each month during the tax year that the individual is a caregiver for a qualifying person. The maximum credit in a tax year is $2,400. The commissioner may require claimants to certify that the claimant and the qualifying person meet the requirements of this section. An individual may claim only one credit in any tax year and only one credit may be claimed for each qualifying person in any tax year.

(b) For a nonresident or part-year resident, the credit must be allocated based on the percentage calculated under section 290.06, subdivision 2c, paragraph (e).

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Qualifying person," means an individual who:

(1) is the parent, stepparent, sibling, stepsibling, child, or stepchild of the taxpayer; and

(2) has been screened by a county preadmission screening team and determined by that team to be eligible for placement in a nursing facility.

(b) "Caregiver" means an individual who:

(1) provides assistance with instrumental activities of daily living for a qualifying person, in either the individual's home or the qualifying person's home; and

(2) attends at least eight hours of (i) caregiver training or education or (ii) caregiver support group sessions during the year for which the credit is claimed.

(c) "Instrumental activities of daily living" means activities such as preparation of meals, light housekeeping, personal laundry, handling money, and using the telephone. Instrumental activities of daily living are associated with independent living and necessary to support activities of daily living, including eating, transferring, dressing, bathing, toileting, and ambulation.

Subd. 3. [LIMITATIONS.] The credit is reduced to $100 for any month in which a qualifying person receives more than four hours per day on average of state or county-funded home care services under section 144A.43, subdivision 3, including, but not limited to, those funded under chapters 256B and 256L.

Subd. 4. [CREDIT REFUNDABLE.] If the amount of the credit that a claimant is eligible to receive under this section exceeds the claimant's tax liability under this chapter, the commissioner shall refund the excess to the claimant.

Subd. 5. [APPROPRIATION.] An amount sufficient to pay the refunds required by this section is appropriated to the

commissioner of revenue from the general fund.

[EFFECTIVE DATE.] This section is effective for taxable years beginning after December 31, 2004.

Sec. 4. [APPROPRIATION.]

(a) $540,000 is appropriated from the general fund to the commissioner of human services in fiscal year 2006 for the purposes in section 2 to provide grants to new and existing projects.

(b) $100,000 is appropriated from the general fund to the Minnesota Board on Aging in fiscal year 2006 for the purpose of providing caregiver education on resources and services.

Senator ..... moves to amend S.F. No. 378 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 181.9413, is amended to read:

181.9413 [SICK ~~OR INJURED CHILD CARE~~ LEAVE BENEFITS; USE TO CARE FOR CERTAIN RELATIVES.]

(a) An employee may use personal sick leave benefits provided by the employer for absences due to an illness of or injury to the employee's child, spouse, sibling, parent, grandparent, or stepparent for such reasonable periods as the employee's attendance ~~with the child~~ may be necessary, on the same terms upon which the employee is able to use sick leave benefits for the employee's own illness or injury. This section applies only to personal sick leave benefits payable to the employee from the employer's general assets.

(b) For purposes of this section, "personal sick leave benefits" means time accrued and available to an employee to be used as a result of absence from work due to personal illness or injury, but does not include short-term or long-term disability or other salary continuation benefits.

[EFFECTIVE DATE.] This section is effective August 1, 2005, and applies to sick leave used on or after that date.

Sec. 2. Minnesota Statutes 2004, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. [LONG-TERM CARE CONSULTATION TEAM.] (a) A long-term care consultation team shall be established by the county board of commissioners. Each local consultation team shall consist of at least one social worker and at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

(c) For applicants for a credit under section 290.0676, the team must certify in accordance with procedures established by the commissioner that the care provided by the caregiver:

(1) qualifies as personal care assistant services under section 256B.0627, subdivision 4;

(2) is needed and provided in person on a daily basis;

(3) is appropriate based on the service recipient's needs and is likely to delay or avoid transferring the person to an out-of-home placement; and

(4) has been given a score using the caregiver burden scale under section 256B.0917, subdivision 6b.

Sec. 3. Minnesota Statutes 2004, section 256B.0917, is amended by adding a subdivision to read:

Subd. 6a. [INTERNET-BASED CAREGIVER SUPPORT PROGRAM.] The Minnesota Board on Aging shall develop and implement an Internet-based caregiver support program. The goal of the program shall be to provide family caregivers with the information and tools needed to self-manage, plan, purchase, coordinate, monitor, and evaluate the day-to-day activities and care outcomes of family members to whom they provide care. The program must complement Internet-based information services that are currently available. The program must include the following components:

(1) direct connectivity to statewide systems, including, but not limited to, Senior LinkAge Line, MinnesotaHelp.info, RXConnect, and long-term care consultation and to vendors and providers of goods and services, including, but not limited to, respite care, coach services, pharmaceutical vendors, medical supply vendors, grocers, personal care vendors, and electronic assistive technology vendors;

(2) access to on-line resources, including connectivity to daily living and clinical monitoring devices and audio and

visual contact between the care recipient, the caregiver, services providers, and others for tracking or conducting service visits, care meetings, and other service provision;

(3) message boards related to caregiver news, information, and events;

(4) data collection, including surveys, and reporting and registration functions as required by state and federal programs; and

(5) an individual data profile accessible by designated parties to view, add, share, or edit information as needed to support informal caregiving.

Sec. 4. Minnesota Statutes 2004, section 256B.0917, is amended by adding a subdivision to read:

Subd. 6b. [DUTIES WITH RESPECT TO HOME CARE CREDIT; APPLICATIONS.] (a) The commissioner shall develop by December 1, 2005, a caregiver burden scale to score applicants for the home care credit under section 290.0676. The score shall measure hours per week of care provided, the volume and types of assistance provided, and other criteria determined by the commissioner to be pertinent.

(b) Each caregiver applying for a credit under section 290.0676 must apply to the commissioner. The commissioner shall rank applicants on the score developed under paragraph (a). The commissioner shall limit approvals under this paragraph in order to keep the credit payments under section 290.0676 within the limits of appropriations made specifically for this purpose.

(c) In each calendar year, the commissioner shall accept until February 15 applications for a caregiver burden scale score for the previous calendar year. By March 15 of each calendar year, the commissioner must issue approvals for credits under section 290.0676, based on each applicant's score on the scale and the appropriations available for credits. The commissioner may develop procedures to delegate to appropriate organizations the responsibility to assign burden scale scores to applicants.

(d) The commissioner shall be exempt from chapter 14 for

purposes of this subdivision.

Sec. 5. [290.0676.] [MINNESOTA HOME CARE CREDIT.]

Subdivision 1. [DEFINITIONS.] The terms used in this section have the following meanings unless otherwise provided for by text.

Subd. 2. [CAREGIVER.] "Caregiver" means an individual who provides unpaid assistance on a daily basis that qualifies as personal care assistant services under section 256B.0627, subdivision 4, to a service recipient in either the individual's home or the service recipient's home.

