Statewide Trauma System Development

from injury and an "average" age of death at 70. If Minnesota were to measure its deaths using years of potential life lost, our leading cause of death would be trauma – followed by cancer and heart disease.

Benefits of a Trauma System

- 9% decrease in motor vehicle crash deaths in states with a trauma system.
- 15% to 20% increase survival rate of seriously injured patients with trauma system implementation.
- Increase in productive working years.
- Increase in statewide disaster preparedness.

Trauma Care Status in Minnesota

Currently, Minnesota is one of only nine states without a formal statewide trauma system. For many years, a small number of Minnesota hospitals have voluntarily maintained verification through the American College of Surgeons (ACS) as either Level I or II Trauma Centers. Through these individual institutional commitments, pockets of excellence in trauma care and prevention exist in Minnesota, but throughout the state there are many areas where citizens are isolated from these and other trauma care resources.

Trauma and Potential Revenue

Federal law allows hospitals to recover costs related to their internal response to caring for trauma patients. However, eligibility for this revenue is limited to trauma center hospitals verified by the American College of Surgeons or hospitals certified by a state as a participant in each state's statewide trauma system. Clearly, the latter eligibility is where most Minnesota hospitals would benefit – if Minnesota had a statewide trauma system.

Statewide Trauma System Activity

- In December 2003, a Commissioner-appointed stakeholder workgroup completed a comprehensive draft state trauma system plan.
- Widely distributed the plan for review and comments during 2004.
- Pilot tested the plan at seven hospitals to determine feasibility, and needed support and costs both to hospitals and MDH.
- Integrated suggestions and lessons learned into a final version, ensuring a workable plan for Minnesota trauma care providers.
- Maintaining a collaborative partnership with the Minnesota Department of Public Safety, the Minnesota EMS Regulatory Board, and other MDH initiatives to ensure that ongoing efforts are current, connected, and future oriented.
- There is widespread support to seek implementation legislation.

For more information

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The MDH trauma systems development web site contains the finalized "Comprehensive Statewide Trauma System Plan;" issues identified, lessons learned, and an aggregate cost analysis from the hospital pilot projects; and links to numerous state and national trauma resources.

www.health.state.mn.us/traumasystem

Background Information

Minnesota Department of Health January 2005

Statewide Trauma System Development

Why Have a Trauma System?

If you are severely injured, the time between your injury and when you receive definitive surgical care is the most important predictor of whether you will survive – your "golden hour." Your survival chance diminishes with time, regardless of the availability of modern capabilities and technology. A trauma system enhances your survival chances, as well as that of all trauma victims, regardless of proximity to urban trauma centers.

What is a Trauma System?

A trauma system is an organized, multi-disciplinary response to caring for severely injured people. It spans the continuum-of-care, from prevention, through EMS, hospital emergency and surgery departments, recovery, and rehabilitation. Best practices standards and guidelines direct each stage of trauma care to assure that injured people are promptly transported and treated at facilities appropriate to the severity of injury.

A state agency typically oversees a state trauma system and its four primary components: trauma center designation criteria; a trauma registry, monitoring system performance and providing feedback for improvement; EMS pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

A state trauma system provides a foundation for disaster preparedness and response. As part of its day-to-day activities, it coordinates and monitors the movement and care of severely injured people and adjusts to fluctuations in surge capacity and diversions due to limited availability of resources. Thus, a trauma system is designed to expand and contract based on the needs of the moment.

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Impact of Trauma in Minnesota

Trauma is a huge burden on families and communities. In the 1990s, nearly 21,000 Minnesotans died from trauma.

- For Minnesotans, ages 1 to 44, trauma is the leading cause of death. Overall, trauma is the third leading cause of death for all Minnesotans.
- On average, more than 2,300 Minnesotans die from trauma each year. For every death, more than 13 people are hospitalized for trauma-related injuries.
- More than 4,000 Minnesotans are hospitalized each year for central nervous system injury, including spinal cord injuries and traumatic brain injuries.
- Motor vehicle crashes are the leading cause of trauma deaths in Minnesota - 655 in 2003.
- In 2003, 69% of the fatal crashes were in rural areas.
- In 2003, the economic cost of motor vehicle fatalities in Minnesota was $713,950,000. *

** Based on the National Safety Council's economic cost figure of $1,090,000 per traffic fatality.*

Years of Potential Life Lost to Trauma

Death from trauma is tragic at any age, but the loss to society from trauma is especially great because so many young Minnesotans die from trauma before or during their peak productive years. One way to measure the impact of those early trauma deaths is in years of potential life lost – the number of years between early death

Governor's Supplemental Budget Recommendations
Department of Human Services
March 10, 2005

Following are changes from the Governor's January 2005 budget recommendations:

New Initiatives *(Pink Pages)*

- **Adjust Maximum Rates for Certain Child Care Centers.** P. 19.
  The Governor recommends adjustments to child care center rates in counties negatively impacted by the use of regional or statewide rates.

- **Dedicate GAMC Pharmacy Rebates to Pharmacy Assistance Program.** P.24A.
  The Governor recommends that the Department seek to collect rebates from pharmaceutical manufacturers for prescription drugs dispensed to General Assistance Medical Care (GAMC) recipients. The rebates collected would be used to establish a program designed to help people without drug coverage access free or discounted prescription drugs in a coordinated manner.

Budget Fixes *(Pink Pages)*

- **State Operated Services Adult Mental Health Program Transition.** P. 44A
  The Governor recommends that the unspent amount of the state-operated services (SOS) FY 2004-05 appropriations needed to cover the one-time costs of mental health restructuring and regional treatment center (RTC) downsizing cancel on June 30, 2005 and that a like amount be appropriated to SOS for that purpose in FY 2006.

