Senate Counsel, Research,
and Fiscal Analysis

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747

Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 1266 - Modifying Certain Critical Access Hospital Provisions (The Delete-Everything Amendment)

Author: Senator Julie Rosen

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

Date: March 11, 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 4,000 days per year.

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

DG:rdr

Senators Rosen, Wergin, Fischbach and Lourey introduced--

S.F. No. 1266: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying certain critical access hospital provisions; 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 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. Except for 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, eligible hospitals are allowed a total of 1,460 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. Except for critical access hospitals, the commissioner of health must approve swing bed use beyond 1,460 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital. Critical access hospitals are allowed swing bed use as provided in federal law.

Policy Position

Minnesota Department of Health SF 1266

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 65 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 from the hospital 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 not allowed to regain the beds they gave up to comply with the 1997 federal requirements.

MINNESOTA MDH DEPARTMENT OF HEALTH
Commissioner's Office
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 215-1300
www.health.state.mn.us

MDH staff contact: Mark Schoenbaum
(651) 282-3859

What is a Critical Access Hospital (CAH)?

- A CAH is a small, rural, acute care facility that provides outpatient, emergency, and limited inpatient services.

- Is located outside of a Metropolitan Statistical Area, and not classified as "urban" for Medicare standardized payment or by the Medicare Geographic Review Board; be in a rural urban commuting area in an MSA or be designated by the State as a necessary provider.

- Receives enhanced Medicare reimbursement of 101 percent of reasonable costs.

- May have up to 25 beds with any combination of acute or swing (semi-skilled beds for patients meeting certain criteria).

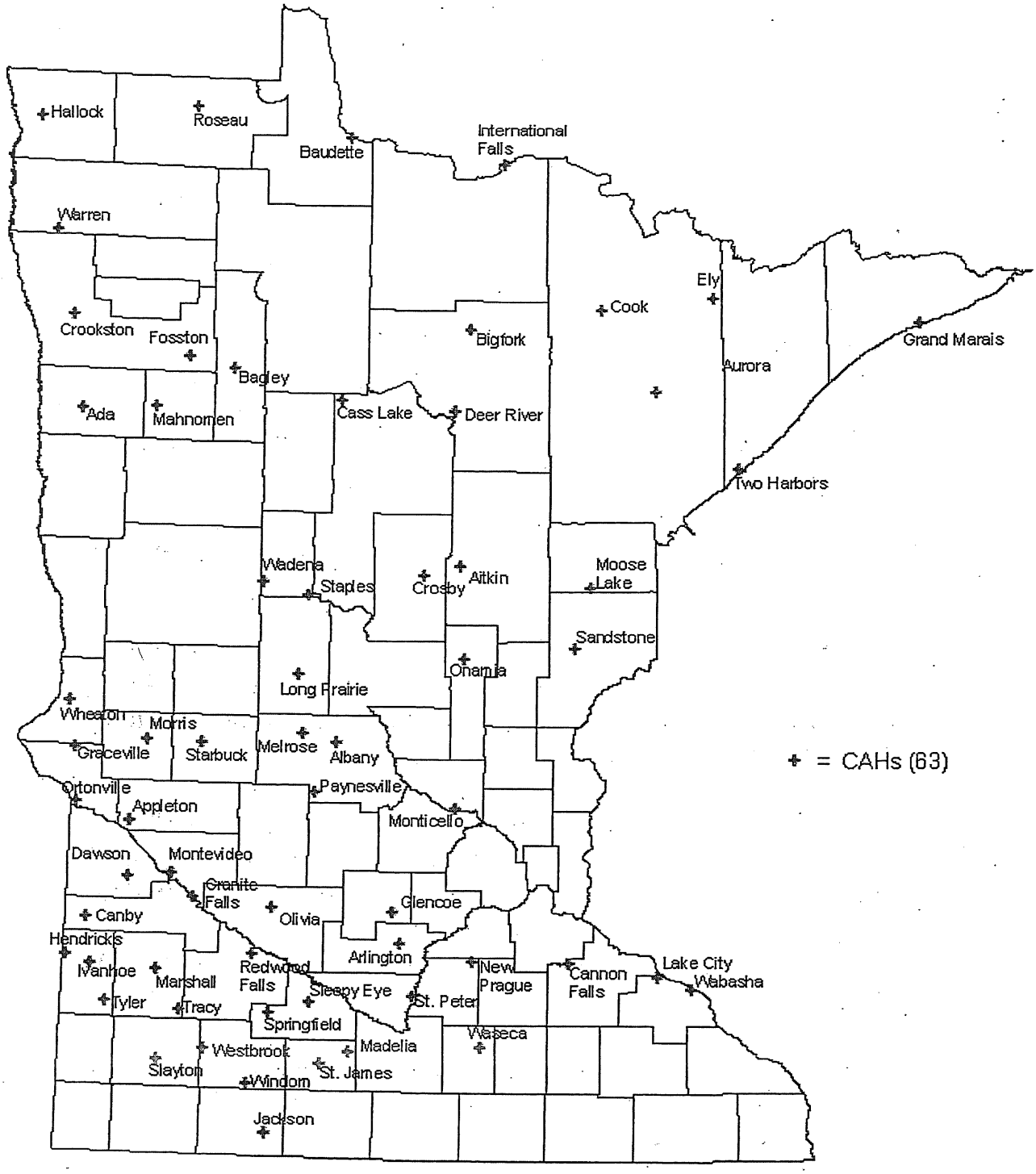
- Provides inpatient care for no more than a 96 hour average length of stay.

- Must be more than a 35-mile drive or 15 miles in mountainous terrain or areas with only secondary roads, from another hospital or CAH. The State may also certify a hospital as being a "necessary provider" according to State guidelines (will end January 1, 2006)

- Must make available 24-hour emergency care but doesn't need to meet all the staffing and service requirements that apply to full service hospitals (e.g. some ancillary and support services may be provided on a part-time off-site basis). Inpatient care in a CAH may be provided by a mid-level practitioner under the remote supervision of a physician.