Subd. 3. [SERVICE RECIPIENT.] "Service recipient" means an individual age 65 or older who:

(1) is the spouse, parent, stepparent, sibling, stepsibling, child, stepchild, grandparent, or stepgrandparent of the taxpayer;

(2) resides other than in a setting licensed or registered by the commissioners of health or human services; and

(3) has been screened by a county long-term care consultation team and determined by that team to be eligible for placement in a nursing home.

Subd. 5. [CREDIT ALLOWED.] (a) An individual is allowed a credit against the tax imposed by this chapter equal to $200 for each month during the tax year that the individual is a caregiver for a service recipient. The maximum credit in a tax year shall be $2,400.

(b) The commissioner shall require individuals claiming the credit to certify that the individual and the service recipient satisfy all the requirements of this section.

(c) An individual may claim only one credit in any tax year. Only one credit may be claimed for each service recipient in any tax year.

(d) For a nonresident or part-year resident, the credit must be allocated based on the percentage calculated under section 290.06, subdivision 2c, paragraph (e).

Subd. 6. [CREDIT LIMITATIONS.] (a) Eligibility for the credit in subdivision 5 is limited to persons with total

household income, as defined in section 290A.03, subdivision 5, that does not exceed the maximum household income level eligible for a refund under section 290A.04, subdivision 2.

(b) Eligibility for the credit in subdivision 5 is limited to persons who have been approved by the commissioner of human services under section 256B.0917, subdivision 6b.

(c) The credit in subdivision 5 is reduced to $100 for any month in which a service recipient receives more than four hours per day on average of federal, state, or county-funded home care services as specified in section 256B.0627, subdivision 2.

Subd. 7. [CREDIT REFUNDABLE.] If the amount of the credit under this section exceeds the individual's tax liability under this chapter, the commissioner shall refund the excess amount to the claimant.

Subd. 8. [CAREGIVER TRAINING.] For each year in which a credit is claimed under this section, the caregiver must attend at least eight hours of (1) caregiver training, education, or counseling, or (2) caregiver support group sessions.

[EFFECTIVE DATE.] This section is effective for taxable years beginning after December 31, 2004.

Sec. 6. [TELEHOME CARE STUDY.]

(a) The commissioner of human services, in consultation with the commissioner of health, shall convene a work group to study and make recommendations on integrating within the home health care delivery system the delivery of home health care services via an interactive telecommunications system and monitoring technologies to homebound patients with chronic illness or disabilities. The study shall examine the effectiveness of video conferencing, Internet access, and physiological monitoring within a home health care setting in terms of cost, accessibility, health outcomes, and provider and patient satisfaction. The study shall:

(1) identify limitations and barriers and recommend possible solutions to providing telehome care, including provider reimbursement; patient and provider recruitment and training; equipment and technology access and support; and

patient privacy;

(2) identify possible populations that may benefit from in-home monitoring and education;

(3) identify best-practices guidelines, policies, and standards for telehome care;

(4) assess the status of current projects providing telehome care in Minnesota; and

(5) identify partnership models and collaboration potential for delivering quality care telehome care delivery system.

(b) The work group shall include representatives of health care providers, hospitals, educators, researchers, home health care providers, and home health care recipients.

(c) The commissioner shall submit a report to the legislature by January 15, 2006, on the results of the study, including any recommendations on necessary legislative changes in order to incorporate telehome care into the health care delivery system.

Sec. 7. [APPROPRIATIONS.]

(a) $..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2005, for the purposes of section 2.

(b) $750,000 in fiscal year 2006 and $200,000 in fiscal year 2007 is appropriated from the general fund to the commissioner of human services for the purposes of section 3.

(c) $4,800,000 is appropriated from the general fund to the commissioner of revenue for the biennium beginning July 1, 2005, for purposes of section 5."

Delete the title and insert:

"A bill for an act relating to human services; modifying use of personal sick leave benefits; establishing an Internet-based caregiver support program; establishing a home care tax credit; requiring a telehome care study; appropriating money; amending Minnesota Statutes 2004, sections 181.9413; 256B.0911, subdivision 3; 256B.0917, by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 290."

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S.F. No. 540 - Long-Term Care Partnership Program

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 11, 2005

S.F. No. 540 authorizes the establishment of a long-term care partnership program in Minnesota to finance long-term care through a combination of private insurance and Medical Assistance (MA), once federal law is modified to permit it or a federal waiver is obtained.

Section 1 (256B.0571) authorizes the program.

Subdivisions 1 to 7 define terms.

Subdivision 8 directs the Commissioner of Human Services, in cooperation with the Commissioner of Commerce, to establish the Partnership for Long-Term Care Program to finance long-term care through a combination of private insurance and MA. To be eligible, a person (1) must be a state resident; (2) must purchase and maintain continuous coverage under a qualifying long-term care insurance policy; and (3) must exhaust the minimum policy benefits. Benefits received before the effective date of the bill do not count towards exhaustion of benefits.

Subdivision 9 outlines MA eligibility for a person who meets the qualifications in subdivision 8. After disregarding assets otherwise exempt under MA, DHS must disregard an additional amount of assets equal to the dollar amount of coverage utilized under the qualifying long-term care insurance policy. The treatment of income is unchanged from current MA law.

Subdivision 10 establishes requirements for a Partnership Policy. They include:

- Minimum coverage must be for a dollar amount equal to at least 24 months of nursing home care. Home health benefits may be substituted at the rate of two home health care days for one nursing home day.

- Minimum daily benefits must be $130 for nursing home care and $65 for home health care. The minimums must be adjusted each October 1 according to the inflation protection feature described in Minnesota Statutes, section 62S.23, subdivision 1, clause (1). This clause requires an annual increase of not less than five percent.

- Special lapse protection features must be included.

- The policy must cover nursing home stays, home care services, care management, and up to 14 days of hospital care while awaiting long-term care placement (paid at the daily nursing home care benefit rate).

- Options, available for an additional premium, must include an elimination period of not more than 100 days and nonforfeiture benefits for applicants between 18 and 75.

Subdivision 11 bars estate recovery procedures against the estate of a person or the person's spouse for the cost of the person's MA benefits if the person qualified for MA under the terms of the Partnership Program.

The Partnership Program does not become effective until full implementation is permitted by federal law. If federal law is changed to permit a waiver of any provisions prohibited by federal law, the Department of Human Services must apply for the waiver.

DG:rdr

Senators Berglin, LeClair, Solon, Higgins and Lourey introduced--
S.F. No. 540: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; authorizing a long-term care partnership program; modifying medical assistance eligibility requirements under certain circumstances; defining approved long-term care insurance policies; limiting medical assistance estate recovery under certain circumstances; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. [256B.0571] [LONG-TERM CARE PARTNERSHIP.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

Subd. 2. [HOME CARE SERVICE.] "Home care service" means care described in section 144A.43.