Forecast Updates *(Green Pages)*

- Freeze Maximum Rates Paid for Child Care Assistance. P. 19.
- MDE Transfer Accounting Solutions. P. 20.
- Finalize 2003 Session TANF Refinancing. P. 21.
- Cost-Effective Pharmaceutical Purchasing. P. 25.
- 5% Reduction to Hospital Rates. P. 28.
- Restructure Health Care Program Eligibility. P. 29.
- Better Manage Health Care Programs. P. 30.
- Refinance Health Care Programs. P. 37.
- Nursing Facility Quality and Rate Reform. P. 39.
- Manage Caseload Growth in Home and Community-Based Waivers. P. 41.
- SOS Forensic Services Utilization. P. 43

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, regardless of when the policy was first issued.

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 (f).

(b) Minimum coverage shall be for a period of not less than one year and for a dollar amount equal to 12 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 with one home health care day benefit worth at least 50 percent of 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; and

(3) care management.

(f) 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 limit 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 to an amount that exceeds the dollar amount of coverage utilized under the partnership policy.

[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.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 540 - Long-Term Care Partnership Program (The First Engrossment)

Author: Senator Linda Berglin

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

Date: April 1, 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 12 months of nursing home care. Home health benefits may be substituted for nursing home benefits, with one home health care day worth at least 50 percent of 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, and care management.

- 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 protects from MA estate recovery procedures an amount of assets equal in value to the dollar amount of coverage utilized under 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

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/15/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

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

Agencies: Human Services Dept (03/15/05) Commerce (03/01/05)

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund		45	45	45	45
Commerce		45	45	45	45
Revenues					
General Fund		6	6	6	6
Commerce		6	6	6	6
Net Cost <Savings>					
General Fund		39	39	39	39
Commerce		39	39	39	39
Total Cost <Savings> to the State		39	39	39	39

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

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/15/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

Agency Name: Human Services Dept

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

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

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

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

NARRATIVE: SF 540-1E

Bill Description

This bill requires the Commissioners of Human Services and Commerce to work together to establish a long-term care (LTC) partnership program in Minnesota to finance LTC through a combination of private long term care insurance and Medical Assistance (MA). A LTC Partnership program would allow an individual to be eligible for MA with an increased asset limit equal to the current MA asset limit plus the total amount of LTC expenses paid for by a qualified long term care insurance (LTCI) policy. The bill establishes the requirements that must be met in order for a LTCI policy to qualify as a partnership policy. Additionally, the bill would reduce estate recovery by an amount equal to the increased asset limit.

Current federal law does not permit the estate recovery exemptions and the bill only becomes effective if and when federal law is changed to permit its full implementation (asset limit and estate recovery exemptions).

Assumptions

There are no program or administrative fiscal impacts associated with the asset limit and estate recovery exemption provisions of the bill because they cannot take effect until such time as there is a change to federal law. There are no other DHS administrative fiscal impacts associated with this bill.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Lisa Knazan 297-5628
FN Coord Signature: STEVE BARTA
Date: 03/02/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/01/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

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

Agency Name: Commerce

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		45	45	45	45
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		45	45	45	45
Revenues					
General Fund		6	6	6	6
Net Cost <Savings>					
General Fund		39	39	39	39
Total Cost <Savings> to the State		39	39	39	39

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

Bill Description

1) Senate File 540-1E authorizes a partnership program in Minnesota to finance long-term care through a combination of private insurance and medical assistance. The program would become effective when federal law is modified to permit such a program, or when Minnesota obtains a federal waiver.
2) The partnership program is designed to help people avoid spending down or transferring assets.
3) Under this proposal, Minnesota will create a long-term care policy with certain benefits. When a person exhausts the benefits under this policy, special medical assistance eligibility rules will allow continued coverage without regard to the person's financial assets.
4) Example:
   a) A person could purchase a long-term care policy to provide 12 months of coverage.
   b) When the person used the full 12 months of purchased coverage, medical assistance would provide an additional 12 months of coverage.
   c) Special eligibility rules for medical assistance will allow the second 12 months of coverage.
   d) The person would receive a total of 24 months of coverage, including the 12 months on medical assistance, without have to reduce assets.
5) The program will be administered by the Commissioner of Human Services in cooperation with the Commissioner of Commerce.

Assumptions

1) The Department of Commerce will review and approve long-term care policies.
2) Fees for policy review and approval will generate revenue.
3) Revenue will be paid into the General Fund.

Expenditure and/or Revenue Formula

Expenditure

	FTE	FY 2006	FY 2007
Policy Analyst	0.25	$15,000	$15,000
Actuary	0.25	$30,000	$30,000

Revenue

Policies Reviewed	Fee	FY 2006	FY 2007
75	$75.00	$5,625	$5,625

Long-Term Fiscal Considerations

Continuing staff expenditures and fee revenues.

Local Government Costs

Not applicable.

References/Sources

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Agency Contact Name: John Gross 651-297-2319
FN Coord Signature: MICHAEL F. BLACIK
Date: 02/28/05 Phone: 297-2117

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/01/05 Phone: 296-7642

ATTACHMENT "A"

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

Page 2, delete lines 33 to 36

Page 3, delete lines 1 to 26 and insert:

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

(b) A partnership policy must satisfy the requirements of chapter 62S.

(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 partnership policy must offer an elimination period of not more than 100 days for an adjusted premium.

(e) A partnership policy must satisfy the requirements established by the commissioner of human services under subdivision 12."

Page 3, after line 34, insert:

"Subd. 12. [IMPLEMENTATION.] (a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivision 10, paragraphs (c) and (d), and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.

(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on

the state budget.

(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.

(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.

(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable."

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

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

S.F. No. 540: 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.

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

Pages 2 and 3, delete subdivision 10 and insert:

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

(b) A partnership policy must satisfy the requirements of chapter 62S.

(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 partnership policy must offer an elimination period of not more than 100 days for an adjusted premium.

(e) A partnership policy must satisfy the requirements established by the commissioner of human services under subdivision 12."

Page 3, after line 34, insert:

"Subd. 12. [IMPLEMENTATION.] (a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivision 10, paragraphs (c) and (d), and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase

of qualifying policies by Minnesota residents while controlling medical assistance costs.

(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.

(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.

(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.

(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable."