- Can have 10 bed distinct part units (rehab and/or psych, but only one of each) that does not count against the bed limit and is paid under PPS. (goes into effect 10/1/2004)

Critical Access Hospitals - Minnesota



As of 02/09/2005

Senate Testimony: March 17, 2005

Good afternoon. My name is Michael Milbrath and I am the Executive Vice President of the Waseca Medical Center-Mayo Health System located in Waseca, Minnesota. I am here to offer comment on Senate File #1266 authored by Senator Rosen which seeks to amend the 1,460 swing bed day cap for Critical Access Hospitals.

Before I begin my comments I would like to thank the Chair of the Senate Health and Family Security Committee, Senator Lourey and the other Committee Members for the opportunity to speak today.

For your general information, I would like to note that the Waseca Medical Center-Mayo Health System is a Critical Access Hospital and provides access to twenty-five Critical Access Beds which may be used as "swing beds" as allowed by Federal Medicare Regulation.

I would like to call to your attention that Critical Access Hospitals are reimbursed at a cost plus 1% factor from Medicare. Approximately 98% of the patients served in the "Swing bed Program" are Medicare Patients.

Over recent years many Hospitals in Minnesota were forced to close primarily as a result of reimbursement issues. The Critical Access Hospital status provides the Waseca Medical Center-Mayo Health System and other small, rural Hospitals an opportunity to continue to provide necessary access to health care services in the communities we serve.

Today, I believe that at the center of this debate is a need to focus on the needs of the patient and what is best for the patients that we serve. This thought is embedded in the principle of ensuring that "The needs of the patients come first" not necessarily the needs of the providers. Another way to state this principle is that we all must work to ensure that patients receive the "Right Care, at the Right Time, at the Right Place."

As we think about the delivery of health care you likely have heard about a continuum of care that exists in the delivery system. A continuum of care implies that patients are provided healthcare at various levels of complexity during the course of their care. An example of this would be the continuum of care that exists from acute care to swing bed care to nursing home care.

In this example of a continuum of care, the swing bed program provides the patient an effective alternative to patients who no longer are in need of acute care and yet require more care than what many nursing homes might be able to provide the patient especially in many rural nursing homes.

Please note that I am not implying that the quality of care is poor in rural nursing homes but rather that given the limited resources available at many nursing homes in the rural area certain levels of "skilled care" are not provided or nursing homes are unwilling to accept the patient per the providers choice.

A logical question you likely would ask is, "What types of patients are we really talking about that utilize the swing bed level of care?" The patients typically requiring swing bed care at Critical Access Hospitals would include;

1. those requiring intensive IV therapy following infections
2. those patients recovering from a major trauma
3. those patients in need of wound care and regular debridement of wounds
4. those patients requiring behavioral care including medication support
5. ventilator dependant patients

A swing bed might best be described as a "step down bed" from acute care in which the costs associated with the patients care are paid at a per diem rate much less than that of an acute care stay. Of note, under the swing bed concept, 24 hour RN nursing care is provided as well as immediate access to physicians working at the Hospital.

It is also important to note at this point that in order to be admitted to a swing bed the patient must have been an acute care patient for three days. Direct admission to a swing bed is not allowed if the three day acute care stay has not taken place.

In caring for patients I am a firm believer that patients should receive the appropriate care in the appropriate location. As noted earlier, I believe that the swing bed program fits this principle perfectly as we discuss the continuum care concept. In other words, when patients no longer require an acute level of care, and nursing homes do not have the equipment, staff and training to provide a skilled level of care on patients that I have described, a swing bed becomes a very appropriate alternative for the patient.

Recently I received information that Minnesota may be the only State that has imposed any type of a cap on swing bed utilization in terms of the number of days a swing bed program may be used. That cap as you are aware rests at 1,460. It is my hope that the swing bed day cap might be removed or at east

adjusted upward significantly so that as our population continues to age and with the arrival of the Baby Boomers in the mix of patients to be served by the Medicare program that a cost effective program such as the Swing Bed program is not limited in its ability to provide the appropriate level of care for these patients as a result of a day limitation on the swing bed program.

You may also ask the question, "Why change now?" To this question I would offer the following thoughts;

1. The health care delivery system has changed since the inception of swing beds.
2. With continued pressure to find more cost effective ways of delivering healthcare, the swing bed program provides an effective option.
3. Given limited nursing home reimbursements over the years many nursing homes, especially in the rural area, have not been able to acquire the equipment, staff, and training to deal with the types of patients that I described earlier.
4. If we truly keep the patient at the heart of this discussion a swing bed becomes a very viable alternative in the continuum of care for the patient.
5. With an increasing population of elderly and a baby boomer generation set to utilize Medicare as their primary payer source the Swing Bed program does provide a necessary level of care when acute care is no longer warranted.

In closing, I believe that the elimination of the 1,460 swing bed day cap for Critical Access Hospitals is in the best interest of the patients we serve. The needs of the patients we serve should be at the heart of this discussion.

We need to focus this debate on what is right for the patient and is the patient allowed a choice in what setting they would like to be cared for. A cap on days may at some point restrict the use of swing beds for patients who need this level of care in their community. It would be unfortunate some day to have a patient in need of this level of care told that we are out of days and we must now move you to community many miles away for your care.

I don't believe that Hospitals have the intention to become nursing homes. The concern that Hospitals will take away huge portions of nursing home business I believe are largely unfounded. The removal of the cap is based on doing what is right for the patients and allowing patients a choice in where they might seek health care services. I believe that we all have a high desire to do what is right for the patient and allowing patients choices in where there healthcare is delivered.

It strikes me that the elimination of the swing bed day cap is good public policy as patients and patients families will not need to worry about access to a swing bed program and inconvience that may come about it hospitals do find themselves dealing with the swing bed cap.

Once again I would reiterate that I believe it is important that we all remember in this debate the needs of the patients must come first, that patients deserve to have a choice in where they receive their health care and that the "Right Care" at the "Right Time" at the "Right Place" is a foundation principle to be considered in addressing this bill.