Subd. 3. [LONG-TERM CARE INSURANCE.] "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. [MEDICAL ASSISTANCE.] "Medical assistance" means the program of medical assistance established under section 256B.01.

Subd. 5. [NURSING HOME.] "Nursing home" means a nursing home as described in section 144A.01.

Subd. 6. [PARTNERSHIP POLICY.] "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10.

Subd. 7. [PARTNERSHIP PROGRAM.] "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 8. [PROGRAM ESTABLISHED.] (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintain the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.

Subd. 9. [MEDICAL ASSISTANCE ELIGIBILITY.] (a) Upon application of an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the commissioner shall disregard an additional amount of financial assets equal to the dollar amount of coverage utilized under the partnership policy.

(c) The commissioner shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 10. [APPROVED POLICIES.] (a) A partnership policy must meet all of the requirements in paragraphs (b) to (g).

(b) Minimum coverage shall be for a period of not less than two years and for a dollar amount equal to 24 months of nursing home care at the minimum daily benefit rate determined and

adjusted under paragraph (c). The policy shall provide for home health care benefits to be substituted for nursing home care benefits on the basis of two home health care days for one nursing home care day.

(c) Minimum daily benefits shall be $130 for nursing home care or $65 for home care. These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1). Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

(d) A third party designated by the insured shall be entitled to receive notice if the policy is about to lapse for nonpayment of premium, and an additional 30-day grace period for payment of premium shall be granted following notification to that person.

(e) The policy must cover all of the following services:

(1) nursing home stay;

(2) home care service;

(3) care management; and

(4) up to 14 days of nursing care in a hospital while the individual is waiting for long-term care placement.

(f) Payment for service under paragraph (e), clause (4), must not exceed the daily benefit amount for nursing home care.

(g) A partnership policy must offer the following options for an adjusted premium:

(1) an elimination period of not more than 100 days; and

(2) nonforfeiture benefits for applicants between the ages of 18 and 75.

Subd. 11. [LIMITATIONS ON ESTATE RECOVERY.] For an individual determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual.

[EFFECTIVE DATE.] (a) If any provision of this section is

prohibited by federal law, no provision shall become effective until federal law is changed to permit its full implementation. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If federal law is changed to permit a waiver of any provisions prohibited by federal law, the commissioner of human services shall apply to the federal government for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect.

Senator ..... moves to amend S.F. No. 540 as follows:

Page 1, line 24, before the period, insert ", regardless of when the policy was first issued"

Page 2, line 35, delete "two years" and insert "one year" and delete "24" and insert "12"

Page 3, line 3, delete "on the basis of two home health care days for" and insert "with one home health care day benefit worth at least 50 percent of"

Page 3, line 19, after the semicolon, insert "and"

Page 3, line 20, delete "; and" and insert a period

Page 3, delete lines 21 and 22

Page 3, line 32, delete "not seek" and insert "limit"

Page 3, line 35, before the period, insert "to an amount that exceeds the dollar amount of coverage utilized under the partnership policy"

Partnership for Long-Term Care

(Excerpts from *Public and Private Financing of Long-Term Care: Options for Minnesota* a report to the Minnesota Legislature, January 2005, prepared by the Department of Human Services, Continuing Care Administration.)

2. Partnership for Long-Term Care

Summary: Option sends clear message about public and private responsibility for long-term care costs

Description. The Partnership for Long-Term Care is a program (now available in only four states) that allows these states to provide Medicaid long-term care coverage to individuals who have purchased a "qualified" LTCI policy in that state, have exhausted those benefits and still need long-term care. Partnership policyholders receive a disregard of the maximum asset limit to be eligible for Medicaid long-term care coverage, and a disregard of an equivalent amount of assets in estate recovery after the individual's death. The disregard is equal to the value of the LTCI policy, but in some states it can include all assets. One of the chief goals of the Partnership is to broaden the LTCI market so that it is attractive to those who have been hesitant to buy coverage in the past.

National Partnership Experience. This program is currently limited to four states by federal law, and is not available in Minnesota. There is substantial interest in establishing the program in the state, when and if the federal prohibition is eliminated. As of December 2003, a total of 180,000 policies had been purchased in the four Partnership states between 1993 and 2003. During that time, 2,000 policyholders had received payments under their LTCI policy, and 89 had exhausted these benefits and accessed Medicaid.[1]

The Partnership for Long-Term Care has not expanded beyond its initial demonstration states of New York, Connecticut, Indiana, and California because in 1993, as part of the Omnibus Budget Reconciliation Act (OBRA '93), Congress removed the asset protection provision, except for the states with already existing programs, thus requiring estate recovery and making the program less attractive to individuals and states. Efforts are underway to eliminate this prohibition at the federal level, and if successful, a number of states would be seriously interested in offering the program. The elimination of this prohibition on asset protection was included in the Bush administration's Medicaid budget proposals last year, and legislation to do so was introduced in Congress last year. This provision is again included in the administration's Medicaid budget proposal this year (2005). There is also growing interest in the possibility of making the program national in order to standardize the program and eliminate the state reciprocity issue.

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1 University of Maryland Web site at http://www.hhp.umd.edu/AGING/PLTC/index.html

Advantages. Proponents of the Partnership program cite its potential for expanding the market for LTCI products. The additional consumer protections put in place through the development of Partnership-qualified policies have set a new standard for the industry. It is estimated that the Partnership program doubles the size of the potential market for LTCI and reduces the incentive to transfer assets in order to qualify for Medicaid. The state then saves money under the Partnership program to the extent that those who purchase the LTCI products are at some real risk of spending down to Medicaid. The Partnership states of California, Connecticut and Indiana have estimated combined Medicaid savings in the range of $8-$10 million during the relatively short time their programs have been operational.

Disadvantages. If individuals purchase a Partnership-qualified product instead of a conventional LTCI product, it may cost the state more if they need large amounts of long-term care because of the state's inability to recover assets. Thus far, it is unclear whether the program has successfully targeted the individuals most likely to use Medicaid, or whether those who have purchased the policies are individuals who would not have purchased LTCI otherwise. In Minnesota, some in the LTCI industry have complained that the minimum requirements for a Partnership-qualified policy would make these policies more expensive and harder to sell, e.g., inflation protection, minimum coverage thresholds. The current lack of reciprocity among states is also cited as a drawback to the purchase of these products.

Report's recommendation regarding Partnership for LTC:

2. Partnership for Long-Term Care Program

- Monitor developments at the federal level regarding authorization to expand the Partnership program to other states.
- Study the possibility of broadening the Partnership concept and allowing private dollars invested in long-term care through other products in addition to LTCI to count toward asset protection.