Amend the title as follows:

Page 1, line 7, after the semicolon, insert "providing implementation options;"

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

Linda J. Berglin
(Division Chair)

April 5, 2005
(Date of Division action)

Senators Bakk, Saxhaug, Skoe and Stumpf introduced--

S.F. No. 1101: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying requirements for the provision of medical assistance swing bed services; amending Minnesota Statutes 2004, section 256B.0625, subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. [SKILLED AND INTERMEDIATE NURSING CARE.] Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with mental retardation or related conditions who are residing in intermediate care facilities for persons with mental retardation or related conditions. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (a) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (b) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (c) the patient was screened as provided by law; (d) the patient no longer requires acute care services; and (e) no nursing home

beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (a) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

[EFFECTIVE DATE.] This section is effective the day following final enactment and applies to medical assistance payments for swing bed services provided on or after March 5, 2005.

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Jo Anne Zoff Sellner
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Senate

State of Minnesota

S.F. No. 1101 - Medical Assistance Payment for Swing Bed Services

Author: Senator Thomas Bakk

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

Date: March 7, 2005

S.F. No. 1101 establishes an exception to the requirement in state law that nursing care provided in a nonpublic hospital swing bed may only be reimbursed by Medical Assistance (MA) if the hospital qualifies as a sole community provider. An exception is granted for hospitals that were approved to provide MA swing bed services as of January 1, 2004. The bill applies to swing bed services provided on or after March 5, 2005.

DG:rdr

Fiscal Note – 2005-06 Session

Bill #: S1101-0 **Complete Date:** 03/02/05

Chief Author: BAKK, THOMAS

Title: MODIFY SWING BED SVCS REQUIREMENTS

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

Agency Name: Human Services Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	4	4	4	4
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	4	4	4	4
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	4	4	4	4
Total Cost <Savings> to the State	0	4	4	4	4

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

NARRATIVE: HF 1157/SF 1101

Bill Description

This bill allows hospitals that had a provider agreement prior to January 1, 2004 to provide long term care services in a swing bed funded by Medical Assistance funds to be resumed after March 1, 2005 waiving the requirement that they are designated as a sole community provider as required by this statute.

Assumptions

Figures are based on days paid versus number of recipients.

Expenditure and/or Revenue Formula

$33,000 in paid days annually.

Seventy-five percent of swing bed payments would have otherwise occurred in nursing facilities elsewhere.

Long-Term Fiscal Considerations

None

Local Government Costs

None

References/Sources

Minnesota Hospital Association

Agency Contact Name: Kent Dufresne 296-5661
FN Coord Signature: STEVE BARTA
Date: 03/02/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/02/05 Phone: 286-5618

Senator Frederickson introduced--

S.F. No. 1589: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; providing for the relocation of an ICF/MR facility in Brown County; amending Minnesota Statutes 2004, section 252.291, by adding a subdivision.

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

Section 1. Minnesota Statutes 2004, section 252.291, is amended by adding a subdivision to read:

Subd. 2b. [EXCEPTION FOR BROWN COUNTY FACILITY.] (a) The commissioner shall authorize and grant a new license under chapter 245A to a new intermediate care facility for persons with mental retardation under the following circumstances:

(1) the new facility replaces an existing six-bed intermediate care facility for the mentally retarded located in Brown County that has been operating since June 1982;

(2) the new facility is located on an already purchased parcel of land; and

(3) the new facility is handicapped accessible.

(b) The medical assistance payment rate for the new facility shall be the higher of the rate specified in paragraph (c) or as otherwise provided by law.

(c) The new facility shall be considered a newly established facility for rate-setting purposes and shall be eligible for the investment per bed limit specified in section 256B.501, subdivision 11, paragraph (c), and the interest

expense limitation specified in section 256B.501, subdivision 11, paragraph (d). Notwithstanding section 256B.5011, the newly established facility's initial payment rate shall be set according to Minnesota Rules, part 9553.0075, and shall not be subject to the provisions of section 256B.501, subdivision 5b.

(d) During the construction of the new facility, Brown County shall work with residents, families, and service providers to explore all service options open to current residents of the facility.

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State of Minnesota

S.F. No. 1589 - Replacement of Brown County ICF/MR

Author: Senator Dennis Frederickson

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

Date: April 1, 2005

S.F. No. 1589 authorizes the replacement of a six-bed intermediate care facility for persons with mental retardation (ICF/MR) in Brown County. The new facility must replace one that has been in operation since 1982; must be built on land already purchased; and must be handicapped accessible.

The bill outlines a formula for establishing the new facility's reimbursement rate.

During construction of the new facility, Brown County must work with residents, families, and service providers to explore all service options for current residents.

DG:rdr

Fiscal Note – 2005-06 Session

Bill #: S1589-0 **Complete Date:** 03/15/05

Chief Author: FREDERICKSON, DENNIS

Title: BROWN CTY ICF/MR RELOCATION AUTH

Agency Name: Human Services Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	0	115	125	125
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	0	115	125	125
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	0	115	125	125
Total Cost <Savings> to the State	0	0	115	125	125

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

NARRATIVE: HF 1407/WSF 1589

Bill Description

Section 1 of the bill authorizes the commissioner to grant a new license under chapter 245A (Exception to ICF/MR moratorium) to a new intermediate care facility for persons with mental retardation or related conditions in Brown County; and establish the payment rate for the facility as if it were an newly established facility (rather than just a relocated facility). During the construction of the new facility, Brown County is required to work with the residents and their families in exploring service options for current residents.

Assumptions

1. This proposal is similar to the proposal submitted to the statewide advisory committee three years ago.
2. The new facility would be operational by July 2006 and would be fully occupied. The effect on cash payments would be experienced after 30 days.
3. The facility will continue to be funded under Medicaid, where the federal and state share is each 50% of the total cost.