At this point it clearly would be my preference to eliminate the swing bed cap for all Critical Access Hospitals in Minnesota all together and not treat hospitals differently from hospitals with nursing homes. I do understand however that there has been a compromise with the LTC providers on this topic and would support the bill as stated in order to advance some movement of the day swing bed day cap. I would however request the committee address a Mayo Health System request to allow Mayo Health System facilities the ability to re-allocate the a full continuum of 9,000 Swing bed days as necessary within our Health System.

Thank You for your time and attention to this matter today.

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

Delete everything after the enacting clause and insert:

"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:

regional treatment center site to another; or

(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 ~~17460~~ 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 ~~17460~~ 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 4,000 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

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747

Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

S.F. No. 1260 - Regulating Internet Tobacco Product Sales

Author: Senator Yvonne Prettner Solon

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

Date: March 11, 2005

S.F. No. 1260 regulates the sale and delivery of certain tobacco products sold over the Internet.

Section 1 (297F.21, subdivision 1) expands the definition of "contraband" in the cigarette and tobacco tax law to include cigarettes and tobacco products sold in violation of section 2.

Section 2 (325F.781) regulates the sale and delivery of tobacco products when the purchase is made over the Internet and the tobacco products are delivered to the purchaser through the mail or by another delivery service.

Subdivisions 1 to 6 define terms, including "tobacco products," which are defined as cigarettes and smokeless tobacco.

Subdivision 7 establishes requirements for accepting an order for an Internet sale. When accepting the first order from a consumer, the retailer must acquire the following information from the consumer: (1) a copy of valid, government-issued identification; and (2) a signed statement that the purchaser is of legal age to purchase tobacco products, has made a choice whether to receive mailings from a tobacco retailer, and understands that providing false information may be illegal and purchasing products for eventual use by underage persons is illegal. If an order is made as the result of an Internet advertisement, the retailer must receive payment by credit card or check prior to shipping the order. Prior to shipping the tobacco products, the retailer must verify the information provided by the purchaser.

Subdivision 8 establishes requirements for shipping an Internet sale order. The retailer must clearly mark the package "tobacco products – adult signature required." The retailer must

use a delivery service that (1) requires an adult to sign for the delivery, and (2) requires the person signing for the delivery to produce a valid government-issued identification indicating the person is of legal age to purchase tobacco products and resides at the delivery address. This subdivision authorizes the Commissioner of Revenue to enforce this section by issuing cease-and-desist orders. The penalty for a second violation within two years is a misdemeanor, and for a third violation, a gross misdemeanor.

Subdivision 9 states that this section does not impose liability on any common carrier when acting within the scope of its business.

Subdivision 10 requires distributors to register with the state prior to making Internet sales.

Subdivision 11 requires retailers to collect and pay all state excise taxes prior to shipping tobacco products after an Internet sale. A retailer who fails to pay any tax due must pay a penalty of 50 percent of the unpaid tax in addition to any other penalty.

Subdivision 12 provides that all state laws that apply to instate tobacco product retailers also apply to Internet sellers.

Subdivision 13 makes any tobacco products sold in an Internet sale not meeting the requirements in this section subject to forfeiture.

Subdivision 14 applies the remedies of Minnesota Statutes, section 8.31, to violations of this section. Section 8.31 authorizes the Attorney General to investigate and prosecute suspected violations of a variety of business, commerce, and trade laws.

DG:rdr

Senators Solon, Scheid, Belanger, Bakk and Moua introduced--
S.F. No. 1260: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; regulating certain sales and deliveries of tobacco products; imposing criminal and civil penalties; providing remedies; amending Minnesota Statutes 2004, section 297F.21, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 325F.

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

Section 1. Minnesota Statutes 2004, section 297F.21, subdivision 1, is amended to read:

Subdivision 1. [CONTRABAND DEFINED.] The following are declared to be contraband and therefore subject to civil and criminal penalties under this chapter:

(a) Cigarette packages which do not have stamps affixed to them as provided in this chapter, including but not limited to (i) packages with illegible stamps and packages with stamps that are not complete or whole even if the stamps are legible, and (ii) all devices for the vending of cigarettes in which packages as defined in item (i) are found, including all contents contained within the devices.

(b) A device for the vending of cigarettes and all packages of cigarettes, where the device does not afford at least partial visibility of contents. Where any package exposed to view does not carry the stamp required by this chapter, it shall be presumed that all packages contained in the device are unstamped and contraband.

(c) A device for the vending of cigarettes to which the commissioner or authorized agents have been denied access for the inspection of contents. In lieu of seizure, the commissioner or an agent may seal the device to prevent its use until inspection of contents is permitted.

(d) A device for the vending of cigarettes which does not carry the name and address of the owner, plainly marked and visible from the front of the machine.

(e) A device including, but not limited to, motor vehicles, trailers, snowmobiles, airplanes, and boats used with the knowledge of the owner or of a person operating with the consent of the owner for the storage or transportation of more than 5,000 cigarettes which are contraband under this subdivision. When cigarettes are being transported in the course of interstate commerce, or are in movement from either a public warehouse to a distributor upon orders from a manufacturer or distributor, or from one distributor to another, the cigarettes are not contraband, notwithstanding the provisions of clause (a).

(f) A device including, but not limited to, motor vehicles, trailers, snowmobiles, airplanes, and boats used with the knowledge of the owner, or of a person operating with the consent of the owner, for the storage or transportation of untaxed tobacco products intended for sale in Minnesota other than those in the possession of a licensed distributor on or before the due date for payment of the tax under section 297F.09, subdivision 2.

(g) Cigarette packages or tobacco products obtained from an unlicensed seller.

(h) Cigarette packages offered for sale or held as inventory in violation of section 297F.20, subdivision 7.

(i) Tobacco products on which the tax has not been paid by a licensed distributor.

(j) Any cigarette packages or tobacco products offered for sale or held as inventory for which there is not an invoice from a licensed seller as required under section 297F.13, subdivision 4.

(k) Cigarette packages which have been imported into the United States in violation of United States Code, title 26, section 5754. All cigarettes held in violation of that section shall be presumed to have entered the United States after December 31, 1999, in the absence of proof to the contrary.

(l) Cigarettes and tobacco products sold or attempted to be sold in violation of section 325F.781.