*Additional fiscal analysis regarding Partnership for LTC will be included in a report from the University of Minnesota's State Health Access Data Assistance Center (SHADAC) in March 2005.

Additional Information about the Partnership for LTC from Appendix B of the report follows. The complete report is available on the DHS Web site at:

http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_025734.hcsp

Table 2: Basic Plan Elements

Tool	Partnership Program for Long-Term Care
Who is Eligible?	Residents of one of the four states "grandfathered" in to the Program before the OBRA language took effect. Those purchasing also need to be eligible to purchase long-term care insurance.
Payment, Administration, Services, Limits on Services	These elements will generally be the same as when one purchases a long-term care insurance policy in any other state. The insurer must meet certain requirements before offering the product, and though aimed at being higher quality, the product may contain certain limits on services. In terms of administration, the difference lies in asset requirements for determining Medicaid eligibility.
Portability or Flexibility of Plan	In 2001 CMS approved legislation creating reciprocity between Connecticut's and Indiana's Medicaid programs for granting asset protection in the determination of Medicaid eligibility. The Connecticut and Indiana reciprocity agreement is the first of its kind in the country and represents the first step in portability of the Medicaid asset protection benefit. Under the agreement, Indiana Partnership policyholders who move to Connecticut will be able to receive dollar-for-dollar Medicaid asset protection if they apply to Connecticut's Medicaid program. The same is true for Connecticut policyholders who relocate to Indiana and apply to Indiana's Medicaid program. For the other states, policy holders could probably access care in states accepting their policy, but to retain asset protection, they would need to spend down in the state in which protection was purchased.
Status of the option in Minnesota or other states	21 states initiated legislative activity to establish a Partnership. The current OBRA language has prevented the programs from coming into effect. Ongoing efforts in other states include planning activities, statutory changes to facilitate development of Partnership programs and appeals to the US Congress to repeal restrictions enacted in 1993 that have stymied Partnership expansion. Minnesota has introduced legislation that would introduce the Partnership Program and to nationally repeal the federal statute. This legislation has not yet passed. The Partnership model continues to operate in the original four states: Connecticut, New York, Indiana and California.
	Connecticut: Began in March 1992 The Dollar for Dollar Partnership model allows consumers to purchase an amount of private coverage equal to the amount of assets that they wish to protect. Generally, the minimum policy must cover at least one year in a nursing home. If and when the private insurance benefits are utilized, the amount of private insurance benefits that was paid out for long-term care services is disregarded in determining eligibility for Medicaid. As with all Medicaid clients, policyholders who become eligible for Medicaid must contribute their income towards the cost of care under Medicaid

Tool	Partnership Program for Long-Term Care
	New York: Began in April 1993 The Total Assets model adopted by New York requires that consumers purchase three years of private coverage for the initial period of care, but then does not require any further contribution of the policyholder's assets once the private benefits have been exhausted. A minimum of three years of nursing home and six years of home care coverage, or a combination of the two, is required. After these private benefits are exhausted, none of the policyholder's assets will be considered in the determination of Medicaid eligibility, although the policyholder must contribute his/her income towards the cost of care.
	Indiana: Began in May 1993 Indiana initially adopted the Dollar for Dollar model, but in March 1998 changed to a combination of the Total Assets and Dollar for Dollar Models. Purchasers receive Total Asset protection if they purchase a policy having at least a state-defined amount of coverage ($140,000 in 1998, $147,000 in 1999, $154,350 in 2000 and increasing annually on January 1 for new policies purchased during that year) and Dollar for Dollar protection if the policy has less than that amount of coverage. Policies purchased prior to March 1998 were grandfathered into Total Asset protection if their original maximum policy amount was at least $140,000.
	California: Began in August 1994 The Dollar for Dollar Partnership model allows consumers to purchase an amount of private coverage equal to the amount of assets that they wish to protect. Generally, the minimum policy must cover at least one year in a nursing home. If and when the private insurance benefits are utilized, the amount of private insurance benefits that was paid out for long term care services is disregarded in determining eligibility for Medicaid. As with all Medicaid clients, policyholders who become eligible for Medicaid must contribute their income towards the cost of care under Medicaid
Potential Market or Portion of Market this Option Occupies	Currently the program operates in only four states. However, if the OBRA language were repealed, a potential market could exist in any state. The market would be similar to the current market for long-term care insurance, though may be larger due to the added incentive of protecting private assets. One statistic projects that the Partnership doubles the size of the potential market.
Research Findings	Those states participating in the Partnership have found the program must be simple, agents must be viewed as partners, the policies should be comparable to non-partnership policies and effective focus is on younger purchasers. One reviewer noted that as a product promoting the integration of the public and private sectors, Partnership has taken hits from both sides of the ideological perspective, yet retains bipartisan support in its

Tool	Partnership Program for Long-Term Care
	communities. A review entitled, "Long-Term Care Partnership Program: Issues and Options" found that the program has not had a major impact on financing LTC in states with the program. The study calls the program's results to date "modest." Another reviewer has noted that the Partnership's assumption that forgiveness of the Medicaid spend-down requirement would act as an incentive to buy long-term care insurance was wrong.
Characteristics of Current Users	The partnership was intended to attract users who would not otherwise buy LTC insurance because of the asset protection from spend-down.

Table 3: Pros/Cons

Pros (advantages)	Cons (disadvantages)
The Partnerships provide an incentive for insurers to offer high quality products and for consumers to protect themselves from the high cost of long-term care.	The 1993 OBRA language effectively removes incentives for states to offer a Partnership program.
The program helps to avoid Medicaid gaming as well as impoverishment.	Still involves an insurance product, therefore many people think they will never have a need for this product.
Improves the working relationship between the states and insurance providers.	So far, there are no clear savings to Medicaid. It may be too early to determine whether there are clear savings to Medicaid.
The program mitigates means testing concerns.	It is unclear whether the partnership attracts its target audience. So far, more people with middle class incomes have purchased, as opposed to those with modest means.
Improves consumer protection. Partnership policies are more likely to include inflation protection and offer coverage of home-based care.	Weak demand: despite the developments of products with improved consumer protection, overall demand for LTCI remains low.

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State of Minnesota

S.F. No. 687 - Hospice Care Amendments

Author: Senator Linda Higgins

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 14, 2005

S.F. No. 687 makes a number of amendments to various laws governing or relating to hospice care.

Section 1 (144A.751, subdivision 1) modifies the hospice care bill of rights as follows:

- it limits the application of the bill of rights to the individual receiving services by excluding the current reference to the individual's family;
- it expands the right to know in advance of receiving care whether the services are covered by third-party payers by adding Medicare to the list of payers, and it deletes the right to know in advance the charges for services that will not be covered by Medicare and the charges the individual may have to pay;
- it replaces the current right to know what the charges are for services, no matter who will be paying, with the right to receive, upon request, a good-faith estimate of the third-party reimbursement the hospice provider expects to receive;
- it reorder the list of rights so that number 18 becomes number 15; and

- it adds to the list of exceptions for not providing ten days' advance notice of service termination cases where the recipient is no longer certified as terminally ill.