Expenditure and/or Revenue Formula

INDIVIDUAL RATE COMPONENTS		
STAFFING		88.00
PAYROLL TAXES		21.12
MISC		3.65
DEVELOPMENT		0.73
HEALTH CARE		2.37
TRAVEL		3.93
PROGRAM SUPPLIES		0.89
CONTINUING ED.		2.35
ORIENTATION		1.12
ADMIN - VARIABLE		0.82
ADMIN - FIXED		43.32
		168.30
CPI INFLATIONARY INCREASE		
SINCE 2002 THROUGH 7/1/06 *		1.12
		188.50
PROPERTY RATE		42.44
TOTAL RATE		230.94
CURRENT RATE		116.57
NET INCREASE		114.37
RESIDENT DAYS		2190
ANNUAL NET COST DIFFERENCE		250,462
	Federal	125,231
	State	125,231

* 2002 = 2.3%, 2003 = 1.9%, 2004 = 3.3%, est 2005 = 3.0%, est 2006 1.5%

In the first year (SFY 2007) the state share is 11/12ths of the net state cost difference, or $114,795.

Long-Term Fiscal Considerations

This proposal will result in on-going costs to the state.

Local Government Costs
None

References/Sources
ICF/MR Rates
Continuing Care Research and Analysis

Agency Contact Name: Robert F. Meyer 582-1935
FN Coord Signature: STEVE BARTA
Date: 03/15/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Senator Metzen introduced--

S.F. No. 1607: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; authorizing a project to downsize an existing 14-bed facility for persons with developmental disabilities; amending Minnesota Statutes 2004, section 252.28, by adding a subdivision.

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

Section 1. Minnesota Statutes 2004, section 252.28, is amended by adding a subdivision to read:

Subd. 3b. [DOWNSIZING A 14-BED ICF/MR FACILITY LOCATED IN DAKOTA COUNTY.] (a) Notwithstanding any contrary provision of law, the commissioner of human services shall allow an existing 14-bed intermediate care facility for persons with mental retardation or related conditions located in Dakota County to be converted to an eight-bed ICF/MR facility. The facility shall develop a plan to decertify six beds that shall include criteria for determining how individuals to be relocated are determined, the alternative services that will be required, and timelines for resident relocation and the decertification of the beds to be eliminated. The plan must also include the facility's current operating cost rate under sections 252.282 and 256B.5011 to 256B.5014.

(b) The facility's new operating rate will be determined by identifying line item "fixed costs" which are unrelated to the number of residents served and "variable costs" which are related to the number of residents served. Variable costs,

prorated from 14 to 8 residents, added to fixed costs, is then divided by the full occupancy resident days after downsizing, to arrive at the new payment rate, adjusted to account for inflation using the Consumer Price Index-All Items, United States City Average.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1607 - Dakota County ICF/MR Downsizing

Author: Senator James Metzen

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

Date: Aptil 1, 2005

S.F. No. 1607 authorizes downsizing a 14-bed intermediate care facility for persons with mental retardation (ICF/MR) in Dakota County to an eight-bed facility.

The facility must develop a plan to decertify six beds, including criteria for choosing individuals to be relocated, the alternative services that will be required, and timelines for resident relocation and bed closings.

The facility's new operating rate is determined by adding total fixed costs (unrelated to the number of residents) plus variable costs (adjusted to reflect bed closures), dividing the result by full occupancy resident days, and adjusting for inflation.

DG:rdr

Fiscal Note – 2005-06 Session

Bill #: S1607-0 **Complete Date:** 03/15/05

Chief Author: METZEN, JAMES

Title: DAKOTA CTY DEV DISABILITY FAC

Agency Name: Human Services Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	0	12	13	13
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	0	12	13	13
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	0	12	13	13
Total Cost <Savings> to the State	0	0	12	13	13

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

NARRATIVE: HF 1627/SF 1607

This bill adjusts the payment rate for a 14 bed ICF/MR in Dakota County as it downsizes to 8 beds. The facilities new operating payment rate must account for the current level of expenditures for fixed costs, prorate the payment for variable costs, and add inflation to variable costs.

Assumptions

1. The downsizing of the facility can occur under current law; however, ICF/MR payment rates do not change due to downsizing under current law. Also, ICF/MR payment rates are not adjusted for inflation under current law.
2. The cost of this proposal is the difference between the new and current rate.
3. The downsizing of the new facility would be completed by July 2006 and would be fully occupied. The effect on cash payments would be experienced after 30 days.
4. The facility will continue to be funded under Medicaid, where the federal share is 50%, the state share is 40%, and the county share is 10% of the total cost.

Expenditure and/or Revenue Formula

HF 1627 FISCAL ANALYSIS	
CURRENT PAYMENT RATE	131.47
CURRENT FIXED RATE	8.13
ADJUSTMENT FROM 14 BEDS TO 8 BEDS	14.23
CURRENT VARIABLE RATE	123.34
CPI INDEX ADJUSTMENT *	1.039
* projected CPI of 2.1% and 1.8% for fiscal yr 2006 and 2007	
ADJUSTED VARIABLE RATE	128.15
TOTAL PAYMENT RATE	142.38
CURRENT PAYMENT RATE	131.47
NET RATE INCREASE	10.91
RESIDENT DAYS	2,920
ANNUAL INCREASE IN COST	31,858
FEDERAL SHARE	15,929
STATE SHARE	12,743
COUNTY SHARE	3,186

Long-Term Fiscal Considerations

This bill would increase the state costs for this facility by 13,000 per year on an ongoing basis by increasing the rate for this facility beyond what is allowed under current law.

Local Government Costs

County costs would increase modestly due to the rate change.

References/Sources

ICF/MR Rates

Continuing Care Research and Analysis

Agency Contact Name: Robert F. Meyer 582-1935
FN Coord Signature: STEVE BARTA
Date: 03/15/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

HISTORY:

-CareCo Homes, 14 bed Intermediate Care Facility (ICR/MR), for profit, built & opened in 1984

-10 of 12 current residents moved here in 1984 – its their home, long term

PROBLEM:

-November 2004, 2 clients moved to nursing home – empty bed caused 15% budget loss

- 9 staff positions cut
- most "extras" eliminated (community ed classes, trips, etc.)
- all staff benefits eliminated or reduced – this to staff who have had no pay increase since July 2003.

-No new admits – why

- shared bedrooms – standard in 1984, not now

SOLUTION: SF1607

-Allows downsizing to 8 beds – all single bedrooms

-Per diem change from $131.47 to $230.07

Positive – Will continue to offer attractive residence to 8, plus be able to attract new clients.

Negative – 4 will need to move but all have identified alternatives that would keep them with friends, keep same job.

February 7, 2005

HISTORY:

CareCo Homes, Inc. opened in December, 1984, as a 15 bed Intermediate Care Facility for the Mentally Retarded (ICF-MR) and is licensed as a Supervised Living Facility (Minnesota Department of Health) and a Rule 245B Residential Services (formerly Rule 34) facility (Department of Human Services).

The building, built specifically for this purpose has four two bedroom apartments – two on each level. Each bedroom is shared by two residents (the standard at that time) and has been at capacity for most of the 20 years of operation.

In 2000, CareCo decertified one of its beds, changing the licensed capacity to 14 residents.

In the fall of 2001, a client died and we had an open bed, and CareCo continued operating as at that time the State of Minnesota had a system that provided payments for open bed for 90 days while another client was sought. This system was eliminated from the state budget in the spring of 2003.

In November, 2004, two of our long time clients declined physically due to dementia and early Alzheimer's like symptoms. No longer able to walk, feed themselves, or communicate and in need of total physical care, we were forced to move them to a nursing home. This meant CareCo had two open beds and no process available to address the funding loss.

CURRENT PROBLEM:

We currently serve 12 clients. CareCo receives **no income** at all for the two open beds. The system of temporary payment was never put back into effect by the State. As of the day the two clients moved, (11/10/04), CareCo immediately lost 15% of its income.

CareCo currently receives $131.47/per day per resident to cover all areas of their care. This rate has not changed since July, 2003. With two open beds, we are losing $8000.00 per month. Yet, we still must meet the needs of the 12 clients living at CareCo, make our payroll, and pay the monthly bills. Most costs of running the facility DO NOT change whether there are 14 or 12 clients living here.

Dakota County and all area metro counties have been notified of our current client opening. We face two major problem areas in the attempt to fill our two beds. One is the current age of our population (45-70), which is not the age group currently seeking a home. The second, and probably main reason, that we are being unsuccessful is that our bedrooms are shared by two people. Most potential clients have lived in family homes and always had their own bedroom. The residential system has changed, and rightfully so, to acknowledge the need to provide private space to clients who live in long term care facilities. Again, most families and social workers are not interested in placement if bedrooms have to be shared.

CareCo can not continue long term with the current situation of having two open beds, the accompanying loss of income, and serve the twelve clients residing here.

SOLUTIONS:

The first thing CareCo did to meet this income loss was a line item budget analysis to find out where costs could be contained or decreased. Most costs in the facility are fixed – mortgage, insurance taxes, utilities. The food budget is impacted minimally with two less clients in the facility.

The only budget item that CareCo has total control over is staffing and staff benefits. We have cut to the bone. As of December, 2004, CareCo changed its staffing pattern to a 1 to 6 staff to resident ratio. We

have had to eliminate seven part time counseling positions as well as the housekeeper and maintenance position. We transferred these duties to remaining staff. This has drastically changed our services at CareCo. Community activities and programs have been reduced or eliminated. Basic needs of the residents are being met, but programming for socialization, independence in daily living skills, community integration, and recreation had to be cut to the minimum. We simply cannot afford to pay the staff needed to keep the program running at the level of quality it has in the past.

This is a short term solution and will not be economically feasible to continue past this year. Eventually our costs, even at that level of service, will not be covered by our reduced income.

It is apparent that single bedrooms are the single most significant requirement for placement. CareCo has eight bedrooms. We feel that the only way for CareCo to continue in operation as a long term home is to downsize to an 8 bed ICF/MR facility. We will then remain an acceptable alternative for future placement for all clients. The per diem rate will then need to be reset to cover the basic budget based on eight clients.

CONCLUSION:

We would like to remain proactive on the needed changes at CareCo. Our residents who have lived here for twenty years deserve to stay in their long term home where they feel safe and secure. If CareCo is unable to make the needed budgetary changes to stay open, **all the clients here will lose their home** and be scattered throughout the county. Families who have been content to have their disabled person stay in our care will have to find new residential placements with strangers.

CareCo currently employs 15 staff, down from a high of 25. If forced to close, all jobs will be lost. Our annual property taxes are substantial and beneficial to the local community, the school district, and the state itself. All of this will be lost.

In a state as progressive as Minnesota in its long term care of its disabled citizens, it seems wrong that there is no process to be followed in retaining the homes of the clients who have lived all this time at CareCo. Because two of their friends had to move to a nursing home to have their own personal and physical care needs met, the entire program and home environment for 12 other disabled adults is in jeopardy.

We are asking the legislature to fulfill its commitment to the care of disabled adults by providing an alternative to their home being closed and their lives disrupted. We are asking to be allowed to downsize from 14 beds to 8 beds in order to stay a viable residential option now and in the future. As a result of this downsizing, the per diem rate of the clients must be changed to cover all the fixed costs involved in running the facility and in providing a staffing pattern that will meet the requirements of quality care and programming. We have the clients, the physical plant, the willing and well trained staff to continue this residential program for many years. We need the change in the per diem rate that will allow us to downsize immediately this year.

per diem needed 230.07

Senator Solon introduced--

S.F. No. 23: Referred to the Committee on Health and Family Security.

A bill for an act

relating to pharmacy; modifying wholesale drug distributor requirements; amending Minnesota Statutes 2004, section 151.47, subdivision 1, by adding a subdivision.

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

Section 1. Minnesota Statutes 2004, section 151.47, subdivision 1, is amended to read:

Subdivision 1. [REQUIREMENTS.] All wholesale drug distributors are subject to the requirements in paragraphs (a) to ~~(f)~~ (g).

(a) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying the required fee.

(b) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(c) The board may require a separate license for each facility directly or indirectly owned or operated by the same business entity within the state, or for a parent entity with divisions, subsidiaries, or affiliate companies within the state, when operations are conducted at more than one location and joint ownership and control exists among all the entities.

(d) As a condition for receiving and retaining a wholesale

drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has complied with paragraph (g) and that it has and will continuously maintain:

(1) adequate storage conditions and facilities;

(2) minimum liability and other insurance as may be required under any applicable federal or state law;

(3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;

(4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;

(5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;

(6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;

(7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or product shipping and receiving, outdated product or other unauthorized product control, appropriate disposition of returned goods, and product recalls;

(8) sufficient inspection procedures for all incoming and

outgoing product shipments; and

(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.

(e) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.

(f) A wholesale drug distributor shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement or other compensation authorized under section 151.461, clauses (3) to (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more, to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this provision are public data.

(g) Manufacturers shall, on a quarterly basis, report by National Drug Code the following pharmaceutical pricing criteria to the commissioner of human services for each of their drugs: average wholesale price, wholesale acquisition cost, average manufacturer price as defined in United States Code, title 42, chapter 7, subchapter XIX, section 1396r-8(k), and best price as defined in United States Code, title 42, chapter 7, subchapter XIX, section 1396r-8(c)(1)(C). The calculation of average wholesale price and wholesale acquisition cost shall be the net of all volume discounts, prompt payment discounts, chargebacks, short-dated product discounts, cash discounts, free goods, rebates, and all other price concessions or incentives provided to a purchaser that result in a reduction in the ultimate cost to the purchaser. When reporting average wholesale price, wholesale acquisition cost, average manufacturer price, and best price, manufacturers shall also include a detailed description of the methodology by which the prices were calculated. When a manufacturer reports average wholesale price, wholesale acquisition cost, average manufacturer price, or best price, the president or chief executive officer of the manufacturer shall certify to the Medicaid program, on a form provided by the

commissioner of human services, that the reported prices are accurate. Any information reported under this paragraph shall be classified as nonpublic data under section 13.02, subdivision 9. Notwithstanding the classification of data in this paragraph and subdivision 2, the Minnesota Attorney General's Office or another law enforcement agency may access and obtain copies of the data required under this paragraph and use that data for law enforcement purposes.

Sec. 2. Minnesota Statutes 2004, section 151.47, is amended by adding a subdivision to read:

Subd. 3. [PENALTIES AND REMEDIES.] The attorney general may pursue the penalties and remedies available to the attorney general under section 8.31 against any manufacturer who violates subdivision 1, paragraph (g).

ADOPTED BY DIVISION 3/16/05

Senator ..... moves to amend S.F. No. 23 as follows:

Page 1, delete line 11 and insert "to (f), and if applicable in paragraph (g)."

Page 4, after line 14, insert:

"Sec. 3. [256.957] [HEALTH CARE QUALITY IMPROVEMENT ACCOUNT.]

A health care quality improvement account is established in the general fund.

Sec. 4. [REBATE REVENUE RECAPTURE.]

Any money received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate shall be deposited in the health care quality improvement account established in Minnesota Statutes, section 256.957."

Amend the title accordingly

Senate Counsel, Research, and Fiscal Analysis

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S.F. No. 23 - Pharmaceutical Pricing Disclosure

Author: Senator Yvonne Prettner Solon

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

Date: March 4, 2005

S.F. No. 23 requires drug manufacturers to disclose certain pharmaceutical pricing to the Commissioner of Human Services as a requirement for licensure under Minnesota Statutes, chapter 151.

Section 1 (151.47, subdivision 1) requires drug manufacturers to on a quarterly basis report to the Board of Pharmacy and to the Commissioner of Human Services the following pharmaceutical pricing criteria for each of their drugs: average wholesale price (AWP); wholesale acquisition cost (WAC); average manufacturer price (AMP) as defined under federal law; and best price as defined under federal law. Describes the calculation to be used to determine the AWP and WAC. Requires a detailed description of the methodology used to calculate the reported AWP, WAC, AMP, and best price be included in the report. Requires the president or chief executive officer of the manufacturer to certify to the medical assistance program on a form provided by the Commissioner of Human Services that the reported prices are accurate. States that any information reported shall be classified as nonpublic data under section 13.02, subdivision 9, but authorizes the attorney general's office or another law enforcement agency to access and obtain copies of th data and use it for law enforcement purposes.

Section 2 (151.45, subdivision 3) authorizes the attorney general to pursue penalties and remedies available under section 8.31 against any manufacturer who violates **section 1.**

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 02/14/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agencies: Human Services Dept (02/14/05)
Pharmacy Board (01/31/05)
Attorney General (01/31/05)

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund		122	108	108	108
Human Services Dept		122	108	108	108
Revenues					
General Fund		49	43	43	43
Human Services Dept		49	43	43	43
Net Cost <Savings>					
General Fund		73	65	65	65
Human Services Dept		73	65	65	65
Total Cost <Savings> to the State		73	65	65	65

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	1.00	1.00	1.00
Human Services Dept		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 02/14/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 02/14/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

Agency Name: Human Services Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		122	108	108	108
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		122	108	108	108
Revenues					
General Fund		49	43	43	43
Net Cost <Savings>					
General Fund		73	65	65	65
Total Cost <Savings> to the State		73	65	65	65

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

Bill Description: Requires pharmaceutical manufacturers to report certain pricing information to the Department of Human Services.

Assumptions While this bill requires manufacturers to supply certain drug pricing information to DHS, it does not specifically require the department to use that data to calculate reimbursement to providers. Consequently, this will have no impact on program costs. There will be an administrative cost because staff will have to somehow process, track and store the data. Assume Pharmacy Program would need 1 FTE on an ongoing basis for staff to process data and to follow-up with manufacturers as necessary. There would be only negligible systems cost to set up a database.

(Note – even if the authors of the bill assume that DHS would use the drug pricing information to establish reimbursement rates, DHS would not be able to do so given the current language of the bill. Consequently, the fiscal analysis remains the same – DHS would need 1 FTE to handle the data).

Expenditure and/or Revenue Formula

1 FTE needed for data collection and processing:

	FY06	FY07	FY08
Staff Costs	122	108	108
Revenue	49	43	43
Net Cost to State	73	65	65

Long-Term Fiscal Considerations Would have to continue processing this data for as long as it is being sent to us.

Local Government Costs None

References/Sources

Agency Contact Name: Cody Wiberg 282-6496
FN Coord Signature: STEVE BARTA
Date: 02/03/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 02/14/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 01/31/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agency Name: Pharmacy Board

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

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

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

This bill version has no fiscal effect on our agency.

FN Coord Signature: JULI VANGSNESS
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EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 01/31/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 01/31/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

Agency Name: Attorney General

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

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

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

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

This bill version has no fiscal effect on our agency.

FN Coord Signature: TERRY POHLKAMP
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EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 01/31/05 Phone: 215-0595

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 23 as follows:

Page 4, line 2, after the period, insert "The commissioner of human services may use the prices reported under this section in determining reimbursement payments under section 256B.0625, subdivision 13e."

Page 4, line 5, after "Office" insert ", the federal Centers for Medicare and Medicaid Services"

Page 4, after line 14, insert:

"Sec. 3. [APPROPRIATIONS.]

(a) The Board of Pharmacy shall increase the licensing fee for drug manufacturers required under Minnesota Statutes, sections 151.42 to 151.51, by $275 per year beginning July 1, 2005.

(b) On July 1, 2005, and each fiscal year thereafter, the commissioner of finance shall transfer $73,000 from the state government special revenue fund to the general fund.

(c) $73,000 is appropriated in fiscal year 2006 and $73,000 in fiscal year 2007 from the general fund to the commissioner of human services for the data received under Minnesota Statutes, section 151.47, subdivision 1, paragraph (g)."

Senators Higgins, Lourey, Berglin, Rosen and Koering introduced--
S.F. No. 1864: Referred to the Committee on Finance.

A bill for an act

relating to health; appropriating money for the start-up of a Center of Nursing.

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

Section 1. [MINNESOTA CENTER OF NURSING.]

(a) $500,000 is appropriated in fiscal year 2006 from the state government special revenue fund to the Board of Nursing to be used as start-up funding to establish a Minnesota Center of Nursing. The goals of the center shall be to:

(1) maintain information on the current and projected supply and demand of nurses through the collection and analysis of data on the nursing workforce;

(2) develop a strategic statewide plan for the nursing workforce;

(3) convene work groups of stakeholders to examine issues and make recommendations regarding factors affecting nursing education, recruitment, and retention;

(4) promote recognition, reward, and renewal activities for nurses in Minnesota; and

(5) provide consultation, technical assistance, and data on the nursing workforce to the legislature.

(b) The Board of Nursing shall submit a report to the legislature by January 15, 2007, on the Center of Nursing's progress, the center's collaboration efforts with other

organizations and governmental entities, and the activities conducted by the center in achieving the goals outlined.

A bill for an act

relating to medical assistance; requiring medical assistance to cover medication therapy management services; amending Minnesota Statutes 2004, section 256B.0625, by adding a subdivision.

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

Section 1. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13h. [MEDICATION THERAPY MANAGEMENT CARE.] (a) Medical assistance covers medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to

identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May of 1996; or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting; and

(4) make use of an electronic patient record system that meets state standards.

(c) For the purposes of reimbursement for medication

therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall convene a nine-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee shall expire on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance program that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 973 - Medication Therapy Management Services (First Engrossment)

Author: Senator Becky Lourey

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

Date: April 4, 2005

S.F. No. 973, paragraph (a), provides medical assistance coverage for medication therapy management services for recipients taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or for recipients with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or likely to result in significant nondrug program costs. "Medication therapy management" means the provision of the following pharmaceutical care services provided by a licensed pharmacist:

(1) performing or obtaining assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating a patient's response to therapy;

(4) performing a comprehensive medication review;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training in the understanding and use of the patient's medication;

(7) providing information, support services, and resources designed to enhance patient adherence with the therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader services being provided to the patient.

Nothing in the subdivision shall be construed to expand or modify the scope of practice of the licensed pharmacist.

Paragraph (b) states that in order to be eligible for reimbursement, a licensed pharmacist must:

(1) have a valid license;

(2) have graduated from an accredited college of pharmacy on or after May of 1996, or completed an education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education;

(3) be practicing in an ambulatory care setting as a part of a multidisciplinary team or have developed a patient care process that is offered in a private or semiprivate area that is separate from commercial business area; and

(4) make use of an electronic patient record system that meets state standards.

Paragraph (c) states that for reimbursement purposes, the commissioner may enroll individual pharmacists as medical assistance providers and may establish contact requirement between the pharmacist and recipient.

Paragraph (d) requires the Commissioner of Human Services to convene a medication therapy management advisory committee to advise the commissioner on the implementation and administration of the medication therapy management services.

Paragraph (e) requires the commissioner to evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs and to report to the legislature by December 15, 2007. Permits the commissioner to contract with a vendor or academic institution to conduct this evaluation.

KC:ph

Fiscal Note – 2005-06 Session

Bill #: S0973-1A **Complete Date:** 04/04/05

Chief Author: LOUREY, BECKY

Title: MA COV MEDICATION THERAPY MGMT SVCS

Agency Name: Human Services Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	52	(104)	(250)	(321)
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	52	(104)	(250)	(321)
Revenues					
General Fund	0	12	20	0	0
Net Cost <Savings>					
General Fund	0	40	(124)	(250)	(321)
Total Cost <Savings> to the State	0	40	(124)	(250)	(321)

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	0.50	0.00	0.00	0.00
Total FTE	0.00	0.50	0.00	0.00	0.00

NARRATIVE: SF 973-1A

Bill Description

This bill directs the Commissioner to establish a nine-member committee of physicians, pharmacists and a consumer representative. In consultation with the committee, DHS would implement and administer a new benefit called medication therapy management (MTM).

MTM is a professional service provided by pharmacists. It involves a comprehensive review of a patient's medications in attempt to identify and correct any drug-related problems. The goal of MTM is to improve the quality of care and to reduce overall healthcare costs.

This bill would require DHS to enroll pharmacists as providers and to pay them for the provision of MTM. It requires DHS to evaluate the impact of MTM on quality of care, patient outcomes and program costs.

Assumptions

See attached worksheets.

Expenditure and/or Revenue Formula

Fiscal Analysis: SF 973 and HF 979
2005 Session

Projected MA enrollees not in managed care, excluding those with Medicare Rx coverage	130,000
Est. half meet inclusion criteria*	65,000
Est. 10% get PC services at full operation	6,500
Est. 2 encounters per recipient	13,000

Annual MA Program Costs

Reimbursement Level	Distribution of Encounters	Number of Encounters	Cost per Encounter	Service Payments
Level 1	20.00%	2,600	37.08	96,408
Level 2	30.00%	3,900	48.02	187,278
Level 3	30.00%	3,900	63.03	245,817
Level 4	15.00%	1,950	90.84	177,138
Level 5	5.00%	650	108.44	70,486
Total	100%	13,000	59.78	777,127

Annual MA Cost Avoidance**

Type Of Events Avoided	Minimum Events Avoided	Maximum Events Avoided	Mid-range Events Avoided	Cost per Event	Program Savings
Hospitalizations	40.0	60.0	50.0	14,000	700,000
Emergency room visits	165.0	210.0	187.5	455	85,313
Urgent care visits	120.0	150.0	135.0	135	18,225
Clinic office visits	4800.0	5400.0	5100.0	80	408,000
Laboratory tests	275.0	360.0	317.5	25	7,938
Home care visits	16.0	30.0	23.0	265	6,095
LTC facility stays	10.0	18.0	14.0	13,786	193,004
Total Program Savings					1,418,574

MA Costs (Savings) by FY	FY 2006	FY 2007	FY 2008	FY 2009
Phase-in service costs	15%	70%	100%	100%

Phase-in cost avoidance	5%	60%	90%	100%
Rx Service Cost	116,569	543,989	777,127	777,127
Effect on other services	(70,929)	(851,144)	(1,276,717)	(1,418,574)
Net MA Eld. & Dis. Basic Cost	45,640	(307,156)	(499,590)	(641,447)
Federal Share	22,820	(153,578)	(249,795)	(320,724)
State Share	22,820	(153,578)	(249,795)	(320,724)
Administrative Costs				
Contract for Evaluation		50,000		
Provider Enrollment and training (.50 FTE)	29,000			
Total Admin Costs	29,000	50,000	0	0
Total Gen. Fund Costs	51,820	(103,578)	(249,795)	(320,724)
Admin. Reimbursement	11,600	20,000	0	0
Net Gen. Fund cost	40,220	(123,578)	(249,795)	(320,724)

* Expected patient encounter projections based on the provision of pharmaceutical care to 20,761 patients (59,361 patient encounters) from 1994 – 2004. Data on file in the Peters Institute of Pharmaceutical Care at the University of Minnesota includes 29,986 drug therapy problems identified and resolved by pharmacists throughout the United States and 12 foreign countries.

** Health care savings projections based on a 2000-2004 data set of 4,105 adults, private sector insured patients (10,223 patient encounters) taking at least four drugs to treat or prevent two chronic medical conditions (12,608 drug therapy problems).

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

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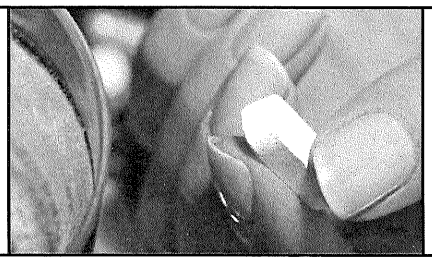
EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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



MEDICATION THERAPY MANAGEMENT SERVICES THROUGH MEDICAID

THE VALUE OF PHARMACISTS SERVICES AND MTMS

- Iowa, Wisconsin, Washington, Missouri, Mississippi, and Florida have implemented MTMS programs in Medicaid prescription and medical expenditures and have reported improved patient health outcomes and health care expenditure savings. The Missouri Medicaid program has showed decreased ER visits and hospitalizations for patients receiving MTMS compared to a control group not receiving MTMS and that there is an absolute savings of $10,000 per patient per year in those patients receiving MTMS. These services have proven to improve outcomes and save money in the health care system.

THE PROBLEM OF MEDICATION MISUSE AND PATIENT CARE

- The use of medications and the number of medications available to patients have greatly increased and will continue to increase. These medications are a great advancement in the care of patients; however, if not used properly the medications may not be effective and could be unsafe for patients. Physicians, nurse practitioners, and physician assistants can benefit from the drug therapy knowledge of pharmacists. Pharmacists can partner with patients and providers through MTMS to make sure that the medications are utilized correctly, ensure patient compliance and proper dosage, increase generic substitutions, and prevent drug-drug interactions. According to the Institute of Medicine, more than $176 billion is wasted each year on the improper and unsafe use of medications.

PHARMACISTS TRAINING

- For more than 15 years, Minnesota pharmacists graduating from the University of Minnesota College of Pharmacy have been educated with an increased focus on drug therapy knowledge and patient care expertise. Many pharmacists in practice have also received continued education to enhance better care for patients through medication therapy management services. Pharmacists are educated in the various aspects of disease states including; pathophysiology, diagnosis, monitoring and treatment. Pharmacists also know exactly how medications work and are absorbed by the body. Pharmacists are the only health professional whose educational focus is on medication use to this extent. Encompassing all this knowledge, pharmacists are unique members of the healthcare team who can help patients and fellow providers make the best use of medications with MTMS.

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