Sec. 2. [325F.781] [REQUIREMENTS OF TOBACCO PRODUCT INTERNET SALES.]

Subdivision 1. [SCOPE OF DEFINITIONS.] The terms in this section have the meanings given unless the context clearly indicates otherwise.

Subd. 2. [CONSUMER.] "Consumer" means an individual who purchases, receives, or possesses tobacco products for personal consumption and not for resale.

Subd. 3. [DISTRIBUTOR.] "Distributor" means a person, whether located inside or outside of this state, other than a retailer, who sells or distributes tobacco products in the state. Distributor does not include a tobacco products manufacturer, export warehouse proprietor, or importer with a valid permit under United States Code, title 26, section 5712, if the person sells or distributes tobacco products in this state only to distributors who hold valid and current licenses under the laws of a state, or to an export warehouse proprietor or another manufacturer. Distributor does not include a common or contract carrier that is transporting tobacco products under a proper bill of lading or freight bill that states the quantity, source, and destination of tobacco products, or a person who ships tobacco products through this state by common or contract carrier under a bill of lading or freight bill.

Subd. 4. [INTERNET SALE.] "Internet sale" means a sale of tobacco products to a consumer in Minnesota when the purchaser submits the order for the sale by means of the Internet or other online service and the tobacco products are delivered by use of the mail or other delivery service, regardless of whether the seller is located inside or outside of Minnesota.

Subd. 5. [RETAILER.] "Retailer" means a person, whether located inside or outside of Minnesota, who sells or distributes tobacco products to a consumer in Minnesota.

Subd. 6. [TOBACCO PRODUCTS.] "Tobacco products" means:

(1) cigarettes, as defined in section 297F.01, subdivision 3; and

(2) smokeless tobacco as defined in section 325F.76.

Subd. 7. [REQUIREMENTS FOR ACCEPTING ORDER FOR INTERNET SALE.] (a) This subdivision applies to acceptance of an order for an Internet sale of tobacco products.

(b) When accepting the first order from a consumer for an Internet sale, the retailer shall obtain the following information from the person placing the order:

(1) a copy of a valid government-issued document that provides the person's name, current address, photograph, and date of birth; and

(2) an original written statement signed by the person documenting that the person:

(i) is of legal age to purchase tobacco products in the state;

(ii) has made a choice whether to receive mailings from a tobacco retailer;

(iii) understands that providing false information may be a violation of law; and

(iv) understands that it is a violation of law to purchase tobacco products for subsequent resale or for delivery to persons who are under the legal age to purchase tobacco products.

(c) If an order is made as a result of advertisement over the Internet, the retailer shall request the e-mail address of the purchaser and shall receive payment by credit card or check prior to shipping.

(d) Before shipping the tobacco products, the retailer shall verify the information provided under paragraph (b) against a commercially available database. Any such database or databases may also include age and identity information from other government or validated commercial sources, if that

additional information is regularly used by government and businesses for the purpose of identity verification and authentication, and if the additional information is used only to supplement and not to replace the government-issued identification data in the age and identity verification process.

Subd. 8. [REQUIREMENTS FOR SHIPPING AN INTERNET SALE.] (a) This subdivision applies to a retailer shipping tobacco products as the result of an Internet sale.

(b) The retailer shall clearly mark the outside of the package of tobacco products to be shipped "tobacco products - adult signature required" and show the name of the retailer.

(c) The retailer shall use a delivery service that imposes the following requirements:

(1) an adult must sign for the delivery; and

(2) the person signing for the delivery must show valid government-issued identification that contains a photograph of the person and indicates that the person is of legal age to purchase tobacco products and resides at the delivery address.

(d) The retailer must provide delivery instructions that clearly indicate the requirements of this subdivision and that Minnesota law requires compliance.

(e) No criminal penalty may be imposed on a person for a violation of this section other than a violation described in paragraph (f) or (g). If it appears to the commissioner of revenue that any person has engaged in any act or practice constituting a violation of this section, and the violation is not within two years of any previous violation of this section, the commissioner shall issue and cause to be served upon the person an order requiring the person to cease and desist from violating this section. The order must give reasonable notice of the rights of the person to request a hearing and must state the reason for the entry of the order. Unless otherwise agreed between the parties, a hearing must be held not later than seven days after the request for the hearing is received by the commissioner, after which and within 20 days after the receipt of the administrative law judge's report and subsequent

exceptions and argument the commissioner shall issue an order vacating the cease and desist order, modifying it, or making it permanent as the facts require. If no hearing is requested within 30 days of the service of the order, the order becomes final and remains in effect until modified or vacated by the commissioner. All hearings must be conducted according to chapter 14. If the person to whom a cease and desist order is issued fails to appear at the hearing after being duly notified, the person shall be deemed in default and the proceeding may be determined against the person upon consideration of the cease and desist order, the allegations of which may be deemed to be true.

(f) Any person who violates this section within two years of a violation for which a cease and desist order was issued under paragraph (e) is guilty of a misdemeanor.

(g) Any person who commits a third or subsequent violation of this section, including a violation for which a cease and desist order was issued under paragraph (c), within any subsequent two-year period is guilty of a gross misdemeanor.

Subd. 9. [COMMON CARRIERS.] This section does not impose liability upon any common carrier, or officers or employees of the common carrier, when acting within the scope of business of the common carrier.

Subd. 10. [REGISTRATION REQUIREMENT.] Before making Internet sales or shipping tobacco products in connection with any sales, a distributor shall file with the Department of Revenue a statement setting forth the distributor's name, trade name, and the address of the distributor's principal place of business and any other place of business.

Subd. 11. [COLLECTION OF TAXES.] (a) Before shipping any tobacco products to a purchaser in Minnesota, a retailer shall comply with chapter 297F and shall ensure that all state excise taxes that apply are collected and paid to the state and that all related state excise tax stamps or other indicators of state excise tax payment are properly affixed to those tobacco products.

(b) In addition to any penalties under chapter 297F, a retailer who fails to pay any tax due according to paragraph (a) shall pay, in addition to any other penalty, a penalty of 50 percent of the tax due but unpaid.

Subd. 12. [APPLICATION OF STATE LAWS.] All state laws that apply to in-state tobacco product retailers shall apply to Internet sellers that sell in Minnesota.

Subd. 13. [FORFEITURE.] Any tobacco products sold or attempted to be sold in an Internet sale that does not meet the requirements of this section are deemed to be contraband and are subject to forfeiture under section 297F.21.

Subd. 14. [ENFORCEMENT.] The remedies of section 8.31 apply to violations of this section.

Senator Moua moves to amend S.F. No. 1260 as follows:

Page 3, line 9, delete "INTERNET" and insert "DELIVERY"

Page 3, after line 15, insert:

"Subd. 3. [DELIVERY SALE.] "Delivery sale" means a sale of tobacco products to a consumer in this state when:

(1) the purchaser submits the order for the sale by means of a telephonic or other method of voice transmission, the mail or any other delivery service, or the Internet or other online service, regardless of whether the seller is located inside or outside of the state; or

(2) the tobacco products are delivered by use of the mail or other delivery service.

For purposes of this subdivision, a sale of tobacco products to an individual in this state must be treated as a sale to a consumer, unless the individual is licensed as a distributor or retailer of tobacco products."

Page 3, line 16, delete "3" and insert "4"

Page 3, delete lines 31 to 36

Page 4, line 8, delete "INTERNET" and insert "DELIVERY"

Page 4, line 10, delete "an Internet" and insert "a delivery"

Page 4, lines 11 and 12, delete "an Internet" and insert "a delivery"

Page 5, line 6, delete "AN INTERNET" and insert "A DELIVERY"

Page 5, line 8, delete "an Internet" and insert "a delivery"

Page 6, line 25, delete "Internet" and insert "delivery"

Page 7, line 7, delete "Internet" and insert "delivery"

Page 7, line 9, delete "an Internet" and insert "a delivery"

Seven years of welfare reform in Minnesota – Weighing the results

By Lynda McDonnell

Sponsored by the University of Minnesota Center for Urban and Regional Affairs & Center for Advanced Studies in Child Welfare, School of Social Work

In partnership with the Welfare Reform Research and Evaluation Roundtable

With generous support from The Minneapolis Foundation

The MFIP Field Trials

- 1994-1998 -- before federal welfare reform
- Financial incentives to work (earnings disregard) and eligible until income reached 140% of poverty line
- Mandatory participation for long-term recipients in employment and training activities
- Simplified rules and procedures -- consolidated grant with "cashed out" food stamps

The MFIP Field Trials

- Conducted in eight counties
- Experimental research design
  - Control group received traditional AFDC

Results of the MFIP Field Trials: More employment, more income

For single-parent long-term recipients on MFIP (compared to AFDC):

- Employment increased 35 percent
- Earnings increased 23 percent
- More employed in stable, full-time jobs
- Higher incomes, reduced poverty

Results of the MFIP Field Trials: More safe and stable families

For single-parent long-term recipients on MFIP (compared to AFDC):

- More likely to be married at three-year follow-up
- Less likely to report domestic abuse

Results of the MFIP Field Trials: More child well-being

For single-parent long-term recipients on MFIP (compared to AFDC):

- Fewer children with problem behavior (attributed to the increased money available in MFIP families)
- Children did better in school
- Child care arrangements more stable, and more likely to be formal

Statewide MFIP began January 1998

- Basic structure of the program remained the same
- Statewide changes largely a response to federal changes (TANF)

Changes in statewide MFIP: Less time, less cash

- 60-month time limit
- Reduced exit level to 120% of poverty line (reduced again to 115% in 2003)
- Food portion no longer "cashed out"

Changes in statewide MFIP: More work required sooner

- Mandatory participation for all participants
  - Federal performance measure, "TANF Work Participation Rate"
- Work first emphasis, with some limited opportunities for education and training
- Fewer categories of participants "exempt" from participation
  - All exemptions ended by 2003 Legislature

MFIP trends: fewer participants

Number of participants

	Families	Individuals
Nov. 1998	38,627	126,736
Nov. 2000	32,408	106,529
Nov. 2002	36,166	114,945
Nov. 2004	27,939	86,610

MFIP trends: fewer working

Employment (among those eligible)

	Percent employed
Nov. 1998	38.1 %
Nov. 2000	37.5 %
Nov. 2002	32.9 %
Nov. 2004	32.7 %

MFIP trends: total grant amounts have changed little

Average MFIP payment (actual dollars)

	Food + Cash
Nov. 1998	$621
Nov. 2000	$650
Nov. 2002	$644
Nov. 2004	$644

MFIP has three official goals

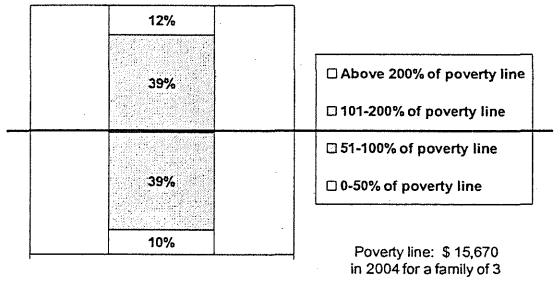
- Encourage and enable all families to find employment
- Help families increase their income and move out of poverty
- Prevent long-term dependence on welfare as a primary source of family income

7 in 10 working or off welfare after 3 years

Percent of clients working 30+ hours/week or exiting MFIP:

- 51 percent by 1 year
- 66 percent by 2 years
- 70 percent by 3 years

Half out of poverty after 3 years



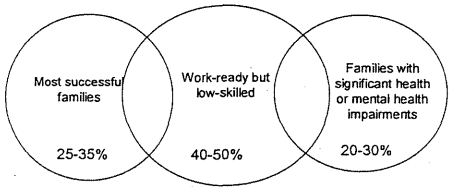
Poverty line: $ 15,670 in 2004 for a family of 3

50 studies: Four main findings

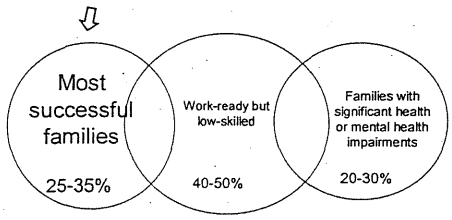
1. The most successful families have more initial advantages
2. Work does not always improve a family's well-being
3. The least successful families often have multiple and serious disabilities
4. There are significant racial disparities in outcomes

The overlapping categories of MFIP participants

- Three broad categories of families on MFIP
- Categories overlap
- Percentages shown are estimates, from studies that have tracked participant progress over time



Finding #1: The most successful families have more initial advantages



1. Most successful families: Who are they?

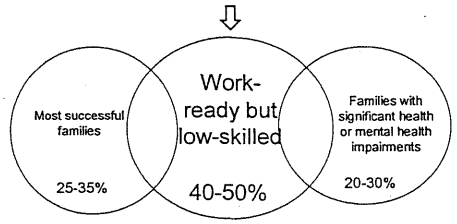
Participants who are more likely to have:

- More education, job skills
- Suburban or rural residence
- Reliable transportation
- Older children
- Few personal challenges

Why are they most successful?

- Most are in low-wage jobs, *but*
- More likely to live with second parent
- More likely to receive child support
- Continue to receive help with food support, health care, child care

Finding #2: Work does not always improve a family's well-being



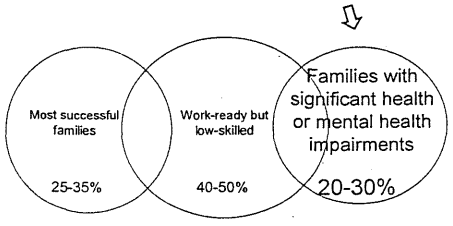
2. Working poor families: Who are they?

- Not as much education as the most successful group
- Not as many or as serious disabilities as the least successful group
- In general: some work experience, but low-skilled

Why are they still poor despite working?

- Continued financial instability
- Low wages
- Health care gaps
- Hard to find and pay for housing, transportation, child care

Finding #3: The least successful families often have multiple and serious disabilities



3. Least successful families: Who are they?

Participants still on MFIP after 52 months:

- 83% have at least one of:
  - Learning disability
  - Physical disability
  - Mental illness
- 91% including physical limitation or a disabled, ill, or incapacitated family member

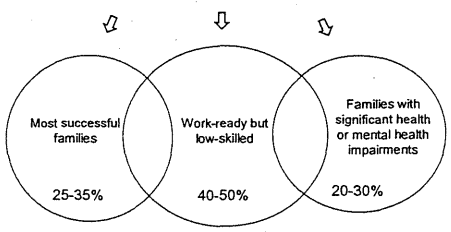
Why is it not working for them?

- Less likely to be offered jobs
- More likely to lose assistance through sanctions
- More likely to use up 60-month limit without gaining skills needed for work
- More likely to live in deep poverty

Least successful families: what does not work

- Financial incentives and penalties do *not* appear to make much difference
  - Unless combined with intensive outreach and sanction resolution help
- Counties lack needed resources to identify and address many disabilities

Finding #4: Disparities are pervasive for African American and American Indian participants



What disparities do they experience?

- More disabilities
- Fewer skills
- Job, housing discrimination
- Reported lack of cultural competence in some case workers
- More sanctions, fewer extensions

Five changes that have been shown to increase success for more MFIP participants

Changes shown to increase success

1. Smaller caseloads, more intense casework
   - Enough cash to address needs (crisis or on-going)
   - Supportive relationship

Changes shown to increase success

2. Availability of work support programs
   - Child care assistance
   - Health insurance
   - Housing subsidies
   - Food support
   - Earned income, working family tax credits
   - Job retention support

Changes shown to increase success

3. Skill development: Better pay and benefits found from programs with:
   - Skill training ("hard" and "soft")
   - Help to find jobs with potential
   - Job retention and advancement help
   - Help for worker and employer both
   - Support to balance work, family, *and* training

Changes shown to increase success

4. For least successful:
   - Outreach, home visits
   - Assessments and needed treatment
5. Transitional jobs
   - Temporary, subsidized
   - Intensive supervision and support
   - Opportunities for incremental progress

Where to get reports

http://ssw.che.umn.edu/CASCW/papers_reports.html

Includes:

- Full synthesis report (33 pages)
- Executive summary (4 pages)
- Annotated bibliography of the studies

Welfare Reform Research and Evaluation Roundtable

- Public and private organizations, began 2003
- Synthesis project:
  - Sponsored by University of Minnesota
  - Funded by Minneapolis Foundation
  - Over 50 studies synthesized by a professional with expertise in poverty, business, *and* policy
- Today's presenters:
  - Lynda McDonnell, synthesis author
  - Scott Chazdon, MN Dept. of Human Services
  - Ellen Shelton, Wilder Research

SEVEN YEARS OF WELFARE REFORM:
Weighing the Results

A Summary of Research Findings on the Minnesota Family Investment Program (MFIP)

Major challenges face Minnesota's low-income families, policy-makers, and all Minnesotans as we aim to help fare parents support their families through work.

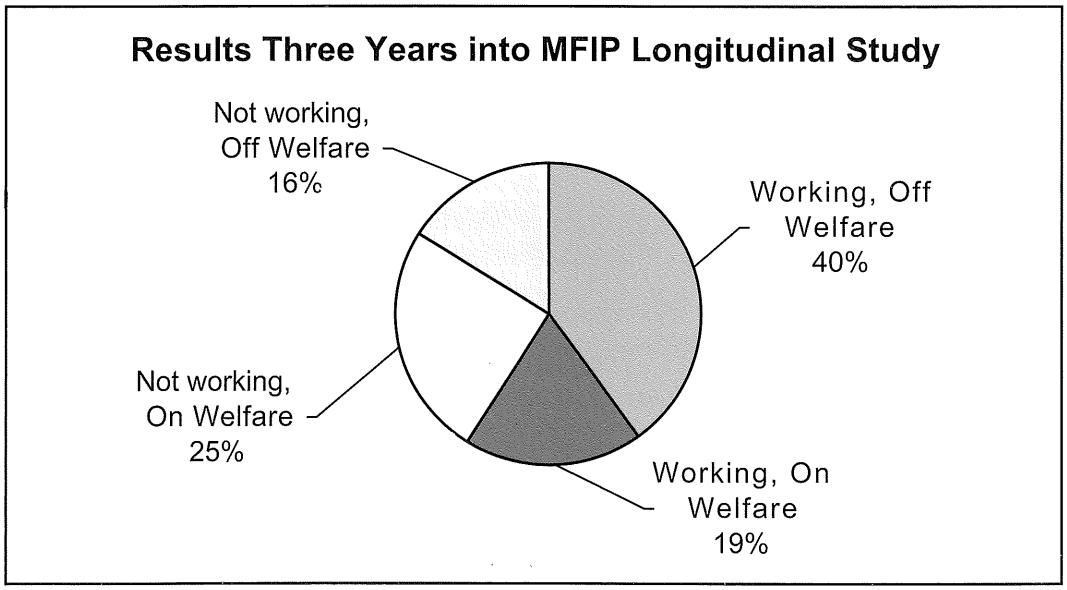
In the seven years since Minnesota's version of federal welfare reform took effect statewide, more than 50 research studies have looked at one central question from many different angles:

How well has Minnesota's welfare-to-work system succeeded?

By emphasizing employment and time limits on cash assistance, the Minnesota Family Investment Program (MFIP) has shown considerable success at moving many poor parents – primarily single mothers – into jobs and helping them raise their incomes modestly above the federal poverty guideline. Most families leave MFIP initially within 12 to 18 months. The state's welfare caseload fell nearly 19 percent between 1997 and 2003.

More than half of MFIP recipients are successful within one year, as measured by the state's "Self-support Index," and 70 percent are successful three years later. The "Self-support Index" counts welfare participants as successful if they are working 30 or more hours per week or are no longer receiving MFIP cash assistance.

Three years into the state's longitudinal study that tracks a large sample of welfare families for five years, 40 percent of recipients were working and off MFIP, while another 19 percent were working but earning little enough to still qualify for some cash assistance.

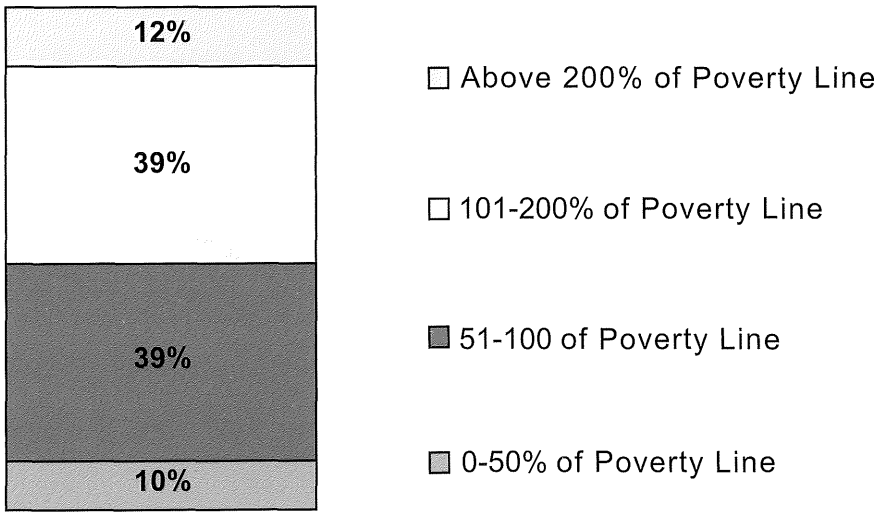


Report by Lynda McDonnell
Sponsored by the Center for Urban and Regional Affairs &
Center for Advanced Studies in Child Welfare, School of Social Work
at the University of Minnesota
In partnership with the Welfare Reform Research and Evaluation Roundtable
With generous support from The Minneapolis Foundation

On average, this most successful 40 percent of families were living at 1.7 times the federal poverty guideline. And 12 percent had family income of at least twice the federal poverty level, an important milestone for financial stability. (In 2004, the federal poverty guideline for a family of three was $15,670; 170 percent equaled $26,639 for a three-person family. Eligibility for MFIP cash benefits phases out at 115 percent of the federal poverty guideline, or $18,020 for a three-person family.)

On the other hand, most of the jobs offer low wages, few benefits, part-time hours and little opportunity for wage growth. Due to MFIP's work emphasis, education and training opportunities that might help workers raise their skills and income are extremely limited. As a result, despite extensive work, many families who leave MFIP continue to rely on government programs for food support, health care, child care and other essentials. About one-third of families return to MFIP after a crisis or for more help in finding or keeping a job.

Average Income Relative to Federal Poverty Guideline-- Three Years into MFIP Longitudinal Study



Important questions remain to be answered. We know very little from Minnesota research about how parent-focused welfare-to-work efforts affect children, or about what policies might be effective to discourage teenage pregnancy and encourage or sustain marriage among low-income adults.

Major challenges face Minnesota's low-income families, policy-makers, and all Minnesotans as we aim to help welfare parents support their families through work.

Across several settings and using diverse methodologies, the research studies reviewed for this report generally found that:

1. MFIP has been most successful in helping suburban or rural parents who have more education, few personal challenges, older children, better access to reliable transportation, and other strengths.

Not surprisingly, the fewer barriers— adverse circumstances or conditions — an MFIP participant faces, the easier it is to find work and earn enough to leave welfare. The most successful group of families, those able to leave the program due to employment, had the fewest serious personal or family challenges, on average. These challenges

include transportation problems, health conditions that prevent or interfere with work, depression, involvement with child protective services, or caring for a child with special needs.

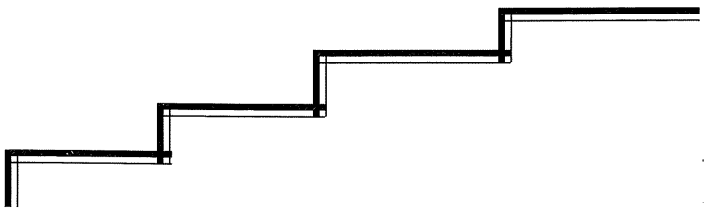
Several studies corroborate that those leaving MFIP for work were more likely to have completed high school, more likely to be living with the other parent of the household, and less likely to have young children. A study conducted in Hennepin County found that residential stability was strongly related to employment. In other words, the fewer residences a participant lived in, the more months they were likely to have worked. This strong relationship between housing stability and employment success had also been found in the MFIP field trials.

2. Although MFIP is helping many parents to find work, the jobs tend to offer low wages, few benefits, little opportunity for wage growth, and/or only part-time work.

A recurrent finding in Minnesota studies is that the transition from "welfare poor" to "working poor" often makes little difference in a family's financial stability. Working families, regardless of whether they still receive cash assistance from MFIP, often remain at or near poverty. Nearly one in five of the longitudinal study's "working leavers" still lived at or below the poverty guideline.

One reason is that Minnesota adults who leave welfare for work are concentrated in low-wage industries and have little wage growth, even with significant years of work experience. Studies also consistently show other, related problems for families that have succeeded on MFIP's work and exit measures - especially gaps in health care coverage, unstable housing, unreliable transportation, and difficulty finding and paying for child care.

For example, 30 percent of long-term MFIP recipients were uninsured when they left the state's public assistance program. And transportation was found over and over again to be a major problem for current and former MFIP recipients alike. Low wages make it difficult to buy reliable cars, and lack of reliable transportation makes it hard to find and retain jobs - especially in rural areas.



3. MFIP has been least successful in helping parents who have significant health impairments, learning disabilities or low IQ, or children with significant health impairments to find jobs and leave MFIP.

As families with fewer barriers and brighter prospects leave welfare, the adults who continue to participate in MFIP tend to have a diverse and daunting array of barriers to finding or keeping a job. In the state's longitudinal study, 19 percent of recipients were unemployed during the entire third year of the study—one indicator of a population with multiple, persistent barriers to self-sufficiency: serious mental and physical health problems, learning dis ability, or low IQ; and some have children with serious health problems.

State analysts have stressed that the work emphasis of welfare reform makes it imperative to identify and treat serious work barriers as soon as possible. But many counties and communities that serve the hard-to-employ lack the resources – developmental disability, rehabilitation, mental health and child welfare systems – to address the complex barriers of participants who need more intensive and specialized help.

A range of studies show that MFIP recipients with multiple, serious work barriers are less likely to find jobs, more likely to lose cash assistance because of sanctions for program noncompliance, and more likely to exhaust their 60 months of eligibility for federal cash assistance than families with few barriers. Most of these families are living in deep poverty: State researchers found that participants who were on MFIP and not working after three years were living on average at 68 percent of the federal poverty guideline. The studies make clear that this group, whose employment status hasn't changed significantly despite MFIP's incentives and penalties, has the greatest need and poses the greatest challenges for the state's welfare-to-work system and policymakers.

As families with fewer barriers and brighter prospects leave welfare, the adults who continue to participate in MFIP tend to have a diverse and daunting array of barriers to finding or keeping a job.

The roundtable report highlights successful strategies for addressing these challenges, including:

⇨Temporary, subsidized jobs in closely supervised and supportive settings for people with serious employment barriers. Such transitional jobs have proven effective at helping participants find unsubsidized jobs in the private sector.

⇨ Help in short-term crises for people with relatively few employment barriers, including more intense casework and generous cash benefits to resolve the crisis.

⇨ Business loans to child-care providers and co-locating Head Start programs and child care centers to improve the supply and convenience of child-care slots for working parents.

⇨ Projects that help individuals buy and maintain cars. Access to a reliable car is a key predictor for successful exit from welfare.

4. American Indian and African American welfare participants do not succeed as well in MFIP as immigrant or other racial groups.

African American and American Indian participants fare worse than other racial/ethnic or immigrant groups on MFIP's main performance measure, the Self-support Index. Furthermore, African American and American Indian participants receive a disproportionate number of financial penalties and are more likely than other groups to lose MFIP benefits due to time limits.

Focus group studies conducted with participants and welfare providers from several communities of color found evidence that participants in these communities have higher levels of employment barriers and are more likely to experience discrimination in the labor market. Minority MFIP recipients also described rude and demeaning treatment and asserted that job counselors withheld information and resources that could help them.

Recommendations from these studies ranged from early and more intensive assessment of barriers to employment to decreased worker caseloads and improvements in the cultural competency and racial composition of welfare and employment services personnel.

Conclusion

In summary, this review of more than 50 studies demonstrates that over the past seven years, Minnesota has made substantial progress toward the goals set by state policymakers: moving low-income families from welfare to work, reducing poverty through increased earnings and work supports, and preventing long-term dependence on welfare as a primary source of family support.

But the studies also show that much difficult work remains. Moving adults with limited skills and multiple barriers into immediate and sustained employment is perhaps the biggest challenge facing Minnesota's welfare-to-work efforts. Research suggests a need for additional time and targeted resources, as was provided through LIGSS grants. However, findings from projects targeted at the hard-to-employ suggest that some MFIP recipients' disabilities are so severe that these adults are unlikely to succeed at unsubsidized employment and might be better served through SSI, rehabilitation services or sheltered workshops, or through reasonable accommodations called for by the Americans with Disabilities Act.

These studies also demonstrate that the prevalence of low-wage, part-time jobs for MFIP recipients means that many face ongoing challenges finding stable and affordable housing, transportation, health care and child care.

MFIP does not operate in isolation from other market forces that impact the day-to-day lives of parents seeking to support their families through work. The most plentiful job openings are in industries with low-wages, meaning that families must struggle to provide for their basic needs and often require help from an array of work support programs.

Many important questions about the long-term effects of welfare reform remain to be answered. At the time of this synthesis, very little Minnesota research has examined how parent-focused welfare-to-work efforts affect children in areas such as health, education attainment, and interaction with child protection services.

Report by Lynda McDonnell
Sponsored by the Center for Urban and Regional Affairs & Center for Advanced Studies in Child Welfare, School of Social Work at the University of Minnesota
In partnership with the Welfare Reform Research and Evaluation Roundtable
With support from The Minneapolis Foundation