Section 2 (144A.755) requires the Commissioner of Health to mandate that hospice providers complete and submit a national data set survey to Hospice Minnesota as a condition of licensure.

Section 3 (383B.225, subdivision 5) modifies the statute governing mandatory death reports to the Hennepin County Medical Examiner. It requires the death of a person receiving hospice care to be reported if the person was not seen by a doctor within 180 days of death, rather than the 90 days currently specified.

Section 4 makes section 2 effective January 1, 2006.

DG:rdr

Senators Higgins, Kiscaden, Fischbach and Kelley introduced--
S.F. No. 687: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying the hospice care bill of rights; requiring hospice providers to complete a specified survey; modifying death report requirements for recipients of hospice care; amending Minnesota Statutes 2004, sections 144A.751, subdivision 1; 144A.755; 383B.225, subdivision 5.

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

Section 1. Minnesota Statutes 2004, section 144A.751, subdivision 1, is amended to read:

Subdivision 1. [STATEMENT OF RIGHTS.] An individual who receives hospice care ~~and the individual's family have~~ has the right to:

(1) receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated;

(2) receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services;

(3) be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequence of these choices, including the consequences of refusing these services;

(4) be told in advance, whenever possible, of any change in the hospice plan of care and to take an active part in any change;

(5) refuse services or treatment;

(6) know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;

(7) know in advance of receiving care whether the services are covered by health insurance, medical assistance, Medicare, or other health programs~~, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay~~;

(8) ~~know what the charges are for services, no matter who will be paying the bill~~ receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services;

(9) know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services;

(10) choose freely among available providers and change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(11) have personal, financial, and medical information kept private and be advised of the provider's policies and procedures regarding disclosure of such information;

(12) be allowed access to records and written information from records according to section 144.335;

(13) be served by people who are properly trained and competent to perform their duties;

(14) be treated with courtesy and respect and to have the patient's property treated with respect;

(15) voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property;

(16) be free from physical and verbal abuse;

~~(16)~~ (17) reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing ~~home-care~~ hospice services; ~~or~~

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the hospice provider; or

(iii) the recipient is no longer certified as terminally ill;

~~(17)~~ (18) a coordinated transfer when there will be a change in the provider of services;

~~(18) voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;~~

(19) know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

(20) know the name and address of the state or county agency to contact for additional information or assistance;

(21) assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation; and

(22) have pain and symptoms managed to the patient's desired level of comfort.

Sec. 2. Minnesota Statutes 2004, section 144A.755, is

amended to read:

144A.755 [INFORMATION AND REFERRAL SERVICES.]

The commissioner shall ensure that information and referral services relating to hospice care are available in all regions of the state. The commissioner shall collect and make available information about available hospice care, sources of payment, providers, and the rights of patients. The commissioner ~~may~~ shall require hospice providers to ~~provide information requested for the purposes of this section~~ complete the National Hospice and Palliative Care Organization national data set survey and submit the survey to Hospice Minnesota as a condition of licensure. The commissioner may publish and make available:

(1) general information describing hospice care in the state;

(2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and

(3) other information the commissioner determines to be appropriate.

Sec. 3. Minnesota Statutes 2004, section 383B.225, subdivision 5, is amended to read:

Subd. 5. [REPORTS OF DEATH.] All sudden or unexpected deaths and all deaths which may be due entirely, or in part, to any factor other than natural disease must be reported to the medical examiner for evaluation. These include, but are not limited to:

(1) unnatural deaths, including violent deaths arising from homicide, suicide, or accident;

(2) deaths associated with burns or chemical, electrical, or radiational injury;

(3) maternal deaths due to abortion;

(4) deaths under suspicious circumstances;

(5) deaths of inmates of public institutions who have not been hospitalized primarily for organic disease and deaths of persons in custody of law enforcement officers;

(6) deaths that occur during, in association with, or as

the result of diagnostic, therapeutic, or anesthetic procedures;

(7) deaths due to neglect;

(8) stillbirths of 20 weeks or longer gestation unattended by a physician;

(9) sudden deaths of persons not disabled by recognizable disease;

(10) unexpected deaths of persons notwithstanding a history of underlying disease;

(11) deaths of persons to be cremated if an autopsy was not performed;

(12) deaths in which a fracture of a major bone such as a femur, humerus, or tibia, has occurred within the past six months;

(13) deaths unattended by a physician occurring outside of a licensed health care facility;

(14) deaths of persons not seen by their physician within 90 days of demise, or within 180 days for deaths of persons under the care of a licensed hospice provider;

(15) physician attended deaths of persons occurring in an emergency department; or

(16) deaths of unborn or newborn infants in which there has been maternal use of or exposure to unprescribed controlled substances.

No person, other than the medical examiner, shall issue a record of death in cases of accidental, suicidal, violent, or mysterious deaths, including suspected homicides, occurring in the county.

Sec. 4. [EFFECTIVE DATE.]

Section 2 is effective January 1, 2006.

Senator ..... moves to amend S.F. No. 687 as follows:

Page 2, line 8, after "the" insert "hospice"

Page 2, line 9, strike "are" and insert "may be"

Page 2, line 12, before the semicolon, insert "in which the individual is enrolled"

Page 2, line 27, after the second comma, insert "Medicare,"

Page 3, lines 9 and 10, strike "as specified in the employment contract"

Page 3, after line 35, insert:

"Sec. 2. Minnesota Statutes 2004, section 144A.751, subdivision 3, is amended to read:

Subd. 3. [DISCLOSURE.] A copy of these rights must be provided to an individual at the time hospice care is initiated. The copy shall contain the address and telephone number of the Office of Health Facility Complaints and the Office of the Ombudsman for Older Minnesotans and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of the Ombudsman for Older Minnesotans shall be included in notices of change in ~~client~~ provider fees and in notices where hospice providers initiate transfer or discontinuation of services."

Pages 3 and 4, delete section 2

Page 5, delete section 4

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

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S.F. No. 811 - Provider Rate Increases, Nursing Facility Health Insurance Pool, Etc.

Author: Senator Becky Lourey

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 11, 2005

S.F. No. 811 provides three percent rate increases each year of the biennium for nursing facilities and a variety of community-based providers. It establishes a nursing facility health insurance assessment, offset by an equivalent rate increase, and creates a board to develop a self-insured purchasing pool for nursing facility employees. It reinstates the requirement that nursing facilities file an annual cost report. It increases the minimum nursing hours requirement at a nursing facility to 4.1 hours per day. It requires a review of the nursing assistant and home health aide training curriculum. It appropriates money for these purposes.

Section 1 (256B.431, subdivision 40) provides a three percent nursing facility operating rate increase each year of the coming biennium. The additional money must be used to increase compensation for nonmanagement employees or to add nonadministrative staff. Policies that have been applied to rate increases granted in prior years are restated: (1) facilities must apply to the Department of Human Services (DHS) for the rate increase, and (2) facilities must develop a plan to distribute the funds as permitted under this section. The facility must give each employee a copy of the plan or post it in an accessible area.

Section 2 (256B.4351) establishes a nursing facility health insurance assessment.

Subdivision 1 establishes an assessment of 10 cents per staff hour worked each month. Facilities are exempt if they provide health insurance that meets specified requirements.

Subdivision 2 requires the assessments to be deposited in a health insurance purchasing pool account.

Subdivision 3 provides a nursing facility rate increase equal to the assessment or, for exempt facilities, to what the assessment would have been if the facility was not exempt.

Section 3 (256B.4352) establishes a Nursing Facility Health Insurance Board, outlines its duties, and establishes parameters for the health insurance purchasing pool.

Subdivision 1 requires DHS to appoint a ten-member board, consisting of five nursing facility representatives and five employee representatives.

Subdivision 2 outlines the board's duties to design a purchasing pool that meets the criteria in subdivision 3, develop an implementation plan, and, upon legislative approval, implement and administer the pool.

Subdivision 3 establishes parameters for the design of the purchasing pool. The design must describe coverage, eligibility requirements, minimum employer contributions, specify how the facility assessment will be allocated between a reserve fund and premium subsidies, etc.

Subdivision 4 requires the board to report to the Legislature by December 15, 2005.

Section 4 provides a three percent rate increase each year for a variety of community-based providers, which must also be used for nonadministrative compensation increases or to add nonadministrative staff. Policies that have been applied to rate increases granted in prior years are restated. These providers are not required to apply for the rate increase but must give each employee a copy of the distribution plan or post it an accessible area.

Section 5 reinstates the requirement that nursing facilities file annual cost reports. The reports must satisfy the requirements of, and are subject to the penalties provided in, Minnesota Statutes, section 256B.440, which required facilities to provide information in 2004 to be used to develop a new nursing home reimbursement system.

Section 6 increases the nursing facility minimum nursing hours requirement to 4.1 hours per resident day, including 2.8 hours of certified nursing assistant care, and 1.3 hours of licensed practical nursing (LPN) or registered nurse (RN) care, of which .75 hours must be provided by an RN. This section also requires nursing facility payment rates to be reasonable and adequate to meet the costs of satisfying these staffing requirements.

Section 7 requires a review of the training curriculum for nursing assistants and home health aides and a report in 2006 with recommendations for updating the curriculum.

Section 8 requires DHS, in coordination with the Minnesota Department of Health, to establish a task force to develop a plan to reduce nursing facility bed capacity, with the goal of developing a smaller, well-supported system while utilizing a variety of community-based services. A report is due by December 15, 2007.

Section 9 is a blank appropriation for the costs of sections 1 to 8.

DG:rdr

AARP® Minnesota

TESTIMONY OF KARINA ALLEN, AARP MINNESOTA HEALTH AND LONG-TERM CARE TEAM MEMBER BEFORE THE SENATE HEALTH AND FAMILY SECURITY COMMITTEE

FEBRUARY 17, 2004

Thank you for the opportunity to testify today about Senate File 811. I am Karina Allen, Co-Chair of AARP Minnesota's Health and Long-term Care Team, and I would like to specifically speak to Sections 5 and 6 of the bill, addressing the issues of cost reporting and improving the current staffing standards required in long-term care facilities.

One of AARP Minnesota's top priorities is to improve the quality of care for the vulnerable nursing home and assisted living residents in our state. For decades, we have been advocating on behalf of the frail and elderly – who often cannot speak for themselves. We believe that this bill in its entirety will improve resident care.

Section 5 requires facilities to file annual statistical and cost reports in detail to the state as a way to transition to a new reimbursement system that rewards facilities for quality care. AARP supports the provision in Governor Pawlenty's budget that helps facilities move toward this new reimbursement system, because we believe that it will provide incentives to facilities to improve the quality of care for residents. This section also provides taxpayer accountability by requiring that any new funds be spent on the goal of improving staffing needs.

Section 6 addresses AARP's concern about Minnesota's inadequate staffing standards. AARP is concerned that when it comes to staffing, we are moving in the wrong direction in Minnesota– away from quality care for all nursing home residents. Staff are overworked and often burn out quickly. Quality care suffers

as a result. We believe that the most effective way to improve the quality of care in Minnesota's nursing homes is to raise the level of staffing and increase the direct care hours spent between a resident and a member of the staff.

AARP has found in surveys of its members that the overwhelming majority of Minnesotans want increased enforcement of standards and better staffing in our nursing homes. Nearly nine in ten would support legislation to increase staffing levels to ensure the proper amount of face-to-face and hands-on care. Clearly, we have a strong tradition in Minnesota of ensuring quality care and we want that to continue.

We know that adequate, high quality staffing is essential to quality care and we believe that Minnesota is facing a staffing crisis. Minnesota currently ranks 47th out of 50 states when it comes to staffing levels for direct care in nursing homes. Facilities in Minnesota are required to spend two hours per day per resident, while the federally-identified minimum standard – as stated by the Center for Medicare and Medicaid Services -- is 4.1 hours. This bill raises our standard to that minimum of 4.1 hours per resident per day, beginning July 2005.

Clearly, Minnesota must improve this staffing standard and immediately address the current staff levels in our nursing homes

We strongly urge you to support this bill.

Thank you.

An initiative of the Seniors and Workers for Quality Coalition....

"Quality Staffing, Quality Care" – SF 811

Senate Health and Family Security hearing
February 17, 2005 - noon

"Quality Staffing, Quality Care" is based on the principle that attaining quality in long-term care begins with attracting, supporting, and maintaining the long-term care workforce, particularly those who deliver "hands on" care. To that end, the bill proposes:

- cost of living adjustments (3% for each of the next two years) targeted directly to workers in residential, community and home care services
- an insurance pooling approach to provide health care coverage for nursing facility workers
- updated nursing home staffing levels to ease the pressure of "working short," with a provision to assure that MN's nursing facility payment rates be reasonable and adequate to cover costs incurred in facilities that are operated efficiently and economically
- continued development of a data-driven nursing home reimbursement system that rewards quality
- review of the core curriculum for nursing assistants and home health aides
- strategic reduction of nursing facility buildings with the perspective that a decentralized, consumer-driven long-term care system will require the growth and development of an expanded workforce for care. Therefore, the savings should be used to support the development of the workforce for increasingly specialized facility care and increasingly diverse community care.

Seniors and Workers for Quality, a coalition of AARP, the Alzheimer's Association, ElderCare Rights Alliance, MN Nurses Association, National Association of Social Workers-MN, the Union Coalition of Long-Term Care Workers, and the League of Women Voters. For further information, contact Iris C. Freeman, 612-834-4747.

Senators Lourey, Koering, Higgins, Kiscaden and Wergin introduced--
S.F. No. 811: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; requiring the Department of Human Services to increase nursing facility and community services payment rates; appropriating money; amending Minnesota Statutes 2004, sections 256B.431, by adding a subdivision; 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 256B.431, is amended by adding a subdivision to read:

Subd. 40. [NURSING FACILITY RATE INCREASE FOR JULY 1, 2005 AND JULY 1, 2006.] (a) For each of the rate years beginning July 1, 2005, and July 1, 2006, the commissioner shall provide to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate.

(b) Money resulting from the rate adjustment under paragraph (a) must be used to:

(1) increase wages and benefits and pay associated costs for employees except management fees, the administrator, and central office staff; or

(2) add staff, other than administrative personnel, above the facility's average staff complement for the previous year.

(c) Money received by a facility as a result of the rate adjustment provided in paragraph (a), which must be used as provided in paragraph (b), must be used only for wage, benefit,

and staff increases implemented on or after July 1, 2005, and must not be used for increases implemented prior to that date.

(d) Nursing facilities may apply for the portions of the rate adjustment under paragraph (a), which must be used as provided in paragraph (b). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by December 31, 2005. If a facility's distribution plan is effective after July 1, 2005, the portion of the rate adjustments, which must be used as provided in paragraph (b), are effective the same date as the facility's plan.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

(f) Notwithstanding section 256B.48, subdivision 1, paragraph (a), upon the request of a nursing facility, the commissioner may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments

allowable under paragraph (a). The commissioner shall require any amounts collected under this paragraph, which must be used as provided in paragraph (b), to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance until the medical assistance rate is finalized. The commissioner shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until medical assistance rates are increased to reflect the rate adjustment; and

(2) any amounts collected from private-pay residents in excess of the final medical assistance rate are repaid to the private-pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the distribution plan is approved by the commissioner of human services.

Sec. 2. [256B.4351] [ASSESSMENT FOR HEALTH INSURANCE.]

Subdivision 1. [NURSING FACILITY ASSESSMENT.] (a) Effective July 1, 2005, each nursing facility with rates set under sections 256B.431 and 256B.435 shall pay to the commissioner, on a monthly basis, an assessment of ten cents per staff hour worked each month, according to the payment procedure established by the commissioner.

(b) Nursing facilities are exempt from the assessment in paragraph (a) if they:

(1) provide health coverage that is actuarially equivalent to a qualified number two plan under section 62E.06;

(2) pay for at least 80 percent of the cost of employee-only coverage; and

(3) have a participation rate of at least 70 percent of employees.

Subd. 2. [HEALTH INSURANCE PURCHASING POOL ACCOUNT.] The commissioner shall establish a health insurance purchasing pool account in the general fund and shall deposit all payments received under this section into that account.

Subd. 3. [RATE INCREASE.] Effective July 1, 2005, the

commissioner shall increase rates of all nursing facilities reimbursed under sections 256B.431 and 256B.435 by an amount equal to the assessment paid under subdivision 1. For facilities meeting the criteria in subdivision 1, paragraph (b), the commissioner shall increase reimbursement rates by an amount equal to the assessment that would have been paid had the facilities not been exempt.

Sec. 3. [256B.4352] [NURSING FACILITY HEALTH INSURANCE BOARD.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of human services shall appoint a ten-member nursing facility health insurance board, consisting of five representatives of nursing facility operators and five representatives of nursing facility employees. The commissioner shall provide technical support to the board. The board is governed by section 15.0575.

Subd. 2. [DUTIES.] The board shall:

(1) design a self-insured health insurance purchasing pool that meets the criteria in subdivision 3;

(2) develop a timeline and plan for implementation of the purchasing pool; and

(3) upon a legislative approval, implement and administer the purchasing pool.

Subd. 3. [DESIGN OF PURCHASING POOL.] The design for the health insurance purchasing pool must:

(1) describe the health insurance coverage to be provided, the estimated cost of coverage to employees, and any cost-sharing requirements;

(2) specify eligibility requirements for employees and nursing facilities;

(3) specify the minimum levels of employer contributions toward the cost of health coverage;

(4) require nursing facilities purchasing coverage through the pool to remain members of the pool for a specified minimum time period;

(5) provide subsidies for the employee share of health insurance premiums; and

(6) specify how the funds provided through the assessment established under section 256B.436 will be allocated between a reserve fund and premium subsidies for employees.

Subd. 4. [REPORT TO LEGISLATURE.] The board shall present a report to the legislature by December 15, 2005, on the design, implementation, and administration of a health insurance purchasing pool for nursing facility employees.

Sec. 4. [COMMUNITY SERVICES PROVIDER RATE INCREASES.]

(a) The commissioner of human services shall increase reimbursement rates by 3.0 percent for each of the rate years beginning July 1, 2005, and July 1, 2006, effective for services rendered on or after that date.

(b) The 3.0 percent annual rate increases described in this section must be provided to:

(1) home and community-based waivered services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46;

(10) alternative care services under Minnesota Statutes,

section 256B.0913;

(11) adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000;

(12) adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760;

(13) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(14) adult mental health integrated fund grants under Minnesota Statutes, section 245.4661;

(15) semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(16) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and

(17) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living.

(c) Providers that receive a rate increase under this section shall use the additional revenue to:

(1) increase wages and benefits and pay associated costs for employees except management fees, the administrator, and central office staff; or

(2) add staff, other than administrative personnel, above the provider's average staff complement for the previous year.

(d) For public employees, the portion of this increase reserved to increase wages and benefits for certain staff is available and pay rates shall be increased only to the extent that they comply with laws governing public employees collective bargaining. Money received by a provider for pay increases under this section may be used only for increases implemented on or after the first day of the state fiscal year in which the increase is available and must not be used for increases implemented prior to that date.

(e) A copy of the provider's plan for complying with

paragraph (c) must be made available to all employees by giving each employee a copy or by posting a copy in an area of the provider's operation to which all employees have access. If an employee does not receive the adjustment described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a telephone number provided by the commissioner and included in the provider's plan.

Sec. 5. [REPORTING OF STATISTICAL AND COST INFORMATION.]

(a) Nursing facilities shall annually file a statistical and cost report on or before December 15 for the reporting period ending September 30.

(b) Nursing facilities shall provide the information to the commissioner in no lesser detail than the information required on the form established by Minnesota Statutes, section 256B.440.

(c) The commissioner may reject a report filed by the nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate. If a report is rejected or is not submitted in a timely manner, the commissioner shall reduce payments to a nursing facility to 85 percent of amounts due until the information is completely and accurately filed. The reinstatement of withheld payments shall be retroactive for no more than 90 days. A nursing facility whose report is rejected shall be given a notice of the rejection, the reasons for the rejection, and an opportunity to correct the report prior to any payment reduction. A nursing facility that does not submit a report shall be given a prior written notice of the payment reduction.

(d) The commissioner may determine, in consultation with stakeholders, additional items to be reported.

Sec. 6. [NURSING HOURS AND RATES.]

(a) On July 1, 2005, the required minimum nursing hours in nursing facilities licensed in Minnesota shall be increased to

4.1 per resident per day.

(b) The minimum staffing ratios are 2.8 hours per resident day of certified nursing assistant (CNA) care and 1.3 hours per resident day of care by an LPN or RN, of which 0.75 is provided by an RN.

(c) Staffing must be adjusted upward to meet residents' higher care needs.

(d) Nursing facility payment rates must be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to conform with the requirements established in paragraphs (a), (b), and (c).

Sec. 7. [NURSING ASSISTANT; HOME HEALTH AIDE CURRICULUM.]

(a) The commissioner of health, in consultation with long-term care consumers, advocates, unions, and trade associations, shall review the content of the current curriculum for the training of nursing assistants and home health aides.

(b) This review will identify how changes in the current training can improve students' caregiving skills, job satisfaction, and motivation to work in long-term care settings. These topics shall include, but not be limited to, working with challenging behaviors and terminal illnesses; improving communications with residents, families, and other employees; and understanding techniques for stress management and how stress in personal life can impact performance in the work setting. The review will also assess how the curriculum can be improved to address more effectively the issues of cultural diversity among employees and cultural issues in employees' relationships with residents and clients.

(c) By January 1, 2006, the commissioner shall submit the recommendations for updating the curriculum to the chairs of the legislative committees having jurisdiction over health care policy. The recommendations shall include implementation timelines and cost estimates for curriculum development and implementation.

Sec. 8. [LONG-TERM CARE SYSTEM PLANNING AND REDESIGN.]

(a) The commissioner of human services in consultation and

coordination with the commissioner of health shall create a long-term care task force to develop a plan to reduce nursing facility bed capacity. The goal is to develop a smaller, well-supported nursing home system while utilizing a variety of diverse services in the community. The task force shall address the following areas:

(1) develop explicit policy decisions for the future use of nursing homes for short-term and chronic care;

(2) define specific steps to protect consumers from problems accessing nursing homes, community services, and extended hospitalization; and

(3) develop a plan to utilize savings to fund facility and community care workforce development.

(b) The commissioner shall issue a report to the chairs of the legislative committees having jurisdiction over health care policy by December 15, 2007.

Sec. 9. [APPROPRIATIONS.]

$..... is appropriated in fiscal years 2006 and 2007 from the general fund to the commissioner of human services for the purposes of sections 1 to 8.

Senator ..... moves to amend S.F. No. 811 as follows:

Pages 3 to 5, delete sections 2 and 3

Page 7, after line 33, insert:

"Sec. 4. [NURSING FACILITY HEALTH INSURANCE STUDY.]

(a) The commissioner of human services shall appoint a ten-member nursing facility health insurance task force, consisting of five representatives of nursing facility operators and five representatives of nursing facility employees. The commissioner shall provide technical support to the task force.

(b) The board shall:

(1) design a self-insured health insurance purchasing pool that meets the criteria in paragraph (c);

(2) develop a timeline and plan for implementation of the purchasing pool; and

(3) present a report to the legislature by December 15, 2005, on the design, implementation, and administration of a health insurance purchasing pool for nursing facility employees.

(c) The design for the health insurance purchasing pool must:

(1) describe the health insurance coverage to be provided, the estimated cost of coverage to employees, and any cost-sharing requirements;

(2) specify eligibility requirements for employees and nursing facilities;

(3) specify the minimum levels of employer contributions toward the cost of health coverage;

(4) require nursing facilities purchasing coverage through the pool to remain members of the pool for a specified minimum time period;

(5) estimate subsidies for the employee share of health insurance premiums; and

(6) make recommendations to finance the purchasing pool."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator ..... moves to amend S.F. No. 811 as follows:

Page 1, line 21, delete "or"

Page 1, line 23, after "year" insert "; or

(3) any combination of clauses (1) and (2)"

Page 1, line 25, delete "must" and insert "is to"

Page 1, line 26, after "(b)" insert ", clause (1)"

Page 2, line 1, after the second comma, insert "and July 1, 2006, respectively,"

Page 2, line 3, delete "portions of the"

Page 2, lines 4 and 5, delete ", which must be used as provided in paragraph (b)"

Page 2, line 18, before the period, insert ", and December 31, 2006, respectively"

Page 2, line 19, delete "July 1, 2005, the portion of" and insert "the first day of the applicable rate year that the funds are available,"

Page 2, line 20, delete ", which must be used as provided in paragraph (b),"

Page 2, line 26, after "adjustment" insert ", if any,"

Page 3, lines 2 and 3, delete ", which must be used as provided in paragraph (b),"

Page 3, line 20, delete "256B.435" and insert "256B.434"

Page 4, line 2, delete "256B.435" and insert "256B.434"

Page 4, line 21, delete "a"

Page 5, line 2, delete "256B.436" and insert "256B.4351"

Page 5, after line 7, insert:

"Sec. 4. Minnesota Statutes 2004, section 256B.5012, is amended by adding a subdivision to read:

Subd. 6. [ICF/MR RATE INCREASES BEGINNING JANUARY 1, 2006, AND JANUARY 1, 2007.] (a) For the rate years beginning January 1, 2006, and January 1, 2007, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of three percent.

(b) Money resulting from the rate adjustment under paragraph (a) must be used to:

(1) increase wages and benefits and pay associated costs

for employees except administrative and central office employees;

(2) add staff, other than administrative personnel, above the facility's average staff complement for the previous year; or

(3) any combination of clauses (1) and (2).

(c) Money received by a facility as a result of the rate adjustment provided in paragraph (a), which is to be used as provided in paragraph (b), clause (1), must be used only for wage, benefit, and staff increases implemented on or after January 1, 2006, and January 1, 2007, respectively, and must not be used for increases implemented prior to that date.

(d) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding December 31. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(e) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(f) A facility may apply for the payment rate adjustment provided under paragraph (a). The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by September 30, 2006, and September 30, 2007, respectively. If a

facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(g) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan."

Page 6, line 24, delete "or"

Page 6, line 26, after "year" insert "; or

(3) any combination of clauses (1) and (2)"

Page 7, line 4, after "adjustment" insert ", if any,"

Page 8, line 4, delete "is" and insert "hours are"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly