A bill for an act

relating to the operation of state government; modifying parental contributions; modifying several MFIP provisions; modifying medical assistance estate recovery provisions; eliminating recoveries for alternative care costs; removing liens against life estates and joint tenant interests; appropriating money; amending Minnesota Statutes 2004, sections 252.27, subdivision 2a; 256B.15, subdivisions 1, 1a, 1d, 1e, 1f, 1h, 1i, 1j, 2, 3, 4; 256J.21, subdivision 2; 256J.95, subdivision 9; 514.981, subdivision 6; 524.3-805; repealing Minnesota Statutes 2004, sections 256B.15, subdivision 1g; 256J.37, subdivisions 3a, 3b; 514.991; 514.992; 514.993; 514.994; 514.995.

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

ARTICLE 1

HUMAN SERVICES

Section 1. Minnesota Statutes 2004, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. [CONTRIBUTION AMOUNT.] (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the

parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to ~~375~~ 575 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to ~~375~~ 575 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than ~~375~~ 575 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be ten percent of adjusted gross income; and

(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by ~~$2,400~~ $5,000 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home and funds from early withdrawn qualified retirement accounts under the Internal Revenue Code shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph

(a) ~~.--An-amount-equal-to-the-annual~~, except that a court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the ~~adjusted-gross income~~ contribution of the parent making the payment ~~prior-to calculating-the-parental-contribution-under-paragraph-(b)~~.

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 2. Minnesota Statutes 2004, section 256J.21, subdivision 2, is amended to read:

Subd. 2. [INCOME EXCLUSIONS.] The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9545.0010 to 9545.0260 and 9555.5050 to 9555.6265, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender

expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment

issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, ~~except as described in section 256J.37, subdivision 3b~~;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with mental retardation or related conditions, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children

(WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living

with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash; and

(46) the principal portion of a contract for deed payment.

Sec. 3. Minnesota Statutes 2004, section 256J.95, subdivision 9, is amended to read:

Subd. 9. [PROPERTY AND INCOME LIMITATIONS.] The asset limits and exclusions in section 256J.20 apply to applicants and recipients of DWP. All payments, unless excluded in section 256J.21, must be counted as income to determine eligibility for the diversionary work program. The county shall treat income as outlined in section 256J.37~~,-except-for-subdivision-3a~~. The initial income test and the disregards in section 256J.21, subdivision 3, shall be followed for determining eligibility for the diversionary work program.

Sec. 4. [REPEALER.]

Minnesota Statutes 2004, section 256J.37, subdivisions 3a and 3b, are repealed effective July 1, 2005.

ARTICLE 2

MEDICAL ASSISTANCE LIENS

Section 1. Minnesota Statutes 2004, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. [POLICY~~,-APPLICABILITY,-PURPOSE,-AND CONSTRUCTION~~; DEFINITION.] (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the total cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) ~~subdivisions-1c-to-1k-shall-not-apply-to-claims-arising under-this-section-which-are-presented-under-section-525.313,~~

~~(2)~~ the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions; and

~~(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;~~

~~(4)~~ (2) all laws, rules, and regulations governing or involved with a recovery of medical assistance ~~shall~~ must be liberally construed to accomplish their intended purposes~~;~~.

~~(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remaindermen or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and~~

~~(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which~~

~~the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.~~

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D ~~and~~ but does not include the alternative care program for nonmedical assistance recipients under section 256B.0913.

[EFFECTIVE DATE.] The amendments in this section relating to the alternative care program are effective retroactively from July 1, 2003, and apply to the estates of decedents who die on or after that date. The remaining amendments in this section are effective retroactively from August 1, 2003, and apply to the estates of decedents who die on or after that date.

Sec. 2. Minnesota Statutes 2004, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. [ESTATES SUBJECT TO CLAIMS.] If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, ~~or as otherwise provided for in this section,~~ the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according

to sections 525.31 to 525.313.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over 55 years of age, and received services under this chapter, excluding alternative care;

(b) the person resided in a medical institution for six months or longer, received services under this chapter, excluding alternative care, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

(c) the person received general assistance medical care services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. ~~Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.~~

[EFFECTIVE DATE.] The amendments in this section relating to the alternative care program are effective retroactively from July 1, 2003, and apply to the estates of decedents who die on or after that date. The remaining amendments in this section are effective retroactively from August 1, 2003, and apply to the estates of decedents who die on or after that date.

Sec. 3. Minnesota Statutes 2004, section 256B.15, subdivision 1d, is amended to read:

Subd. 1d. [EFFECT OF NOTICE.] From the time it takes effect, the notice shall be notice to ~~remaindermen, joint tenants, or to~~ anyone ~~else~~ owning or acquiring an interest in or encumbrance against the property described in the notice that the medical assistance recipient's ~~life estate, joint tenancy, or other~~ interests in the real estate described in the notice:

(1) ~~shall, in the case of life estate and joint tenancy interests, continue to exist for purposes of this section, and be subject to liens and claims as provided in this section;~~

~~(2)~~ shall be subject to a lien in favor of the claimant effective upon the death of the recipient and dealt with as provided in this section;

~~(3)~~ (2) may be included in the recipient's estate, as defined in this section; and

~~(4)~~ (3) may be subject to administration and all other provisions of chapter 524 and may be sold, assigned, transferred, or encumbered free and clear of their interest or encumbrance to satisfy claims under this section.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 4. Minnesota Statutes 2004, section 256B.15, subdivision 1e, is amended to read:

Subd. 1e. [FULL OR PARTIAL RELEASE OF NOTICE.] (a) The claimant may fully or partially release the notice and the lien arising out of the notice of record in the real estate records where the notice is filed or recorded at any time. ~~The claimant may give a full or partial release to extinguish any life estates or joint tenancy interests which are or may be continued~~

~~under this section or whose existence or nonexistence may create a cloud on the title to real property at any time whether or not a notice has been filed.~~ The recorder or registrar of titles shall accept the release for recording or filing. If the release is a partial release, it must include a legal description of the property being released.

(b) At any time, the claimant may, at the claimant's discretion, wholly or partially release, subordinate, modify, or amend the recorded notice and the lien arising out of the notice.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 5. Minnesota Statutes 2004, section 256B.15, subdivision 1f, is amended to read:

Subd. 1f. [AGENCY LIEN.] (a) The notice shall constitute a lien in favor of the Department of Human Services against the recipient's interests in the real estate it describes for a period of 20 years from the date of filing or the date of the recipient's death, whichever is later. ~~Notwithstanding any law or rule to the contrary, a recipient's life estate and joint tenancy interests shall not end upon the recipient's death but shall continue according to subdivisions 1h, 1i, and 1j.~~ The amount of the lien shall be equal to the total amount of the claims that could be presented in the recipient's estate under this section.

(b) If no estate has been opened for the deceased recipient, any holder of an interest in the property may apply to the lien holder for a statement of the amount of the lien or for a full or partial release of the lien. The application shall include the applicant's name, current mailing address, current home and work telephone numbers, and a description of their interest in the property, a legal description of the recipient's interest in the property, and the deceased recipient's name, date of birth, and Social Security number. The lien holder shall send the applicant by certified mail, return receipt requested, a written statement showing the amount of the lien, whether the lien holder is willing to release the

lien and under what conditions, and inform them of the right to a hearing under section 256.045. The lien holder shall have the discretion to compromise and settle the lien upon any terms and conditions the lien holder deems appropriate.

(c) Any holder of an interest in property subject to the lien has a right to request a hearing under section 256.045 to determine the validity, extent, or amount of the lien. The request must be in writing, and must include the names, current addresses, and home and business telephone numbers for all other parties holding an interest in the property. A request for a hearing by any holder of an interest in the property shall be deemed to be a request for a hearing by all parties owning interests in the property. Notice of the hearing shall be given to the lien holder, the party filing the appeal, and all of the other holders of interests in the property at the addresses listed in the appeal by certified mail, return receipt requested, or by ordinary mail. Any owner of an interest in the property to whom notice of the hearing is mailed shall be deemed to have waived any and all claims or defenses in respect to the lien unless they appear and assert any claims or defenses at the hearing.

(d) If the claim the lien secures could be filed under subdivision 1h, the lien holder may collect, compromise, settle, or release the lien upon any terms and conditions it deems appropriate. If the claim the lien secures could be filed under subdivision 1i or 1j, the lien may be adjusted or enforced to the same extent had it been filed under subdivisions 1i and 1j, and the provisions of subdivisions 1i, clause ~~(f)~~ (e), and 1j, clause (d), shall apply to voluntary payment, settlement, or satisfaction of the lien.

~~(e) If no probate proceedings have been commenced for the recipient as of the date the lien holder executes a release of the lien on a recipient's life estate or joint tenancy interest, created for purposes of this section, the release shall terminate the life estate or joint tenancy interest created under this section as of the date it is recorded or filed to the~~

~~extent-of-the-release.--If-the-claimant-executes-a-release-for purposes-of-extinguishing-a-life-estate-or-a-joint-tenancy interest-created-under-this-section-to-remove-a-cloud-on-title to-real-property,-the-release-shall-have-the-effect-of extinguishing-any-life-estate-or-joint-tenancy-interests-in-the property-it-describes-which-may-have been-continued-by-reason-of this-section-retroactive-to-the-date-of-death-of-the-deceased life-tenant-or-joint-tenant-except-as-provided-for-in-section 514.9817,-subdivision-6.~~

~~(f)~~ If the deceased recipient's estate is probated, a claim shall be filed under this section. The amount of the lien shall be limited to the amount of the claim as finally allowed. If the claim the lien secures is filed under subdivision 1h, the lien may be released in full after any allowance of the claim becomes final or according to any agreement to settle and satisfy the claim. The release shall release the lien but shall not extinguish or terminate the interest being released. If the claim the lien secures is filed under subdivision 1i or 1j, the lien shall be released after the lien under subdivision 1i or 1j is filed or recorded, or settled according to any agreement to settle and satisfy the claim. The release shall not extinguish or terminate the interest being released. If the claim is finally disallowed in full, the claimant shall release the claimant's lien at the claimant's expense.

[EFFECTIVE DATE.] <u>This section is effective retroactively from August 1, 2003.</u>

Sec. 6. Minnesota Statutes 2004, section 256B.15, subdivision 1h, is amended to read:

Subd. 1h. [ESTATES OF SPECIFIC PERSONS RECEIVING MEDICAL ASSISTANCE.] (a) For purposes of this section, paragraphs (b) ~~to (k)~~ <u>and (c)</u> apply if a person received medical assistance for which a claim may be filed under this section and died single, or the surviving spouse of the couple and was not survived by any of the persons described in subdivisions 3 and 4.

(b) For purposes of this section, the person's estate consists of: (1) their probate estate; (2) ~~all-of-the-person's~~

~~interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death; (3)~~ all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent they become part of the probate estate under section 524.6-307; and ~~(4)~~ (3) all of the person's interests in joint accounts, multiple party accounts, and pay on death accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent they become part of the probate estate under section 524.6-207. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section shall be a creditor under section 524.6-307.

~~(c) Notwithstanding any law or rule to the contrary, the person's life estate or joint tenancy interest in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon the person's death and shall continue as provided in this subdivision. The life estate in the person's estate shall be that portion of the interest in the real property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in real property in the estate shall be equal to the fractional interest the person would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the person died.~~

~~(d) The court upon its own motion, or upon motion by the personal representative or any interested party, may enter an order directing the remaindermen or surviving joint tenants and their spouses, if any, to sign all documents, take all actions, and otherwise fully cooperate with the personal representative~~

and the court to liquidate the decedent's life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of those interests to the personal representative and provide for any legal and equitable sanctions as the court deems appropriate to enforce and carry out the order, including an award of reasonable attorney fees.

(e) The personal representative may make, execute, and deliver any conveyances or other documents necessary to convey the decedent's life estate or joint tenancy interest in the estate that are necessary to liquidate and reduce to cash the decedent's interest or for any other purposes.

(f) Subject to administration, all costs, including reasonable attorney fees, directly and immediately related to liquidating the decedent's life estate or joint tenancy interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation allocable to the decedent's interest and the net proceeds shall be turned over to the personal representative and applied to payment of the claim presented under this section.

(g) The personal representative shall bring a motion in the district court in which the estate is being probated to compel the remaindermen or surviving joint tenants to account for and deliver to the personal representative all or any part of the proceeds of any sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the decedent's life estate or joint tenancy interest in the decedent's estate, and do everything necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of the sale or other disposition over to the personal representative. The court may grant any legal or equitable relief including, but not limited to, ordering a partition of real estate under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy interest available to the estate for payment of a claim under this section.

(h) Subject to administration, the personal representative shall use all of the cash or proceeds of interests to pay an allowable claim under this section. The remaindermen or

surviving joint tenants and their spouses, if any, may enter into a written agreement with the personal representative or the claimant to settle and satisfy obligations imposed at any time before or after a claim is filed.

(i) The personal representative may, at their discretion, provide any or all of the other owners, remaindermen, or surviving joint tenants with an affidavit terminating the decedent's estate's interest in real property the decedent owned as a life tenant or as a joint tenant with others, if the personal representative determines in good faith that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section, or if the personal representative has filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as presented, or if there is a written agreement under paragraph (h), or if the claim, as allowed, has been paid in full or to the full extent of the assets the estate has available to pay it. The affidavit may be recorded in the office of the county recorder or filed in the Office of the Registrar of Titles for the county in which the real property is located. Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a joint tenant with others. The affidavit shall: (1) be signed by the personal representative; (2) identify the decedent and the interest being terminated; (3) give recording information sufficient to identify the instrument that created the interest in real property being terminated; (4) legally describe the affected real property; (5) state that the personal representative has determined that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section; (6) state that the decedent's estate has other assets sufficient to pay the claim, as presented, or that there is a written agreement between the personal representative and the claimant and the other owners or

~~remaindermen or other joint tenants to satisfy the obligations imposed under this subdivision; and (7) state that the affidavit is being given to terminate the estate's interest under this subdivision, and any other contents as may be appropriate. The recorder or registrar of titles shall accept the affidavit for recording or filing. The affidavit shall be effective as provided in this section and shall constitute notice even if it does not include recording information sufficient to identify the instrument creating the interest it terminates. The affidavit shall be conclusive evidence of the stated facts.~~

~~(j) The holder of a lien arising under subdivision 1c shall release the lien at the holder's expense against an interest terminated under paragraph (h) to the extent of the termination.~~

~~(k)~~ (c) If a lien arising under subdivision 1c is not released ~~under paragraph (j),~~ prior to closing the estate, the personal representative shall deed the interest subject to the lien to the ~~remaindermen or surviving joint tenants as their interests may appear. Upon recording or filing, the deed shall work a merger of the recipient's life estate or joint tenancy interest, subject to the lien, into the remainder interest or interest the decedent and others owned jointly~~ heirs or devisees subject to the lien. The lien shall attach to and run with the property to the extent of the decedent's interest at the time of the decedent's death.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 7. Minnesota Statutes 2004, section 256B.15, subdivision 1i, is amended to read:

Subd. 1i. [ESTATES OF PERSONS RECEIVING MEDICAL ASSISTANCE AND SURVIVED BY OTHERS.] (a) For purposes of this subdivision, the person's estate ~~consists of the person's probate estate and all of the person's interests in real property the person owned as a life tenant or a joint tenant at the time of the person's death~~ is as defined in subdivision 1h, paragraph (b).

(b) Notwithstanding any law or rule to the contrary, this subdivision applies if a person received medical assistance for

which a claim could be filed under this section but for the fact the person was survived by a spouse or by a person listed in subdivision 3, or if subdivision 4 applies to a claim arising under this section.

(c) ~~The person's life estate or joint tenancy interests in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon death and shall continue as provided in this subdivision. The life estate in the estate shall be the portion of the interest in the property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in the estate shall be equal to the fractional interest the medical assistance recipient would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the medical assistance recipient died.~~

~~(d)~~ The county agency shall file a claim in the estate under this section on behalf of the claimant who shall be the commissioner of human services, notwithstanding that the decedent is survived by a spouse or a person listed in subdivision 3. The claim, as allowed, shall not be paid by the estate and shall be disposed of as provided in this paragraph. The personal representative or the court shall make, execute, and deliver a lien in favor of the claimant on the decedent's interest in real property in the estate in the amount of the allowed claim on forms provided by the commissioner to the county agency filing the lien. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

~~(e)~~ (d) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles for each county in which any of the real property is located. The recorder or registrar of titles shall accept the lien for filing or recording. All recording or filing fees shall be paid by the Department of Human Services. The recorder or registrar of titles shall mail the recorded lien to the Department of Human Services. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. ~~Upon recording or filing of a lien against a life estate or a joint tenancy interest, the interest subject to the lien shall merge into the remainder interest or the interest the recipient and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.~~

~~(f)~~ (e) The department shall make no adjustment or recovery under the lien until after the decedent's spouse, if any, has died, and only at a time when the decedent has no surviving child described in subdivision 3. The estate, any owner of an interest in the property which is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. Such payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient, and neither the process of settling the claim, the payment of the claim, or the acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

~~(g)~~ (f) The lien under this subdivision may be enforced or foreclosed in the manner provided by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien is paid, satisfied, or otherwise discharged, the state or county agency shall prepare and file a release of lien at its own expense. No action to

foreclose the lien shall be commenced unless the lien holder has first given 30 days' prior written notice to pay the lien to the owners and parties in possession of the property subject to the lien. The notice shall: (1) include the name, address, and telephone number of the lien holder; (2) describe the lien; (3) give the amount of the lien; (4) inform the owner or party in possession that payment of the lien in full must be made to the lien holder within 30 days after service of the notice or the lien holder may begin proceedings to foreclose the lien; and (5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service of the notice shall be complete upon mailing or publication.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 8. Minnesota Statutes 2004, section 256B.15, subdivision 1j, is amended to read:

Subd. 1j. [CLAIMS IN ESTATES OF DECEDENTS SURVIVED BY OTHER SURVIVORS.] For purposes of this subdivision, the provisions in subdivision 1i, paragraphs (a) ~~to (c)~~ and (b) apply.

(a) If payment of a claim filed under this section is limited as provided in subdivision 4, and if the estate does not have other assets sufficient to pay the claim in full, as allowed, the personal representative or the court shall make, execute, and deliver a lien on the property in the estate that is exempt from the claim under subdivision 4 in favor of the commissioner of human services on forms provided by the commissioner to the county agency filing the claim. If the estate pays a claim filed under this section in full from other assets of the estate, no lien shall be filed against the property described in subdivision 4.

(b) The lien shall be in an amount equal to the unpaid balance of the allowed claim under this section remaining after the estate has applied all other available assets of the estate

to pay the claim. The property exempt under subdivision 4 shall not be sold, assigned, transferred, conveyed, encumbered, or distributed until after the personal representative has determined the estate has other assets sufficient to pay the allowed claim in full, or until after the lien has been filed or recorded. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

(c) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles in each county in which any of the real property is located. The department shall pay the filing fees. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. The recorder or registrar of titles shall accept the lien for filing or recording.

(d) The commissioner shall make no adjustment or recovery under the lien until none of the persons listed in subdivision 4 are residing on the property or until the property is sold or transferred. The estate or any owner of an interest in the property that is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. The payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient and neither the process of settling the claim, the payment of the claim, or acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

(e) A lien under this subdivision may be enforced or foreclosed in the manner provided for by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien has been paid,

satisfied, or otherwise discharged, the claimant shall prepare and file a release of lien at the claimant's expense. No action to foreclose the lien shall be commenced unless the lien holder has first given 30 days prior written notice to pay the lien to the record owners of the property and the parties in possession of the property subject to the lien. The notice shall: (1) include the name, address, and telephone number of the lien holder; (2) describe the lien; (3) give the amount of the lien; (4) inform the owner or party in possession that payment of the lien in full must be made to the lien holder within 30 days after service of the notice or the lien holder may begin proceedings to foreclose the lien; and (5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service shall be complete upon mailing or publication.

(f) ~~Upon filing or recording of a lien against a life estate or joint tenancy interest under this subdivision, the interest subject to the lien shall merge into the remainder interest or the interest the decedent and others owned jointly, effective on the date of recording and filing. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.~~

~~(g)~~(1) An affidavit may be provided by a personal representative, at their discretion, stating the personal representative has determined in good faith that a decedent survived by a spouse or a person listed in subdivision 3, or by a person listed in subdivision 4, or the decedent's predeceased spouse did not receive any medical assistance giving rise to a claim under this section, or that the real property described in subdivision 4 is not needed to pay in full a claim arising under this section.

(2) The affidavit shall:

(i) describe the property and the interest being

extinguished;

(ii) name the decedent and give the date of death;

(iii) state the facts listed in clause (1);

(iv) state that the affidavit is being filed to terminate the life estate or joint tenancy interest created under this subdivision;

(v) be signed by the personal representative; and

(vi) contain any other information that the affiant deems appropriate.

~~(3) Except as provided in section 514.981, subdivision 6, when the affidavit is filed or recorded, the life estate or joint tenancy interest in real property that the affidavit describes shall be terminated effective as of the date of filing or recording. The termination shall be final and may not be set aside for any reason.~~

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 9. Minnesota Statutes 2004, section 256B.15, subdivision 2, is amended to read:

Subd. 2. [LIMITATIONS ON CLAIMS.] The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. ~~Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003.~~

[EFFECTIVE DATE.] This section is effective retroactively from July 1, 2003, for decedents dying on or after that date.

Sec. 10. Minnesota Statutes 2004, section 256B.15, subdivision 3, is amended to read:

Subd. 3. [~~SURVIVING SPOUSE,~~ MINOR, BLIND, OR DISABLED CHILDREN.] If a decedent ~~is survived by a spouse, or~~ who was single or who was the surviving spouse of a married couple ~~and~~ is survived by a child who is under age 21 or blind or permanently and totally disabled according to the supplemental security income program criteria, ~~a~~ no claim shall be filed against the estate ~~according to this section~~.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 11. Minnesota Statutes 2004, section 256B.15, subdivision 4, is amended to read:

Subd. 4. [OTHER SURVIVORS.] If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate in an amount not to exceed the value of the nonhomestead property included in the estate ~~and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid balance of the claim to the claimant as provided under this section~~:

~~(a)~~ (1) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

~~(b)~~ (2) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

[EFFECTIVE DATE.] This section is effective retroactively

from August 1, 2003, and applies to decedents who die on or after that date.

Sec. 12. Minnesota Statutes 2004, section 514.981, subdivision 6, is amended to read:

Subd. 6. [TIME LIMITS; CLAIM LIMITS~~;-LIENS-ON-LIFE-ESTATES AND-JOINT-TENANCIES~~.] (a) A medical assistance lien is a lien on the real property it describes for a period of ten years from the date it attaches according to section 514.981, subdivision 2, paragraph (a), except as otherwise provided for in sections 514.980 to 514.985. The agency may renew a medical assistance lien for an additional ten years from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the medical assistance lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The registrar of titles or the recorder shall file, record, index, and return the certificate of renewal in the same manner as provided for medical assistance liens in section 514.982, subdivision 2.

(b) A medical assistance lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the agency's medical assistance lien in whole or in part because of the homestead exemption under section 256B.15, subdivision 4, the rights of the surviving spouse or minor children under section 524.2-403, paragraphs (a) and (b), or claims with a priority under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult children to exempt property under section 524.2-403, paragraph (b), shall not be considered costs of administration under section 524.3-805, paragraph (a), clause (1).

~~(c) Notwithstanding any law or rule to the contrary, the provisions in clauses (1) to (7) apply if a life estate subject to a medical assistance lien ends according to its terms, or if a medical assistance recipient who owns a life estate or any interest in real property as a joint tenant that is subject to a medical assistance lien dies.~~

~~(1) The medical assistance recipient's life estate or joint tenancy interest in the real property shall not end upon the recipient's death but shall merge into the remainder interest or other interest in real property the medical assistance recipient owned in joint tenancy with others. The medical assistance lien shall attach to and run with the remainder or other interest in the real property to the extent of the medical assistance recipient's interest in the property at the time of the recipient's death as determined under this section.~~

~~(2) If the medical assistance recipient's interest was a life estate in real property, the lien shall be a lien against the portion of the remainder equal to the percentage factor for the life estate of a person the medical assistance recipient's age on the date the life estate ended according to its terms or the date of the medical assistance recipient's death as listed in the Life Estate Mortality Table in the health care program's manual.~~

~~(3) If the medical assistance recipient owned the interest in real property in joint tenancy with others, the lien shall be a lien against the portion of that interest equal to the fractional interest the medical assistance recipient would have owned in the jointly owned interest had the medical assistance recipient and the other owners held title to that interest as tenants in common on the date the medical assistance recipient died.~~

~~(4) The medical assistance lien shall remain a lien against the remainder or other jointly owned interest for the length of time and be renewable as provided in paragraph (a).~~

~~(5) Subdivision 5, paragraph (a), clause (4), paragraph (b), clauses (1) and (2), and subdivision 6, paragraph (b), do~~

not apply to medical assistance liens which attach to interests in real property as provided under this subdivision.

(6) The continuation of a medical assistance recipient's life estate or joint tenancy interest in real property after the medical assistance recipient's death for the purpose of recovering medical assistance provided for in sections 514.980 to 514.985 modifies common law principles holding that these interests terminate on the death of the holder.

(7) Notwithstanding any law or rule to the contrary, no release, satisfaction, discharge, or affidavit under section 256B.15 shall extinguish or terminate the life estate or joint tenancy interest of a medical assistance recipient subject to a lien under sections 514.980 to 514.985 on the date the recipient dies.

(8) The provisions of clauses (1) to (7) do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship.--Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies.--For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies.--The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause.--The affidavit shall be prima facie evidence of the facts it states.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 13. Minnesota Statutes 2004, section 524.3-805, is amended to read:

524.3-805 [CLASSIFICATION OF CLAIMS.]

(a) If the applicable assets of the estate are insufficient to pay all claims in full, the personal representative shall make payment in the following order:

(1) costs and expenses of administration;

(2) reasonable funeral expenses;

(3) debts and taxes with preference under federal law;

(4) reasonable and necessary medical, hospital, or nursing home expenses of the last illness of the decedent, including compensation of persons attending the decedent, ~~a claim filed under section 256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913,~~ and including a claim filed pursuant to section 256B.15;

(5) reasonable and necessary medical, hospital, and nursing home expenses for the care of the decedent during the year immediately preceding death;

(6) debts with preference under other laws of this state, and state taxes;

(7) all other claims.

(b) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due and payable shall not be entitled to a preference over claims not due, except that if claims for expenses of the last illness involve only claims filed under section ~~256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913,~~ section 246.53 for costs of state hospital care and claims filed under section 256B.15, ~~claims filed to recover expenditures for alternative care for nonmedical assistance recipients under section 256B.0913 shall have preference over claims filed under both sections 246.53 and other claims filed under section 256B.15, and.~~ Claims filed

under section 246.53 have preference over claims filed under section 256B.15 ~~for recovery of amounts other than those for expenditures for alternative care for nonmedical assistance recipients under section 256B.0913~~.

[EFFECTIVE DATE.] This section is effective retroactively from July 1, 2003, for decedents dying on or after that date.

Sec. 14. [REFUNDS; NOTICES, AND IMMUNITY.]

(a) The commissioner of human services and any county agency that, after a recipient's death, has collected any sum (1) from the estate of a recipient of alternative case services, or (2) attributable to a life estate or joint tenancy interest in real estate that was continued after the death of the recipient, shall promptly refund the amount collected to the person or persons who paid the amount collected, in proportion to each person's contribution to the amount.

(b) If the commissioner determines a person entitled to a refund is dead, the commissioner shall pay the refund to the person's estate if it is open, or to their heirs or devisees as finally determined in any completed probate proceedings or under a final decree of descent. In all other cases, the refund shall be deemed to be abandoned property and the commissioner shall pay and deliver the refund to the commissioner of commerce. The commissioner of commerce shall administer and dispose of the refund in accordance with Minnesota Statutes, sections 345.42 through 345.60. The commissioner of human services shall not be liable to anyone with respect to the refund after paying or delivering the refund as provided for in this paragraph.

(c) Lien notices of record against life estate or joint tenancy interests filed on and after August 1, 2003, shall have no effect and shall not constitute record notice after the death of the person named in the lien or notice unless continued after that time by the terms of the instrument creating the interest, shall be disregarded by examiners of title, and shall not be carried forward to subsequent certificates of title.

(d) The commissioner of human services, county agencies, elected officials, and their employees are immune from all

liability for actions taken or not taken in accordance with Laws 2003, First Special Session chapter 14, article 2, sections 47 to 52; article 12, sections 40 to 52 and 90; and sections 1 to 14 of this act.

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

Sec. 15. [APPROPRIATIONS.]

$..... is appropriated from the general fund to the commissioner of human services for fiscal years 2004 and 2005 and $..... is appropriated from the general fund to the commissioner of human services for fiscal years 2006 and 2007 for the purposes of sections 1 to 14.

Sec. 16. [REPEALER.]

Minnesota Statutes 2004, sections 256B.15, subdivision 1g; 514.991; 514.992; 514.993; 514.994; and 514.995, are repealed retroactively from July 1, 2003.

APPENDIX
Repealed Minnesota Statutes for S0254-2

256B.15 CLAIMS AGAINST ESTATES.

Subd. 1g. **Estate property.** Notwithstanding any law or rule to the contrary, if a claim is presented under this section, interests or the proceeds of interests in real property a decedent owned as a life tenant or a joint tenant with a right of survivorship shall be part of the decedent's estate, subject to administration, and shall be dealt with as provided in this section.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the county agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section 256J.34.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and prevents the person from obtaining or retaining employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI recipient.

(d) Prior to implementing this provision, the commissioner must identify the MFIP participants subject to this provision and provide written notice to these participants at least 30 days before the first grant reduction. The notice must inform the participant of the basis for the potential grant reduction, the exceptions to the provision, if any, and inform the participant of the steps necessary to claim an exception. A person who is found not to meet one of the exceptions to the provision must be notified and informed of the right to a fair hearing under section 256J.40. The notice must also inform the participant that the participant may be eligible for a rent reduction resulting from a reduction in the MFIP grant and encourage the participant to contact the local housing authority.

Subd. 3b. **Treatment of supplemental security income.** Effective July 1, 2003, the county shall reduce the cash portion of the MFIP grant by $125 per SSI recipient who resides in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but is excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives less than $125 of SSI, only the amount received shall be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under

section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

514.991 ALTERNATIVE CARE LIENS; DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 514.991 to 514.995.

Subd. 2. **Alternative care agency, agency, or department.** "Alternative care agency," "agency," or "department" means the Department of Human Services when it pays for or provides alternative care benefits for a nonmedical assistance recipient directly or through a county social services agency under chapter 256B according to section 256B.0913.

Subd. 3. **Alternative care benefit or benefits.** "Alternative care benefit" or "benefits" means a benefit provided to a nonmedical assistance recipient under chapter 256B according to section 256B.0913.

Subd. 4. **Alternative care recipient or recipient.** "Alternative care recipient" or "recipient" means a person who receives alternative care grant benefits.

Subd. 5. **Alternative care lien or lien.** "Alternative care lien" or "lien" means a lien filed under sections 514.992 to 514.995.

514.992 ALTERNATIVE CARE LIEN.

Subdivision 1. **Property subject to lien; lien amount.** (a) Subject to sections 514.991 to 514.995, payments made by an alternative care agency to provide benefits to a recipient or to the recipient's spouse who owns property in this state constitute a lien in favor of the agency on all real property the recipient owns at and after the time the benefits are first paid.

(b) The amount of the lien is limited to benefits paid for services provided to recipients over 55 years of age and provided on and after July 1, 2003.

Subd. 2. **Attachment.** (a) A lien attaches to and becomes enforceable against specific real property as of the date when all of the following conditions are met:

(1) the agency has paid benefits for a recipient;

(2) the recipient has been given notice and an opportunity for a hearing under paragraph (b);

(3) the lien has been filed as provided for in section 514.993 or memorialized on the certificate of title for the property it describes; and

(4) all restrictions against enforcement have ceased to apply.

(b) An agency may not file a lien until it has sent the recipient, their authorized representative, or their legal representative written notice of its lien rights by certified mail, return receipt requested, or registered mail and there has been an opportunity for a hearing under section 256.045. No person other than the recipient shall have a right to a hearing under section 256.045 prior to the time the lien is filed. The hearing shall be limited to whether the agency has met all of the prerequisites for filing the lien and whether any of the exceptions in this section apply.

(c) An agency may not file a lien against the recipient's homestead when any of the following exceptions apply:

(1) while the recipient's spouse is also physically present and lawfully and continuously residing in the homestead;

(2) a child of the recipient who is under age 21 or who is

blind or totally and permanently disabled according to supplemental security income criteria is also physically present on the property and lawfully and continuously residing on the property from and after the date the recipient first receives benefits;

(3) a child of the recipient who has also lawfully and continuously resided on the property for a period beginning at least two years before the first day of the month in which the recipient began receiving alternative care, and who provided uncompensated care to the recipient which enabled the recipient to live without alternative care services for the two-year period;

(4) a sibling of the recipient who has an ownership interest in the property of record in the office of the county recorder or registrar of titles for the county in which the real property is located and who has also continuously occupied the homestead for a period of at least one year immediately prior to the first day of the first month in which the recipient received benefits and continuously since that date.

(d) A lien only applies to the real property it describes.

Subd. 3. **Continuation of lien.** A lien remains effective from the time it is filed until it is paid, satisfied, discharged, or becomes unenforceable under sections 514.991 to 514.995.

Subd. 4. **Priority of lien.** (a) A lien which attaches to the real property it describes is subject to the rights of anyone else whose interest in the real property is perfected of record before the lien has been recorded or filed under section 514.993, including:

(1) an owner, other than the recipient or the recipient's spouse;

(2) a good faith purchaser for value without notice of the lien;

(3) a holder of a mortgage or security interest; or

(4) a judgment lien creditor whose judgment lien has attached to the recipient's interest in the real property.

(b) The rights of the other person have the same protections against an alternative care lien as are afforded against a judgment lien that arises out of an unsecured obligation and arises as of the time of the filing of an alternative care grant lien under section 514.993. The lien shall be inferior to a lien for property taxes and special assessments and shall be superior to all other matters first appearing of record after the time and date the lien is filed or recorded.

Subd. 5. **Settlement, subordination, and release.** (a) An agency may, with absolute discretion, settle or subordinate the lien to any other lien or encumbrance of record upon the terms and conditions it deems appropriate.

(b) The agency filing the lien shall release and discharge the lien:

(1) if it has been paid, discharged, or satisfied;

(2) if it has received reimbursement for the amounts secured by the lien, has entered into a binding and legally enforceable agreement under which it is reimbursed for the amount of the lien, or receives other collateral sufficient to secure payment of the lien;

(3) against some, but not all, of the property it describes upon the terms, conditions, and circumstances the agency deems

appropriate;

(4) to the extent it cannot be lawfully enforced against the property it describes because of an error, omission, or other material defect in the legal description contained in the lien or a necessary prerequisite to enforcement of the lien; and

(5) if, in its discretion, it determines the filing or enforcement of the lien is contrary to the public interest.

(c) The agency executing the lien shall execute and file the release as provided for in section 514.993, subdivision 2.

Subd. 6. **Length of lien.** (a) A lien shall be a lien on the real property it describes for a period of ten years from the date it attaches according to subdivision 2, paragraph (a), except as otherwise provided for in sections 514.992 to 514.995. The agency filing the lien may renew the lien for one additional ten-year period from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate of renewal shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The recorder or registrar of titles shall record, file, index, and return the certificate of renewal in the same manner provided for liens in section 514.993, subdivision 2.

(b) An alternative care lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the lien in whole or in part because of the homestead exemption under section 256B.15, subdivision 4, the rights of a surviving spouse or a minor child under section 524.2-403, paragraphs (a) and (b), or claims with a priority under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult children to exempt property under section 524.2-403, paragraph (b), shall not be considered costs of administration under section 524.3-805, paragraph (a), clause (1).

514.993 LIEN; CONTENTS AND FILING.

Subdivision 1. **Contents.** A lien shall be dated and must contain:

(1) the recipient's full name, last known address, and Social Security number;

(2) a statement that benefits have been paid to or for the recipient's benefit;

(3) a statement that all of the recipient's interests in the real property described in the lien may be subject to or affected by the agency's right to reimbursement for benefits;

(4) a legal description of the real property subject to the lien and whether it is registered or abstract property; and

(5) such other contents, if any, as the agency deems appropriate.

Subd. 2. **Filing.** Any lien, release, or other document required or permitted to be filed under sections 514.991 to 514.995 must be recorded or filed in the office of the county recorder or registrar of titles, as appropriate, in the county where the real property is located. Notwithstanding section 386.77, the agency shall pay the applicable filing fee

for any documents filed under sections 514.991 to 514.995. An attestation, certification, or acknowledgment is not required as a condition of filing. If the property described in the lien is registered property, the registrar of titles shall record it on the certificate of title for each parcel of property described in the lien. If the property described in the lien is abstract property, the recorder shall file the lien in the county's grantor-grantee indexes and any tract indexes the county maintains for each parcel of property described in the lien. The recorder or registrar shall return the recorded or filed lien to the agency at no cost. If the agency provides a duplicate copy of the lien, the recorder or registrar of titles shall show the recording or filing data on the copy and return it to the agency at no cost. The agency is responsible for filing any lien, release, or other documents under sections 514.991 to 514.995.

514.994 ENFORCEMENT; OTHER REMEDIES.

Subdivision 1. **Foreclosure or enforcement of lien.** The agency may enforce or foreclose a lien filed under sections 514.991 to 514.995 in the manner provided for by law for enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. The lien shall remain enforceable as provided for in sections 514.991 to 514.995 notwithstanding any laws limiting the enforceability of judgments.

Subd. 2. **Homestead exemption.** The lien may not be enforced against the homestead property of the recipient or the spouse while they physically occupy it as their lawful residence.

Subd. 3. **Agency claim or remedy.** Sections 514.992 to 514.995 do not limit the agency's right to file a claim against the recipient's estate or the estate of the recipient's spouse, do not limit any other claims for reimbursement the agency may have, and do not limit the availability of any other remedy to the agency.

514.995 AMOUNTS RECEIVED TO SATISFY LIEN.

Amounts the agency receives to satisfy the lien must be deposited in the state treasury and credited to the fund from which the benefits were paid.

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State of Minnesota

S.F. No. 254 - Parental Contributions; MFIP; Liens (The Second Engrossment)

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)
David Giel, Senate Research (651/296-7178)

Date: April 15, 2005

ARTICLE 1
HUMAN SERVICES

Section 1 (252.27, subdivision 2a) amends the parental fee schedule for children receiving services under TEFRA and Community Based Services waiver options. Below are two tables showing the proposed language and current law.

Proposed language

Adjusted Gross Income (AGI) as a percentage of the Federal Poverty Guidelines (FPG)	Parental Fee
175% up to 575%6	Sliding scale from 1% to 7.5% of AGI
575% up to 675%	7.5% of AGI
675% and less than 975%	10% of AGI
975% and above	12.5% of AGI

Current Law

Adjusted Gross Income as a percentage of the FPG	Fee
175% up to 375%	Sliding scale 1% to 7.5% of AGI
375% up to 675%	7.5% of AGI
675% up to 975%	10% of AGI
975% and above	12.5% of AGI

Further, under current law the parent's AGI is reduced by $2400 if the child lives with the parent. The proposed language increases the reduction to $5000. In paragraph (d), excludes from the definition of income funds from early withdrawn qualified retirement accounts, effective retroactive from July 1, 2003. In paragraph (g), related to child support, the language is changed to allow the amount of the child support to be deducted from the fee. Under current law, the annualized amount of child support is deducted from the AGI.

Sections 2 and 3 (256J.21, subdivision 2, and 256J.95, subdivision 9) strikes references to provisions repealed in section 4.

Section 4 repeals Minnesota Statutes, section 256J.37, subdivisions 3a and 3b, which are MFIP provisions that count $50 of a rental subsidy as unearned income and reduce the MFIP cash grant by $125 per Supplemental Security Income recipient living in the household, respectively.

ARTICLE 2
MEDICAL ASSISTANCE LIENS

Section 1 (256B.15, subdivision 1) deletes language making life estates and joint tenancies subject to MA estate claims. This section also reinstates language that was in effect until 2003 that prohibited MA estate claims to collect for Alternative Care (AC) service costs.

Section 2 (256B.15, subdivision 1a) excludes AC costs from MA estate claims and removes language allowing counties to retain ten percent of their AC related collections.

Section 3 (256B.15, subdivision 1d) deletes, from a subdivision establishing the effect of a notice of potential claim, references to the continuation of life estate and joint tenancy interests after death.

Section 4 (256B.15, subdivision 1e) deletes, from a subdivision regarding the claimant's right to release a lien, references to the continuation of life estate and joint tenancy interests.

Section 5 (256B.15, subdivision 1f) deletes, from a subdivision regarding the establishment of liens against real estate, references to the continuation of life estate and joint tenancy interests.

Section 6 (256B.15, subdivision 1h) deletes, from a subdivision regarding the estates of specific MA recipients, references to the continuation of life estate and joint tenancy interests.

Section 7 (256B.15, subdivision 1i) deletes, from a subdivision regarding the estates of MA recipients survived by others, references to the continuation of life estate and joint tenancy interests.

Section 8 (256B.15, subdivision 1j) deletes, from a subdivision regarding the estates of MA recipients survived by other survivors, references to the continuation of life estate and joint tenancy interests.

Section 9 (256B.15, subdivision 2) deletes another reference to MA estate claims for AC costs.

Section 10 (256B.15, subdivision 3) reinstates language that was in effect before the 2003 session barring state claims if the decedent, who was either single or the surviving spouse of a married couple, is survived by a child who is under age 21, or is blind, or is permanently and totally disabled.

Section 11 (256B.15, subdivision 4) deletes language adopted in 2003 authorizing liens against homestead property in an estate for any unpaid balance of a claim in cases where the claim is limited to the value of the nonhomestead property in the estate.

Section 12 (514.981, subdivision 6) deletes language added to the state lien law in 2003 authorizing liens against life estates and joint tenant interests.

Section 13 (524.3 805) deletes language added to the Uniform Probate Code in 2003 referencing MA estate claims for AC costs.

Section 14 relates to refunds and notices.

Paragraph (a) requires refunds to be paid of any amounts collected from the estate of a recipient of alternative care services or because of the continuation of life estates and joint tenancies after the death of the recipient.

Paragraph (b) establishes a procedure for handling refunds if the person entitled to the refund is dead.

Paragraph (c) makes lien notices ineffective against life estates or joint tenancies after the death of the recipient unless continued after death by the document creating the life estate or joint tenancy.

Paragraph (d) establishes immunity for public officials for actions taken or not taken with respect to the 2003 law relating to MA and AC liens.

Section 15 is a blank appropriation section.

Section 16 is a repealer section. It repeals Minnesota Statutes, section 256B.15, subdivision 1g, which makes a life estate or joint tenancy interest part of a deceased's estate for purposes of MA estate recovery. It also repeals Minnesota Statutes, sections 514.991 through 514.995. These sections were adopted in 2003 and establish Alternative Care liens and procedures for enforcing them.

DG/JW:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0254-1A **Complete Date:** 04/15/05

Chief Author: BERGLIN, LINDA

Title: HUMAN SVCS COST RECOVERY REQUIREMNTS

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

Agencies: Human Services Dept (04/15/05) Revenue Dept (02/17/05)

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	0	20,469	18,930	18,955	18,947
Human Services Dept	0	20,469	18,930	18,955	18,947
Federal TANF Fund	0	13,430	14,613	14,527	14,310
Human Services Dept	0	13,430	14,613	14,527	14,310
Revenues					
General Fund	0	90,994	91,869	92,789	97,207
Human Services Dept	0	(6,406)	(6,031)	(6,011)	(5,993)
Revenue Dept	0	97,400	97,900	98,800	103,200
Net Cost <Savings>					
General Fund	0	(70,525)	(72,939)	(73,834)	(78,260)
Human Services Dept	0	26,875	24,961	24,966	24,940
Revenue Dept	0	(97,400)	(97,900)	(98,800)	(103,200)
Federal TANF Fund	0	13,430	14,613	14,527	14,310
Human Services Dept	0	13,430	14,613	14,527	14,310
Total Cost <Savings> to the State	0	(57,095)	(58,326)	(59,307)	(63,950)

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

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0254-1A **Complete Date:** 04/15/05

Chief Author: BERGLIN, LINDA

Title: HUMAN SVCS COST RECOVERY REQUIREMNTS

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	20,469	18,930	18,955	18,947
Federal TANF Fund	0	13,430	14,613	14,527	14,310
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	20,469	18,930	18,955	18,947
Federal TANF Fund	0	13,430	14,613	14,527	14,310
Revenues					
General Fund	0	(6,406)	(6,031)	(6,011)	(5,993)
Net Cost <Savings>					
General Fund	0	26,875	24,961	24,966	24,940
Federal TANF Fund	0	13,430	14,613	14,527	14,310
Total Cost <Savings> to the State	0	40,305	39,574	39,493	39,250

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

NARRATIVE: SF 254-1A

Bill Description: Article 1, Section 1, modifies the calculation of parental fees for parents of disabled children receiving medical assistance under TEFRA, waivered services, and certain out of home placements by (1) revising the sliding fee scale, (2) increasing the parental income deduction when the child resides in the home, (3) allowing funds from early withdrawn qualified retirement accounts under the Internal Code to be an income deduction, and (4) crediting a noncustodial parent's fee for court ordered child support paid on behalf of the child receiving medical assistance rather than deducting this amount from parental income.

Article 1, Sections 2-4, repeal the requirement to count $50 as unearned income for MFIP households receiving subsidized housing and $125 for those with SSI income.

Article 2 repeals the portions of Minnesota Statutes 2003, sections 256B.15 and 514.981, Subd. 6(c) dealing with liens and recoveries from post-death life estates and jointly owned interests in real estate retroactive to August 1, 2003. It also repeals the Alternative Care lien law (Minnesota Statutes 2003, sections 514.991-514.995) and the portions of section 256B.15 authorizing estate claims for recovery of Alternative Care retroactive to July 1, 2003. The commissioner and county agencies are required to refund recoveries they made under the statutes being repealed. The bill provides for appropriations to pay for the refund and to replace lost revenues for fiscal years 2006 and 2007 only.

Assumptions See analyses below.

Expenditure and/or Revenue Formula See analyses below.

Long-Term Fiscal Considerations See analyses below.

Local Government Costs Minimal

References/Sources See analyses below.

1. PARENTAL FEES

Description
Article 1, Section 1, modifies the calculation of parental fees for parents of disabled children receiving medical assistance under TEFRA, waivered services, and certain out of home placements by (1) revising the sliding fee scale, (2) increasing the parental income deduction when the child resides in the home, (3) allowing funds from early withdrawn qualified retirement accounts under the Internal Code to be an income deduction, and (4) crediting a noncustodial parent's fee for court ordered child support paid on behalf of the child receiving medical assistance rather than deducting this amount from parental income.

Summary:

Fiscal Impact ($'000s)	FY 2006	FY 2007	FY 2008	FY 2009
Reduction in General Fund Revenue	1,522	1,452	1,452	1,452
Increase in MA Elderly and Disabled	446	893	893	893
Increase in MA LTC Waivers and Home Care Grants	446	893	893	893
Totals:	2,414	3,238	3,238	3,238

Assumptions:

⇒ Annual Income Deduction when the Child Resides In-Home: Increased from $2,400 to $5,000

⇒ Child Support: Deducted from Fee

⇒ Minimum Fee: $4.00

⇒ Fee and FPG Levels:

- Sliding Scale from 175% FPG to 575% FPG (1% of AGI to 7.5% of AGI)
- 7.5% of AGI from 575% to 675% FPG
- 10% of AGI from 675% to 975% FPG
- 12.5% of AGI above 975% FPG

⇒ Effective Date: July 1, 2005

Fiscal Analysis:
Numbers are based on FY04 data. The number of accounts for FY05 is currently 92% of the FY04 accounts. The savings will be adjusted to reflect this decrease in accounts.
From FY03 to FY05, we have seen a decrease of approximately 440 active accounts. This is due both to children going off the program and to a decrease in the number of children coming on the program. The average annual usage for children going off the program was $9,400.
The decrease in fees is 87% of the difference between the current fee structure and the fee structure prior to the 2003 legislative changes. Based on this, it was assumed that 87% of the reduction in accounts would be reversed.
The return of children to the program was phased in, assuming that 190 children would come back in FY06 and an additional 190 children would come back in FY07. One hundred ninety accounts is 2.5% of current FY05 accounts. This increase in accounts will increase both revenue due to fee assessment and to MA program costs.

Annual Net Billings Before	$9,859,443.00
Annual Net Billings under SF254	$6,278,855.00
Percent Change	- 36%

Reduction in Fee Revenue					
	Billings	Allowance*	Decrease in Accounts	Collections FY06	Collections FY07,FY08, FY09
Fee calculation with changes	$6,278,855.00	($210,156.11)	0.92	$5,583,202.98	$5,583,202.98
Est. Increase due to returning children				1.025	1.05
Subtotal				$5,722,783.06	$5,862,363.13
Current fee calculation	$9,859,443.00	($330,000.00)	0.92	$8,767,087.56	$8,767,087.56
Est. change in collections				($3,044,304.50)	($2,904,724.43)
MA percentage				0.5%	0.5%
Estimated change to General Fund				($1,522,152.25)	($1,452,362.21)
*Estimated Allowance for Doubtful Accounts					
Based on current FY01 receivables	$330,000.00				
Net percent change in billings	-36%				
Est. change for doubtful accts based on decreased billings	($119,843.89)				
Based on Decreased Billings					
Current allowance for doubtful accts.	$330,000.00				
Change in allowance	($119,843.89)				
Revised allowance for doubtful accts.	$210,156.11				

Increase in Program Costs				
	FY 2006	FY 2007	FY 2008	FY 2009
Increase due to children returning	190	380	380	380
Average cost per child	$9,400	$9,400	$9,400	$9,400
Additional program costs	$1,786,000	$3,572,000	$3,572,000	$3,572,000
State share	0.50	0.50	0.50	0.50
Increase to program costs	$893,500	$1,786,000	$1,786,000	$1,786,000

Increase to program costs will be split between MA Basic Health Care Grants - Elderly and Disabled and MA LTC Waivers and Home Care Grants.

Long-Term Fiscal Considerations

Local Government Costs
The changes will impact counties that use the formula in statute for calculating parental fees for out-of-home placements.

References/Sources
Terri Engel, Department of Human Services Parental Fee Unit, 651-297-3043

2. MEDICAL ASSISTANCE AND ALTERNATIVE CARE

Description
Eliminates MA recovery from post-death life estates and jointly owned interests in real estate; eliminates recovery of alternative care costs by liens and estate claims; requires refunds of recoveries made from those interests.

Assumptions
Three types of fiscal effects are anticipated for this bill:
1. Future MA and AC recoveries will be reduced;
2. Retroactive repeal requires that fund be appropriated to refund past collections (with no federal contribution in the case of MA recoveries);
3. The caseload of the AC program, which was reduced by 20% when lien and recovery provisions were initiated, will go back to previously expected levels.

a. Recovery Changes and Refunds of Recoveries
Recovery projections are based on actual recovery data through December 2004. Starting from data for the quarter ending 12-31-2004, growth of 5% per quarter is projected for four quarters; and then recoveries are assumed to level off at the projection for the quarter ending 12-31-2005.

Medical Assistance Lien Recoveries Projected Costs to Repeal 2003 Session Changes (State share = 50%)				
	Total State MA Lien Recoveries	Estimated Increment Owing to 2003 Changes	State Share Cost to Repeal Prospectively (Reduced Revenue)	State Share Cost to Repeal Retroactively (Appropriation Needed for FY 2006)
ACTUAL				
FY 2003	$3,869,407			
FY 2004	6,165,821	$2,165,821		$2,165,821

FY 2005 (first half)	5,126,277	3,126,277		
PROJECTED				
FY 2005	$11,026,277	$7,026,277		$7,026,277
FY 2006	13,160,000	9,160,000	$4,580,000	
FY 2007	13,320,000	9,320,000	4,660,000	
FY 2008	13,320,000	9,320,000	4,660,000	
FY 2009	13,320,000	9,320,000	4,660,000	
Fiscal effects of retroactive repeal (state share)			**Cost of Reduced Revenue**	**Expenditures for Refunds**
FY 2006			$4,580,000	$9,192,099
FY 2007			4,660,000	0
FY 2008			4,660,000	0
FY 2009			4,660,000	0

Medical Assistance NPC Lien Recoveries
(A subset of above, included for information only; costs for repeal included above)

ACTUAL	**Recoveries**
FY 2003	0
FY 2004	$598,661
FY 2005 (first half)	1,106,230
PROJECTED	
FY 2005	$2,356,230
FY 2006	2,770,000
FY 2007	2,800,000
FY 2008	2,800,000
FY 2009	2,800,000

Alternative Care Lien Recoveries Projected Costs to Repeal 2003 Session Changes
(State share = 100%)

	Total AC Lien Recoveries	**State Revenue Cost to Repeal (Reduced Revenue)**	**State Revenue Cost to Repeal (Appropriation Needed for FY 2006) Needed for '06)**	**Total State Cost to Repeal**
ACTUAL				
FY 2003	0			
FY 2004	$74,766		$74,766	$74,766
FY 2005 (first half)	292,113			
PROJECTED				
FY 2005	$642,000		$642,000	$642,000
FY 2006	790,000	$790,000		790,000
FY 2007	800,000	800,000		800,000
FY 2008	800,000	800,000		800,000
FY 2009	800,000	800,000		800,000

Fiscal effects of retroactive repeal (state share):

	Cost of Reduced Revenue	**Expenditures for Refunds**
FY 2006	$790,000	$716,766
FY 2007	800,000	
FY 2008	800,000	
FY 2009	800,000	

b. Projected Effect on Alternative Care Program Costs

Alternative Care Program Cost to Repeal Authority to Recover AC Benefits through Liens and Claims against Estates

In the 2003 Session fiscal note on the establishment of liens against real property and claims against the estates of AC recipients, it was projected that AC caseload would be reduced by 20% because of these changes. Actual experience with AC caseload appears to have confirmed the accuracy of these projections, so we assume repeal of these provisions will lead to a 25% increase in caseload over the November 2004 forecast (restoring 80% to 100% = 25% increase).

The 2003 Session fiscal note projected that the decrease in AC caseload would result in increases in numbers eligible for MA and using either Elderly Waiver or Nursing Facility services. Actual data appear not to bear out either of these assumptions, so the AC caseload increase projected in this analysis is not projected to affect MA costs.

AC Forecast (November 2004)	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Average recipients (given full funding for FY 2006-07)	5,325	5,445	5,259	5,083
Average recipients (given base level funding)	5,313	5,112	4,935	4,778
Average monthly cost	$1,007	$1,050	$1,088	$1,126
Projected expenditures	$64,221,533	$64,383,841	$64,447,960	$64,526,219
Base-level funding	$67,425,000	$67,528,000	$67,528,000	$67,528,000
Projected premium revenue	$3,236,087	$3,309,013	$3,381,939	$3,454,865
Total available funds	$70,661,087	$70,837,013	$70,909,939	$70,982,865
Projected cancellation to MA	$6,439,554	$6,453,172	$6,461,979	$6,456,646

AC Caseload Effects of Repeal	FY2006	FY2007	FY2008	FY2009
Effect on avg. mo. AC recip. @ 25% increase (15% first year)	799	1,361	1,315	1,271
Avg. mo. AC cost for added recipients @ AC average payment	$1,007	$1,050	$1,088	$1,126
Effect on AC payments	$9,654,382	$17,144,185	$17,168,893	$17,161,408
Effect on AC premium revenue	$486,479	$881,127	$900,946	$918,857
Net effect on AC expenditures	$9,167,903	$16,263,058	$16,267,947	$16,242,551

Fiscal Summary (thousands of dollars)	FY2006	FY2007	FY2008	FY2009
Cost of reduced MA recoveries	$4,580	$4,660	$4,660	$4,660
Cost of MA repayments	$9,192	0	0	0
Cost of reduced AC recoveries	$790	$800	$800	$800
Cost of AC repayments	$717	0	0	0
AC program costs	$9,168	$16,263	$16,268	$16,243
General Fund Net Cost	$24,447	$21,723	$21,728	$21,703

Local Government Costs: Minimal

References/Sources: George Hoffman, Reports and Forecasts Division (612) 296-6154

3. MINNESOTA FAMILY INVESTMENT PROGRAM (MFIP)

Description:
Article 1, Sections 2-4, repeal the requirement to count $50 as unearned income for MFIP households receiving subsidized housing and $125 for those with SSI income.

Assumptions:
See analysis below.

Expenditures and/or Revenue Formula:
Administrative costs for this bill include systems costs for programming changes. The total cost is estimated at $25,325, of which 55% is the state General Fund share of $13,929.

Long-Term Fiscal Consideration:
None.

Local Government Costs:
None.

Article 1, Section 4, Repealer
Minnesota Statutes 2003 Supplement, section 256J.37, subd. 3a. This section repeals the requirement to budget up to $50 as unearned income for certain MFIP cases who receive subsidized housing. Excluded from this current law budgeting requirement are: 1) cases which include a person who is a) age 60 or older, b) ill or incapacitated, c) required in the home because another member of the household is disabled; or 2) cases that contain a parental caregiver who receives supplemental security income (SSI). This section will have the effect of increasing cash grant amounts for non-excluded cases by up to $50 for each affected household.

Based on MAXIS data, it is projected that roughly 17% of MFIP cases are impacted by the subsidized housing budgeting requirement in a given month. It is further estimated that on average about $42 per case is budgeted off the cash portion of the MFIP grant for affected cases.

Note that the average grant effect in this fiscal analysis assumes the simultaneous repeal of the SSI budgeting. This includes additional costs (of about $12,000 per year) due to the fact that a handful of families budgeting both subsidized housing and SSI have excess SSI in the budget (i.e, some of the SSI in the budget is not actually counted since the cash grant has already been reduced to zero). If only the subsidized housing budget is repealed, such cases wouldn't receive the full $50 increase since at least some of the excess SSI would then be counted instead of the subsidized housing.

The effective date for this section is 07-01-2005. Due to the requirement that DHS receive prior approval from the U. S. Department of Agriculture, this section is projected to be implemented 08-01-2005.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP cases	41,392	41,287	41,043	40,429
Percent of MFIP cases with subsidized housing deduction	17%	17%	17%	17%
Average monthly MFIP cases with subsidized housing deduction	7,006	6,988	6,947	6,843
Average monthly budgeted amount	$42	$42	$42	$42
Months	11	12	12	12
Total cost for Repeal of Subsidized Housing Budget	$3,237,640	$3,523,061	$3,502,215	$3,449,868

Minnesota Statutes 2003 Supplement, section 256J.37, subd. 3b. This section would repeal the requirement to budget up to $125 per SSI recipient as unearned income for certain MFIP cases that include at least one SSI recipient in the household. Affected MFIP cases are those in which the SSI recipient is a mandatory assistance unit member and is MFIP ineligible solely due to SSI recipient status. Excluded from this current law budgeting requirement are MFIP cases in which a relative caregiver (including a grandparent) could elect to be included in the MIFP assistance unit, unless the caregiver's children or stepchildren are also included in the unit. This proposal will have the effect of increasing grant amounts for non-excluded cases by up to $125 for each SSI recipient within the household.

Based on MAXIS data, it is projected that roughly 17% of MFIP cases are impacted by the SSI budgeting requirement. It is further estimated that on average $135 per case is budgeted off the cash portion of the MFIP grant.

The effective date for this section is 07-01-2005. Due to the requirement that DHS receive approval from the U. S> Department of Agriculture, this section is projected to be implemented 08-01-2005.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP cases	41,392	41,287	41,043	40,429
Estimated percent of MFIP cases with SSI deduction	17%	17%	17%	17%
Estimated average monthly MFIP cases with SSI deduction	6,881	6,864	6,823	6,721
Average monthly budgeted amount	$135	$135	$135	$135
Months	11	12	12	12
Total cost for Repeal of Subsidized Housing Budget	$10,191,877	$11,090,364	$11,024,741	$10,859,956

Fiscal Summary (in thousands)	FY 2006	FY 2007	FY 2008	FY 2009
Subsidized housing	$3,238	$3,523	$3,502	$3,450
SSI recipients	$10,192	$11,090	$11,025	$10,860
Total MFIP Cost	**$13,430**	**$14,614**	**$14,527**	**$14,310**

References/Sources: Shawn Welch, Department of Human Services, Reports and Forecasts Division 651-282-3932

4. **SUMMARY**

	FY06	FY07	FY08	FY09
General Fund Expenditures				
MA Elderly & Disabled	$446	$893	$893	$893
MA LTC Waivers & HC Grants	$446	$893	$893	$893
MA Lien Recoveries Retroactive	$9,192	$0	$0	$0
AC Lien Recoveries Retroactive	$717	$0	$0	$0
AC Program Payments	$9,654	$17,144	$17,169	$17,161
MFIP Administration	$14	$0	$0	$0
General Fund Expenditures Total:	$20,469	$18,930	$18,955	$18,947
TANF Fund Expenditures				
Subsidized Housing	$3,238	$3,523	$3,502	$3,450
SSI Recipients	$10,192	$11,090	$11,025	$10,860
TANF Fund Expenditures Total:	$13,430	$14,613	$14,527	$14,310
General Fund Revenues				
Parental Fees	($1,522)	($1,452)	($1,452)	($1,452)
MA Lien Recoveries	($4,580)	($4,660)	($4,660)	($4,660)
AC Premium Revenue	$486	$881	$901	$919
AC Lien Recoveries	($790)	($800)	($800)	($800)
General Fund Revenues Total:	($6,406)	($6,031)	($6,011)	($5,993)
General Fund Costs:	$26,876	$24,961	$24,966	$24,940
TANF Fund Costs:	$13,430	$14,613	$14,527	$14,310
Total Costs:	$40,305	$39,574	$39,493	$39,250

Agency Contact Name: Lisa Knazan 297-5628
FN Coord Signature: STEVE BARTA
Date: 04/15/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0254-1A **Complete Date:** 02/17/05

Chief Author: BERGLIN, LINDA

Title: HUMAN SVCS COST RECOVERY REQUIREMNTS

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

Agency Name: Revenue Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
General Fund	0	97,400	97,900	98,800	103,200
Net Cost <Savings>					
General Fund	0	(97,400)	(97,900)	(98,800)	(103,200)
Total Cost <Savings> to the State	0	(97,400)	(97,900)	(98,800)	(103,200)

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

Bill Description - *Corporate Franchise Tax – Foreign Operating Corporations*

Minnesota allows certain income of a unitary group to be classified as the income of a foreign operating corporation (FOC). This income is considered a deemed dividend, and up to 80% of this income may be claimed as a dividend received deduction. In effect, 20% of the deemed dividends from an FOC is subject to taxation.

The bill redefines an FOC. Under this new definition, a corporation with foreign operations will still be classified as an FOC. Current Minnesota law allows a corporation to be classified as an FOC if the average of its domestic property and payroll is 20% or less. Under the bill, the percent of foreign property and payroll must be 80% or more to qualify as an FOC. Also, the FOC must have at least $2 million of property and at least than $1 million of payroll.

In addition, the bill disallows a dividend received deduction from an FOC if the deemed dividend includes dividends, interest, royalties, or capital gains income (i.e. income other than income from ongoing operations).

Corporate Franchise Tax – Foreign Royalty Subtraction

Under Minnesota law, corporations are allowed a subtraction against their net income equal to 80% of foreign royalty income received from an FOC or a foreign corporation. Royalty income is defined as royalties, fees, or other like income. The foreign royalty subtraction would be repealed under this bill.

Individual Income Tax

Under current law, there is an exemption from the individual income tax for wage income that was earned while the taxpayer was a resident but is received in a year that the taxpayer was a nonresident for the full year. The bill would eliminate this exemption.

There will be a positive revenue impact to the state's general fund if this bill passes.

There will not be a fiscal impact to the department of revenue if the proposed bill passes.

Revenue Assumptions

Corporate Franchise Tax Provisions

- The revenue estimates are based on data from returns received by the Department of Revenue in calendar year 2003.
- Compared to previous estimates, analysis of the most recent data indicates that a higher portion of FOC income would not be eligible for the dividend received deduction under this bill.
- Runs of tax calculation programs against corporate data were used to calculate the revenue effect from disallowing the foreign royalty subtraction and from disallowing the dividend received deduction if the FOC deemed dividend includes non-operating income such as dividends, interest, royalties and capital gains.
- Annual percentage changes in overall corporate tax collections as projected by the Department of Finance in the November 2004 forecast are used to project future revenue gains.
- About 1,600 corporations will be affected by the bill.

Individual Income Tax Provision

- The estimates are based on information that was developed following the Minnesota Supreme Court decision in Victor C. Benda v. James Girard in His Capacity as Commissioner of Revenue, et al.
- Amended returns filed in response to the court case were the primary source of information, supplemented with a sample of 1997 individual income tax returns of nonresidents.
- Annual growth of 6% was assumed.

Fiscal Impact Assumptions

- There will not be a fiscal impact to the department of revenue if the proposed bill passes.

Revenue Formula

	Fund Impact			
	F.Y. 2006	F.Y. 2007	F.Y. 2008	F.Y. 2009
		(000's)		
Foreign Operating Corporation Change	$42,000	$42,200	$42,500	$44,300
Repeal of Foreign Royalty Subtraction	$44,800	$45,000	$45,400	$47,400
Interaction	$8,700	$8,700	$8,800	$9,200
Corporate Franchise Tax	$95,500	$95,900	$96,700	$100,900
Individual Income Tax	$1,900	$2,000	$2,100	$2,300
General Fund Total	**$97,400**	**$97,900**	**$98,800**	**$103,200**

Effective for tax years beginning after December 31, 2004.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: JOHN POWERS
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EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: NANCY HOMANS
Date: 02/17/05 Phone: 296-9370

OLD AGE LEIN LAW—MN.STATUE-256B.15

This law was first made to protect people's property rights, when they have to ask for medical assistance. In 2003 the legislator's changed this law to give the Social Service's all the rights to take peoples home's away if they ask for medical help. This is morally wrong-this is taking people's homestead rights away-this is stopping people from asking for medical help, because they don't want their property taken away from them.

My father had a bad car accident and had brain damage. He was in the St. Cloud Hospital for three months. He was in and out of nursing homes and hospitals for 10 years. He was a farmer with brain damage and not a candidate for nursing homes. In one nursing home, he ran in a corn field and became lost. He ran down by a river in another nursing home and almost drown. I tried to get him into a neurological brain trama hospital at the Brainerd Regional Human Service Center and he was over 65 years old, so they would not accept him there. At that time, there was no home care provided to people to stay in their home, so I hired guys and trained them to be home care people and spent my parents money on the home care. When the money ran out, my mother was unable to care for my father and he wondered in a corn field and laid in the mud unable to get up, until we found him. So, I was forced to put him in a nursing home. I turned the nursing home in many times for lack of care. Finally, a staff person beat my father up and my father died. I promised myself that I would never put a parent of mine in a nursing home again.

My mother had a tumor removed on her brain, she had to learn to function all over again and she became vulnerable to people. Later, she had a tumor removed from her spine and needed 24 hour home care in the home. I was denied home care, and appealed this denial of home care and won, so I had someone to care for my mother while I went to work. She later had a gall bladder surgery and had complications and ended up with a seizure disorder. She had osteoperosis and fractured her leg. She had many more medical problems. She died on Sept. 30, 2004.
I cared for my mother every day, every night for 12 years in her home. She wanted to live on her farm, so that's what I provided for her. Since we had spent all our families money, I was forced to use medical assistance and use all of my own money as well. I had to private pay people to care for my mother, so I could buy groceries and wash cloths. I could never leave my mother alone.

I sold my home and lived with my mother for 12 years. I had our farmstead rewired for 220 wtts, so I could install air conditioning for my mother.

People coming from other countries get medical assistance and do not have to pay for medical assistance. Why should land owners—that are the backbone of America be the only one's to pay for medical assistance? That's discrimination.
Landowner's are penalized for being responsible citizens. Why are we going to overseas fighting wars, when our government is taking our own land in the U.S.??
You take people's land that's been in the family for generations—you are stripping a culture, family roots, a person's heart and their way of life. Real estate is real estate, but a home can not be replaced.

Having this lein law is wrong-it needs to be appealed. Legislator's have the power to appeal this law—DO IT.
Under this lein law—the land owner's have no rights and the social service's have all the rights.

My mother died Sept. 30, 2004 and I am sad. Now I feel like a criminal to fight for my home. If I don't get this law changed—I will be homeless, because I had to give everything I had to my mother for her care.

I worked for the state and my job was discontinued, so I have no job with the state. I have to pay my lawyer's to fight for my own land, because of the lein law.
I did my first step of the lein law, I had to write out a hardship waiver. The social service denied this claim immediately. I am appealing this denial. If I loose again, than I have to go to court and fight a lein of $350,000. How would you like to have that responsibility? The lein law is written for the gain to social service and not for landowner's. I have four years of college and I have a very hard time to figure out how to keep my home. (What a mess this is.) I should not have this kind of pressure.

This lein law was sopose to be for the child, that took care of their parent's in their home,than the property would go to the child. Not now, landowner's have no right's under this lein law. Legistator's please appeal this law—All it takes is to make your mark on the paper.

The social service has a lein on our farm for the past 10 years. This is wrong, because they should only have a lein on from 2003-2004, because that's when the new lein law was established.

Many home owner's are being violated—not just me. I speak for all. You have the power to change/appeal this lein law. DO IT.

My mother needs her land to pay for her funeral, because she did not have enough cash. I sopose the social service will take all our land and I will have to pay for her funeral costs. This reality to me is just unforgiving.
I don't think legislator's knew what they were doing when they changed the law in 2003. I can't imagine people making a law to take our homes away, when we are forced to ask for medical assistance. Tell me how that's right?

Since the social service put a claim in for $350,000, I put a claim in for $950,000 for taking care of my mother for the last 12 years. The $950,000 is what I figured I saved the county because I took care of my mother daily. The social service want the court to throw out this claim, because they said I did not have a right to put a claim in and that I just did the work or free.
Everything I try to do to come up with to save my home, it seems that this lein law has my hands tied.

Legislator's please change this awful law, that has the right to take our homes away.

Our homestead has been in our family for 75 years. Our land is used for agriculture. My parents worked very hard to make payments on the farm. During the depression time, my parents sold potatoes to make farm payments. How many people would do that today? I deer hunt and my mother would pet the deer when I would bring them up to the farm house. We raise special hay for horses. We have wild turkey habitat. We value our home and it should be for our family to live on not given to social service.

Native Americans have valued their land and lived on their land many generations. If they ask for medical assistance, they do not have to give up there land.

People who don't have land and get medical assistance, do not have to pay back medical assistance. Why must just the landowner's pay?

PLEASE APPLEAL THE LEIN LAW

Jule Borg

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Preserving Lives, Conserving Costs: CDCS Works

A Campaign to Support Persons with Developmental Disabilities and Their Families Hurt By Changes in Consumer Directed Community Supports (CDCS)

Thomas Kasemodel

Thomas is a wonderful 7-year-old boy who is severely Autistic. Besides Autism, he has a hearing loss, a diagnosis of Speech Apraxia, allergies, food sensitivities, motor skill impairments; sensory integration issues; and difficulties with sleeping.

Thomas' level of functioning is more than 3 standard deviations below the mean, where 2 standard deviations below is considered mentally retarded. Although he is 7, his functioning is less than 2 years old.

Thomas' impairments can be grouped into four major categories: communication, eye contact, interactive attention span and physical contact. With the help of the Consumer Directed Community Supports (CDCS) Waiver, we are running a home-based program that addresses all of these.

Our first goal is to honor and accept Thomas for who he is and to help him lead the best life possible. In developing "Team Thomas", our goal is to inspire his growth in all areas of life: his ability to communicate, positive relationships with people, daily functional skills, and elimination of challenging behaviors with positive reinforcement.

Through CDCS, we have been able to set up a team of very loving, caring individuals. Thomas now has friends to play with and learn from that are committed to inspiring growth in our child. Thomas requires 24/7 supervision in order to ensure no harm comes to him. Having "Team Thomas" trained in how to work with him not only increases his abilities, but also allows some break time for us and our other son.

"Team Thomas" has given us back our son. We have established contact and a loving relationship with our Thomas, who was completely closed off to us 5 years ago. He is engaging us in play, indicating wants and needs calmly through pointing, taking our hand and occasional use of words.

As Thomas grows and changes, his needs change – and additional training for us is a must. Although the training can be reimbursed, travel expenses now come out of our pocket. As our TEFRA Parental Fees have increased – from $168/month to $512/month – our only option was to refinance our home. We did this in November of 2004 to catch up on our parental fees. The future of our family living together, and of Thomas' world, is in great jeopardy.

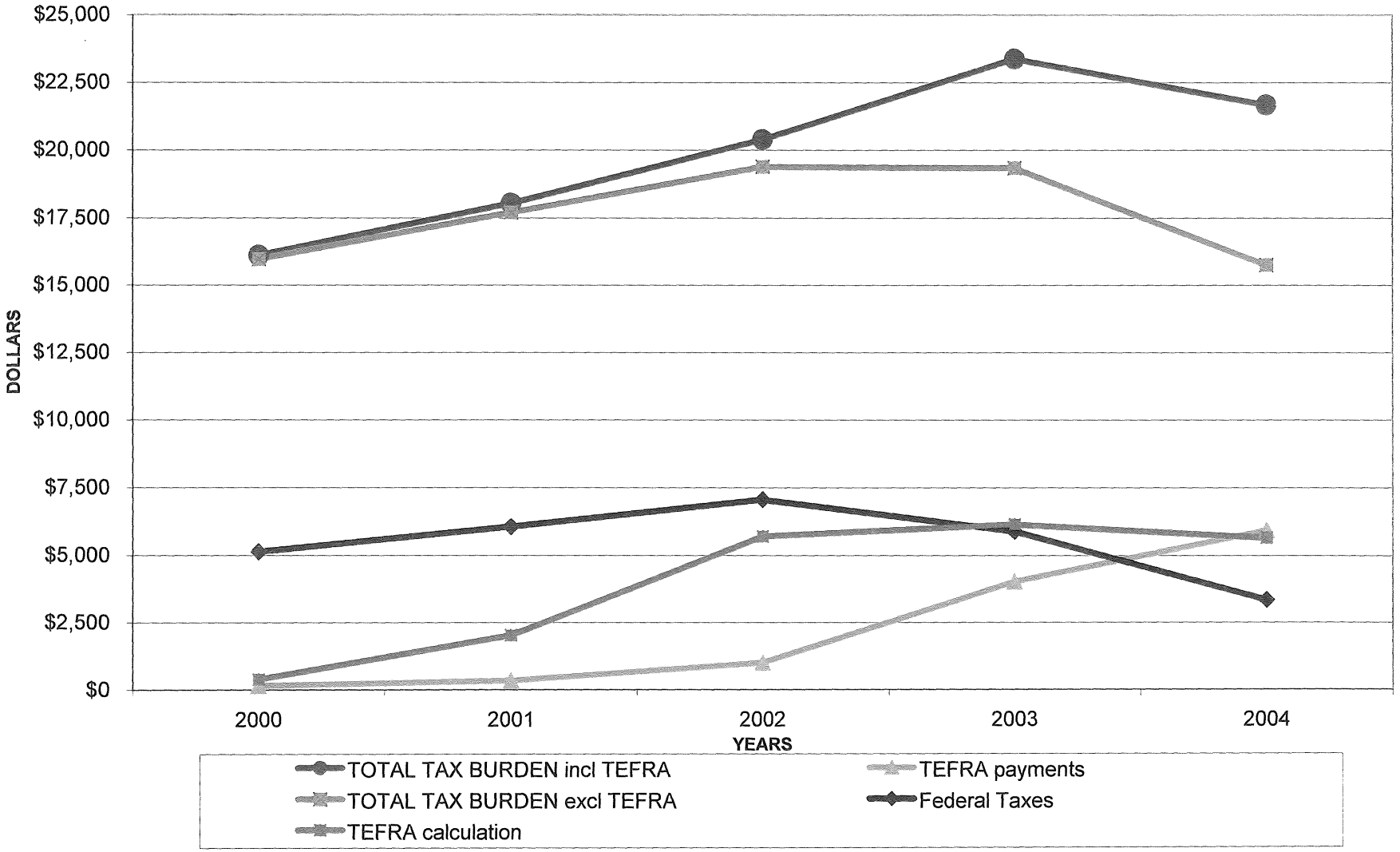
It is shocking to realize that our 2004 TEFRA Parental Fee (based on our 2003 federal taxes) was higher than any of our taxes! For the 2003 tax year, we paid $5,891 in federal tax, $3,134 in state tax, and $3,652 in property tax. Our parental fee for that same period was **$6,141**.

For Thomas' sake, and for all the kids and families in our position, please fight to restore funding for CDCS. It is a wise choice for families and communities in Minnesota.

Laura and Tim Kasemodel
Wayzata, MN

Produced by The Arc of Minnesota; 770 Transfer Road, Suite 26; St. Paul, MN; 55114
651-523-0823 or 1-800-582-5256; web site: www.arcminnesota.com; e-mail: mail@arcminnesota.com

TAXES AND TEFRA



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Testimony of Legal Services Advocacy Project in Support of SF 254
Health and Family Security Committee

Good afternoon. My name is Reggie Wagner and I am an attorney with the Legal Services Advocacy Project. Our office engages in education, policy analysis and administrative and legislative advocacy on a range of issues affecting low –income persons, including welfare-to-work, health care, family law, landlord/tenant and consumer issues.

I am here this afternoon to speak in favor SF 254 and the repeal of the grant reductions imposed on families receiving income support with basic needs through the state's welfare-to-work program, the Minnesota Family Investment Program (MFIP).

This modest income support was **reduced by up to $125 for each disabled family member** living in the household and by up to $50 for those living in public housing or receiving Section 8 rent assistance.

Of the two grant reductions, the one affecting disabled households is having the most severe impact, both in terms of numbers of households affected and the loss of monthly income: Approximately 6,800 families have had their grants reduced an average of $142/month. **Of these families, we estimate that almost 75% of them are "child-only cases" in which the child receives MFIP cash assistance to help meet their basic needs because the parent they live with is disabled and unable to work and the other parent is not paying child support.**

These children receive financial help from MFIP when because neither parent, albeit for different reasons, are able to contribute to the support of their children. I emphasize this point not to blame those fathers. There are many reasons child support does not get paid: these fathers may be unable to find a job, or may be earning so little that they cannot make a payment with putting themselves at risk of being homeless.

Congress created the SSI program to provide modest financial help to people over 65 or people who are disabled or blind and have no other means of supporting themselves. The monthly benefit is about $564, or 80% of the poverty level.

People who receive SSI support each month first and foremost because they meet very strict disability criteria set forth by the government. It isn't just any health problem that will qualify someone for SSI: it must be one that results in severe limitations and is expected to result in death or which has lasted or can be expected to last longer than 12 months. The process is very difficult and often takes 2, 3 or even 4 years before a final decision is made. Data from the Social Security Administration confirm that only a small percentage of the applications received are ultimately approved. After 1996, the eligibility criteria for children were made even stricter,

resulting in thousands of children being found ineligible for benefits. It is safe to say that if a child is currently receiving SSI, the nature and extent of that disability is severe.

It has been said that a state's budget reflect its values: I do not believe that pushing children of disabled parents deeper into poverty is a value held by most Minnesotans, but that is clearly the result of the budget that was adopted last session. SF 254 will help to provide these households with much needed support to meet their basic needs, and will alleviate the stress and anxiety that are compounding the frail health of these disabled persons. As one parent told me the other day, "I feel so bad for my kids, like I'm not a good mother because I can't give them the things they need like I could do before this cut."

You are probably wondering why more of parents are not here today, filling this room and lining up to testify about the harm that was done to their children because of this cut. The answer is quite simple: They are, by and large, simply too disabled to travel to the Capitol and engage in the legislative process. That is the sad irony of this particular cut: Disabled parents with children on MFIP have seen perhaps the **largest mandatory reduction in their monthly incomes as a proportion of their family budgets – with absolutely no way to avoid it or to offset it** – than most of the families impacted by the numerous cuts and fee increases last session. Yet, precisely because of their severe disabilities, they are unable to be at this table and tell their stories.

In the past two weeks, I spoke with several parents on SSI whose children's MFIP grants have been cut, and eliminated altogether in some cases. They gave me permission to tell you about their families and how this grant reduction has impacted them:

Tammy lives in Austin. Tammy's has two sons, ages 15 and 13. Tammy's disabilities consist of severe depression from years of abuse, chronic bronchitis and other health problems that prevent her from working. Tammy was very reluctant to talk with me about her disabilities, but during our conversation she told me that she was taking numerous prescription drugs, suffers from panic attacks and rarely leaves the house. Her older son, Tyler, is also disabled due to mental illness and the trauma from abuse he experienced years earlier. Until July 1, 2003 Tammy's youngest son, Travis, received $250 from MFIP to assist with meeting his basic needs. He receives no child support from his father. Because two members of the household receive SSI, Travis' MFIP grant was reduced to $0. As a result,

- Tammy immediately fell behind in rent. She soon moved from a 3-BR to a 2-BR apartment to save costs. In order to ensure that her disabled son has his own room to provide space for both boys, Tammy sleeps in the living room.
- She's behind in rent again as well as her utilities. She fears her utilities will be shut off when the cold-weather protection ends in April.
- She has stopped buying some of the prescription drugs she is advised to take because of new co-pays in Medical Assistance that affect her. She made her own decisions about which ones to stop taking, and didn't consult with a doctor.
- She has developed ulcers since July caused by the stress this lack of income has placed on her. She told me that has become more depressed and cries often because she cannot provide for her sons like she used to.

Sheila lives in Worthington with her 16-year old son. She has severe depression, suicidal tendencies, irritable bowel syndrome with frequent diarrhea, chronic pain syndrome, has severe back pain which makes it hard for her to stand or sit for very long, cannot hold on to objects with her hands. She receives $564 in SSI benefits for her basic needs and her son, who receives no child support, now receives only $125 from MFIP rather than the $250 she used to. She lives in a mobile home she is buying. Since the grant reduction, she has had trouble buying groceries for her son after her food support benefits run out. "Do you know how much a 16-year old boy can eat?" she asked me. She is worried about being able to make her monthly home payments and the insurance payments that are due every three months and the taxes that are due every six months. She, too, is paying more for prescription drugs and office visits than she was before those changes took effect. She finds that the stress from not knowing what will happen month to month with their bills and living expenses has made aggravated her depression and suicidal thoughts. "I have neighbors who listen, so I call them to try and calm me down."

Tracy has Multiple Sclerosis. She has difficulty walking and standing for long periods and has limited physical mobility. She wanted to come to the hearing today but was unable to do so because she is starting weekly chemotherapy treatment. She is married and lives with her husband and their three children in St. Paul. Her husband works but has not been able to work enough hours in this economy to move the family from welfare to self-sufficiency.

- With the family's MFIP grant reduced by $125 since July 1, they run out of money a lot earlier in the month. They barely have enough money to cover the rent and utilities and little else.
- Have had to borrow from family several times to pay bills and pay for new prescription drug co-pays.
- Spend less for groceries after their food support grant is used up.

Welfare Rights Committee *310 E. 38th St. #207 Minneapolis, MN 55409 612-822-8020*

2-3-2005

Today we are here to testify in support of Senate File 254 - which should be familiar to you as Senate File 1991 from last year, and which had bipartisan support in the Senate as well as in the House. Here is what the bill will do.

SF254 will repeal two of the biggest and worst welfare cuts in the history of Minnesota, the $125 per person, per month MFIP grant cut to families with disabled family members -- this is often called the "SSI Penalty" or the "125 Cut". It also repeals the $50 per month MFIP grant cut to families in subsidized housing.

Here is how these cuts affect Minnesota families. Before these cuts, a family of three lived on a cash grant of $532 per month, which put that mother and her kids over 50% below the poverty line, into what is called *extreme* poverty. But now $125 is taken away each month for each disabled family member on SSI, and $50 dollar per month for the housing cut. So, a family of four including one disabled child, living in subsidized housing is seeing their monthly MFIP grant go from $532 to $357. In other words, this families MFIP grant was cut by 33%. No one else suffered such extreme cuts in the 2003 session.

Over 11,000 *families* are affected by the $50.00 subsidized housing cut. Over 6,500 *families* are effected by the SSI plenty. These cuts are affecting real people every day of their lives. Instead of sending people in subsidized housing *down*, this state should be bringing everyone *up* and out of poverty, by raising the welfare grants or providing affordable housing for ALL in need. Poor families on MFIP should not be penalized for dealing with disability in the family. If the parent or parents are disabled, it's not right to punish the children - the parents *can't* work, and neither can the kids. If the children are disabled, we know it makes it much harder for the parents to get a job, because of caring for the special needs of the children. These cuts are cruel, should never have happened, and must be undone.

The bill also undoes laws passed in the 2003 session that force people to use their assets to pay their share of Medical Assistance costs and that put liens on the property of sick people who are forced to use Medical Assistance because of serious or terminal illness. Finally, the bill also reduces the parental fees for families who use TEFRA to pay for health care and services for their disabled children - fees and income restrictions that rose astronomically because of the cuts that where past in the 2003 Legislative Session.

SF254 pays for itself by getting rid of a $56 million tax loophole that has allowed some corporations that do business in Minnesota to get out of paying MN taxes, because they have a plaque on the wall in another state or a foreign country.

We want to end with the point that no one would be on welfare if we had a choice. The welfare issue always comes to jobs. There are simply not enough jobs for everyone who needs one, and certainly there are not enough livable wage jobs. In the past 4 years the number of unemployed adults has risen by 45,000. We see the fallout from that every day.

In our organizing, we stand outside the welfare offices every week, gathering names. We talk to hundreds of people on the phone. We let our community know about our basic rights in this system; and how the laws made right here affect our lives. Unfortunately, our basic rights of survival have been under attack these past several years. We hope that those of you in this room will join us in our fight to turn these attacks around.

ISSUE BRIEF: Cuts in MFIP for SSI Families

1/31/05

Background:

The 2003 legislature reduced MFIP grants for households with family members who have a disability severe enough that they receive Supplemental Security Income (SSI) benefits. A family's MFIP grant is reduced by $125 per month for *each* family member on SSI. SSI is a federal program that provides assistance to adults and children with significant disabilities, including mental health, that either prevent employment or restrict normal functioning. SSI grants are approximately $560 per month and are intended to help meet the needs of the person with the disability. Eligibility for SSI is strictly controlled (more than half of initial applications are rejected), meaning that applicants must demonstrate *significant disabilities* to qualify.

According to DHS data from October 2004, close to 6,500 families, including 7,850 people, have been affected by this legislative change. Twenty percent of the affected families have *two or more* family members with a disability, meaning that the average grant reduction is actually $145 per month. Communities of color are disproportionately affected by the legislative changes. Although the majority of families on MFIP are white, Asians and African Americans were impacted more often by the SSI cuts. This was especially true of those households with two or more family members on SSI.

Example of the impact

Family of three, one parent, two children
One child has a disability and receives SSI benefit ($564/month)
MFIP grant is based on family size of 2 since SSI recipient not counted when calculating the grant
Old law: MFIP grant = $437
New law: MFIP grant = $312

Result is a **28% reduction** in household income. (Even if the SSI benefit is considered to be available to the entire household, the new law results in a 12.6% reduction each month, from $1,001 to $876, which places this family **below** poverty.)

The cuts significantly limit a family's ability to meet their basic needs and care for their family members with disabilities. It can also limit a parent's ability to maintain employment and move off public assistance.

Change Needed:

Restore the full MFIP grant for households with family members with disabilities

Rationale:

- MFIP families that receive SSI are not better off than other MFIP families; caring for a person with a disability imposes additional costs on the family, for which SSI is intended. Reducing MFIP grants to families receiving SSI **undermines the family's ability** to care for the person with a disability and for parents to remain on the path toward work and self-sufficiency
- MFIP households with family members receiving SSI are some of the **poorest and most vulnerable families** in Minnesota and should not bear the brunt of solving the budget deficit
- Reducing the income of households that have family members with disabilities **decreases family stability**
- Because of these cuts, close to 6,500 families (including 23,000 family members) collectively have **$1 million less in their family budgets** each month
- Minnesota is one of only a few states that reduce assistance for households with family members with disabilities; this **sets a bad precedent** and goes against Minnesota values

Prepared by Affirmative Options Coalition, Family & Children's Service, and Legal Services Advocacy Project.
For more information contact: Karen Kingsley: 651-642-1904 x229 or karen@affirmativeoptions.org, Andrea Ayres: 612-341-1647 or andrea.ayres@fcsmn.org or Reggie Wagner: 651-222-3749 or rwagner@mnlsap.org

Testimony for Senate Health and Family Security Committee 2-3-2005

Hello, My name is Virginia Weldon. I am a recipient of MFIP and a mother of 2.

I was working at a job, but because of a surgery and a medical condition that I still am suffering from, I was forced to leave my job. I needed to go on welfare in order to support my family.

While on MFIP, I was a victim of domestic violence from my husband. In 2001, I started doing job search. This is about the same time that the recession hit, so I was competing with many others who needed jobs. The day I graduated from a training program, myself and my youngest child were evicted from our apartment unfairly in retaliation for reporting serious maintenance problems involving water damage and mold growth. So my son and I were put into the streets and had to go to a homeless shelter for about 5 weeks.

During all of this crisis I was also having to go to therapeutic pool therapy for spinal damage 2x a week, every week. I continued intensive job search and sent applications, but did not find a job. I have doing an average of 30 hours a week of job search. I have not been accepted for any job, have only been given one interview, and the rest have been rejection letters. Here is the documentation of all my work search and rejections. (show binders of work search)

During this time, up until July 2003, while I was dealing with severe medical problems, domestic violence, homelessness, joblessness and living in poverty, my son and I were trying to survive on a cash grant from MFIP of $437 a month. The welfare is only a survival check, it is not something to be able to do anything beyond surviving, like doing anything enjoyable with my son. You can't look for a job easily, because you have no phone. And it really is not enough to even survive. It sucks. If my son has activities or events at school, I don't have the money to pay for them.

After paying rent and utilities, (and I have subsidized rent), if I have ANY money left after the first week of the month, it's less than $100. And that's supposed to last me and my child for the rest of the month. I still need to buy household cleaning products, and personal hygiene products. Part of that money has to be used to buy food to supplement the food stamps which aren't enough to last a month. I have to take a bus to go get groceries, and then I have to spend money on a taxi to get all the groceries home. It can be hard to even find the money to pay for the bus ride to get anywhere. The convenience stores that are within walking distance charge triple the amount for food that the big stores do. But we often end up paying it, because we can't get to the bigger stores.

Now for the past year and a half, because of welfare cuts passed by Minnesota politicians, my son and I have had $50 dollars a month cut in the MFIP grant. Now we are trying to survive on $387 a month. Tell me how anyone in Minnesota thinks a family can survive on this little money? And why, when the state is in deficit, are they taking money away from our kids who are already just barely surviving?

Lien

January 17, 2005
An individual called about the lien that was placed on her home.

"A Referee called up and had another Referee on the other line - 3 way conversation - This was the Hearing to put that lien against my house. I complained to them that I had talked to Mike Hatch, and they came down from 11,900 to $5,026. They said they made a mistake. I talked to everyone to get the price for services they have here. Here was 2 fellows on the phone for the hearing and no one has yet told me what the cost of these services are.

I was told I could get the price of my services from my worker, and she doesn't know anything. She did, however, find out I was paying $5.80 for each of those meals on wheels. I quit mine because I didn't want to get it charged to my house. After I quit, the person who brings the meals said that I could pay whatever I could afford. Now I go to a local community center and get meals much cheaper and the food is better.

You and the others gave me the number of 3 or 4 people who are in charge of what the costs are and still no one has gotten back to me regarding the actual costs. I've been promised a list in the mail to me.

When they had the hearing on the phone, he said he sent me a letter and I hadn't gotten it yet. I hear promises and then they had this hearing before I got the letter, and then I finally got it and they don't say anything in the letter.

If I go to K Mart to get a tube of toothpaste, I'm informed how much money it costs and what I get back, printed right on the receipt. I don't think they should have held the hearing until I know how much I spent. They slap a big lien on my house and won't even tell me what it's for.

Now I got a letter 2 days ago , that said they have a housekeeper comes 4 x a month. The housekeepers keep stealing everything, and it takes a couple of weeks to get a new one. And still they charge me for 4 times a month @ 4 hours at a time. Now no body comes and they still charge. If the girls are any good, right away they find a better job. One of them stole my brother's watch and my jewelry and they want me to call the police and prosecute her, but I am disabled I can't do it.

One of them even stole my dishtowels that my grandchildren made for me and she also stole my clothes (she was my size) One of them a good worker, but she was almost ready to deliver any minute. If she had a baby at my place I would have blood-pressure through the roof.

My son who lives up North in Minnesota is also disabled and lives on Social Security. He comes down to see me about twice a year. He's despondent over his divorce and is mad at the world and I can't take living with him. He can live here after I'm gone. They said they won't take the house from me and my son can live it until it's sold. I don't really believe anything unless it's on paper.

Legal Aid Man writes a very clear concise letter about what he can do to help me but he can't defend me He said my child has to be under 21 and he claims I owe $11,900 and now it's $5,026 .

I have the names and numbers of all these people and a couple of them have called me back, in the meantime they put a lien on my house. They don't even know how much anything was. I don't trust any government.

I told them on the phone hearing, no matter who I call they don't know anything. The Referee said "My job is only to put the lien on the house". It's a colossal joke being paid on the Seniors who have no recourse.

January 31, 2005

No I don't want to testify in public! I'd probably have a heart attack!
Also, I'm very vulnerable here, and if the wrong people see my address they could come to my house.

I finally got an accounting of what is charged for the ACG Services. I'm exhausted, my blood pressure goes up so badly when I get into this.

The case manager who sees that I get services, gets $ 500 a month and she only calls around to get someone to try to come. I haven't had anyone to clean house for 2 months.! The way they did my snow, the city sent me a letter to say they are charging me $25.00 for snow removal. I talk and talk to them over at the County. I finally told them it was the most dishonest thing I ever saw. I'm not calling them anymore.

I can't take it, I'm 81. Its' a racket. They're tearing down Nursing Homes. Then they take a figure out of the air and slap a lien on your house.

Now, finally, I got the whole evidence down on paper, and so now I dropped all of the ACG services. It's not worth it! The house cleaners rip you off, the snow is done so poorly, and the food is cheaper at the Community Center. I don't want to testify, because as I get worse I may break down and may need to call for a Nurse to come to my house, and I'm afraid they'll retaliate because I told the world how it really is.

SSI MFIP

Hello my name is Tracy Furney and I am a current welfare recipient. My husband and I both have disabilities and are unable to work we receive SSI for our disability. I have two daughters that I receive MFIP for. My daughters MFIP grant was cut $250.00 a month this leaves only $289.00 a month for my two daughters to live on. This cut adds up to be $3000 a year, which is a 49% CUT INTO THE CASH GRANT! The SSI money is suppose to be there to take care of me and my husbands disability.

After the cuts I find that it is not enough to stretch to the end of the month. The things that I have to pay like rent, garage rent, electricity, phone bill, gas, and car insurance are necessary things that we have to pay these are not leisure items. We also have household items and hygiene stuff that we have to buy that you cannot buy with food stamps. I only get $221.00 in food stamps to feed 4 people so I find myself borrowing money thru out the month and then having to pay it back it becomes a vicious cycle. I have also had to pawn items in my household to compensate for the money that has been cut because I need to still buy clothes for my growing daughters and things that they might need for school. Why when are families are suffering they take money from the least when there are people who have way more then what they need who should be paying there fair share.

Since the cuts I have been feeling more and more stressed out which is having a more negative effect on my health. I feel that this is sending a message to my children that they are not worthy enough to have things like other people. I also feel like it is sending out a negative message that if you are on Public Assistance or you are receiving SSI that you deserve to live in poverty. I really do not think that this is the type of message that we should be sending to people.
Why should my daughters be punished when there are rich corporations getting out of paying their fare share in taxes?

February 2, 2005

To Whom It May Concern:

My husband Steve is 46 yrs old. He was promised the farm when he was 17. His dad had a triple heart bypass 2 yrs later and Steve took over. The farm was transferred after the siblings left in 1985. (20 Yrs ago). The income went to his mom to build social security.

Steve has never worked off this farm!! We have no outside income. I'm not eligible for social security because I've also been working on this farm for the past 20 years. There's not enough income to divide.

We built our house, a dairy barn, a cattle shed and a garage 150 feet from Dad's house.

We took care of Dad 3 years before he went to the nursing home needing constant supervision.

This bill penalizes us for staying home and taking care of his folks!

The lien is 34% of our investment in the farm. The value of the farm at time of transfer was less than 60,000.The value now is 229,000.According to Gregory Lulic, of the Special Recovery Unit, the % is not the value at the time of transfer; not the value at time of death; but the value at time of sale years down the road. In 20 years Steve will be 66- past retirement age. What are we working for? We're a small family 50 cow farm. This is our retirement.

This retroactive bill left us no options. Thank you for your time.

Julie Norman
Clearwater County

MFIP SSI cuts

2/3/05

Lynn's story

Lynn has two sons
Lynn has an anxiety disorder and receives SSI ($574/month)
Her younger son has autism and receives SSI (amount unknown, it's lower than the regular SSI benefit because she also receives some child support from her son's father)

Before the SSI cuts to MFIP passed in 2003, Lynn received an MFIP child-only grant to support her older son ($250)

Lynn has a representative payee who manages her budget
The rep payee pays for rent, utilities and car insurance
Lynn receives a personal needs check from the rep payee of $110/week ($440 per month) to pay for clothes, gas, food and other necessities

The MFIP changes have exacerbated Lynn's anxiety
It has been difficult to buy things for the family.
Her son just got boots for the winter this past week.
She's had to go to the food shelves for food.

For more information, contact Karen Kingsley, Affirmative Options Coalition, 651-642-1904 x229

file repeal lien's bill SF254

OLD AGE LEIN LAW—MN.STATUE-256B.15

This law was first made to protect people's property rights, when they have to ask for medical assistance. In 2003 the legislator's changed this law to give the Social Service's all the rights to take peoples home's away if they ask for medical help. This is morally wrong-this is taking people's homestead rights away-this is stopping people from asking for medical help, because they don't want their property taken away from them.

My father had a bad car accident and had brain damage. He was in the St. Cloud Hospital for three months. He was in and out of nursing homes and hospitals for 10 years. He was a farmer with brain damage and not a candidate for nursing homes. In one nursing home, he ran in a corn field and became lost. He ran down by a river in another nursing home and almost drown. I tried to get him into a neurological brain trama hospital at the Brainerd Regional Human Service Center and he was over 65 years old, so they would not accept him there. At that time, there was no home care provided to people to stay in their home, so I hired guys and trained them to be home care people and spent my parents money on the home care. When the money ran out, my mother was unable to care for my father and he wondered in a corn field and laid in the mud unable to get up, until we found him. So, I was forced to put him in a nursing home. I turned the nursing home in many times for lack of care. Finally, a staff person beat my father up and my father died. I promised myself that I would never put a parent of mine in a nursing home again.

My mother had a tumor removed on her brain, she had to learn to function all over again and she became vulnerable to people. Later, she had a tumor removed from her spine and needed 24 hour home care in the home. I was denied home care, and appealed this denial of home care and won, so I had someone to care for my mother while I went to work. She later had a gall bladder surgery and had complications and ended up with a seizure disorder. She had osteoperosis and fractured her leg. She had many more medical problems. She died on Sept. 30, 2004.
I cared for my mother every day, every night for 12 years in her home. She wanted to live on her farm, so that's what I provided for her. Since we had spent all our families money, I was forced to use medical assistance and use all of my own money as well. I had to private pay people to care for my mother, so I could buy groceries and wash cloths. I could never leave my mother alone.

I sold my home and lived with my mother for 12 years. I had our farmstead rewired for 220 wtts, so I could install air conditioning for my mother.

People coming from other countries get medical assistance and do not have to pay for medical assistance. Why should land owners—that are the backbone of America be the only one's to pay for medical assistance? That's discrimination.
Landowner's are penalized for being responsible citizens. Why are we going to overseas fighting wars, when our government is taking our own land in the U.S.??
You take people's land that's been in the family for generations—you are stripping a culture, family roots, a person's heart and their way of life. Real estate is real estate, but a home can not be replaced.

Senators Dibble and Lourey introduced--

S.F. No. 1279: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; removing the sunset for a provision exempting certain antihemophilic factor drugs from prior authorization under medical assistance; amending Minnesota Statutes 2004, section 256B.0625, subdivision 13f.

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

Section 1. Minnesota Statutes 2004, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. [PRIOR AUTHORIZATION.] (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on

program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner. ~~This paragraph expires July 1, 2005.~~

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

[EFFECTIVE DATE.] <u>This section is effective June 30, 2005.</u>

Senate Counsel, Research, and Fiscal Analysis

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S.F. No. 1279 - Prior Authorization for Antihemopliliac Factor Drugs Under the Medical Assistance

Author: Senator D. Scott Dibble

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

Date: April 8, 2005

S.F. No. 1279 would prohibit the Department of Human Services from requiring or utilizing prior authorization for any antihemophiliac factor drug where there is no generically equivalent drug available as part of the supplemental drug rebate program or preferred drug list. (Currently, this prohibition expires July 1, 2005. Under this bill, this expiration date would be removed.)

KC:ph

Fiscal Note – 2005-06 Session

Bill #: S1279-0 **Complete Date:** 03/30/05

Chief Author: DIBBLE, SCOTT

Title: ANTIHEMOPHILIC FACTOR DRUG EXEMPTION

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					
-- 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: HF 855/SF 1279

Bill Description

This bill removes the sunset for a provision exempting certain antihemophilic factor drugs from prior authorization under medical assistance, making the exemption permanent.

Assumptions

Because these products are occasionally used in emergency situations, it is unlikely the department would subject these products to prior authorization, even if the authority to do so was restored.

The fiscal impact of this bill is therefore $0.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Cody Wiberg 282-6496
FN Coord Signature: STEVE BARTA
Date: 03/30/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KATIE BURNS
Date: 03/30/05 Phone: 296-7289

Senators Foley, Solon, Jungbauer and Berglin introduced--

S.F. No. 1395: Referred to the Committee on Finance.

A bill for an act

relating to human services; providing supportive housing services; appropriating money; amending Minnesota Statutes 2004, section 256K.25, subdivisions 2, 4.

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

Section 1. Minnesota Statutes 2004, section 256K.25, subdivision 2, is amended to read:

Subd. 2. [DEFINITION.] For purposes of this section, "homeless" means having no appropriate housing available and lacking the resources necessary to access permanent housing, as determined by the county requesting funding under subdivision 3, and:

(1) living, or being at imminent risk of living, on the street or in a shelter; or

(2) ~~having been~~ evicted from a dwelling; or

(3) discharged from a regional treatment center, state-operated community-based program, community hospital, or residential treatment program, or ready to be discharged but is in need of supportive housing services.

Sec. 2. Minnesota Statutes 2004, section 256K.25, subdivision 4, is amended to read:

Subd. 4. [PARTICIPANT ELIGIBILITY.] (a) In order to meet initial eligibility criteria for the pilot project, the county must determine that a participant is homeless or is at risk of

homelessness and is a family that meets the criteria in paragraph (b) or is an individual who meets the criteria in paragraph (c).

(b) An eligible family must include a minor child or a pregnant woman, and:

(1) be receiving or be eligible for MFIP assistance under chapter 256J; or

(2) include an adult caregiver who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10.

(c) An eligible individual must:

(1) meet the eligibility requirements of the group residential housing program under section 256I.04, subdivision 1; ~~or~~

(2) be a noncustodial parent who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10; or

(3) be recently discharged or ready to be discharged from a regional treatment center, community hospital, or residential treatment program.

(d) Counties participating in the pilot project may develop and initiate disenrollment criteria, subject to approval by the commissioner of human services.

Sec. 3. [TRANSITIONING INDIVIDUALS DISCHARGED FROM ANOKA REGIONAL TREATMENT CENTER INTO THE COMMUNITY.]

The commissioner of human services shall diligently work towards transitioning individuals who are currently in the Anoka Regional Treatment Center into the community, who are ready to be discharged, by providing appropriate, thorough, and sufficient community supports for this targeted population.

Sec. 4. [APPROPRIATION.]

$5,000,000 is appropriated from the general fund to the commissioner of human services for the biennium beginning June 30, 2005, for purposes of section 3. Unused funds shall not

cancel, but may be used until expended.

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1395-1A **Complete Date:**

Chief Author: FOLEY, LEO

Title: SUPPORTIVE HOUSING SERVICES

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	1,543	466	1,096	(664)
Health Care Access Fund	0	7	12	24	24
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	1,543	466	1,096	(664)
Health Care Access Fund	0	7	12	24	24
Revenues					
General Fund	0	0	(426)	(851)	(1,204)
Net Cost <Savings>					
General Fund	0	1,543	892	1,947	540
Health Care Access Fund	0	7	12	24	24
Total Cost <Savings> to the State	0	1,550	904	1,971	564

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

Preliminary

Bill Description

The bill charges the commissioner of human services and counties to implement supportive housing and other community treatment and support services necessary to facilitate the closing of 100 beds at the Anoka Regional Treatment Center (AMRTC). The bill permits the commissioner to redirect the savings in state appropriations from reduced operations at the AMRTC to fund the ongoing costs of the increased local service capacity.

Sec. 5 amends the MSA Shelter Needy program to include people who are discharged from community residential treatment (Rule 36). This change will facilitate the development of alternatives to AMRTC and will also result in shortened lengths of stay in residential treatment, with associated savings in MA, which are also reinvested in additional community services under this bill.

Assumptions

Community services are developed and appropriate to client needs before beds are closed at the RTC. Individuals who really need RTC-level of care continue to be served at the RTC.

Expenditure and/or Revenue Formula

RTC eligibility data, based on FY04 actual:	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Percent of AMRTC discharges who are **MA-SSI eligible**	82%	82%	82%	82%
Percent of AMRTC discharges who are **GA** eligible	13%	13%	13%	13%
Percent of AMRTC discharges who are **MnCare** eligible	5%	5%	5%	5%
Percent of AMRTC discharges who are VA or **private pay**	*	*	*	*

* 18% of FY04 RTC discharges had no state coverage; the above assumes that all discharges under this fiscal note will need state subsidized health care and housing

Housing / Room / Board Costs				
Standard GRH room and board pymt per person per month	$ 713.00	$ 713.00	$ 713.00	$ 713.00
SSI applicable to GRH (excl. $96 disregard and personal needs)	$ 483.00	$ 483.00	$ 483.00	$ 483.00
Net state share for GRH per month for SSI eligibles	$ 230.00	$ 230.00	$ 230.00	$ 230.00
Net state share for GRH per day for SSI eligibles	$ 7.67	$ 7.67	$ 7.67	$ 7.67
Net state share for GRH per month for **non-** SSI eligibles	$ 713.00	$ 713.00	$ 713.00	$ 713.00
Net state share for GRH per day for **non-**SSI eligibles (GA)	$ 23.77	$ 23.77	$ 23.77	$ 23.77
Standard MSA shelter needy pymt per person per month	$ 801.00	$ 801.00	$ 801.00	$ 801.00
SSI applicable to MSA	$ 579.00	$ 579.00	$ 579.00	$ 579.00
Net state share for Shelter Needy per month for SSI eligibles	$ 222.00	$ 222.00	$ 222.00	$ 222.00
Net state share for Shelter Needy per day for SSI eligibles	$ 7.40	$ 7.40	$ 7.40	$ 7.40
Average metro housing subsidy per month (based on metro Bridges)	$ 500.00	$ 500.00	$ 500.00	$ 500.00
Housing subsidy state cost per day (divide above by 30) (fund through State MH Grants)	$ 16.67	$ 16.67	$ 16.67	$ 16.67
Estimated mix of housing arrangements for RTC discharges:				
GRH/SSI	41%	41%	41%	41%

GRH/GA	9%	9%	9%	9%
MSA shelter needy	10%	10%	10%	10%
Housing subsidy	40%	40%	40%	40%
Total	100%	100%	100%	100%
Avg. state cost per day per person for housing/room/board, excl. services and health care	$ 12.69	$ 12.69	$ 12.69	$ 12.69
Service and health care costs				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Total cost per day for services and health care	$ 211.00	$ 211.00	$ 211.00	$ 211.00
less reinvestment of historical 10% county share (use for non-MA eligible services)	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 166.00	$ 166.00	$ 166.00	$ 166.00
state share for MA eligibles @50%	$ 83.00	$ 83.00	$ 83.00	$ 83.00
Avg. state cost per day per person for services and health care based on above MA eligibility, assuming 100% state funding for GA and MnCare eligibles, since GA and MnCare do not cover ACT, IRT, ARMHS, TCM and CADI	$ 97.94	$ 97.94	$ 97.94	$ 97.94
Combined Housing and Service Costs				
Average state share cost per person per day for housing and services	$ 110.63	$ 110.63	$ 110.63	$ 110.63
Avg state share cost per year per person	$ 40,380	$ 40,380	$ 40,380	$ 40,380
Average number of individuals to be maintained in the community	15	25	50	50
Total on-going state cost for community housing and services	$ 605,694	$ 1,009,490	$ 2,018,979	$ 2,018,979
One-time state funding for housing development	$ 1,000,000	$ -	$ -	$ -
Non-MA contract beds in community hospitals equivalent to 25 beds of RTC capacity, beginning 7/1/06, and another 25 beds beginning 7/1/07	$ -	$ 1,825,000	$ 3,650,000	$ 3,650,000
Net impact of MSA Shelter Needy - Rule 36 amendment (see separate analysis)	$ (55,695)	$ (225,052)	$ (296,172)	$ (288,378)
Projected fiscal effects due to closure of AMRTC units:				
One unit by 7/1/06	0	(1,250,000)	(1,250,000)	(1,250,000)
Second unit by 1/1/07	0	(881,500)	(1,763,000)	(1,763,000)
Third unit by 7/1/07	0	0	(1,250,000)	(1,250,000)
Fourth unit by 1/1/08	0	0	(1,409,000)	(2,818,000)
SOS mitigation costs	0	0	1,418,000	1,060,320
Total SOS costs (savings)	0	(2,131,500)	(4,254,000)	(6,020,680)

County share revenue increase (decrease)	0	(426,300)	(850,800)	(1,204,136)
Net SOS costs (savings) less change in revenue	0	(1,705,200)	(3,403,200)	(4,816,544)
Net state cost (savings)	1,549,999	904,238	1,969,607	564,057
Biennial totals		2,454,237		2,533,665

Conversion of above data into budget activities:

	FY 2006	FY 2007	FY 2008	FY 2009
Minnesota Supplemental Aid (MSA)				
Net state share for Shelter Needy per day for SSI eligibles	$ 7.40	$ 7.40	$ 7.40	$ 7.40
Average number of new MSA Shelter Needy recipients per year as a result of RTC restucturing	1.50	2.50	5.00	5.00
Total new MSA cost per year for RTC restructuring	$ 4,052	$ 6,753	$ 13,505	$ 13,505
Net MSA impact from MSA Shelter Needy Rule 36 amendment	$117,884	$359,498	$487,125	$494,919
Total MSA cost	$ 121,936	$ 366,251	$ 500,630	$ 508,424
Group Residential Housing				
Net state share for GRH per day for SSI eligibles	$ 7.67	$ 7.67	$ 7.67	$ 7.67
Average number of new GRH recipients per year as a result of RTC restucturing	6.15	10.25	20.50	20.50
Total new GRH cost per year for RTC restructuring - SSI eligibles	$ 17,210	$ 28,683	$ 57,366	$ 57,366
Net state share for GRH per day for non-SSI eligibles (GA)	$ 23.77	$ 23.77	$ 23.77	$ 23.77
Average number of new GRH recipients per year as a result of RTC restucturing	1.35	2.25	4.50	4.50
Total new GRH cost per year for RTC restructuring - non-SSI eligibles	$ 11,711	$ 19,518	$ 39,037	$ 39,037
Net GRH impact from MSA Shelter Needy Rule 36 amendment	$ (72,095)	$ (219,206)	$ (296,172)	$ (296,172)
Total GRH cost	$ (43,174)	$ (171,005)	$ (199,769)	$ (199,769)
Medical Assistance for Elderly and Disabled				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Total cost per day for services and health care	$ 211.00	$ 211.00	$ 211.00	$ 211.00
less reinvestment of historical 10% county share (use for non-MA eligible services)	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 166.00	$ 166.00	$ 166.00	$ 166.00
Average number of MA eligibles to be served per year	12.30	20.50	41.00	41.00
Total MA E&D payments for expanded treatment and support	$ 745,257	$ 1,242,095	$ 2,484,190	$ 2,484,190
state share @ 50%	$ 372,629	$ 621,048	$ 1,242,095	$ 1,242,095

(to the extent that CADI is needed, funds will be transferred from MA E&D to MA Waivers)

Net MA E&D state share impact from MSA Shelter Needy Rule 36 amendment	$ (101,484)	$ (365,344)	$ (487,125)	$ (487,125)
Total MA E&D state share	$ 271,144	$ 255,704	$ 754,970	$ 754,970
GAMC and MnCare				
GA and MnCare do not cover ACT, IRT, ARMHS, TCM and CADI, so State MH Grants (see below) will be used for those services				
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Average number of GAMC eligibles to be served per year	1.95	3.25	6.50	6.50
Total GAMC payments per year @ 100%	$ 18,506	$ 30,843	$ 61,685	$ 61,685
Average number of MnCare eligibles to be served per year	0.75	1.25	2.50	2.50
Total MnCare payments per year @ 100%	$ 7,118	$ 11,863	$ 23,725	$ 23,725
State Mental Health Grants				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
less reinvestment of historical 10% county share	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 140.00	$ 140.00	$ 140.00	$ 140.00
Average number of non-MA eligibles to be served per year	2.7	4.5	9.0	9.0
Total state MH grant payments per year @100% for community services for non-MA	$ 137,970	$ 229,950	$ 459,900	$ 459,900
Housing subsidy state cost per day	$ 16.67	$ 16.67	$ 16.67	$ 16.67
Average number receiving housing subsidies per year	6.00	10.00	20.00	20.00
Total state MH grant payments per year @100% for housing subsidies	$ 36,500	$ 60,833	$ 121,667	$ 121,667
One-time state funding for housing development	$ 1,000,000	$ -	$ -	$ -
Non-MA contract beds in community hospitals	$ -	$ 1,825,000	$ 3,650,000	$ 3,650,000
Total State MH Grants	$ 1,174,470	$ 2,115,783	$ 4,231,567	$ 4,231,567
State Operated Services				
SOS Operations net change, including reduced cost due to unit closure and increases due to mitigation	$ -	$ (2,131,500)	$ (4,254,000)	$ (6,020,680)
Summary by Budget Activity (dollars rounded off in thousands)				
29 Minnesota Supplemental Aid	$ 122	$ 366	$ 501	$ 508
30 Group Residential Housing	$ (43)	$ (171)	$ (200)	$ (200)
41 MA Elderly and Disabled (General Fund)	$ 271	$ 256	$ 755	$ 755
43 GAMC (General Fund)	$ 19	$ 31	$ 62	$ 62
74 Mental Health Grants (General Fund)	$ 1,174	$ 2,116	$ 4,232	$ 4,232
90 State Operated Services (General Fund)	$ -	$ (2,132)	$ (4,254)	$ (6,021)

	General Fund Sub-total	1,543	466	1,096	(664)
40	MnCare without FFP	$ 7	$ 12	$ 24	$ 24
	Health Care Access Fund Sub-total	7	12	24	24
Total expenditures		$ 1,550	$ 478	$ 1,120	$ (640)
Revenue increase (decrease)		$ -	$ (426)	$ (851)	$ (1,204)
Net fiscal impact (expenditures less revenues) - General Fund		$ 1,543	$ 892	$ 1,947	$ 540
Net fiscal impact (expenditures less revenues) - HCAF		$ 7	$ 12	$ 24	$ 24
Net fiscal impact (expenditures less revenues)		$ 1,550	$ 904	$ 1,971	$ 564

Long-Term Fiscal Considerations

Mitigation costs will decline in FY10-11 to the point where the proposal will be budget neutral for the FY10-11 biennium. FY08-09 costs will be less if the closed units at AMRTC are used for other services.

Local Government Costs

Counties are required re-invest a portion of savings in local share of current RTC expenditures in community based services, but should experience an overall decline in costs.

References/Sources

DHS data warehouse; AMRTC staff

Fiscal Worksheet

2005 Legislative Session / FY 2006-07 Biennial Budget

Community Alternatives for AMRTC - SF1395

This proposal provides upfront funding for community housing and services for individuals at AMRTC, with RTC savings reinvested to maintain the commun

RTC eligibility data, based on FY04 actual:	**FY 2006**	**FY 2007**	**FY 2008**	**FY 20**
Percent of AMRTC discharges who are **MA-SSI eligible**	82%	82%	82%	
Percent of AMRTC discharges who are **GA** eligible	13%	13%	13%	
Percent of AMRTC discharges who are **MnCare** eligible	5%	5%	5%	
Percent of AMRTC discharges who are VA or **private pay**	*	*	*	*

* 18% of FY04 RTC discharges had no state coverage; the above assumes that all discharges under this fiscal note will need state subsidized health care and housing

Housing / Room / Board Costs				
Standard GRH room and board pymt per person per month	$ 713.00	$ 713.00	$ 713.00	$ 713.00
SSI applicable to GRH (excl. $96 disregard and personal needs)	$ 483.00	$ 483.00	$ 483.00	$ 483.00
Net state share for GRH per month for SSI eligibles	$ 230.00	$ 230.00	$ 230.00	$ 230.00
Net state share for GRH per day for SSI eligibles	$ 7.67	$ 7.67	$ 7.67	$ 7.67
Net state share for GRH per month for **non-** SSI eligibles	$ 713.00	$ 713.00	$ 713.00	$ 713.00
Net state share for GRH per day for **non-**SSI eligibles (GA)	$ 23.77	$ 23.77	$ 23.77	$ 23.77

Preliminary

Standard MSA shelter needy pymt per person per month	$ 801.00	$ 801.00	$ 801.00	$ 801.00
SSI applicable to MSA	$ 579.00	$ 579.00	$ 579.00	$ 579.00
Net state share for Shelter Needy per month for SSI eligibles	$ 222.00	$ 222.00	$ 222.00	$ 222.00
Net state share for Shelter Needy per day for SSI eligibles	$ 7.40	$ 7.40	$ 7.40	$ 7.40
Average metro housing subsidy per month (based on metro Bridges)	$ 500.00	$ 500.00	$ 500.00	$ 500.00
Housing subsidy state cost per day (divide above by 30) (fund through State MH Grants)	$ 16.67	$ 16.67	$ 16.67	$ 16.67
Estimated mix of housing arrangements for RTC discharges:				
GRH/SSI	41%	41%	41%	
GRH/GA	9%	9%	9%	
MSA shelter needy	10%	10%	10%	
Housing subsidy	40%	40%	40%	
Total	100%	100%	100%	
Avg. state cost per day per person for housing/room/board, excl. services and health care	$ 12.69	$ 12.69	$ 12.69	$ 12.69
Service and health care costs				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Total cost per day for services and health care	$ 211.00	$ 211.00	$ 211.00	$ 211.00
less reinvestment of historical 10% county share (use for non-MA eligible services)	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 166.00	$ 166.00	$ 166.00	$ 166.00
state share for MA eligibles @50%	$ 83.00	$ 83.00	$ 83.00	$ 83.00
Avg. state cost per day per person for services and health care based on above MA eligibility, assuming 100% state funding for GA and MnCare eligibles, since GA and MnCare do not cover ACT, IRT, ARMHS, TCM and CADI	$ 97.94	$ 97.94	$ 97.94	$ 97.94
Combined Housing and Service Costs				
Average state share cost per person per day for housing and services	$ 110.63	$ 110.63	$ 110.63	$ 110.63
Avg state share cost per year per person	$ 40,380	$ 40,380	$ 40,380	$ 40,380
Average number of individuals to be maintained in the community	15	25	50	50
Total on-going state cost for community housing and services	$ 605,694	$ 1,009,490	$ 2,018,979	$ 2,018,979
One-time state funding for housing development	$ 1,000,000	$ -	$ -	$ -
Non-MA contract beds in community hospitals equivalent to 25 beds of RTC capacity, beginning 7/1/06, and another 25 beds beginning 7/1/07	$ -	$ 1,825,000	$ 3,650,000	$ 3,650,000

Net impact of MSA Shelter Needy - Rule 36 amendment (see separate analysis)	$ (55,695)	$ (225,052)	$ (296,172)	$ (288,378)
Projected fiscal effects due to closure of AMRTC units:				
One unit by 7/1/06	0	(1,250,000)	(1,250,000)	
Second unit by 1/1/07	0	(881,500)	(1,763,000)	
Third unit by 7/1/07	0	0	(1,250,000)	
Fourth unit by 1/1/08	0	0	(1,409,000)	
SOS mitigation costs	0	0	1,418,000	
Total SOS costs (savings)	0	(2,131,500)	(4,254,000)	
County share revenue increase (decrease)	0	(426,300)	(850,800)	
Net SOS costs (savings) less change in revenue	0	(1,705,200)	(3,403,200)	
Net state cost (savings)	1,549,999	904,238	1,969,607	
Biennial totals		2,454,237		

Conversion of above data into budget activities:

	FY 2006	FY 2007	FY 2008	FY 20
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Total new MSA cost per year for RTC restructuring	$ 4,052	$ 6,753	$ 13,505	$ 13,505
Net MSA impact from MSA Shelter Needy Rule 36 amendment	$117,884	$359,498	$487,125	
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Group Residential Housing				
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Average number of new GRH recipients per year as a result of RTC restucturing	6.15	10.25	20.50	20.50
Total new GRH cost per year for RTC restructuring - SSI eligibles	$ 17,210	$ 28,683	$ 57,366	$ 57,366
Net state share for GRH per day for non-SSI eligibles (GA)	$ 23.77	$ 23.77	$ 23.77	$ 23.77
Average number of new GRH recipients per year as a result of RTC restucturing	1.35	2.25	4.50	4.50
Total new GRH cost per year for RTC restructuring - non-SSI eligibles	$ 11,711	$ 19,518	$ 39,037	$ 39,037
Net GRH impact from MSA Shelter Needy Rule 36 amendment	$ (72,095)	$ (219,206)	$ (296,172)	$ (296,172)
Total GRH cost	$ (43,174)	$ (171,005)	$ (199,769)	$ (199,769)
Medical Assistance for Elderly and Disabled				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Total cost per day for services and health care	$ 211.00	$ 211.00	$ 211.00	$ 211.00
less reinvestment of historical 10% county share (use for non-MA eligible services)	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 166.00	$ 166.00	$ 166.00	$ 166.00
Average number of MA eligibles to be served per year	12.30	20.50	41.00	41.00

Total MA E&D payments for expanded treatment and support	$ 745,257	$ 1,242,095	$ 2,484,190	$ 2,484,190
state share @ 50%	$ 372,629	$ 621,048	$ 1,242,095	$ 1,242,095
(to the extent that CADI is needed, funds will be transferred from MA E&D to MA Waivers)				
Net MA E&D state share impact from MSA Shelter Needy Rule 36 amendment	$ (101,484)	$ (365,344)	$ (487,125)	$ (487,125)
Total MA E&D state share	$ 271,144	$ 255,704	$ 754,970	$ 754,970
GAMC and MnCare				
GA and MnCare do not cover ACT, IRT, ARMHS, TCM and CADI, so State MH Grants (see below) will be used for those services				
Average cost per day for ancillary health services, based on historical GAMC-IMD-non-RTC claims	$ 26.00	$ 26.00	$ 26.00	$ 26.00
Average number of GAMC eligibles to be served per year	1.95	3.25	6.50	6.50
Total GAMC payments per year @ 100%	$ 18,506	$ 30,843	$ 61,685	$ 61,685
Average number of MnCare eligibles to be served per year	0.75	1.25	2.50	2.50
Total MnCare payments per year @ 100%	$ 7,118	$ 11,863	$ 23,725	$ 23,725
State Mental Health Grants				
Avg. cost per day for community MH treatment and support, incl. mixture of ACT, IRT, ARMHS, TCM and CADI services	$ 185.00	$ 185.00	$ 185.00	$ 185.00
less reinvestment of historical 10% county share	$ (45.00)	$ (45.00)	$ (45.00)	$ (45.00)
State payment per day for services and health care	$ 140.00	$ 140.00	$ 140.00	$ 140.00
Average number of non-MA eligibles to be served per year	2.7	4.5	9.0	9.0
Total state MH grant payments per year @100% for community services for non-MA	$ 137,970	$ 229,950	$ 459,900	$ 459,900
Housing subsidy state cost per day	$ 16.67	$ 16.67	$ 16.67	$ 16.67
Average number receiving housing subsidies per year	6.00	10.00	20.00	20.00
Total state MH grant payments per year @100% for housing subsidies	$ 36,500	$ 60,833	$ 121,667	$ 121,667
One-time state funding for housing development	$ 1,000,000	$ -	$ -	$ -
Non-MA contract beds in community hospitals	$ -	$ 1,825,000	$ 3,650,000	$ 3,650,000
Total State MH Grants	$ 1,174,470	$ 2,115,783	$ 4,231,567	$ 4,231,567
State Operated Services				
SOS Operations net change, including reduced cost due to unit closure and increases due to mitigation	$ -	$ (2,131,500)	$ (4,254,000)	$ (6,020,680)
Summary by Budget Activity (dollars rounded off in thousands)				
29 Minnesota Supplemental Aid	$ 122	$ 366	$ 501	$ 508
30 Group Residential Housing	$ (43)	$ (171)	$ (200)	$ (200)
41 MA Elderly and Disabled (General Fund)	$ 271	$ 256	$ 755	$ 755
43 GAMC (General Fund)	$ 19	$ 31	$ 62	$ 62

74	Mental Health Grants (General Fund)	$	1,174	$	2,116	$	4,232	$	4,232
90	State Operated Services (General Fund)	$	-	$	(2,132)	$	(4,254)	$	(6,021)
	General Fund Sub-total		1,543		466		1,096		
40	MnCare without FFP	$	7	$	12	$	24	$	24
	Health Care Access Fund Sub-total		7		12		24		
Total expenditures		$	1,550	$	478	$	1,120	$	(640)
Revenue increase (decrease)		$	-	$	(426)	$	(851)	$	(1,204)
Net fiscal impact (expenditures less revenues) - General Fund		$	1,543	$	892	$	1,947	$	540
Net fiscal impact (expenditures less revenues) - HCAF		$	7	$	12	$	24	$	24
Net fiscal impact (expenditures less revenues)		$	1,550	$	904	$	1,971	$	564

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 1395 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 8. [SUPPORTIVE HOUSING AND OTHER COMMUNITY SERVICES FOR INDIVIDUALS TRANSITIONING FROM ANOKA-METRO REGIONAL TREATMENT CENTER.] The commissioner, through agreements with counties and in consultation with providers of supportive housing with services and others, shall transition individuals who are currently at Anoka-Metro Regional Treatment Center into the community, who are ready to be discharged or who are at imminent risk of admission. The commissioner shall expand the adult mental health initiative pilot projects under section 245.4661 to provide appropriate, thorough, flexible, and sufficient services that may include supportive housing with services, assertive community treatment, case management, and other community supports for individuals with a mental illness who:

(1) are at imminent risk of being admitted to, or are ready to be discharged or have recently been discharged from, a regional treatment center, community hospital, or residential treatment program; and

(2) have no appropriate housing available or lack the resources necessary to access permanent housing.

Sec. 2. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 9. [BED CLOSING.] The commissioner shall close 50 beds at the Anoka-Metro Regional Treatment Center by January 1, 2007, and an additional 50 beds by January 1, 2008, or after sufficient alternative services have been developed. The commissioner shall transfer state savings resulting from these bed closures into appropriate accounts in accordance with subdivision 10 to pay for the ongoing provision of the alternative services in subdivision 8 and for expansion of contract beds under section 256.9693.

Sec. 3. Minnesota Statutes 2004, section 245.4661, is

amended by adding a subdivision to read:

Subd. 10. [BUDGET FLEXIBILITY.] The commissioner may make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

Sec. 4. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 11. [COUNTY ELIGIBILITY.] The commissioner may approve funding for services under subdivision 8 in accordance with subdivisions 9 and 10 for a county or group of counties that:

(1) agrees to outcome-based performance criteria that includes a reduction in utilization of regional treatment center inpatient services through provision of quality services that meet individual needs;

(2) agrees to the collection and submission of data necessary to measure progress towards the criteria in clause (1) and measurement of any resulting state or county savings;

(3) agrees to reinvest in the services defined in subdivision 8 an amount equal to the ten percent county share of regional treatment center services for the fiscal year ending June 30, 2004, applied against the bed utilization reduction in clause (1); and

(4) agrees to develop a supportive housing program that insures the delivery of employment services, supportive services, housing and health care for eligible individuals, or agrees to contract with an existing integrated program.

Sec. 5. Minnesota Statutes 2004, section 256D.44, subdivision 5, is amended to read:

Subd. 5. [SPECIAL NEEDS.] In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for

medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly of

$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution, or an adult mental health residential treatment program under section 256B.0622, and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

Sec. 6. [APPROPRIATION.]

$...,... is appropriated from the general fund to the

commissioner of human services for the biennium beginning June 30, 2005, for purposes of sections 1 to 4. Unused funds shall not cancel but may be used until expended."

Amend the title accordingly

A bill for an act

relating to human services; establishing the work participation rate enhancement program; amending Minnesota Statutes 2004, sections 119B.011, by adding a subdivision; 119B.05, subdivision 1; 256J.021; 256J.08, subdivision 65; 256J.521, subdivision 1; 256J.626, subdivisions 1, 2, 3, 4, 7; proposing coding for new law in Minnesota Statutes, chapter 256J.

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

Section 1. Minnesota Statutes 2004, section 119B.011, is amended by adding a subdivision to read:

Subd. 23. [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.] "Work participation rate enhancement program" means the program established under section 256J.575.

Sec. 2. Minnesota Statutes 2004, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE PARTICIPANTS.] Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

~~(7)~~ (8) families who are participating in the transition year extension under section 119B.011, subdivision 20a.

Sec. 3. Minnesota Statutes 2004, section 256J.021, is amended to read:

256J.021 [SEPARATE STATE ~~PROGRAM~~ PROGRAMS FOR USE OF STATE MONEY.]

(a) Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

(b) Beginning October 1, 2005, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a household participating in the work participation rate enhancement program under section 256J.575 as expenditures under a separately funded state program

and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 4. Minnesota Statutes 2004, section 256J.08, subdivision 65, is amended to read:

Subd. 65. [PARTICIPANT.] "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant. A person who receives cash payments under the work participation rate enhancement program under section 256J.575 is a participant.

Sec. 5. Minnesota Statutes 2004, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. [ASSESSMENTS.] (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to

develop and update the employment plan under subdivision 2 or 3, as appropriate, and to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the work participation rate enhancement program under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2,

paragraph (d). Failure to complete the screens will result in sanction under section 256J.46; and

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to the work participation rate enhancement program under section 256J.575.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 6. [256J.575] [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.]

Subdivision 1. [PURPOSE.] (a) The work participation rate enhancement program (WORK PREP) is Minnesota's TANF program to serve families who are not making significant progress within MFIP due to a variety of barriers to employment.

(b) The goal of this program is to stabilize and improve the lives of families at risk of long-term welfare dependency or

family instability due to employment barriers such as physical disability, mental disability, age, and caring for a disabled household member. WORK PREP provides services to promote and support families to achieve the greatest possible degree of self-sufficiency. Counties may provide supportive and other allowable services funded by the MFIP consolidated fund under section 256J.626 to eligible participants.

Subd. 2. [DEFINITIONS.] The terms used in this section have the meanings given them in paragraphs (a) to (d).

(a) The "work participation rate enhancement program" means the program established under this section.

(b) "Case management" means the services provided by or through the county agency to participating families, including assessment, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

(c) "Family stabilization plan" means a plan developed by a case manager and the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the family's circumstances.

(d) "Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:

(1) obtaining and retaining unsubsidized employment;

(2) family stability;

(3) economic stability; and

(4) barrier reduction.

The goal of the program is to achieve the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.

Subd. 3. [ELIGIBILITY.] (a) The following MFIP or DWP participants are eligible for the program under this section:

(1) a participant identified under section 256J.561, subdivision 2, paragraph (d), who has or is eligible for an

employment plan developed under section 256J.521, subdivision 2, paragraph (c);

(2) a participant identified under section 256J.95, subdivision 12, paragraph (b), as unlikely to benefit from the diversionary work program;

(3) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3; and

(4) a participant who is applying for supplemental security income or Social Security disability insurance.

(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.

Subd. 4. [UNIVERSAL PARTICIPATION.] All caregivers must participate in family stabilization services as defined in subdivision 2.

Subd. 5. [CASE MANAGEMENT; FAMILY STABILIZATION PLANS; COORDINATED SERVICES.] (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the work participation rate enhancement program. The case manager, with the full involvement of the family, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family.

(b) The family stabilization plan shall include:

(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;

(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and

(3) an identification of the services, supports, education, training, and accommodations needed to overcome any barriers to

enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant must meet within 30 days of the family's referral to the case manager. The initial family stabilization plan shall be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and modify if necessary the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed to comply with a family stabilization plan requirement;

(4) services required by the plan are unavailable; or

(5) changes to the plan are needed to promote the well-being of the children.

(d) Family stabilization plans under this section shall be written for a period of time not to exceed six months.

Subd. 6. [COOPERATION WITH PROGRAM REQUIREMENTS.] (a) To be eligible, a participant must comply with paragraphs (b) to (f).

(b) Participants shall engage in family stabilization plan activities listed in clause (1) or (2) for the number of hours per week that the activities are scheduled and available, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1:

(1) in single-parent families with no children under six years of age, the case manager and the participant must develop a family stabilization plan that includes 30 to 35 hours per week of activities; and

(2) in single-parent families with a child under six years of age, the case manager and the participant must develop a

family stabilization plan that includes 20 to 35 hours per week of activities.

(c) The case manager shall review the participant's progress toward the goals in the family stabilization plan every six months to determine whether conditions have changed, including whether revisions to the plan are needed.

(d) When the participant has increased participation in work-related activities sufficient to meet the federal participation requirements of TANF, the county agency shall refer the participant to the MFIP program and assign the participant to a job counselor. The participant and the job counselor must meet within 15 days of referral to MFIP to develop an employment plan under section 256J.521. No reapplication is necessary and financial assistance shall continue without interruption.

(e) Participants who have not increased their participation in work activities sufficient to meet the federal participation requirements of TANF may request a referral to the MFIP program and assignment to a job counselor after 12 months in the program.

(f) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision shall be excused when the case management services, training and educational services, and family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.

Subd. 7. [SANCTIONS.] (a) The financial assistance grant of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (f).

(b) Given the purpose of the work participation rate enhancement program in this section and the nature of the underlying family circumstances that act as barriers to both employment and full compliance with program requirements,

sanctions are appropriate only when it is clear that there is both ability to comply and willful noncompliance on the part of the participant.

(c) Prior to the imposition of a sanction, the county agency must review the participant's case to determine if the family stabilization plan is still appropriate and meet with the participants face-to-face. The participant may bring an advocate to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1):

(1) during the face-to-face meeting, the county agency must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed family stabilization service, as defined in subdivision 2, paragraph (d);

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(iii) determine whether activities in the family stabilization plan are appropriate based on the family's circumstances;

(iv) explain the consequences of continuing noncompliance;

(v) identify other resources that may be available to the participant to meet the needs of the family; and

(vi) inform the participant of the right to appeal under section 256J.40; and

(2) if the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity.

(d) After the requirements of paragraph (c) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action

as provided in section 256J.31.

(e) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Sec. 7. [256J.621] [WORK PARTICIPATION BONUS.]

Upon exiting the diversionary work program (DWP) or upon terminating MFIP cash assistance with earnings, a participant shall be eligible for a work participation bonus of $75 per month to assist the household in meeting work-related expenses, including child care, transportation, and clothing, as the participant continues to move toward self-sufficiency. A participant is eligible for the work participation bonus if the participant is employed and working at least 24 hours a week when the MFIP case is closed. The participant will receive the work participation bonus in any month that the participant is employed an average of 24 hours per week, for a maximum of 12 months upon exiting DWP or MFIP. The commissioner shall establish policies and forms for verifying the level of employment necessary to qualify for the work participation bonus.

Sec. 8. Minnesota Statutes 2004, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. [CONSOLIDATED FUND.] The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2, and to provide case management services to participants of the work participation rate enhancement program. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Sec. 9. Minnesota Statutes 2004, section 256J.626, subdivision 2, is amended to read:

Subd. 2. [ALLOWABLE EXPENDITURES.] (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal

Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program; to administer financial assistance~~,~~; and to provide specialized services intended to assist hard-to-employ participants to transition to work or transition from the work participation rate enhancement program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment; and

(13) services to help families participating in the work participation rate enhancement program achieve the greatest possible degree of self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

Sec. 10. Minnesota Statutes 2004, section 256J.626, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY FOR SERVICES.] Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program, and families at risk of receiving MFIP or diversionary work program.

Sec. 11. Minnesota Statutes 2004, section 256J.626, subdivision 4, is amended to read:

Subd. 4. [COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.] (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

(b) The service agreements will be completed in a form

prescribed by the commissioner. The agreement must include:

(1) a statement of the needs of the service population and strengths and resources in the community;

(2) numerical goals for participant outcomes measures to be accomplished during the biennial period. The commissioner may identify outcomes from section 256J.751, subdivision 2, as core outcomes for all counties and tribes;

(3) strategies the county or tribe will pursue to achieve the outcome targets. Strategies must include specification of how funds under this section will be used and may include community partnerships that will be established or strengthened; ~~and~~

(4) strategies the county or tribe will pursue under the work participation rate enhancement program; and

(5) other items prescribed by the commissioner in consultation with counties and tribes.

(c) The commissioner shall provide each county and tribe with information needed to complete an agreement, including: (1) information on MFIP cases in the county or tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome measures; and (4) promising program practices.

(d) The service agreement must be submitted to the commissioner by October 15, 2003, and October 15 of each second year thereafter. The county or tribe must allow a period of not less than 30 days prior to the submission of the agreement to solicit comments from the public on the contents of the agreement.

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

(f) The service agreement in this subdivision supersedes the plan requirements of section 116L.88.

Sec. 12. Minnesota Statutes 2004, section 256J.626, subdivision 7, is amended to read:

Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar year 2005, each county and tribe will be allocated 95 100 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds from federal TANF bonus funds the state receives based on performance as follows:

(1) for calendar year 2005, a county or tribe that achieves a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(2) for calendar year 2006, a county or tribe that achieves a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(3) for calendar year 2007, a county or tribe that achieves a 50 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(4) for calendar year 2008 and yearly thereafter, a county or tribe that achieves a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(5) for calendar years 2005 and thereafter, a county or tribe that performs above the top of its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year will receive an additional allocation ~~equal to five percent of its initial allocation~~ to be determined by the commissioner based upon available funds; or

(6) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds.

(b) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

~~(c) (1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.~~

~~(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).~~

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1955-0 **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: MFIP WORK PARTICIP RATE ENHANCEMENT

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	268	12,379	12,716	8,638
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	268	12,379	12,716	8,638
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	268	12,379	12,716	8,638
Total Cost <Savings> to the State	0	268	12,379	12,716	8,638

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

Preliminary

Narrative: SF 1955

Bill Description
This bill would establish a state-funded work participation rate enhancement program and a work participation bonus for Minnesota Family Investment Program (MFIP) participants. It would require counties to determine as part of ongoing assessments, whether a participant should be referred to the work participation enhancement program based on progress during the past 12 months on MFIP.

The bill also provides for a work participant bonus of $75 upon leaving MFIP cash assistance or the Diversionary Work Program (DWP) as a result of employment. This bonus would be available for up to 12 months and is contingent upon the participant remaining employed for 24 hours per week.

This bill would change the county allocations from 95% to 100% and would pass through to counties and tribes any federal Temporary Assistance to Needy Families (TANF) bonus funds.

Assumptions
See attached

Programming of the computer system that supports the MFIP program would be required to implement the changes in this bill. The changes needed to implement the work participation rate enhancement program could be done by July 1, 2005.

Implementation of the work participation bonus would require significant programming changes and would take approximately 11 months to design, program and test.

Expenditure and/or Revenue Formula
See attached.

Programming costs are estimated at $372,960, 55% of which is the state share of $205,128.

Long-term Fiscal Considerations

Local Government Costs
The allocation formula used to distribute the MFIP consolidated grant to counties would change to allow 100% of the funds to be distributed to counties as part of the initial allocation. Currently, 95% of the funds are allocated with the remainder available if counties meet certain performance measurements.

References/Sources
Shawn Welch,
Reports & Forecasts Division
MN Dept of Human Services
651.282.3932

Minnesota
MINNESOTA FAMILY INVESTMENT PROGRAM
Fiscal Analysis of SF1955

Section 6. Subd. 3. Eligibility
This section creates the eligibility categories for the Work Participation Enhancement Program (Work PREP). Included in this program are the following groups: 1) MFIP cases with an eligible caregiver over 60 years old, 2) MFIP cases with a caregiver who is ill or incapacitated longer than 30 days, 3) MFIP cases with a caregiver who is needed in the home to care for someone who is ill or incapacitated, 4) MFIP cases that meet the requirements for the Hard to Employ hardship extension, 5) MFIP cases in which the caregiver is applying for SSI or RSDI, and 6) MFIP cases who have been identified as unlikely to benefit from DWP. This fiscal analysis assumes that the separate and segregated state programs in the current law forecast are unaffected by the creation of the Work PREP program.

The Work PREP program does not result in eligibility or payment changes for the eligible cases. However, it is assumed that the Work PREP program is a separate state program. This implies that the Work PREP program must be funded with state General Fund dollars.
To the extent that there are not enough available General Fund expenditures in the current law MFIP forecast, the creation of this separate state program would result in a net cost as additional General Fund dollars would be required in the forecast. The alternative would be to refinance TANF expenditures out of the current law MFIP forecast and replace them with General Fund dollars.

It is estimated that approximately $16 million per year would be needed to fund cash assistance for the Work PREP eligible cases. It is also estimated that the current law forecast has between $12-$16 million in available General Funds depending on the fiscal year. Thus, this fiscal analysis identifies in which fiscal years there is a projected deficit of General Fund dollars with the creation of the Work PREP program, and the amount of the deficit.

	FY 2006	FY 2007	FY 2008	FY 2009
Projected available General Fund in the current law forecast	$16,518,287	$12,665,052	$12,272,788	$22,528,002
Projected General Funds needed for the Work PREP program	$16,452,225	$16,405,302	$16,350,135	$16,255,052
Total additional General Funds required	$0	$3,740,250	$4,077,347	$0

Section 6. Subd. 6. Cooperation With Program Requirements This section outlines the sanction policy with respect to the MFIP cases eligible for the Work PREP separate state program. The primary difference from current law for these cases is that a sanction can only be imposed on a Work PREP case if it is clear that there is both the ability to comply and willful noncompliance on the part of the participant. This would result in fewer sanctions for these cases.

Based on MAXIS data, it is estimated that about 2% of the Work PREP cases are currently in sanction status. It is assumed that the new sanction policy will decrease the percent sanctioned by one-half, to about 1%. The estimated increase in average monthly payment is about $123. The effective date is assumed to be July 1, 2005.

	FY 2006	FY 2007	FY 2008	FY 2009
Avg monthly Work PREP cases with current sanction	85	85	85	85
Percent with no sanction under new policy	50%	50%	50%	50%
Avg monthly Work PREP cases with no sanction under new policy	43	43	43	43
Increase in average monthly payment	$123	$123	$123	$123
Months	12	12	12	12
Total cost for sanction policy	$62,938	$62,938	$62,938	$62,938

Section 7. Work Participation Bonus
This section creates the work participation bonus. This bonus is $75 per family per month for up to 12 months. The bonus is paid to families that a) exit DWP or b) exit MFIP cash assistance with earnings, as long as the eligible caregivers are working at least 24 hours per week when the DWP or MFIP case is closed. This implies that some MFIP cases who would be receiving only the food portion under current law will also be receiving the $75 work participation bonus based on the language in this bill. Further, DWP cases who apply and are found eligible for MFIP could also receive the bonus while receiving MFIP cash and food benefits. Families who exit DWP without becoming eligible for MFIP or exit MFIP cash assistance without receiving the MFIP food portion are also eligible for this bonus for up to 12 months. Additionally the bonus can be paid in non-consecutive months during the twelve months that the family is eligible for the bonus payments. Finally, it is assumed that eligibility for this work participation bonus constitutes a segregated state program, which implies that the bonus must be paid out of state General Fund dollars.

Based on MAXIS data, it is projected that there are about 1000 DWP closings in a given month and that about 2800 MFIP cases exit cash assistance in a given month. It is estimated that about 24% of DWP closings and 34% of MFIP exits meet the 24 hours per week work requirement. For those cases who exit DWP and do not become eligible for MFIP and those cases who exit MFIP cash assistance, receipt of segregated state funds requires the family to assign child support collections to offset state expenditures. This requirement to assign child support along with the potential for a family to miss the hours of work requirement in a given month imply that not all families will receive the full 12 months of bonus payments. It is assumed that eligible families will receive an average of 8 of 12 possible months of the work participation bonus.

The effective date for this section is July 1, 2005. Due to the requirement that DHS receive prior approval from the US Department of Agriculture, the first possible implementation date would be August 1, 2005. Systems programming would take an additional 11 months to complete so the projected implementation date is July 1, 2006.

MFIP cash assistance exits	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly exits from MFIP cash assistance	2,800	2,800	2,800	2,800
Percent meeting hours requirement	34%	34%	34%	34%

Preliminary

Avg monthly cases eligible for bonus	955	955	955	955
Avg number of months receiving bonus	8	8	8	8
Monthly bonus payment	$75	$75	$75	$75
Phase-in	0%	100%	100%	100%
Total cost for MFIP cash exits	$0	$6,876,052	$6,876,052	$6,876,052

DWP closings	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly closings from DWP	1,000	1,000	1,000	1,000
Percent meeting hours requirement	24%	24%	24%	24%
Avg monthly cases eligible for bonus	236	236	236	236
Avg number of months receiving bonus	8	8	8	8
Monthly bonus payment	$75	$75	$75	$75
Phase-in	0%	100%	100%	100%
Total cost for DWP closings	$0	$1,699,200	$1,699,200	$1,699,200

Fiscal Summary	FY2006	FY2007	FY2008	FY2009
		(in thousands)		
Work PREP	$0	$3,740	$4,077	$0
Sanctions	$63	$63	$63	$63
MFIP bonus	$0	$6,876	$6,876	$6,876
DWP bonus	$0	$1,699	$1,699	$1,699
Total Cost	$63	$12,379	$12,716	$8,638

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 1955 as follows:

Page 11, delete lines 7 to 18 and insert "who is employed and working 24 hours a week may be eligible for transitional assistance of $50 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

To be eligible for a transitional assistance payment, the participant must not receive MFIP cash assistance or diversionary work program assistance during the month and must be employed an average of at least 24 hours a week. Transitional assistance shall be available for a maximum of 12 months from the date the participant exited the diversionary work program or terminated MFIP cash assistance.

The commissioner shall establish policies and develop forms to verify eligibility for transitional assistance. The forms must contain all data elements required to meet federal TANF reporting requirements.

Expenditures on the transitional assistance program shall be state-funded and treated as segregated funds under the state's TANF maintenance of effort requirement. Months in which a participant receives transitional assistance under this section shall not count toward the participant's MFIP 60-month time limit.

If federal law changes the work participation rates that states must meet, the commissioner has the authority to determine if this provision is implemented or continued."

A bill for an act

relating to health; requiring disclosure of and limiting certain charges to the uninsured; limiting provider recourse; providing remedies; requiring disclosure of certain hospital charges; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Section 1. [62J.82] [CHARGES TO UNINSURED; PROVIDER RECOURSE.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Covered individual" means an individual who has health plan company or public health care program coverage for health care services.

(c) "CPT code" means a code contained in the most current edition of the Physician's Current Procedural Terminology (CPT) manual published by the American Medical Association and available for purchase through the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610.

(d) "Dependent" has the meaning given under section 62L.02, subdivision 11.

(e) "Health care service" has the meaning given under section 62J.17, subdivision 2.

(f) "Health plan company" has the meaning given under

section 62Q.01, subdivision 4.

(g) "Person" means an individual, corporation, firm, partnership, incorporated or unincorporated association, or any other legal or commercial entity.

(h) "Provider" has the meaning given under section 144.50, subdivision 2.

(i) "Third-party payer" means a health plan company or a public health care plan or program.

(j) "Uninsured individual" means a person or dependent who does not have health plan company coverage or who is not otherwise covered by a third-party payer.

Subd. 2. [NOTICE TO UNINSURED.] (a) A provider may attempt to obtain from a person or the person's representative information about whether any third-party payer may fully or partially cover the charges for health care services rendered by the provider to the person.

(b) A provider shall inform each person, both orally and in writing, immediately upon first meeting with that person, or as soon as practicable thereafter, that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3.

(c) If, at the time health care services are provided, a person has not provided proof of coverage by a third-party payer or a provider otherwise determines that the person is an uninsured individual, the provider, as part of any billing to the person, shall provide the person with a clear and conspicuous notice that includes:

(1) a statement of charges for health care services rendered by the provider; and

(2) a statement that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3.

(d) For purposes of the notice required under paragraph (c), a provider may incorporate the items into the provider's existing billing statements and is not required to develop a separate notice. All communications to a person required by

this subdivision must be language appropriate.

Subd. 3. [PROVIDER CHARGES TO THE UNINSURED.] In billing or charging an uninsured individual or the individual's representative for medically necessary health care services, a provider must bill by CPT code, or other billing identifier as may be routinely used for billing that health care service. A provider shall not bill or charge an uninsured individual or the individual's representative more than 120 percent of the amount the provider is paid for that service by a nongovernmental third-party payer plus any applicable cost-sharing payments payable by a patient during the previous calendar year. After a bill or charge is issued under this subdivision, a provider may not increase the bill or charge.

Subd. 4. [LIMITATIONS.] Notwithstanding any other provision of law, the amounts paid by uninsured individuals for health care services according to subdivision 3 does not constitute a provider's uniform, published, prevailing, or customary charges, or its usual fees to the general public, for purposes of any payment limit under the Medicare or medical assistance programs or any other federal or state financed health care program.

Subd. 5. [RECOURSE LIMITED.] (a) Providers under agreement with a health plan company or public health care plan or program to provide health care services shall not have recourse against covered individuals, or persons acting on their behalf, for amounts above those specified in the evidence of coverage or other plan or program document as co-payments or coinsurance for health care services. This subdivision applies but is not limited to the following events:

(1) nonpayment by the health plan company;

(2) insolvency of the health plan company; and

(3) breach of the agreement between the health plan company and the provider.

(b) This subdivision does not limit a provider's ability to seek payment from any person other than the covered individual, the covered individual's guardian or conservator, the covered

individual's immediate family members, or the covered individual's legal representative in the event of nonpayment by a health plan company.

Subd. 6. [REMEDIES.] A person may file an action in district court seeking injunctive relief and damages for violations of this section. In any such action, a person may also recover costs and disbursements and reasonable attorney fees.

Subd. 7. [GROUNDS FOR DISCIPLINARY ACTION.] Violations of this section may be grounds for disciplinary or regulatory action against a provider by the appropriate licensing board or agency.

Subd. 8. [AUTHORITY OF ATTORNEY GENERAL.] The attorney general may investigate violations of this section under section 8.31. The attorney general may file an action for violations of this section according to section 8.31 or may pursue other remedies available to the attorney general.

Subd. 9. [INCOME AND ASSET LIMITATIONS.] The provisions of this section shall not apply to uninsured individuals with an annual family income above $125,000.

Sec. 2. [62J.83] [HOSPITAL COST DISCLOSURE.]

Subdivision 1. [IDENTIFICATION OF HOSPITAL PROCEDURES.] Based on state or national data, the commissioner of health shall select the following:

(1) the 25 most frequently performed hospital inpatient procedures;

(2) the 25 most frequently performed hospital outpatient procedures; and

(3) the 50 most frequently administered drugs in a hospital inpatient setting.

Subd. 2. [REPORT.] Not later than 45 days after the end of each calendar quarter, a hospital shall report to the commissioner of health the average and the median allowable charge by the hospital or outpatient surgical center for the procedures and drugs identified in subdivision 1.

Subd. 3. [COMPUTATION.] For purposes of subdivision 2, the

computation of an average and median price for a procedure or a drug shall be in accordance with a methodology prescribed by the commissioner of health.

Subd. 4. [DISCLOSURE.] This information shall be available to the public on a comparative basis.

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Senate
State of Minnesota

S.F. No. 1162 - Provider Payment Disclosure and Limitation (First Engrossment)

Author: Senator Linda Berglin

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

Date: April 8, 2005

S.F. No. 1162 requires hospitals and outpatient surgical centers to disclose the allowable charges for certain procedures and limits the amount a hospital can charge to uninsured individuals.

Section 1 (62J.82) limits the amount a hospital can charge to uninsured individuals.

Subdivision 1 defines the following terms: "covered individuals," "CPT code," "dependent," "health care service," "health plan company," "person," "provider," "third-party payer," and "uninsured individual." The definition of "provider" is limited to hospitals and outpatient surgical centers.

Subdivision 2, paragraph (a), authorizes a provider to obtain information about whether any third-party payer may fully or partially cover the charges for health care services rendered by the provider.

Paragraph (b) requires the provider to inform each person, both orally and in writing, that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3.

Paragraph (c) requires the provider as part of any billing to any person who has not provided proof of coverage by a third-party payer or the provider determines that the person is uninsured a clear and conspicuous notice that includes:

(1) a statement of charges for health care services rendered by the provider; and

(2) a statement that uninsured individuals will be charged or billed for services in amounts that do not exceed the amounts described in subdivision 3.

Paragraph (d) permits the provider to incorporate the items into the provider's existing billing statements. States that all required communications under this subdivision must be language appropriate.

Subdivision 3 states that a provider must bill or charge an uninsured individual for medically necessary services by CPT code or other billing identifier that is routinely used for billing and may not bill or charge an uninsured individual more than 120 percent of the amount the provider is paid for that service by a nongovermental third-party payer, including any cost-sharing payments.

Subdivision 4 states that the amounts paid by uninsured individuals do not constitute a provider's uniform, published, prevailing, or customary charges or its usual fees to the general public for purposes of any payment limit under the Medicare or medical assistance programs or any other federal or state financed health care program.

Subdivision 5, paragraph (a), states that providers under agreement with a health plan company or public health care program shall not have recourse against covered individuals for the amounts above those specified in the evidence of coverage or other document as cost sharing for health care services.

Paragraph (b) states that this does not limit a provider's ability to seek payment from any person other than the covered individual, the covered individual's guardian or conservator, immediate family members, or legal representative in the event of nonpayment by a health plan company.

Subdivision 6 states that a person may file an action in district court seeking injunctive relief and damages for violations of this section. States that a person may also recover costs and disbursements and reasonable attorney fees.

Subdivision 7 states that violations of this section by a provider are grounds for disciplinary or regulatory action by the appropriate licensing board or agency.

Subdivision 8 authorizes the attorney general to investigate violations of this section and to file an action or pursue other remedies available to the attorney general.

Subdivision 9 states that this section only applies to uninsured individuals with an annual family income above $125,000.

Section 2 (62J.83) requires the Commissioner of Health to select the 25 most frequently performed hospital inpatient procedures, the 25 most frequently performed outpatient procedures, and the 50 most frequently administered drugs in a hospital inpatient setting and requires the hospitals to report on a quarterly basis to the commissioner the average and median allowable charge by the hospital or surgical center for these procedures and drugs. Requires the commissioner to prescribe a methodology for computation of an average and median price for each procedure and drug. States that this information shall be made available to the public on a comparative basis.

KC:ph

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1162-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE PROV SVCS PYMTS DISC REQ

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

Agencies: Health Dept
Human Services Dept (04/14/05)

Attorney General (04/07/05)

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					
Health Care Access Fund		40	40	40	40
Health Dept		40	40	40	40
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund		40	40	40	40
Health Dept		40	40	40	40
Total Cost <Savings> to the State		40	40	40	40

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund		0.50	0.50	0.50	0.50
Health Dept		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1162-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE PROV SVCS PYMTS DISC REQ

Agency Name: Health Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Care Access Fund		40	40	40	40
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Health Care Access Fund		40	40	40	40
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund		40	40	40	40
Total Cost <Savings> to the State		40	40	40	40

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Bill Description

Section 2, subd. 1
Directs the Commissioner to identify the 25 most frequently performed hospital inpatient and hospital outpatient procedures, and the 50 most frequently administered drugs in hospital inpatient settings.

Section 2, subd. 2, subd. 3
Requires hospitals to report the average and median allowable charge by the hospital for the procedures and drugs identified under Section 2, subdivision 1 to the Commissioner of Health no later than 45 days after the end of each calendar quarter. Average and median charges for procedures or drugs are to be computed in accordance with a methodology prescribed by the Commissioner.

Section 2, subd. 4
Directs the Commissioner to make information collected under subdivisions 2 and 3 available to the public on a comparative basis.

Assumptions
Subdivision 1 directs the Department to identify the inpatient and outpatient procedures that are most frequently performed by hospitals, along with the most frequently administered drugs in hospital inpatient settings. Information on the frequency with which inpatient and outpatient procedures are performed is already available through hospital discharge databases; identification of these procedures will not require significant new effort on the part of MDH staff.

However, information about the frequency with which drugs are administered in hospitals does not currently exist. Collection of this information would require the development and administration of a survey, through which each Minnesota hospital would identify the most frequently administered drugs in their facility. For the purposes of this fiscal note, we are assuming that this survey would be administered annually.

In addition to staff time required for the collection and collation of data on usage of drugs in inpatient settings, additional staff time will be required for the development of a methodology for computing average and median price charged for each procedure and drug identified in subdivision 1, as well as for the development of quarterly hospital reporting forms, communication with hospitals about their requirements under this section, monitoring of hospital compliance with the provisions of this section, the development of a format for publication of collected information, and the printing or web publishing of this information. We assume that the performance of this work will require 0.5 FTE Research Analysis Specialist, Senior beginning in SFY2006 and continuing through the biennium. *MDH contains the existing capacity and expertise to allow the Department to absorb the costs of one to two studies or surveys per year. Our ability to absorb this particular survey is contingent upon the number of other studies or surveys the department is asked to complete.*

We assume that the intent of the legislation is to gather information on average and median prices actually received by hospitals for these services, rather than hospitals' average and median charges. We also assume that the reporting required of hospitals under Section 2, subdivision 2 is meant to include only prices received by the hospitals, not by hospitals and outpatient surgical centers.

Expenditure and/or Revenue Formula

EXPENDITURES	SFY06	SFY07	SFY08	SFY09
Salary –.5 RAS Sr ongoing	25.735	25.735	25.735	25.735
Fringe 29%	7.463	7.463	7.463	7.463
Subtotal Sal & Fringe	33.198	33.198	33.198	33.198
Indirect costs 19.4%	6.440	6.440	6.440	6.440
TOTAL EXPENSES	39.638	39.638	39.638	39.638

The costs of this survey could be absorbed if this is the only bill passed into law requiring the department to complete a survey of this nature.

Preliminary

Long-Term Fiscal Considerations

Local Government Costs

None

References/Sources

Agency Contact Name: Scott Leitz (651-282-6361)
FN Coord Signature: DAVE HOVET
Date: 04/15/05 Phone: 215-0389

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1162-1A **Complete Date:** 04/14/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE PROV SVCS PYMTS DISC REQ

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					
-- 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					

Preliminary

Narrative; SF 1162-1A

Bill Description

This bill requires providers to disclose the amount the provider receives for provision of health care services. The bill, as amended, also limits the amount a provider can charge to uninsured individuals, whose annual family income is below $125,000.

This bill, as amended has no fiscal impact on DHS.

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Char Sadlak 296-5599
FN Coord Signature: STEVE BARTA
Date: 04/07/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KATIE BURNS
Date: 04/14/05 Phone: 296-7289

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1162-1A **Complete Date:** 04/07/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE PROV SVCS PYMTS DISC REQ

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

Agency Name: Attorney General

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					

Preliminary

Bill Description

S.F. 1162-1A establishes a new law in M.S. Chapter 62J requiring disclosures of certain payments; requiring disclosure of and limiting certain charges to the uninsured; limiting provider recourse; provides for remedies; and provides for the attorney general to investigate violations of this law.

Assumptions

It is likely that the attorney general activities addressed by this bill could be absorbed by existing staff and resources.

Expenditure and/or Revenue Formula

Expenditure: None

Revenue: None

Long-Term Fiscal Considerations

N/A

Local Government Costs

N/A

References/Sources

Agency Contact Name: Ken Peterson (651-296-2731)
FN Coord Signature: TERRY POHLKAMP
Date: 04/06/05 Phone: 297-1143

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 04/07/05 Phone: 215-0595

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. 1162: A bill for an act relating to health; requiring disclosure of and limiting certain charges to the uninsured; limiting provider recourse; providing remedies; requiring disclosure of certain hospital charges; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Page 2, delete lines 5 and 6 and insert:

"(h) "Provider" means a hospital or outpatient surgical center licensed under chapter 144."

Page 3, line 8, delete everything after "than" and insert "the amount the provider is paid for that service by the nongovernmental third-party payer that provided the most revenue to the provider during the previous calendar year, plus any applicable cost sharing payments payable by an individual covered by that provider's highest volume plan."

Page 3, delete lines 9 and 10

Page 3, line 11, delete everything before "After"

Page 3, line 28, delete "but" and insert "only to health plans that provide coverage equal to or greater than a number two qualified plan described under section 62E.08, and"

Pages 4 and 5, delete section 2

Amend the title as follows:

Page 1, line 4, delete "requiring"

Page 1, line 5, delete everything before "proposing"

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

Linda Berglin.....
(Division Chair)

April 18, 2005.....
(Date of Division action)

A bill for an act

relating to civil commitment; expanding early intervention services; amending Minnesota Statutes 2004, section 253B.065, subdivision 5.

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

Section 1. Minnesota Statutes 2004, section 253B.065, subdivision 5, is amended to read:

Subd. 5. [EARLY INTERVENTION CRITERIA.] (a) A court shall order early intervention treatment of a proposed patient who meets the criteria under paragraph (b) or (c). The early intervention treatment must be less intrusive than long-term inpatient commitment and must be the least restrictive treatment program available that can meet the patient's treatment needs.

(b) The court shall order early intervention treatment if the court finds all of the elements of the following factors by clear and convincing evidence:

(1) the proposed patient is mentally ill;

(2) the proposed patient refuses to accept appropriate mental health treatment; and

(3) the proposed patient's mental illness is manifested by instances of grossly disturbed behavior or faulty perceptions and either:

(i) the grossly disturbed behavior or faulty perceptions significantly interfere with the proposed patient's ability to care for self and the proposed patient, when competent, would

have chosen substantially similar treatment under the same circumstances; or

(ii) due to the mental illness, the proposed patient received court-ordered inpatient treatment under section 253B.09 at least two times in the previous three years; the patient is exhibiting symptoms or behavior substantially similar to those that precipitated one or more of the court-ordered treatments; and the patient is reasonably expected to physically or mentally deteriorate to the point of meeting the criteria for commitment under section 253B.09 unless treated.

For purposes of this paragraph, a proposed patient who was released under section 253B.095 and whose release was not revoked is not considered to have received court-ordered inpatient treatment under section 253B.09.

(c) The court may order early intervention treatment if the court finds that a pregnant woman is a chemically dependent person. A chemically dependent person for purposes of this section is a woman who has been engaging during pregnancy in excessive use, for a nonmedical purpose, of controlled substances or their derivatives, alcohol, or inhalants that will pose a substantial risk of damage to a fetus' brain development or physical development.

(d) For purposes of ~~paragraph~~ paragraphs (b) and (c), none of the following constitute a refusal to accept appropriate mental health treatment:

(1) a willingness to take medication but a reasonable disagreement about type or dosage;

(2) a good-faith effort to follow a reasonable alternative treatment plan, including treatment as specified in a valid advance directive under chapter 145C or section 253B.03, subdivision 6d;

(3) an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment; or

(4) an inability to obtain access to needed mental health services because the provider will only accept patients who are

under a court order or because the provider gives persons under a court order a priority over voluntary patients in obtaining treatment and services.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 643 - Civil Commitment Chemically Dependent Pregnant Women Early Intervention Treatment (Second Engrossment)

Author: Senator Don Betzold

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

Date: April 14, 2005

S.F. No. 643 amends the Civil Commitment Act by expanding early intervention treatment. This bill allows the court to order early intervention treatment if the court finds that a pregnant woman is a chemically dependent person, as defined in this paragraph.

JW:rdr

Fiscal Note – 2005-06 Session

Bill #: S0643-2A **Complete Date:** 04/07/05

Chief Author: BETZOLD, DON

Title: CIVIL COMMITMENT;CHEM DEP PREG WOMAN

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					
-- 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 643-2A

Bill Description

This bill has no fiscal impact on the DHS state operated services. Under current law, DHS already receives commitments similar to what the bill would provide for and the proposed change would have no affect on the admissions.

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Shirley Jacobson 582-1876
FN Coord Signature: STEVE BARTA
Date: 03/18/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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

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. 643: A bill for an act relating to civil commitment; expanding early intervention services; amending Minnesota Statutes 2004, section 253B.065, subdivision 5.

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

Linda Berglin
.....
(Division Chair)

April 18, 2005.....
(Date of Division action)

A bill for an act

relating to health; providing for grants related to positive abortion alternatives; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 145.

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

Section 1. [145.4231] [POSITIVE ABORTION ALTERNATIVES.]

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

(1) "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother; and

(2) "unborn child" means an individual organism of the species Homo sapiens from fertilization until birth.

Subd. 2. [ELIGIBILITY FOR GRANTS.] (a) The commissioner of health shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term. Necessary services include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance;

(6) child care assistance; and

(7) parenting education and support services, including services that support the continuation and completion of high school.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not accredited.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives to abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter; and

(6) ensure that none of the funds provided is used to encourage a woman to have an abortion not necessary to prevent

her death or to provide her an abortion.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or the application thereof to any person or circumstance is held invalid, such invalidity shall apply to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or encourages or arranges for abortions is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or encourages or arranges for abortions is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

Subd. 3. [PRIVACY PROTECTION.] Any program receiving a grant under this section must have a privacy policy and procedures in place that ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program shall not be made

public or shared with any other agency or organization without the written consent of the woman and all communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in section 144.335 that apply to providers before releasing any information relating to the medical care provided.

Subd. 4. [DUTIES OF COMMISSIONER.] The commissioner of health shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

Subd. 5. [SEVERABILITY.] Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are declared to be severable.

Sec. 2. [APPROPRIATIONS; COMMUNITY HEALTH AND FAMILY PROMOTION.]

Of the general fund appropriation in fiscal year 2007, $2,500,000 is for positive abortion alternatives under Minnesota Statutes, section 145.4231. Of this amount, $100,000 may be used for administrative costs of implementing the grant program. An additional $50,000 is appropriated from the general fund to the commissioner of health in fiscal year 2006 for administrative costs of program implementation.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
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DIRECTOR

Senate

State of Minnesota

S.F. No. 917 - Providing Grants for Positive Abortion Alternatives (Second Engrossment)

Author: Senator Dallas C. Sams

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

Date: April 18, 2005

S.F. No. 917 creates a positive abortion alternatives grant program.

Section 1 [145.4231] establishes the positive abortion alternatives grant program and public information campaign.

Subdivision 1 defines the following terms: "abortion" and "unborn child."

Subdivision 2, paragraph (a), requires the Commissioner of Health to award grants to eligible applicants for the reasonable expenses of programs to support, encourage, and assist women in carrying their pregnancies to term by providing information, referrals, and assistance with securing necessary services to enable a woman to carry her pregnancy to term. Necessary services include: medical care, nutritional services, housing assistance, adoption services, education and employment assistance, child care assistance, and parenting education and support services. States that an applicant may only provide or assist adoption services from a provider of adoption services that is accredited.

Paragraph (b) states that an eligible program may provide one or more of the necessary services, in addition, to providing information and referral and may refer to other public or private programs rather than provide the care directly.

Paragraph (c) states that to be eligible for a grant, an agency or organization must :

(1) be a private, nonprofit corporation;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of unborn children, including offering the printed information described in the Women's Right to Know Act;

(5) ensure that its alternative to abortion program's sole purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter; and

(6) ensure that none of the grant funds are used to encourage a woman to have an abortion that is not necessary to prevent her death or to provide her with such an abortion.

Paragraph (d) provides an inseverability clause for paragraph (c).

Paragraph (e) states that any organization that provides abortions, promotes abortions, or directly refers for abortions is ineligible to receive a grant, and any affiliate that provides, promotes, or directly refers for abortions are ineligible unless the organization and the affiliate are separately incorporated and independent from each other by not sharing:

(1) the same or similar name;

(2) medical or nonmedical facilities;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies.

Paragraph (f) states that an organization that receives a grant and is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that the affiliate receives no direct or indirect economic or marketing benefit from the grant.

Subdivision 3 requires a grantee to have a privacy policy and procedures in place to ensure that the name, address, telephone number, or other information that may identify a woman seeking services remains confidential. If the grantee provides medical services, the requirements of Minnesota Statutes, section 144.335, must be followed before releasing this information.

Subdivision 4 requires the commissioner to make the grants beginning no later than July 1, 2006, and biannually thereafter. The commissioner is required to monitor and review the programs of each grantee to ensure that the grantee adheres to the purposes and requirements of the grant program, and the commissioner shall cease funding a grantee that fails to do so.

Subdivision 5 provides for a severability clause for this section except as provided in subdivision2, paragraph (d).

Section 2 appropriates $2.5 million in fiscal year 2007 from the general fund to the Commissioner of Health for the grant program, allowing $100,000 of this amount to be used for administrative costs of implementing the program, and $50,000 in fiscal year 2006 for administrative costs of program implementation.

KC:vs

Michele Van Vranken, MD
Medical Director
Annex Teen Clinic (Robbinsdale, MN)
West Suburban Teen Clinic (Excelsior, MN)

I appreciate the opportunity to testify today on the "Positive Alternatives Act." I was present at this committee's first meeting on the legislation, and am especially grateful for the discussion that occurred. At a time in our political climate when taking sides seems to take precedence over working together, discussion seemed to center around an area we can all agree upon – that young women, and subsequently our communities, would greatly benefit from support during pregnancy.

I did, at that time, express support for this legislation with the amendments that were passed that day. I was most concerned that clinics such as the Annex Teen Clinic and West Suburban Teen Clinic would not be able to access funds for these essential services as both clinics include information on parenting, adoption and abortion options when counseling a young woman about her pregnancy. I appreciate the committee addressing this concern at that time. Since then, as I've reread this legislation and further considered how young women would access these services, two further concerns have arisen.

My first concern is that current unplanned pregnancy counseling occurs in a variety of settings. Sometimes this counseling occurs in the setting of a medical clinic, and sometimes it occurs within volunteer or non-profit organizations. More important than my understanding of these differences, however, is the perception of the clients receiving services in each setting. Fairly regularly a young woman tells me she was told of her pregnancy at a "clinic" when this actually occurred at a pregnancy counseling center. I in no way mean to imply that these centers are not capable of running pregnancy tests. My concern is that patient confidentiality is a cornerstone of medical practice, as well as required by federal HIPAA guidelines. It's not clear to me that pregnancy counseling centers fall under the same guidelines. For clients that expect confidentiality with clinical visits, and assume that this applies at the centers, I am asking this committee to consider an amendment to address this concern. Specifically, I am asking that the amendment require sites that receive this funding to follow patient confidentiality guidelines as currently practiced within medical clinics.

My second concern relates to language that specifically defines an "unborn child" as an "individual organism of the species Homo Sapiens from fertilization to birth." Such a definition currently has no medical equivalent. The reasons for this extend beyond the current abortion debate. One small example would include couples that are infertile, or unable to have children. Medical care in this area includes bringing the sperm and egg of each person together, and after fertilization, placing the fertilized egg in the woman's uterus. The definition provided in this legislation does not adequately address this situation or others like them. However, traveling further into this debate, I believe would only be

divisive and limit an attempt on all sides to come together in caring for young pregnant women in our community. I, therefore, propose that this language be deleted. Removing this definition and changing Subdivision 3, number 1 to "scientifically accurate information on pregnancy and various stages of gestation" does not take away from the spirit of caring for pregnant women.

I appreciate the committee's willingness to take time in listening to this testimony today, and hope you will consider addressing these concerns.

MINNESOTA CATHOLIC CONFERENCE

Archdiocese of St. Paul/Minneapolis • Diocese of Crookston • Diocese of Duluth
Diocese of New Ulm • Diocese of St. Cloud • Diocese of Winona

April 18, 2005

The Honorable Linda Berglin, Chair
Committee Members
Senate Health and Human Services Budget Division
State Capitol
St. Paul, MN 55155

Dear Senator Berglin and Members:

I write today in support of Senate File 917, the *Positive Alternatives Act*. This proposal is reflective of the Church's position on life issues, in that it is comprehensive, positive and affirming. As the US Catholic Bishops have stated, "The Church's position on life issues is fundamental. Our belief in the sanctity of human life and the inherent dignity of the human person is the foundation of all the principles of our social teaching."

This legislation directly addresses a range hardships faced by many pregnant women. We feel that if enacted, Senate File 917 could assist women in carrying their pregnancies to term and help get their babies off to a safe and healthy start.

The Church has consistently called for policies that protect and nurture life from conception to natural death. We feel that this legislation speaks directly to our assertion that the measure of every institution is whether it threatens or enhances the life and dignity of the human person.

As Pope John Paul II said, "It is impossible to further the common good without acknowledging and defending the right to life, upon which all the other inalienable rights of individuals are founded and from which they develop."

I respectfully urge your support of this important legislation.

Sincerely,

Christopher Leifeld
Executive Director

475 University Avenue West • St. Paul, MN • 55103
Phone (651) 227-8777 • Fax (651) 227-2675 • www.mncc.org

future pregnancy risks (con't)

- Prior induced abortion increases the risk of delayed delivery. Women who had one, two, or more induced abortions are about 200% more likely to have a post-term delivery (over 42 weeks).

Abortion Risks and Complications, © 1997, 2000 Elliot Institute. Compiled by David C. Reardon, Ph.D.

- Prior induced abortion is associated with an increased risk of ectopic pregnancy. There is a significant trend between the number of previous induced abortions and ectopic pregnancy risk.

C Tharaux-Deneux, et all., "Risk of ectopic pregnancy and previous induced abortion," *American Journal of Public Health*, Vol. 88, Issue 3 401 – 405 (1998).

mothers younger than 20 years old

- Teenagers, who account for about 30% of all abortions, are at a much higher risk for many long-term complications related to abortion.

Abortion Risks and Complications, © 1997, 2000 Elliot Institute. Compiled by David C. Reardon, Ph.D.

- A teenage girl is 10 times more likely to attempt suicide if she has had an abortion in the last six months than is a comparable teenage girl who has not had an abortion.

Garfinkel, et al., *Stress, Depression and Suicide: A Study of Adolescents in Minnesota*, (Minneapolis: University of Minnesota Extension Service, 1986). Cited in *The Post-Abortion Review* 1(2) Summer 1993. © 1993 Elliot Institute.

spiritual health

- Direct abortion is gravely contrary to the moral law. Formal cooperation in abortion risks the loss of one's eternal salvation.

I have set before you life and death, blessing and curse; therefore choose life, that you and your descendants may live (Deut. 30:19).

alternatives

For pregnancy and abortion counseling, information and resources, call toll-free:

Birthright
1-800-550-4900

For information on adoption call toll-free:

Bethany Christian Services
1-800-BETHANY
(1-800-238-4269)

If you or someone you know has had an abortion and would like resources, counseling or information on healing retreats, call toll-free:

Rachel's Vineyard
1-877-HOPE-4-ME
(1-877-467-3463)

ALL
American Life League

P.O. Box 1350, Stafford, VA 22555
(540) 659-4171 • fax (540) 659-2586 • www.all.org

surgical ABORTION your risks

IF YOU THINK ABORTION IS A SAFE PROCEDURE, PLEASE KEEP READING.

short-term complications

- About **1 in 10** women undergoing elective abortion suffers immediate complications, of which **one-fifth** are considered life threatening.
- Common major complications are:
  - infection
  - excessive bleeding
  - embolism
  - anesthesia complications
  - convulsions
  - hemorrhage
  - cervical injury
  - endotoxic shock
  - ripping or perforation of the uterus

Minor complications include:

- infection
- bleeding
- fever
- second-degree burns
- vomiting
- chronic abdominal pain

Abortion Risks and Complications, copyright 1997, 2000 Elliot Institute. Compiled by David C. Reardon, Ph.D. http://www.afterabortion.org/physica.html.

depression

- Women whose first pregnancies ended in abortion were 65% more likely to be at high risk of clinical depression.

Cougle JR, Reardon DC, Coleman PK. "Depression associated with abortion and childbirth: a long-term analysis of the NLSY cohort." *Med Sci Monit*, 2003; 9(4): CR105-112

- After their abortions, married women were 138% more likely to be at high risk of clinical depression compared to similar women who carried their first pregnancies to term.

Reardon DC, Cougle JR. "Depression and unintended pregnancy in the National Longitudinal Survey of Youth: a cohort study." *British Medical Journal*, 324: 151-152.

- Women were 63% more likely to receive mental care within 90 days of an abortion compared to delivery. In addition, abortion was most strongly associated with subsequent treatments for neurotic depression, bipolar disorder, adjustment reactions and schizophrenic disorders.

Coleman PK, Reardon DC, Rue VM, Cougle JR. "State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over five years." *American Journal of Orthopsychiatry*, 2002, Vol. 72, No. 1, 141–152.

- A survey of post-abortive women found that:

60% commented that the decision to abort made their lives worse, and

94% regretted the decision to abort.

"Survey of Reaction to Abortion," *The Post-Abortion Review*, Fall 1994, pp. 6–8.

death

- Women who had abortions were almost twice as likely to die in the following two years.

Also, over the next eight-year period women who aborted had:

154% higher risk of death from suicide,

82% higher risk of death from accidents,

44% higher risk of death from natural causes.

Reardon DC, Ney PG , Scheuren FJ, Cougle JR, Coleman, PK, Strahan T. "Deaths associated with pregnancy outcome: a record linkage study of low income women." *Southern Medical Journal*, August 2002, 95(8):834-841.

substance abuse

- Women with a history of abortion are twice as likely to use alcohol, five times more likely to use illicit drugs and ten times more likely to use marijuana during the first pregnancy they carry to term compared to non-abortive women.

Coleman PK, Reardon DC, Rue VM, Cougle JR. "History of induced abortion in relation to substance use during pregnancies carried to term." *American Journal of Obstetrics and Gynecology*. December 2002; 187(5).

breast cancer

- A meta-analysis of 28 reports concluded that induced abortion is a significant independent risk factor for breast cancer.

J. Brind, et all, "Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis," *Journal of Epidemiology and Community Health*, Vol. 50, 481-496.

- Among women who had been pregnant at least once, the risk of breast cancer in those who had an abortion was 50% higher than among other women. Women 18 and under or 30 and over were at highest risk.

JR Daling, et all, "Risk of breast cancer among young women: relationship to induced abortion," *Journal of Epidemiology and Community Health*, Vol. 86, 21 (1994).

- One abortion almost doubles breast cancer risk; two or more abortions further increases risk.

Elliot Institute, "A List of Major Physical Sequelae Related to Abortion." http://www.afterabortion.org/physica.html.

pelvic inflammatory disease

- Of patients who have chlamydia at the time of the abortion, 23% develop PID within 4 weeks. Studies found that 20 to 27% of patients seeking abortion have chlamydia. About 5% of patients not infected by chlamydia develop PID within 4 weeks after a first trimester abortion.

Abortion Risks and Complications, © 1997, 2000 Elliot Institute. Compiled by David C. Reardon, Ph.D.

future pregnancy risks

- Women who had one, two, or more induced abortions are about 200% more likely to have a subsequent pre-term delivery, compared to women who carry to term. Pre-term delivery increases the risk of neo-natal death and handicaps.

Abortion Risks and Complications, © 1997, 2000 Elliot Institute. Compiled by David C. Reardon, Ph.D.

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. 917 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [127A.145] [POSITIVE ABORTION ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother.

Subd. 2. [ELIGIBILITY FOR GRANTS.] (a) The commissioner of education shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term. Necessary services include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance;

(6) child care assistance; and

(7) parenting education and support services, including services that support the continuation and completion of high school.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not accredited.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets

eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives to abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter; and

(6) ensure that none of the funds provided is used to encourage a woman to have an abortion not necessary to prevent her death or to provide her an abortion.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or the application thereof to any person or circumstance is held invalid, such invalidity shall apply to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or encourages or arranges for abortions is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or encourages or arranges for abortions is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms,

consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) If an organization or agency receiving a grant under this section provides information on abortion, the information provided must be objective, nonjudgmental, and designed to convey only accurate scientific information. The commissioner of education, in consultation with the commissioner of health, shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information meets this requirement.

Subd. 3. [PRIVACY PROTECTION.] (a) Any program receiving a grant under this section must have a privacy policy and procedures in place that ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program shall not be made public or shared with any other agency or organization without the written consent of the woman and all communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in section 144.335 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner of education shall have access to any information necessary to

monitor and review a grantee's program as required under subdivision 4.

Subd. 4. [DUTIES OF COMMISSIONER.] The commissioner of education shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

Subd. 5. [SEVERABILITY.] Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are declared to be severable.

Sec. 2. [APPROPRIATIONS; COMMUNITY HEALTH AND FAMILY PROMOTION.]

Of the general fund appropriation in fiscal year 2007, $2,500,000 is for positive abortion alternatives under Minnesota Statutes, section 145.4231. Of this amount, $100,000 may be used for administrative costs of implementing the grant program. An additional $50,000 is appropriated from the general fund to the commissioner of education in fiscal year 2006 for administrative costs of program implementation."

Delete the title and insert:

"A bill for an act relating to health; providing for grants related to positive abortion alternatives; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 127A."

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. 917: A bill for an act relating to health; providing for grants related to positive abortion alternatives; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 145.

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

Delete everything after the enacting clause and insert:

"Section 1. [127A.145] [POSITIVE ABORTION ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother.

Subd. 2. [ELIGIBILITY FOR GRANTS.] (a) The commissioner of education shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term. Necessary services include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance;

(6) child care assistance; and

(7) parenting education and support services, including services that support the continuation and completion of high school.

An applicant may not provide or assist a woman to obtain

adoption services from a provider of adoption services that is not accredited.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives to abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter; and

(6) ensure that none of the funds provided is used to encourage a woman to have an abortion not necessary to prevent her death or to provide her an abortion.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or the application thereof to any person or circumstance is held invalid, such invalidity shall apply to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or encourages or arranges for abortions is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or

encourages or arranges for abortions is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) If an organization or agency receiving a grant under this section provides information on abortion, the information provided must be objective, nonjudgmental, and designed to convey only accurate scientific information. The commissioner of education, in consultation with the commissioner of health, shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information meets this requirement.

Subd. 3. [PRIVACY PROTECTION.] (a) Any program receiving a grant under this section must have a privacy policy and procedures in place that ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program shall not be made public or shared with any other agency or organization without the written consent of the woman and all communications between

the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in section 144.335 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner of education shall have access to any information necessary to monitor and review a grantee's program as required under subdivision 4.

Subd. 4. [DUTIES OF COMMISSIONER.] The commissioner of education shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

Subd. 5. [SEVERABILITY.] Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are declared to be severable.

Sec. 2. [APPROPRIATIONS; COMMUNITY HEALTH AND FAMILY PROMOTION.]

Of the general fund appropriation in fiscal year 2007, $2,500,000 is for positive abortion alternatives under Minnesota Statutes, section 127A.145. Of this amount, $100,000 may be used for administrative costs of implementing the grant program. An additional $50,000 is appropriated from the general fund to the commissioner of education in fiscal year 2006 for

administrative costs of program implementation."

Delete the title and insert:

"A bill for an act relating to health; providing for grants related to positive abortion alternatives; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 127A."

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

Linda Berglin
(Division Chair)

April 18, 2005
(Date of Division action)

Senator Berglin introduced--

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

A bill for an act

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

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

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

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

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

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

(b) The federal share of the adjustments under paragraph

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

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

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

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

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

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

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

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

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

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

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

manner prescribed by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1979 - Non-Medical Assistance Hospital Payments/Certified Public Expenditures (The A-10 Delete-Everything Amendment)

Author: Senator Linda Berglin

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

Date: April 18, 2005

S.F. No. 1979 authorizes a non-Medical Assistance (MA) payment to certain hospitals, to be financed through nonstate expenditures certified for these purposes.

Section 1 (256.969, subdivision 27) adds a new non-MA payment for hospitals that are located in Minnesota, do not qualify for the "small rural" payment adjustment, and satisfy certain other criteria, as follows:

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

These rate increases are paid annually in a lump sum on July 1 or upon receipt of federal reimbursements under section 2, whichever occurs later. The payments can be reduced on a pro rata basis if the federal reimbursements are less than expected. This section also gives the Department of Human Services (DHS) flexibility to administer the payments and reimbursements in this bill.

Section 2 (256B.199) requires annual reports of certified expenditures by June 1 each year from Hennepin and Ramsey Counties and the University of Minnesota for their respective hospitals. The

bill states that, subject to the reports due June 1, 2005, the amounts anticipated to be reported this year are $19 million from Hennepin County, $10.2 million from Ramsey County, and $15.6 million from the U of M. Based on these reports, DHS must apply for federal reimbursement, and the reimbursement amounts are appropriated to DHS for the non-MA payments in section 1.

Section 3 makes the bill effective the day following final enactment and requires DHS to submit necessary MA plan amendments within 30 days of enactment.

DG:rdr

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1979-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HOSPITAL DISPROPORTIONATE POPUL ADJ

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

Agencies: Human Services Dept Supreme Court (04/12/05)

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
-- No Impact --					
Revenues					
General Fund		4,900	6,800	6,800	6,800
Supreme Court		4,900	6,800	6,800	6,800
Net Cost <Savings>					
General Fund		(4,900)	(6,800)	(6,800)	(6,800)
Supreme Court		(4,900)	(6,800)	(6,800)	(6,800)
Total Cost <Savings> to the State		(4,900)	(6,800)	(6,800)	(6,800)

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

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1979-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HOSPITAL DISPROPORTIONATE POPUL ADJ

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					
-- 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 1979-1A

Bill Description

The bill provides for an increase in the disproportionate population adjustment (DPA) to hospitals meeting medical assistance (MA) utilization and volume criteria. The increased payments are intended to be funded by certified public expenditures (CPE) and an increased surcharge on criminal and traffic offenders.

Assumptions

The bill is designed to allow adjustments so that the CPE revenues and offender surcharges are balanced with the increased DPA expenses and federal limits on aggregate DPA expenditures. Therefore, a fiscal cost will not result.

The revenue and DPA payments are contingent on approval from the federal government. This will not occur prior to passage of a bill. The federal government must approve the following:

The CPE process for obtaining a federal match on local government expenditures
If the CPE payments are included in the Medicare upper limits or the DPA aggregate limits
The DPA formula distribution is reasonable

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1979-1A **Complete Date:** 04/12/05

Chief Author: BERGLIN, LINDA

Title: HOSPITAL DISPROPORTIONATE POPUL ADJ

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

Agency Name: Supreme Court

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					
General Fund		4,900	6,800	6,800	6,800
Net Cost <Savings>					
General Fund		(4,900)	(6,800)	(6,800)	(6,800)
Total Cost <Savings> to the State		(4,900)	(6,800)	(6,800)	(6,800)

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

Preliminary

Bill Description
This bill authorizes a hospital disproportionate population adjustment and increases the surcharge on criminal traffic offenders from $60 to $70 dollars.

Assumptions
It is assumed that the payment rate on surcharges will remain unchanged and that local administrative processes do not supplant court fines and surcharges.
Approximately 680,000 surcharges are collected annually.

Expenditure and/or Revenue Formula
A $10 surcharge increase would raise approximately $6,800,000. Revenue in the first year would be lower because the surcharge would be imposed after August 1, 2005. The first year revenue is estimated to be $4,900,000.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: JUDY REHAK
Date: 04/12/05 Phone: 297-7800

EBO Comments

Calculation of the first year of surcharge revenues is based on a July 1, 2005, effective date.

EBO Signature: JIM KING
Date: 04/12/05 Phone: 296-7964

SEIU
Stronger Together

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April 18, 2005

Senator Berglin
Minnesota Senate
309 Capitol
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St. Paul MN 55155-1606

Dear Senator:

The Service Employees International Union (SEIU) Minnesota State Council urges your support for Senate File 1979. This legislation focuses on increased funding to hospitals throughout Minnesota by drawing down a federal match for uncompensated costs.

Currently, federal Medicaid payments paid to Minnesota hospitals are based on health care costs from 1998, therefore not representing inflationary costs paid by Minnesota hospitals. Drawing down a federal match for uncompensated costs will bring much needed money to hospitals throughout Minnesota.

Our safety net hospitals are in need of additional funding and Senator Berglin's bill addresses this issue. The payment adjustment under this legislation is in addition to all other disproportionate population payments provided by law to hospitals excluding regional treatment centers (RTCs). This new adjustment will allow hospitals to certify uncompensated costs as expenditures. Therefore, Minnesota hospitals are not in jeopardy of losing matching federal dollars because these costs have been incurred.

This legislation will treat rural and urban hospitals fairly and we urge your support for Senate File 1979.

Sincerely,

Jon Youngdahl
Executive Director
SEIU MN State Council

ATTACHMENT "D"

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

Delete everything after the enacting clause and insert:

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

Subd. 27. [ANNUAL NONMEDICAL ASSISTANCE PAYMENT.] (a) In addition to any other payment under this section, the commissioner shall make the following payments:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 19 percent of total patient days during the base year, a payment equal to 13 percent of the total of the operating and payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Hutchinson, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (5) and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a payment equal to five percent of the total of the operating and property payment rates.

(b) The payments under paragraph (a) shall be 100 percent state dollars derived from federal reimbursements to the commissioner to reimburse nonstate expenditures reported under section 256B.199.

(c) The payments under paragraph (a) shall be paid annually on July 1, beginning July 1, 2005, or upon the receipt of

federal reimbursements under section 256B.199, whichever occurs last, for services to be rendered in the fiscal year beginning on July 1, based on services rendered in the previous calendar year.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) If federal reimbursements are not available under section 256B.199 for all payments under paragraph (a), the commissioner shall reduce payments under paragraph (a) on a pro rata basis so that payments under paragraph (a) do not exceed the federal reimbursements.

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

(g) The commissioner may ratably reduce or increase the payments under this subdivision in order to ensure that these total payments equal the amount of reimbursement received by the commissioner under section 256B.199.

(h) The commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision in order to maximize payments to qualifying hospitals.

Sec. 2. [256B.199] [PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.]

(a) Hennepin County, Ramsey County, and the University of Minnesota shall annually report to the commissioner by June 1, beginning June 1, 2005, payments to Hennepin County Medical Center, Regions Hospital, and Fairview-University Medical Center respectively made during the previous calendar year that are certified public expenditures that may qualify for reimbursement under federal law. Subject to the reports due June 1, 2005, the amounts for calendar year 2004 are expected to be as follows:

(1) Hennepin County, $19,000,000;

(2) Ramsey County, $10,200,000; and

(3) University of Minnesota, $15,600,000.

(b) Based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the annual payments under section 256.969, subdivision 27.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective the day following final enactment. The commissioner of human services shall submit necessary medical assistance plan amendments to implement sections 1 and 2 within 30 days of enactment."

Amend the title accordingly

A bill for an act

relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; modifying utilization review provisions; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 62M.06, subdivisions 2, 3; 144.1501, subdivisions 2, 4; 256.045, subdivision 3a; 256.9693; 256B.0625, subdivision 3b, by adding a subdivision; 256B.0627, subdivisions 1, 4, 9; 256B.0631, by adding a subdivision; 256D.03, subdivision 4; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L.

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

Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes

of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of

providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) Notwithstanding paragraphs (a) to (g), the rates must not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62D.12, subdivision 19, is amended to read:

Subd. 19. [COVERAGE OF SERVICE.] A health maintenance organization may not deny or limit coverage of a service which

the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision does not apply to health maintenance organizations for services provided in the prepaid health programs administered under chapter 256B, 256D, or 256L.

Sec. 3. Minnesota Statutes 2004, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major

disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company" has the meaning given in section 62J.041.

(g) For coverage that is provided by a health plan company under the terms of a contract with the Department of Employee Relations, the commissioner of employee relations shall direct the contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 4. Minnesota Statutes 2004, section 62J.04, subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals and premium growth limits;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to

achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal <u>and premium growth limit</u> data available to the public in a consumer-oriented manner.

Sec. 5. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM~~ HEALTH PLAN COMPANY ~~COST-CONTAINMENT GOALS~~ HEALTH CARE EXPENDITURE LIMITS.]

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

(b) "Health plan company" has the definition provided in section 62Q.01 and also includes employee health plans offered by self-insured employers.

(c) "~~Total~~ Health care expenditures" means incurred claims or expenditures on health care services~~, administrative expenses, charitable contributions, and all other payments~~ made by health plan companies ~~out of premium revenues~~.

~~(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.~~

~~(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota Comprehensive Health Association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the Health Coverage Reinsurance Association, assessments by the Minnesota Life and Health Insurance Guaranty Association, assessments by the Minnesota Risk Adjustment Association, and any new assessments imposed by federal or state law.~~

~~(f)~~ "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost containment goals~~ health care expenditure limits for ~~the increase in net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost containment goal~~ health care expenditure limit.

The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health plan companies shall submit to the commissioner of health, by April ~~1, 1994, for calendar year 1993, April 1, 1995, for calendar year 1994, April 1, 1996, for calendar year 1995, April 1, 1997, for calendar year 1996, and April 1, 1998, for calendar year 1997~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, health care expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. ~~The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the~~

~~commissioner.~~

Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the cost containment goals. No premium rate, currently reviewed by the Department of Health or Commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end

of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment-goal~~ health care expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost-containment-goal,~~ health care expenditure limit at least 30 days before publishing the list, and shall provide each health plan company ~~with~~ ten days to provide an explanation for exceeding the ~~cost-containment-goal~~ health care expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Sec. 6. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

(d) This section does not apply to health plan companies offering only limited dental or vision plans.

Sec. 7. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium growth limit compliance;

(4) conduct applied research using existing and new data

and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

Sec. 8. Minnesota Statutes 2004, section 62J.38, is amended to read:

62J.38 [COST CONTAINMENT DATA FROM GROUP PURCHASERS.]

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for

nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made

during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 9. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 10. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

(b) Notwithstanding paragraph (a), the rates shall not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider-the-growth-rates-applied-under-section-62J.04,-subdivision-1,-paragraph-(b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For-premium-rates-proposed-to-go-into-effect-between-July-1,-1993-and-December-31,-1993,-the-pertinent-growth-rate-is-the~~

~~growth-rate-applied-under-section-62J.04,-subdivision-1,~~
~~paragraph-(b),-to-calendar-year-1994.~~

Sec. 11. Minnesota Statutes 2004, section 62M.06, subdivision 2, is amended to read:

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 12. Minnesota Statutes 2004, section 62M.06, subdivision 3, is amended to read:

Subd. 3. [STANDARD APPEAL.] The utilization review

organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(c) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the physician must follow publicly available evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

(e) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Sec. 13. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 14. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities, or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas~~;~~; and

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 15. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that ~~75~~ 50 percent of the funds available are used for rural physician loan forgiveness ~~and~~, 25 percent of the funds available are used for underserved urban communities loan forgiveness, and 25 percent of the funds available are used for pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant

meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 16. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days. Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the

recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. <u>The referee may not overturn a decision by a prepaid health plan to deny or limit coverage for services if the prepaid health plan has used evidence-based criteria or guidelines in making the determination.</u> The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 17. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

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

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured

health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBLE PERSONS.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the

applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under

subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section; to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than

funds appropriated plus the drug rebate proceeds.

Sec. 18. Minnesota Statutes 2004, section 256.9693, is amended to read:

256.9693 [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance or general assistance medical care may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

Sec. 19. Minnesota Statutes 2004, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] Medical assistance

covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation, unless the communication is between a pediatrician and psychiatrist for the purpose of managing the medications of a child with mental health needs. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Sec. 20. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D and 256L, effective for services provided on or after July 1, 2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall

solicit comments and recommendations from any interested persons and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 21. Minnesota Statutes 2004, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have

never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party. Assessments shall not be conducted by the same agency, individual, or organization providing the care services.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be

delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures

specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties <u>who are parents of minors or guardians of minors or incapacitated persons</u> may delegate the responsibility to another adult ~~who is not the personal care assistant~~ <u>during a temporary absence of at least</u>

24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 22. Minnesota Statutes 2004, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18). For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after

insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in

order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

~~(11)~~ (12) home maintenance or chore services;

~~(12)~~ (13) services not specified under paragraph (a); and

~~(13)~~ (14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services.

Sec. 23. Minnesota Statutes 2004, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. [FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total

amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not exceed before the end date; and

(3) how actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must ensure that the month-to-month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 24. Minnesota Statutes 2004, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. [HEALTHY LIFESTYLE WAIVER.] The co-payments described in subdivision 1 shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

Sec. 25. [256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT PAYMENT SYSTEM.]

(a) The commissioner of human services shall establish a performance reporting and payment system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L.

(b) The measures used for the performance reporting and payment system for medical groups or single-physician practices shall include, but are not limited to, measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting and payment system for inpatient hospitals shall include, but are not limited to, measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the

case of a medical group or single-physician practice, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to develop the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) For recipients seen on or after January 1, 2007, the commissioner shall provide a performance bonus payment to providers who have achieved certain levels of performance established by the commissioner with respect to the measures or who have achieved certain rates of improvement established by the commissioner with respect to the measures or whose rates of achievement have increased over a previous period, as established by the commissioner. The performance bonus payment may be a fixed dollar amount per patient, paid quarterly or annually, or alternatively payment may be made as a percentage increase over payments allowed elsewhere in statute for the recipients identified in paragraph (a). In order for providers to be eligible for a performance bonus payment under this section, the commissioner may require the providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may contract with a reporting organization to assist with the collection of reporting information and to prevent duplication of reporting. The commissioner may limit application of the performance bonus payment system to providers that provide a sufficiently large

volume of care to permit adequate statistical precision in the measurement of that care, as established by the commissioner, after consulting with other health care quality reporting organizations.

(d) The performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

(e) The commissioner shall publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year, at least three months prior to the beginning of that calendar year.

(f) By April 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical group, single-physician practice, and hospital of the measures and the performance payments under this section, and shall compare the results by medical group, single-physician practice, and hospital for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may contract with a health care reporting organization that operates a Web site suitable for this purpose.

Sec. 26. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including

home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received, including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under

section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 27. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in

section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the

hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has

reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) The co-payments described in paragraph (d) shall be waived by the provider if the recipient practices a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except

inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 28. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income

of a family or individual exceeds program income limits.

(c)~~(1)~~ Notwithstanding paragraph (b), individuals and families ~~enrolled in MinnesotaCare under section 256L.04, subdivision 1,~~ may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given ~~an 18-month~~ a 12-month notice period from the date that ineligibility is determined before disenrollment. ~~This clause expires February 1, 2004.~~

~~(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment.~~ The premium for ~~children~~ individuals and families remaining eligible under this ~~clause~~ paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

Sec. 29. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at

least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with

income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 30. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the services described in subdivision 2.

(b) Prior authorization shall be conducted by the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director and medical policy director in place, the commissioner may contract prior authorization to a Minnesota-licensed utilization review organization.

(c) This subdivision expires July 1, 2007, or when a list is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) positive emission tomography (PET) scans;

(2) electronic beam computed tomography (EBCT);

(3) virtual colonoscopy;

(4) spinal fusion, unless in an emergency situation related to trauma;

(5) bariatric surgery;

(6) chiropractic visits beyond ten visits;

(7) circumcision; and

(8) orthodontia.

Subd. 3. [SERVICES REQUIRING REVIEW BEFORE ADDITION TO PUBLIC PROGRAMS BENEFIT SETS.] No new medical device, brand drug, or medical procedure shall be included in the medical assistance benefit set until a technology assessment has been completed and the potential benefits are proven to outweigh the

additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations.

Sec. 31. [TASK FORCE ON CHILDHOOD OBESITY.]

(a) The commissioner of health, in consultation with the commissioners of human services and education, shall convene a task force to study and make recommendations on reducing the rate of obesity among the children in Minnesota. The task force shall determine the number of children who are currently obese and set a goal, including measurable outcomes for the state in terms of reducing the rate of childhood obesity. The task force shall make recommendations on how to achieve this goal, including, but not limited to, increasing physical activities; exploring opportunities to promote physical education and healthy eating programs; improving the nutritional offerings through breakfast and lunch menus; and evaluating the availability and choice of nutritional products offered in public schools. The members of the task force shall include representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public Health Association of Minnesota; the Minnesota Dietetic Association; the Minnesota School Food Service Association; the Minnesota Association of Health, Physical Education, Recreation, and Dance; the Minnesota School Boards Association; the Minnesota School Administrators Association; the Minnesota Secondary Principals Association; the vending industry; and consumers. The terms and compensation of the members of the task force shall be in accordance with Minnesota Statutes, section 15.059, subdivision 6.

(b) The commissioner must submit the recommendations of the task force to the legislature by January 15, 2007.

Sec. 32. [IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS SYSTEM.]

The commissioner of health, in consultation with the electronic health record planning work group established in Laws

2004, chapter 288, article 7, section 7, shall develop a statewide plan for all hospitals and physician group practices to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the commissioner shall consider:

(1) creating financial assistance to hospitals and providers for implementing or updating an electronic health records system, including, but not limited to, the establishment of grants, financial incentives, or low-interest loans;

(2) addressing specific needs and concerns of safety-net hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an electronic records system within the hospital or practice; and

(3) providing assistance in the development of possible alliances or collaborations among providers.

The commissioner shall provide preliminary reports to the chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 2007, on the status of reaching the goal for all hospitals and physician group practices to have an interoperable electronic health records system in place by January 1, 2005. The reports shall include recommendations on statutory language necessary to implement the plan, including possible financing options.

Sec. 33. [APPROPRIATION.]

(a) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;

(2) support practical nursing programs in regions of high need;

(3) address the shortage of nursing faculty; and

(4) provide accessible learning opportunities to students through distance education and simulation experiences.

(b) $..... is appropriated for the biennium beginning

July 1, 2005, from the general fund to the commissioner of health for the loan forgiveness program in Minnesota Statutes, section 144.1501.

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S.F. No. 65 - Health Care (Second Engrossment)

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

Date: April 18, 2005

S.F. No. 65 makes a number of modifications to the public health care programs.

Section 1 (62A.65) requires the Commissioners of Commerce and Health to apply the premium growth limits established under Minnesota Statutes, section 62J.04, subdivision 1b, when approving the individual market rates.

Section 2 (62D.12, subdivision 19) permits a health maintenance organization to deny or limit coverage for services requiring prior authorization under public health care programs.

Section 3 (62J.04, subdivision 1b) requires the Commissioner of Health to establish premium growth limits for health plan companies.

Paragraph (a) states that for calendar years 2005 to 2010 the premium limits shall be set at Consumer Price Index (CPI) for urban consumers for the preceding calendar year plus two percent. An additional one percentage point shall be added to be used to finance the implementation of the electronic medical record system. The commissioner is required to ensure that the additional percentage point is being used to provide financial assistance to health care providers for that purpose.

Paragraph (b) states that for calendar years beyond 2010, the premium growth limits shall be set at CPI for urban consumers plus two percent. The Commissioners of Health and Commerce shall make a recommendation to the Legislature on whether to continue the additional percentage point described in **paragraph (a)**.

Paragraph (c) authorizes the commissioner to add additional percentage points if a major disaster, bioterrorism, or a public health emergency event occurs that effects heath care costs.

Paragraph (d) requires the commissioner to publish the annual premium growth limits in the *State Register* by January 31 of the year that the limits are to be in effect.

Paragraph (e) states that premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Requires premium growth rates to be calculated for the individual, small group, and large group lines of business.

Paragraph (f) clarifies that this section applies to employee health plans offered by self-insured employers.

Paragraph (g) requires the Commissioner of Employee Relations to direct contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations.

Section 4 (62J.04, subdivision 3) authorizes the commissioner to use the data collected to be used to monitor the achievement of premium growth limits.

Section 5 (62J.041) requires the Commissioner of Health to establish annual health care expenditure limits not to exceed the premium limits. Defines "health care expenditures" as incurred claims or expenditures on health care services. Requires the commissioner to publish in the *State Register* and make available to the public by July 1, 2007, and each year thereafter a list of all health plan companies that exceeded their health care expenditure limit for the previous calendar year.

Section 6 (62J.255) requires health plan companies to provide educational information to enrollees on the increased personal health risks and the additional cost to the health care system due to obesity and due to smoking. It also requires the Commissioner of Health, in consultation with the Minnesota Medical Association (MMA), to develop an information sheet on the personal health risks and on the additional costs to the health care system associated with obesity and on smoking. States that this section does not apply to health plan companies offering only dental or vision plans.

Section 7 (62J.301, subdivision 3) requires the commissioner to collect and maintain data for the purposes of setting premium growth limits and measuring compliance.

Section 8 (62J.38) requires the cost containment data to be broken down to distinguish between the individual market, the small group market, and the large group market.

Section 9 (62J.692, subdivision 3) states that a clinical medical education program that trains pediatricians is requested to include in their program curriculum training in case management and medication management for children suffering from mental illness in order to eligible for MERC funds.

Section 10 (62L.08, subdivision 8) requires the Commissioners of Health and Commerce to apply the premium growth limits established under section 62J.04, subdivision 1b, when approving the small employer market rates.

Sections 11 and 12 (62M.06) require the review of initial determinations not to certify a service for a prepaid health plan under chapters 256B, 256D, and 256L to follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by a professional association of the specialty that typically provides the service.

Section 13 (62Q.175) states that no health plan company is required to cover any health care service included in the list established under section 256B.0625, subdivision 46.

Sections 14 and 15 (144.1501) extends the loan forgiveness program to medical residents who are specializing in the area of pediatric psychiatry.

Section 16 (256.045, subdivision 3a) states that on appeal, the referee may not overturn a decision on prior authorization for services requiring prior authorization if the prepaid health plan has appropriately used evidence-based criteria or guidelines in making its determination.

Section 17 (256.9545) reinstates the Prescription Drug Discount Program (which expired upon the effective date of an expanded prescription drug benefit under Medicare) and makes changes to the program by eliminating the income limit on eligibility, making individuals who are enrolled in Medicare ineligible, and changing the administration fee to an enrollment fee of $100.

Section 18 (256.9693) extends the continuing care program for persons with mental illness to persons with mental illness who are eligible for general assistance medical care.

Section 19 (256B.0625, subdivision 3b) extends coverage of telemedicine consultations to include telephone conversations between a pediatrician and a psychiatrist when the consultation is for the purpose of managing the medications of a child with mental health needs.

Section 20 (256B.0625, subdivision 46) requires the commissioner, in consultation with the Commissioner of Health, to biennially develop a list of services that are not eligible for reimbursement under chapters 256B, 256D, and 256L effective for services provided on or after July 1, 2007. The commissioner must review the list in effect for the prior biennium and make any additions or deletions from the list as appropriate. The commissioner may convene an ad hoc panel to assist the commissioner in reviewing and establishing the list. The commissioner must solicit comments and recommendations from the public through public hearings. The initial list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, and must be published in the *State Register* by November 1 of the even-numbered years beginning November 1, 2008. The commissioner must submit the list to the Legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Section 21 (256B.0627, subdivision 1) modifies several definitions in the statute outlining home care covered services. It prohibits assessments of client needs from being conducted by the entity providing the services. It places restrictions on the delegation of authority by a responsible party to another person.

Section 22 (256B.0627, subdivision 4) prohibits certain relatives from providing personal care assistant (PCA) services to recipients unless hardship criteria are satisfied and DHS approves the arrangement. This section also requires DHS to establish an ongoing effort to uncover potential fraud and abuse in the PCA program.

Section 23 (256B. 0627, subdivision 9) authorizes the flexible use of PCA house only if allowed by DHS. It establishes requirements for determining whether flexible use of hours is an appropriate option for a recipient. Its authorizes DHS to deny, revoke, or suspend the authorization for flexible use of hours if program requirements are not met.

Section 24 (256B.0631, subdivision 5), states that the medical assistance co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program.

Section 25 (256B.072), paragraph (a), requires the commissioner to establish a performance reporting and payment system for providers who provide services to public program recipients.

Paragraph (b) establishes the measures that are to be used for the reporting and payment system.

Paragraph (c) requires the commissioner to provide a performance bonus payment to providers who have met certain levels of performance established by the commissioner.

Paragraph (d) states the performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

Paragraph (e) requires the commissioner to publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year at least three months before the beginning of that calendar year.

Paragraph (f) requires the commissioner to report annually through a public Web site the results by medical group, single-physician practice, and hospital of the measures and performance payments under this section and shall compare the results for patients enrolled in public programs with those enrolled in private health plans.

Section 26 (256B.0918) provides a rate increase of two-tenths of one percent to specified providers for employee scholarships and job-related training in English as a second language. Eligible provider groups are listed and include all waivered services providers, personal care service providers, home health service providers, day training and habilitation services, etc.

Section 27 (256D.03, subdivision 4) states that the GAMC co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by reforming from tobacco use or if participating in a smoking cessation program.

Section 28 (256L.07, subdivision 1) reinstates the ability of individuals and families to remain on MinnesotaCare if their income increases over the maximum income eligibility level but is less than ten percent of the annual premium for a policy with a $500 deductible available through MCHA.

Section 29 (256L.20) establishes the MinnesotaCare option for small employers.

Subdivision 1 defines the following terms: "dependent," "eligible employer," "eligible employee," "maximum premium," "participating employer," and "program."

Subdivision 2 authorizes enrollment in MinnesotaCare coverage for all eligible employees and their dependents, if the eligible employer meets the requirements of subdivision 3.

Subdivision 3 states that to participate an eligible employer must: (1) agree to contribute toward the cost of the premium for the employee and the employee's dependents; (2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program; (3) offer coverage to all eligible employees and the dependents of those employees; and (4) not have provided employer-subsidized health coverage as an employee benefit during the previous 12 months.

Subdivision 4 requires the employer to pay 50 percent of the maximum premium for eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines (FPG) and for eligible employees with dependents with income equal to or less than 275 percent of FPG. States that for eligible employees without dependents with income over 175 percent of FPG and eligible employees with dependents with income over 275 percent of FPG, the employer must pay the full cost of the maximum premium. Permits employer to require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the total cost. If the employee is required to pay a portion of the premium, the payment shall be made to the employer. Requires the commissioner to collect the premiums from the participating employers.

Subdivision 5 states that the coverage provided shall be the MinnesotaCare covered services with all applicable co-pays and coinsurance.

Subdivision 6 states that upon the payment of the premium eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of section 256L.07, subdivisions 2 and 3, do not apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

Section 30 lists a number of services that will require prior authorization for reimbursement in the public program effective July 1, 2005. This section also requires that a technology assessment be conducted by an independent organization before any new medical device, brand drug, or medical procedure is included in the covered services for public programs.

Section 31 requires the Commissioner of Health, in consultation with the Commissioners of Human Services and Education, to convene a task force to study and make recommendations on reducing the

rate of obesity among children in Minnesota. Requires the task force to set a goal in terms of reducing the rate of childhood obesity and make recommendations as to how to achieve the goal, including increasing the physical education activities, improving the nutritional offerings, exploring opportunities to promote physical education and healthy eating programs, and evaluating the availability and choice of nutritional products offered within the schools. States the make up of the task force. Requires that these recommendations be submitted to the Legislature by January 15, 2007.

Section 32 requires the Commissioner of Health, in consultation with the electronic health records planning work group, to develop a statewide plan for all hospitals ands physician group practices to have in place an interoperable electronic health records system by January 1, 2015.

Section 33 appropriates money: a blank amount to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan; and a blank amount to the Commissioner of Health for the loan forgiveness program.

KC:vs

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

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

Agencies: Human Services Dept
Commerce (04/12/05)
State Colleges & Universities (04/18/05)
Health Dept (04/18/05)
Employee Relations (04/07/05)

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	0	13,747	13,191	13,472	13,909
State Colleges & Universities		4,800	5,200	5,200	5,200
Human Services Dept	0	8,810	7,862	8,110	8,493
Health Dept		137	129	162	216
Health Care Access Fund	0	1,595	9,114	12,216	13,325
Human Services Dept	0	1,595	9,114	12,216	13,325
State Employees Insurance Fund	0	4,510	9,020	9,020	9,020
Employee Relations	0	4,510	9,020	9,020	9,020
Revenues					
General Fund	0	388	541	478	516
Human Services Dept	0	388	541	478	516
Health Care Access Fund	0	132	299	219	196
Human Services Dept	0	132	299	219	196
Net Cost <Savings>					
General Fund	0	13,359	12,650	12,994	13,393
State Colleges & Universities		4,800	5,200	5,200	5,200
Human Services Dept	0	8,422	7,321	7,632	7,977
Health Dept		137	129	162	216
Health Care Access Fund	0	1,463	8,815	11,997	13,129
Human Services Dept	0	1,463	8,815	11,997	13,129
State Employees Insurance Fund	0	4,510	9,020	9,020	9,020
Employee Relations	0	4,510	9,020	9,020	9,020
Total Cost <Savings> to the State	0	19,332	30,485	34,011	35,542

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	12.00	15.25	14.00	15.00
Human Services Dept	0.00	11.00	15.00	14.00	15.00
Health Dept		1.00	0.25		
Health Care Access Fund	0.00	5.00	10.00	8.00	7.00
Human Services Dept	0.00	5.00	10.00	8.00	7.00
Total FTE	0.00	17.00	25.25	22.00	22.00

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

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	8,810	7,862	8,110	8,493
Health Care Access Fund	0	1,595	9,114	12,216	13,325
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	8,810	7,862	8,110	8,493
Health Care Access Fund	0	1,595	9,114	12,216	13,325
Revenues					
General Fund	0	388	541	478	516
Health Care Access Fund	0	132	299	219	196
Net Cost <Savings>					
General Fund	0	8,422	7,321	7,632	7,977
Health Care Access Fund	0	1,463	8,815	11,997	13,129
Total Cost <Savings> to the State	0	9,885	16,136	19,629	21,106

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	11.00	15.00	14.00	15.00
Health Care Access Fund	0.00	5.00	10.00	8.00	7.00
Total FTE	0.00	16.00	25.00	22.00	22.00

Bill Description

Section 8- Cost Containment Data from Group Purchasers.
Requires the cost containment data to be broken down to distinguish between the individual market, the small group market, and the large group market.

Section 11- Expedited Appeal.
States that for review of initial determinations not to certify a service for prepaid health care programs under Medical assistance, general assistance medical care, or Minnesotacare, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

Section 12- Standard Appeal.
States that for review of initial determinations not to certify a service for prepaid health care programs under Medical assistance, general assistance medical care, or Minnesotacare, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

Section 13- Coverage Exemptions.
States that notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46. [see section 20]

Section 16- Prepaid Health Plan Appeals.
States that on appeal, the referee may not overturn a decision by a prepaid health plan to deny or limit coverage for services if the prepaid health plan has used evidence-based criteria or guidelines in making the determination.

Section 17 - Prescription Drug Discount Program.
Establishes the prescription drug discount program. Requires the commissioner administer a drug rebate program to finance. Establishes eligibility criteria. Requires a one-page application form. Sets out application procedures, processing timelines, an annual enrollment fee, annual redeterminations. Requires the commissioner pay a switch fee to pharmacies. Establishes a dedicated fund for the program, and requires the commissioner administer the program so that costs do not exceed appropriations plus rebates.

Section 18 - Continuing care program for persons with mental illness expansion.
Requires the expansion of the current MA psychiatric contract bed benefit to include GAMC effective 7/1/05. However, 1/1/06 is the earliest date by which necessary contract amendments could occur.

Section 19 – Telemedicine Consultations.
Amends MS § 256B.0625, subd. 3b. To expand the scope of telemedicine consultations to allow pediatricians and psychiatrists to bill for telephone only consultations with each other

Section 20 - List of Excluded Services.
This section requires the department to biennially create a list of services excluded from coverage. Allows the commissioner to appoint an ad hoc advisory panel to assist in reviewing and establishing the list. Identifies considerations to be used in establishing the list. Requires the commissioner to solicit comments and recommendations and conduct at least one public hearing. Requires the establishment of the list by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even numbered years beginning October 1, 2008, for the lists effective the following July 1. The list must be published on November 1 of even-numbered years, and submitted to the legislature by January 15 of the odd-numbered years.

Section 21 - Home Care Assessments.
Requires home care assessments to be conducted by an agency or organization that is not the provider of care services; and establishes additional criteria for the delegation of duties for responsible parties for personal care services during temporary absences.

Section 22 - Prior Authorization Personal Care Services.
Establishes a prior authorization for hardship waivers and defines criteria for waivers; requires the commissioner to establish an ongoing audit process for potential fraud and abuse for personal care services.

Section 23 - Flexible Use of Personal Care Assistant Hours.
Makes flexible use of PCA service optional; requires the public health nurse to develop a written month to month plan of the projected use of personal care services; requires the provider to incorporate the month to month plan into the care plan; allows the recipient, responsible party, or commissioner to revoke the authorization for flexible use of PCA hours.

Section 24 – Health Lifestyle Waiver
MA co-payments shall be waived by the provider if the person refrains form tobacco use or is participating in a smoking cessation program This would require federal approval.

Section 25- Performance Reporting & Quality Improvement Payment System
Requires the Commissioner to establish a performance reporting and payment system for providers who provide services to public program recipients.

Section 26 – Employee Scholarship.
This section provides a rate increase of two-tenths of one percent to a variety of home and community-based providers, ICFs/MR, and DT&H settings to be used for employee scholarships. It requires that providers who receive a rate increase of at least $1,000 per year report certain data on use of the scholarship funding to the commissioner. The commissioner must seek and collect the data, analyze it, and create and distribute an annual report to the legislature. The bill does not require the commissioner to enforce the expenditure of these funds for scholarships. Therefore, this fiscal note does not include enforcement costs.

Section 27 – GAMC Co-payments
GAMC copays are waived if the person does not smoke or is participating in a smoking cessation program

Section 28 – Restores MinnesotaCare MCHA Exception.
Restores the Minnesota Comprehensive Health Association (MCHA) exception to all MinnesotaCare enrollees whose income increases to exceed the applicable standard and provides a 12-month notice period. Individuals and families may remain enrolled if 10 percent of their annual income is less than the premium for a policy through MCHA with a $500 deductible. Enrollees who become ineligible due to income above the standard are given a 12-month notice period before coverage ends. Currently, the MCHA exception applies only to children under age 21, and children who lose eligibility under the exception receive a 12-month notice period prior to disenrollment.

Section 29 - MinnesotaCare Small Employer Option.
Adds a MinnesotaCare coverage option for small employers. Eligible employers include businesses that employ 2-50 eligible employees, the majority of whom are employed in Minnesota, and municipalities with 50 or fewer employees. Eligible employees are those who work at least 20 hours per week and more than 26 weeks annually. See worksheets for additional details and assumptions.

Section 30 - Limiting Coverage of Health Care Services
Lists a number of services that will require prior authorization for reimbursement in the public program effective July 1, 2005. This section also requires that a technology assessment be conducted by an independent organization before any new medical device, brand drug, or medical procedure is included in the covered services for public programs.

Section 31- Child Obesity Task Force
Requires a task force to study and make recommendations on reducing the rate of obesity among children in Minnesota.

Fiscal Summary

Fiscal Summary
SF 65 2e
2005 Session

Fund	Description	Section	FY06	FY07	FY08	FY09
General	Systems Costs (State SH)	Various	4,071	0	0	0

General	Admin. HCEA	Various	413	795	638	733
General	Admin.-Tech. Eval. Contract	20	100	100	100	100
General	Admin.- 4 FTEs	21,22	280	280	280	280
General	Admin.- Contract	26	35	35	35	35
General	Admin.- CDMI Contract	30	142	142	142	142
General	Pres. Drug Discount Prog.	17	0	430	217	(120)
General	GAMC	18	1,192	3,203	3,588	4,019
General	MA	19	13	52	65	65
General	MA	21,22	566	(162)	(223)	(278)
General	MA	26	1,848	2,394	2,576	2,761
General	GAMC	27	307	767	872	936
General	MA	30	(140)	(152)	(156)	(156)
General	GAMC	30	(17)	(22)	(24)	(24)
Total General Fund Costs			8,810	7,862	8,110	8,493
HCAF	Admin. HCEA	Various	331	748	548	490
HCAF	MnCare	28	728	1,851	1,875	1,934
HCAF	MnCare	29	589	6,552	9,825	10,932
HCAF	MnCare	30	(53)	(37)	(32)	(31)
Total HCAF Costs			1,595	9,114	12,216	13,325
General	Revenue-HCEA	Various	165	318	255	293
General	Revenue-Tech. Eval. Contract	20	40	40	40	40
General	Revenue-4 FTEs	21,22	112	112	112	112
General	Revenue-Contract	26	14	14	14	14
General	Revenue-CDMI Contract	30	57	57	57	57
Total General Fund Revenue			388	541	478	516
HCAF	Revenue-HCEA	Various	132	299	219	196
General	FTE-HCEA Admin.	Various	7	11	10	11
General	FTEs	21,22	4	4	4	4
Total General Fund FTEs			11	15	14	15
HCAF	FTE-HCEA Admin.	Various	5	10	8	7

Assumptions

The complex design of the innovative HealthMatch system is near completion and programming has begun. Due to the intricacies of programming a new system, any change prior to system completion requires substantial analysis and design rework, in addition to programming the actual changes. This effort delays the HealthMatch implementation date and results in costs of $889,000 per month of delay. Currently, for each month of delay to the project, the associated vendor cost for maintaining staff on the project is $600,000. Concurrent state staff costs per month are $289,000. (Numbers reflect 100% of the cost; state budget costs are less when adjusted for federal participation) The proposed provisions of this bill, in the aggregate, would result in a 16 month HealthMatch delay.

Once HealthMatch is completely built and implemented, the cost for making requested changes will be significantly lower. Legislation with effective dates of August 1, 2006, or upon HealthMatch implementation, whichever is later, will not incur the state staff and associated vendor costs caused by implementation delay, although they will, as with current systems, require investments of time for analysis and design. For instance, these provisions in the aggregate would take an estimated 12 months to incorporate in a post-HealthMatch implementation phase at a total cost of $1,800,000
(state share would be 35% of the total)

See attached worksheets.

Fiscal Worksheets

SYSTEMS

MMIS Costs	
Section 8	7,200
Section 17	442,200
Section 18	1,600
Section 19	4,800
Section 20	64,000
Section 24,27	29,600
Section 26	19,200
Section 29	321,000
Section 30	64,000
TOTAL MMIS Costs	953,600
MMIS Costs, state share (35%)	333,760
MAXIS Costs	8,160
State share, MAXIS costs (45%)	3,672
HealthMatch costs	10,668,000
State share, HealthMatch costs (35%)	3,733,800
Total Systems Costs	$ 11,629,760
State SH, Total Systems Costs	$ 4,071,232

ADMINISTRATIVE

SF 65-2e: Health Care Cost Containment Omnibus Bill
HCEA admin costs + MAXIS, MMIS and HealthMatch costs.

2005 Session

	FY2006	FY2007	FY2008	FY2009
Sections 17, 28, Section 29--Policy and program development and training needs				
Costs include salary, fringe, and overhead				
2 FTE needed for developing policy, implementing program and policy for drug discount and MNCare Small Employers Option, and 1 FTE needed for County training	3	2	0	0
Costs, Policy Development and Maintenance, Training-General Fund	267,000	157,000	0	0
Section 17: Prescription Drug Discount Program				
Staff needed for enrollment administration				
Costs prorated for FY2006				
FTE needed	4	9	10	11
Costs for FTE	141,000	587,708	587,860	682,712
Costs for postage and printing	5,000	50,000	50,000	50,000

Section 17 Total Costs-General Fund	146,000	637,708	637,860	732,712
Section 28 MCHA Exemption				
Staff needed in MinnesotaCare Operations due to small increase in enrollment. Costs include salary, fringe, and overhead, + postage and printing cost increases.				
FTE required for MNCare Ops	1	1	1	1
Enrollment Staff + Printing and Postage	33,436	54,369	41,889	43,279
Section 28--Total Costs-HCAF	33,436	54,369	41,889	43,279
Section 29--MNCare Option for Small Employers				
Staff needed in MinnesotaCare Operations to enroll additional eligibles, and maintain their eligibility. Costs include salary, fringe, overhead.				
FTE needed	4	9	7	6
Costs for FTE	275,586	644,296	458,203	402,784
Costs for postage and printing	21,044	49,260	47,947	43,879
Section 29--Total Costs-HCAF	296,630	693,556	506,150	446,663
HCEA COST, not including systems				
General fund-FTE	7	11	10	11
GF, total costs	413,000	794,708	637,860	732,712
Federal reimbursement offset (40%)	165,200	317,883	255,144	293,085
HCAF-FTE	5	10	8	7
HCAF, total costs	330,066	747,925	548,039	489,942
Federal reimbursement offset (40%)	132,026	299,170	219,216	195,977

SECTION 20
List of Excluded Services

Health Care Services List
It is not possible to predict savings on this section without a specific list of procedures and diagnostic code pairings. It should be noted that the Department was provided funding in FY03 to conduct a study to determine the appropriateness of eliminating reimbursement for certain payment codes. The costs listed below are necessary in addition to the funds appropriated in FY 03.

		FY06	FY07	FY08	FY09
GF	HC Admin.-Tech. Eval. Contract	$100	$100	$100	$100
	Revenue-FFP @ 40%	$40	$40	$40	$40
Net Cost to State:		$60	$60	$60	$60

SECTIONS 21 & 22

Home Care Assessments & PA Personal Care Services

Section 21- (1 FTE)		FY06	FY07	FY08	FY09	
Limits on delegation of Responsible Party	Total Costs	70,000	70,000	70,000	70,000	1
	Revenues					

		28,000	28,000	28,000	28,000
	Net State Costs	42,000	42,000	42,000	42,000

Administrative activities include consumer and provider training, training of public health nurses, monitoring implementation of policy to assure adherence.

Section 22- (2 FTE) Requires prior authorization		FY06	FY07	FY08	FY09	
	Total Costs	140,000	140,000	140,000	140,000	2
for hardship waivers	Revenues	56,000	56,000	56,000	56,000	
	Net State Costs	84,000	84,000	84,000	84,000	

Administrative activities include authorizing hardship waivers, preparing for and attending appeals, consumer and provider training, education of public health nurses and monitoring and verifying compliance with criteria.

Section 22- (1 FTE)		FY06	FY07	FY08	FY09	
Additional Requirements for	Total Costs	70,000	70,000	70,000	70,000	1
flexible use	Revenues	28,000	28,000	28,000	28,000	
	Net State Costs	42,000	42,000	42,000	42,000	

Administrative activities include consumer and provider training, training of public health nurses, monitoring implementation of policy to assure adherence.

Total Admin. Costs	280,000	280,000	280,000	280,000
FFP Revenue	112,000	112,000	112,000	112,000
Net Cost to State:	168,000	168,000	168,000	168,000

SECTION 26
Employee Scholarship

2005 Session
SF-65, Section 26
Fiscal Analysis

		FY06	FY07	FY08	FY09
Admin.	P/T contract and non-salary admin costs	35	35	35	35
	Revenues	14	14	14	14
	Net Cost	21	21	21	21

This includes the cost of determining providers who must submit data, seeking and collecting the data, analyzing and compiling data for an annual report to legislature.

SECTION 30
Limiting Coverage of Health Care Services

Adding Prior Authorization to certain services.

We currently authorize PET scans, EBCT, bariatric surgery and orthodontia - no savings/costs there.

ADMINISTRATIVE COSTS to adding to the Prior Authorization list:

Virtual colonoscopy -	MA	1,084
	GAMC	271
Spinal fusion	MA	6,506
	GAMC	813
Circumcision	MA	82,062
	GAMC	352
Chiropractic after 10 visits	MA	47,009
	GAMC	3,633
Consultant time	75 X 4 hours = 300	
TOTAL DOLLARS:	MA	136,851
	GAMC	5,069
Total Costs (General Fund)		141,920
Revenue-FFP Earned		56,768
Net Cost to State (General Fund)		85,152

PROGRAM

Section 8- Cost Containment Data from Group Purchasers.

No Fiscal Impact.

Section 11- Expedited Appeal.

No Fiscal Impact.

Section 12- Standard Appeal.

No Fiscal Impact.

Section 16
Prior Authorization Appeals

No Fiscal Impact.

SECTION 17
Prescription Drug Discount Program

2005 Session
Prescription Drug Assistance Program
Senate File 65, Section 17

No age limit, DHS administers eligibility, no asset test, no income limit, people enrolled in Medicare not eligible
Enrollment fees rather than having admin costs taken out of rebate

Preliminary

Estimates the cost to the state to advance rebate revenues to pharmacies for discounted drugs provided to individuals without prescription drug coverage. Rebate revenues are billed and received by DHS up to 4 months after the end of a quarter. We assume that 90% of revenue for a quarter is received by the end of the next quarter.

	Total Population	Population Under 250% FPG
Minnesota population	4,919,000	
Assume 16% lack prescription drug coverage	787,000	
Number with Medicare lacking prescription drug coverage, assuming 90% of these are under 250% FPG	257,200	231,480
Number without Medicare lacking prescription drug coverage, assuming 80% of these are under 250% FPG	529,800	423,840
Assume 57% of those with Medicare have drug costs at least $250 / year	146,604	131,944
Assume 5% of those w/o Medicare have drug costs at least $250 / year	26,490	21,192
Assume no enrollment by those with Medicare	0	0
Assume 50% enrollment by those without Medicare	13,245	10,596
Total enrollment by second quarter of CY 2008	13,245	10,596
Assume program participants with Medicare will have 36 Rx per year	36	36
Assume program participants w/o Medicare will have 24 Rx per year	24	24
Weighted average Rx per year	24.00	24.00
Weighted average Rx per quarter	6.00	6.00

Projected avg rebate per Rx	$11.78
Offsets to discount per Rx retained by DHS:	
to repay cash-flow cost to Gen. Fund in 7 years:	$0.5300
for DHS admin. costs:	$0.00
Total retained by DHS per Rx	$0.53
Offset to discount for switch fee:	$0.17
Net rebate per Rx to consumer:	$11.09

Enrollment and Cost Projections

CY 2006	Q1	Q2	Q3	Q4
Enrollment	0	0	2,119	3,709
Prescriptions	0	0	12,715	22,252
Rebate Payments	$0	$0	$143,046	$250,331
Rebate Revenue			$0	$134,807
Quarterly Balance	$0	$0	($143,046)	($115,524)
Running Balance	$0	$0	($143,046)	($258,570)

CY 2007	Q1	Q2	Q3	Q4
Enrollment	5,033	6,358	7,417	8,477
Prescriptions	30,199	38,146	44,503	50,861
Rebate Payments	$339,734	$429,138	$500,661	$572,184

Rebate Revenue	$250,890	$346,378	$439,994	$516,758
Quarterly Balance	($88,844)	($82,760)	($60,667)	($55,426)
Running Balance	($347,414)	($430,174)	($490,842)	($546,267)
CY 2008	Q1	Q2	Q3	Q4
Enrollment	9,536	10,596	10,622	10,649
Prescriptions	57,218	63,576	63,735	63,894
Rebate Payments	$643,707	$715,230	$717,018	$718,811
Rebate Revenue	$591,651	$666,543	$741,436	$750,610
Quarterly Balance	($52,056)	($48,687)	$24,418	$31,800
Running Balance	($598,323)	($647,010)	($622,592)	($590,792)
CY 2009	Q1	Q2	Q3	Q4
Enrollment	10,676	10,702	10,729	10,756
Prescriptions	64,054	64,214	64,375	64,536
Rebate Payments	$720,608	$722,409	$724,215	$726,026
Rebate Revenue	$752,487	$754,368	$756,254	$758,145
Quarterly Balance	$31,879	$31,959	$32,039	$32,119
Running Balance	($558,913)	($526,954)	($494,915)	($462,796)
CY 2010	Q1	Q2	Q3	Q4
Enrollment	10,783	10,810	10,837	10,864
Prescriptions	64,697	64,859	65,021	65,183
Rebate Payments	$727,841	$729,660	$731,485	$733,313
Rebate Revenue	$760,040	$761,940	$763,845	$765,755
Quarterly Balance	$32,199	$32,280	$32,360	$32,441
Running Balance	($430,597)	($398,317)	($365,957)	($333,515)
CY 2011	Q1	Q2	Q3	Q4
Enrollment	10,891	10,918	10,946	10,973
Prescriptions	65,346	65,510	65,673	65,838
Rebate Payments	$735,147	$736,984	$738,827	$740,674
Rebate Revenue	$767,669	$769,588	$771,512	$773,441
Quarterly Balance	$32,522	$32,604	$32,685	$32,767
Running Balance	($300,993)	($268,389)	($235,704)	($202,937)
CY 2012	Q1	Q2	Q3	Q4
Enrollment	11,000	11,028	11,055	11,083
Prescriptions	66,002	66,167	66,333	66,499
Rebate Payments	$742,526	$744,382	$746,243	$748,108
Rebate Revenue	$775,374	$777,313	$779,256	$781,204
Quarterly Balance	$32,849	$32,931	$33,013	$33,096
Running Balance	($170,088)	($137,157)	($104,144)	($71,048)
CY 2013	Q1	Q2	Q3	Q4
Enrollment	11,111	11,139	11,166	11,194
Prescriptions	66,665	66,831	66,999	67,166
Rebate Payments	$749,979	$751,854	$753,733	$755,618
Rebate Revenue	$783,157	$785,115	$787,078	$789,046
Quarterly Balance	$33,179	$33,262	$33,345	$33,428

Running Balance	($37,869)	($4,608)	$28,737	$62,165

Net funding needed	FY 2006	$0
Additional funding needed	FY 2007	$430,174
Additional funding needed	FY 2008	$216,835
Negative = Paid back to Gen. Fund	FY 2009	($120,056)
Negative = Paid back to Gen. Fund	FY 2010	($128,637)
Negative = Paid back to Gen. Fund	FY 2011	($129,928)
Negative = Paid back to Gen. Fund	FY 2012	($131,232)
Negative = Paid back to Gen. Fund	FY 2013	($132,549)
	Total	$4,608

Estimate of enrollment fee needed to cover administrative costs^

	FY 2006*	FY 2007	FY 2008	FY 2009	FY 2006 - 2009
Summary of Admin Costs	$694,000	$783,000	$777,000	$777,000	$3,031,000
Average number of enrollees	0	4,305	9,007	10,662	7,991

Annual enrollment fee	$126
Monthly enrollment fee	$11

^Based on average of approx. 8000 enrollees per year FY 2007 - 2009 and $3,000,000 in admin costs for same period

The figures above represent projected cash-basis costs, by fiscal year, to advance the rebates.

Rationale:

1) 4,919,000	Estimated Population of MN
2) 16%	Estimated percentage of Minnesotans without prescription coverage.
3) 5%	Percentage of people without Medicare and prescription drug coverage who spent more than $250 on prescriptions annually
4) 250% FPG limit	We assumed that this limit would reduce the total population estimate of Medicare enrollees lacking pharmacy coverage by 10% and the total non-Medicare population of people lacking pharmacy coverage by 20%.

Footnotes:

1) Items 1-2 are based on data from "Prescription Drug Coverage in Minnesota and the United States", Minnesota Dept. of Health, December 2000.
2) Item 3 is based on information form "Report to the President, Prescription Drug Coverage, Spending, Utilization and Prices", Federal Department of HHS, April 2000
3) The first engrossment differs from the original bill by shifting responsibility for enrolling participants from the counties to DHS. That increase DHS admin costs. Since DHS is to recover admin costs from rebates that are collected, this change effectively reduces the average discount per prescription received by participants.

SECTION 18

Continuing Care program for persons with MI expansion

2005 Session

Fiscal Analysis of Contract Bed Section (Sec. 18) of SF65

Sec. 18 of SF65 requires expansion of the current MA psychiatric contract bed benefit to include GAMC.

No effective date is specified, meaning that the legal effective date would be 7/1/05. However, 1/1/06 is the earliest date by which contracts could be amended.

Baseline Data	FY 2001	FY 2002	FY 2003	FY 2004
Actual MA payments for contract beds:	5,885,153	6,457,989	7,634,920	9,425,705
Percent growth per year		9.7%	18.2%	23.5%

Note: the increases for FY03 and FY04 are due to an increase in participating hospitals as a result of 2001 legislative action.

Projected future annual growth under current law 12.0%

The RTC MH programs currently serve a population which is similar to contract beds but is not limited by financial eligibility.

Percent of FY04 RTC MI admissions who were MA-only	41%
Percent of FY04 RTC MI admissions who were GAMC	10%
GAMC population as a proportion of the MA-only population	24%

This analysis assumes continuation of current law GAMC eligibility.

If contract hospitals could serve GAMC-eligibles, it is expected that their proportion of MA vs GAMC eligibles would be similar to the RTCs.

Assuming 1/1/06 start for expanded contracts	FY 2006	FY 2007	FY 2008	FY 2009
Projected MA payments for current beds under current law	11,727,705	13,135,030	14,711,233	16,476,581
Projected GAMC payments under proposed law, based on RTC proportions above, with adjustment for partial first year	1,191,840	3,203,666	3,588,106	4,018,678

SECTION 19

Telemedicine Consultations

2005 Session, Fiscal Analysis of SF-65, Section 19

Cost Estimate for Implementing Telemedicine Psychiatry Consultation Benefit for Children

Assumptions:

1. The psychiatry consultation benefit will be limited to psychiatrists who provide opinion / advice regarding the evaluation or management of a specific patient's problem or set of problems at the request of a primary care physician (general medicine, family practice, pediatrician, internal medicine).
2. The consulting psychiatrist will provide a written summary and recommendation of the consultation to the requesting physician.
3. Unlike current MA provisions, no face-to-face examination would be required, but the requesting physician would supply any necessary background information, verbally or by other means.

4.
Since psychiatrists are in short supply, costs will be limited by their availability and offset in part by the costs of services they replace with consultation services.

Calculations:

Number of MHCP Enrolled Physicians listing a Psychiatry Specialty (August 2004)	78
Number estimated to be open to providing consultation as part of practice	10
Average amount of time per year available for consultation (4 hours per 49 weeks / year)	196
Estimated hours of consultation provided once implemented	1960

Rate Info for Consultation Services

CPT	Description			Minutes	Rate	$/minute	Est % of Charges	Weighted per minute
99241	Outpt Consult - str forward 1			15	46.35	3.09	23.75%	0.73
99242	Outpt Consult - str forward 2			30	60.25	2.01	33.25%	0.67
99243	Outpt Consult - low complexity			40	78.79	1.97	23.75%	0.47
99244	Outpt Consult - mod complexity			60	113.55	1.89	9.50%	0.18
99245	Outpt Consult - high complexity			80	135.18	1.69	4.75%	0.08
99251	Inpt Consult - str forward 1			20	46.35	2.32	1.25%	0.03
99252	Inpt Consult - str forward 2			40	60.25	1.51	1.75%	0.03
99253	Inpt Consult - low complexity			55	78.79	1.43	1.25%	0.02
99254	Inpt Consult - mod complexity			80	113.55	1.42	0.50%	0.01
99255	Inpt Consult - high complexity			110	135.18	1.23	0.25%	0.00

Estimated total cost per hour	132.77
Estimated total annual reimbursement for psychiatric consultation services	260,239
Discount for existing services replaced by demand for consultation services (50%)	130,119

Projected benefit costs (assume 1/1/06 start date and phase-in of implementation)

	FY 2006	FY 2007	FY 2008	FY 2009
Implementation Curve	60%	80%	100%	100%
Total Increased Service Cost	26,024	104,096	130,119	130,119
Federal Share	13,012	52,048	65,060	65,060
State Share - all MA programs	13,012	52,048	65,060	65,060
MA Families and Children	9,759	39,036	48,795	48,795
MA Elderly and Disabled	3,253	13,012	16,265	16,265

Admin Costs - DHS Health Care staff estimated a total systems cost of $4,800 in SFY06, of which the state share would be $1,680. Existing staff would be used to amend the state Medicaid plan and conduct provider training.

SECTION 20

List of Excluded Services

No Fiscal Impact.

SECTIONS 21 & 22

Home Care Assessments & PA Personal Care Services

Senate File 65, Sections 21 & 22
2005 Session

		SFY 2006	SFY 2007	SFY 2008	SFY 2009	FTE's
Section 21						
Requires independent	Assessments	7,853	8,128	8,413	8,707	
assessments of	Cost/Assessment	250	250	250	250	
Home Care Services estimated	Total Costs	1,963,250	2,032,000	2,103,125	2,176,625	
5 hours per assessment at	Federal	981,625	1,016,000	1,051,563	1,088,313	
50.00 per hour.	State	981,625	1,016,000	1,051,563	1,088,313	

This provision does not affect PCA assessments conducted by Public Health Nurses.

Currently, these assessments are done by home health care agencies who are service providers. There is no separate payment for assessments. Service agreements are authorized by the department using CDMI. This provision requires that home care assessments be done by an agency that is not providing services to the persons being assessed.

Increased Service Updates by	Reassessments	4,596	5,126	5,384	5,696
Public Health Nurses	Cost/Reassessment	123	123	123	123
for all children under age 22	Total Costs	565,768	631,011	662,770	701,178
and for 10% of adults	Federal	282,884	315,505	331,385	350,589
1 additional update/year on half of the average monthly caseload	State	282,884	315,505	331,385	350,589

Increased number of service updates will be necessary by PHN's to update and adjust authorizations based on actual and planned use of PCA.

Section 22					
Effect on PCA Services	Total Costs	(1,397,036)	(2,986,026)	(3,211,834)	(3,433,607)
reduced program use by 1%	Federal	(698,518)	(1,493,013)	(1,605,917)	(1,716,804)
Effect is delayed by 6 months in the first year	State	(698,518)	(1,493,013)	(1,605,917)	(1,716,804)
Total Sections 21 and 22	Total Costs				

	1,411,981	(43,015)	(165,939)	(275,805)
Federal	565,991	(161,508)	(222,969)	(277,902)
State	565,991	(161,508)	(222,969)	(277,902)

Assumptions:

1. Home Care Assessments. The number of home care assessments is based on information from CDMI in SFY 2004 and 2005. These assessments will increase at a rate of 3.5% per year. CDMI will continue to authorize state plan home care service agreements for the department. Since these service agreements are already authorized by the Department using this contractor, very little, if any, service savings is expected based on implementing this provision.
2. Responsible Party. This provision will limit the use of responsible party delegation for the PCA program. While this is estimated to affect about 250 persons, about 50-60 individuals would be affected for six months of the year(50% of their use) in terms of reduced use of PCA services. Other arrangements would need to be made by the family including institutional placement.

3. Hardship Waivers. Based on previous request rates, 14% of the PCA recipients request hardship waivers, or about 1,500-1,600 per year. Of those requests, 20% are denied or about 300 per year. Of those denied, about half will experience a 50% reduction in PCA use due to lack of PCA providers.
3. Flexible Use. Increased need for PCA service updates by public health nurses would be necessary to implement flexible use provisions to make adjustments to monthly authorizations based on actual use.
4. Reduced Use of PCA Services. The provisions of section 21 and 22 would curtail the use of PCA services by 1% each year from forecasted levels. This saving is a result of the policy changes and the additional administrative activity to implement and assure policy adherence to the provisions of the bill. The reduced use of PCA services results from the denial of hardship waivers resulting in reduced availability of PCAs, and reduced eligibility for PCA services due to delegation restrictions. No consequential savings is expected unused PCA authorization due to tightening flexible use provisions. The savings are estimated to accrue 6 months after the effective date of the policy changes. The overall reduction in PCA use will be modest since most existing recipients and providers will be able to comply with the provisions, while additional documentation and service plan changes are necessary.

Sources:
February 2005 Forecast
CDMI Annual Home Care Reports
Hardship Waiver Reports

SECTION 23

No Fiscal Impact.

SECTION 24

No Fiscal Impact.

SECTION 25

No Fiscal Impact.

SECTION 26
Employee Scholarship

2005 Session
SF-65, Section 26
Fiscal
Analysis

SF 65 As Introduced	Continuing Care Services			
Summary by decision item:	(State dollars in thousands)			
Updated as of 2/15/05	FY2006	FY2007	FY2008	FY2009
MA LTC Waivers and Home Care				
Devel. Disabilities Waiver	717	889	924	959
Elderly Waiver	114	138	131	129
CADI	168	265	327	387
CAC	9	12	15	18
TBI	71	110	134	158
Home Health Agencies	28	35	36	38
Personal Care & PDN	273	348	375	403
MA LTC Waivers and Home Care Subtotal	1,380	1,797	1,942	2,092
MA LTC Facilities				
DT&H for ICF-MR	22	26	24	22
Nursing Facilities	0	0	0	0
ICF-MR	110	115	107	100
MA LTC Facilities Subtotal	132	141	131	122
MA Basic Elderly & Disabled - Transfer to MH Case Mgmt	0	0	0	0
MA Basic Elderly & Disabled - EW Managed Care	16	60	96	129
MA Basic F&C - Non-citizens w/out FFP	0	0	0	0
MA Rehab (PT,OT,ST)	0	0	0	0
GAMC Rehab (PT,OT,ST)	0	0	0	0
MA Respiratory Therapy	0	0	0	0
GAMC Respiratory Therapy	0	0	0	0
Alternative Care Grants	107	129	129	129
GRH supplemental service payments	20	22	22	22
State share of CD Tier I	105	136	147	158
State Share of CSG	0	0	0	0
Adult Mental Health Grants	76	91	91	91
Children's Mental Health Grants	0	0	0	0
DD Comm Supp Grants SILS	11	15	15	15
Comm Soc Svc Grants, non-MA DT&H	0	0	0	0
Comm Soc Svc Grants, former GRH/SILS	0	1	1	1
Deaf and Hard of Hearing Grants	1	2	2	2
Aging and Adult Services Grants - Epilepsy	0	0	0	0
TOTAL GENERAL FUND ABOVE	1,848	2,394	2,576	2,761
Biennial totals		4,242		5,337

	(State dollars in thousands)			
Summary by budget activity	FY2006	FY2007	FY2008	FY2009
MA LTC Waivers and Home Care	1,380	1,797	1,942	2,092
MA LTC Facilities	132	141	131	122
MA Basic Health Care E&D	16	60	96	129
MA Basic Health Care F&C	0	0	0	0
GAMC Basic Health Care	0	0	0	0
Alternative Care Grants	107	129	129	129
Group Residential Housing	20	22	22	22
Adult Mental Health Grants	76	91	91	91

Children's Mental Health Grants	0	0	0	0
DD Comm Supp Grants	11	15	15	15
Comm Soc Svc Grants	0	1	1	1
Deaf and Hard of Hearing Grants	1	2	2	2
Aging and Adult Services Grants	0	0	0	0
State share of CD Tier I	105	136	147	158
Consumer Support Grants	0	0	0	0
TOTAL GENERAL FUND ABOVE	1,848	2,394	2,576	2,761
Biennial Total		4,242		5,337
Grand Total	1,848	2,394	2,576	2,761

Assumptions

1. Continuing care service rates/allocations would be increased by .20% on July 1, 2005. The effects of the rate increase continues in SFY 2007, SFY 2008 and SFY 2009 for affected continuing care programs.

2. Nursing facility, epilepsy grants, children's mental health grants, consumer support grants are not affected by this legislation.
3. The managed care capitation for elderly waiver services would increase at the same rate as the fee-for-service program.
4. The cash effects of rate increase are phased-in based on the program and funding source. The cash estimates are based on the following phase-in for each rate increase.

- ICF/MR rates: 11/12th in the first year, and 1/12th in the second year
- Other MA funded programs including home and community based waivers, home care: 10/12th in the first year,
- and 2/12th in the second year
- State grants not appropriated as part of CCSA, such as adult mental health, SILS, etc : 9/12th in the first year,
- and 3/12th in the second year
- State grants appropriated as part of CCSA (including children's mental health, etc): 9/12th in the first year, and 3/12th in the second year.
- Other state grants such as deaf and hard of hearing: no delay

5. The county social service share of the rate increase for day training and habilitation and SILS is not funded as part of this proposal.
6. For state grant programs that have been folded into CCSA (children's mental health) the SFY 2004 grant base is used to calculate the effect of the rate increase.
7. Medical Assistance federal financial participation rates were estimated at 50% of the total costs with the state paying 100% of the non-federal share.
   The only exception is for payments to larger ICFs/MR (including day training costs) and to nursing facilities for persons under 65,
   where the state pays 80% and the counties pay 20% of the non-federal share;

Expenditure and/or Revenue Formula

1) The operating payment rate for ICFs is estimated to be 94.4% of the total payment rate and would be increased by two/tenths of a percent on July 1, 2005.
2) For the other continuing care programs, the proposed change to the rates is as follows: .20% increase on July 1, 2005.
3) The rate increases in SFY 2006 would have ongoing effects in SFY 2007, SFY 2008 and 2009
4) The rate change for CC programs was applied to the program projections of the current department forecasts for those programs funded by the Medical Assistance or Group Residential Housing programs.
5) The rate change for CC state grant programs was applied to the respective state base to each year for those programs. For state grant programs that have been folded into CCSA (children's mental health, social service funded day training, etc) the SFY 2004 grant base was used to calculate the effect of the rate increase.

Long-Term Fiscal Considerations

H.F. 68 will have on-going cost effects in SFY 2008/2009 and thereafter. In the next biennium (08/09), this bill would cost the state an additional 5.3 million dollars.

Local Government Costs

SF 68 will increase the cost to counties. These costs are related the rate increases to the county share on day training and habilitation services paid by social service dollars, county share for semi-independent living services, and the country share for ICFs/MR.

SECTION 27

GAMC Co-Payments waived for smoking cessation

2005 Session
SF 65, Section 27 (smoking cessation GAMC)

Waiver of copays for people in GAMC who do not smoke or who are in a smoking cessation program

Assumptions: 1) approximately 45% of people in our programs smoke - leaving 55 % who do not
2) guessing that about 10% of the smokers may be in a program - approx 4% of the total

55 + 4= 59% of the GAMC population is either non-smoking or in a program

CY 2004 - $895,992 was deducted from payment to providers for FFS GAMC
59% = $528,635 cost if copays are waived

	CY2004	FY06	FY07	FY08	FY09
Trending	528,635	613,217	766,521	872,248	935,684
Less Phase-in (50%)		(306,608)			
Net GAMC Costs:	528,635	306,608	766,521	872,248	935,684

SECTION 28
MnCare MCHA Exception

Minnesota
MINNESOTACARE
Fiscal Analysis of a Proposal to
Restore the MCHA Exemption for Parents and Adults with No Children
Session 2005
Senate File 65: Section 28

	FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN				
Caretakers				
Number of eligibles	37	192	200	207
Avg. monthly payment	364.03	382.90	408.71	443.95
Avg. monthly revenue	$322	$342	$368	$395
Total payments	162,529	881,020	980,760	1,104,258
Federal share %	0.00%	0.00%	0.00%	0.00%

Federal share	0	0	0	0
State share	162,529	881,020	980,760	1,104,258
Total revenue	143,763	786,902	882,232	983,058
Federal share %	0.00%	0.00%	0.00%	0.00%
Federal share	0	0	0	0
State share	143,763	786,902	882,232	983,058
Net cost	18,766	94,118	98,528	121,199
Federal share	0	0	0	0
State share	18,766	94,118	98,528	121,199
ADULTS WITHOUT CHILDREN				
Number of eligibles	179	383	400	415
Avg. monthly payment	410.82	461.89	450.24	444.33
Avg. monthly revenue	$80.00	$80.00	$80.00	$80.00
Total payments	880,400	2,125,491	2,160,828	2,210,420
Total revenue	171,444	368,141	383,944	397,975
Net state cost	708,956	1,757,350	1,776,884	1,812,444
TOTAL PROGRAM				
Net State Cost Health Care Access Fund	$727,722	$1,851,467	$1,875,412	$1,933,643

SECTION 29
MnCare Small Employer Option

Minnesota
MINNESOTACARE
Fiscal Analysis of a Proposal to
Provide an Option for Small Employers
2005 Session
Senate File 65: Section 29

This section provides an option for small employers (2-50 employees) to enroll uninsured employees and dependents in MinnesotaCare. To use this option employers must enroll 75% of their employees who not not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months. For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

The following data describes the estimated population of employees and their dependents of businesses that do not offer health coverage. (estimates provided by Health Economics Minnesota Dept. of Health):

Employed by Small Employer (2-50) Not Offering Health Coverage

Uninsured Employees / Dependents

Status If

Covered

	Total	Number of Single Persons	Number of Family Persons	Family Policies
All	58,000	28,000	30,000	7,900
Within income limits	32,000	8,300	23,700	6,100
Above income limits	26,000	19,700	6,300	1,800

Insured Employees / Dependents

	Total	Purchase Individual Coverage	Group Coverage Through Spouse
All	224,500	79,500	145,000
Within income limits	44,500	18,500	26,000
Above income limits	180,000	61,000	119,000

Employed by Small Employer (2-50) Not Offering Health Coverage

Insured Employees / Dependents

	Total	Individual Coverage	Family Members
All	282,500	107,500	175,000
Within income limits	76,500	26,800	49,700
Above income limits	206,000	80,700	125,300

"Healthy New York", a generally similar program experienced an enrollment rate after two years equal to 1.1% of the number of employees in small firms not offering coverage. MinnesotaCare offers more comprehensive coverage, but the cost to employers, assuming 50% of the full cost premium, is about 50% higher than in Healthy New York.

Based on this experience, we assume an average enrollment rate of 2.2% from the total population of uninsured or insured employees and dependents of small firms not offering health coverage. (Twice the rate experienced in "Healthy New York," to allow that response in Minnesota may be somewhat different.) We assume relatively higher enrollment by families with children, and relatively higher enrollment by the more subsidized group within MinnesotaCare income limits. We assume 5% enrollment by family members and 3% enrollment by individuals in the more subsidized group within MinnesotaCare income limits. Enrollment by the group above MinnesotaCare income limits is projected at one-third of the rates for those within the limits. Implementation in March 2005 is assumed.

Family

Preliminary

	Total	Individuals	Members
Enrollment Rates			
All	2.19%	1.50%	2.61%
Within income limits	4.30%	3.00%	5.00%
Above income limits	1.41%	1.00%	1.67%
Enrollment			
All	6,184	1,611	4,573
Within income limits	3,289	804	2,485
Above income limits	2,895	807	2,088

	FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN				
Average number of enrollees:				
Pregnant women	6	54	72	72
Under age 2	16	147	196	196
Other children & parents	359	3,229	4,305	4,305
Total	381	3,430	4,573	4,573
Avg. monthly payment				
Pregnant women	476.07	512.01	507.28	574.30
Under age 2	403.55	431.18	429.83	490.92
Other children & parents	254.66	291.72	322.62	351.07
Total payments				
Pregnant women	34,182	330,869	437,079	494,824
Under age 2	79,174	761,358	1,011,961	1,155,793
Other children & parents	1,096,387	11,303,505	16,667,596	18,137,678
Total	1,209,744	12,395,732	18,116,636	19,788,294
ADULTS WITHOUT CHILDREN				
Average number of enrollees	134	1,208	1,611	1,611
Avg. monthly payment	402.01	433.43	470.30	508.52
Total payments	647,644	6,284,334	9,091,766	9,830,730
REVENUE				
Family enrollees @ 50% of full cost	207	1,864	2,485	2,485
Adj. for family enrollees over 3	(37)	(335)	(447)	(447)
Family enrollees charged @ 50% of full cost	170	1,528	2,038	2,038
Individual enrollees @ 50% of full cost	67	603	804	804
Total enrollees charged @ 50% of full cost	237	2,131	2,842	2,842
Family enrollees @ full cost	174	1,566	2,088	2,088
Adj. for family enrollees over 3	(31)	(282)	(376)	(376)
Family enrollees charged @ full cost	143	1,284	1,712	1,712

Individual enrollees @ full cost	67	605	807	807
Total enrollees charged @ full cost	210	1,890	2,519	2,519
Half of full cost premium	161	171	184	198
Full cost premium	322	342	368	395
Revenue @ 50% of full cost	457,514	4,373,376	6,268,506	6,738,644
Revenue @ full cost	811,258	7,754,816	11,115,236	11,948,879
Total revenue	1,268,771	12,128,192	17,383,742	18,687,523
NET COST-HCAF	588,617	6,551,874	9,824,660	10,931,501

SECTION 30

Limiting Coverage of Health Care Services

Prior authorization for certain services.

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Prior-authorize Specific Services
Senate File 65: 2E
Section 30

MANAGED CARE

Base Forecast
Managed Care Enrollment

		FY 2006	FY 2007	FY 2008	FY 2009
			(Average Enrollees)		
Medical Assistance					
	Children and caretakers				
	Base	251,027	254,923	255,741	255,844
	HM shift	3,643	35,428	46,096	47,284
	Total	254,669	290,351	301,837	303,127
	Elderly	41,477	42,193	42,979	43,803
GAMC					
	Base: GA GAMC	6,068	6,169	6,213	6,224
	Base: GAMC-Only	19,891	20,344	20,426	20,202
	HM shift	911	8,942	11,808	12,250
	Total	26,870	35,455	38,448	38,676
MinnesotaCare					
	Parents and ch.	100,941	71,385	62,565	63,072
	PW and inf.	6,663	2,978	1,816	1,787
	Total fam. w children	107,604	74,363	64,381	64,859
	Adults < 75% FPG	14,519	6,430	3,892	3,868
	Adults > 75% FPG	18,106	17,118	16,156	14,807
	Total adults w no kids	32,625	23,547	20,048	18,676
Total enrollment		463,245	465,910	467,693	469,141

Preliminary

Projected Effects of Limits		FY 2006	FY 2007	FY 2008	FY 2009
Bariatric surgery					
	PMPM effect	(0.08)	(0.08)	(0.08)	(0.08
	Cost effect	(37,060)	(37,273)	(37,415)	(37,531,
Chiropractic visits					
	PMPM	(0.05)	(0.05)	(0.05)	(0.05)
	Cost	(23,162)	(23,295)	(23,385)	(23,457)
Orthodontia					
	PMPM	(0.02)	(0.02)	(0.02)	(0.02)
	Cost	(9,265)	(9,318)	(9,354)	(9,383)
Spinal fusion					
	PMPM	(0.08)	(0.08)	(0.08)	(0.08)
	Cost	(37,060)	(37,273)	(37,415)	(37,531)
Radiology services					
	PMPM	(0.40)	(0.40)	(0.40)	(0.40)
	Cost	(185,298)	(186,364)	(187,077)	(187,656)
Personal care limits					
	PMPM	(0.20)	(0.20)	(0.20)	(0.20)
	Cost	(92,649)	(93,182)	(93,539)	(93,828)
Total cost effects		(384,493)	(386,705)	(388,185)	(389,387)

Allocation to budget activities		FY 2006	FY 2007	FY 2008	FY 2009
MA children & parents		(160,442)	(182,921)	(190,158)	(190,970)
	Federal share	(80,221)	(91,461)	(95,079)	(95,485)
	State share	(80,221)	(91,461)	(95,079)	(95,485)
MA elderly & disabled		(118,779)	(119,764)	(120,615)	(121,424)
	Federal share	(59,390)	(59,882)	(60,308)	(60,712)
	State share	(59,390)	(59,882)	(60,308)	(60,712)
GAMC		(16,928)	(22,337)	(24,222)	(24,366)
Total General Fund-State Share		(156,539)	(173,679)	(179,609)	(180,563)
MinnesotaCare fam. w. children		(67,790)	(46,849)	(40,560)	(40,861)
	Federal share	(35,327)	(24,414)	(21,137)	(21,294)
		52.11%	52.11%	52.11%	52.11%
	State share	(32,463)	(22,434)	(19,423)	(19,567)
MinnesotaCare adults w no children		(20,554)	(14,835)	(12,631)	(11,766)
Total HCAF-State Share		(53,016)	(37,269)	(32,053)	(31,33

FEE FOR SERVICE

SF 65 2E
2005 Session
Section 30 (prior authorization for health care services)
Fiscal Worksheet

ASSUMPTIONS:

We currently prior authorize PET scans, EBCT, bariatric surgery and orthodontia, no savings there.
Payment data taken from CY2003.
Prior Authorizing will result in a 10% denial rate.
Fee for Service phase in is 9/12.

	Virtual Colonscopy	Spinal Fusion	Circumcision	Chiropractic
MA FFS Expenditures	36,160	2,993,770	273,995	517,576
10% Prior Authorization	(3,616)	(299,377)	(27,400)	(51,758)
total costs	(3,616)	(299,377)	(27,400)	(51,758)
federal share	(1,808)	(149,689)	(13,700)	(25,879)
state share	(1,808)	(149,689)	(13,700)	(25,879)
MA FFS outpatient costs	45,856,350	45,856,350	45,856,350	45,856,350
savings as a percent of costs	(0)	(0)	(0)	(0)
(apply to FFS outpatient payments)				

	Virtual Colonscopy	Spinal Fusion	Circumcision	Chiropractic
GAMC FFS Expenditures	9,040	448,442	5,014	40,937
10% Prior Authorization	(904)	(44,844)	(501)	(4,094)
total costs	(904)	(44,844)	(501)	(4,094)
federal share	(452)	(22,422)	(251)	(2,047)
state share	(452)	(22,422)	(251)	(2,047)
GAMC FFS outpatient costs	8,367,397	8,367,397	8,367,397	8,367,397
savings as a percent of costs	(0)	(0)	(0)	(0)
(apply to FFS outpatient payments)				

EXPENDITURE FORMULA

	FY 2006	FY 2007	FY 2008	FY 2009
MA F&C (FFS)				
Outpatiient Hospital Forecast	23,745	25,929	27,882	27,049
PA Virtual Colonscopy	(1)	(1)	(1)	(1)
PA Spinal Fusion	(78)	(85)	(91)	(88)
PA Circumcision	(14)	(15)	(17)	(16)
PA Chiropractic	(13)	(15)	(16)	(15)
total costs	(106)	(116)	(125)	(121)
phase-in	(80)	(116)	(125)	(121)
federal share	(40)	(58)	(62)	(60)
state share	(40)	(58)	(62)	(60)
MA E&D (FFS)				
outpatient hospital forecast	36,322	39,295	42,392	43,374
PA Virtual Colonscopy	(3)	(3)	(3)	(3)
PA Spinal Fusion	(237)	(257)	(277)	(283)
PA Circumcision	0	0	0	0
PA Chiropractic	(41)	(44)	(48)	(49)
total costs	(281)	(304)	(328)	(336)
phase-in	(211)	(304)	(328)	(336)
federal share	(105)	(152)	(164)	(168)
state share	(105)	(152)	(164)	(168)
GAMC (FFS)				
outpatient hospital forecast	5,809	5,963	5,911	5,399

PA Virtual Colonscopy	(1)	(1)	(1)	(1)
PA Spinal Fusion	(31)	(32)	(32)	(29)
PA Circumcision	0	0	0	0
PA Chiropractic	(3)	(3)	(3)	(3)
total costs	(35)	(36)	(36)	(32)
phase-in	(26)	(36)	(36)	(32)
federal share	0	0	0	0
state share	(26)	(36)	(36)	(32)
Net Effect General Fund				
MA F&C (FFS)	(40)	(58)	(62)	(60)
MA E&D (FFS)	(105)	(152)	(164)	(168)
GAMC (FFS)	(26)	(36)	(36)	(32)
Net General Fund	(171)	(246)	(262)	(261)
SUMMARY (State Share):				
MA-Mang. Care-C&P	(80,221)	(91,461)	(95,079)	(95,485)
MA-Mang. Care-E&D	(59,390)	(59,882)	(60,308)	(60,712)
MA-FFS-F&C	(40)	(58)	(62)	(60)
MA-FFS-E&D	(105)	(152)	(164)	(168)
MA-Total	(139,756)	(151,552)	(155,612)	(156,425)
GAMC-Mang. Care	(16,928)	(22,337)	(24,222)	(24,366)
GAMC-FFS	(26)	(36)	(36)	(32)
GAMC-Total	(16,954)	(22,373)	(24,258)	(24,398)
HCAF-Mang. Care	(53,016)	(37,269)	(32,053)	(31,333)

SECTIONS 31, 32

No fiscal impact.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:** 04/18/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

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

Agency Name: State Colleges & Universities

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		4,800	5,200	5,200	5,200
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		4,800	5,200	5,200	5,200
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		4,800	5,200	5,200	5,200
Total Cost <Savings> to the State		4,800	5,200	5,200	5,200

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

Preliminary

Bill Description

Relating to health care; regulating health insurance premium growth rates and numerous sections which address various aspects of health care reform. Section 50 appropriates funds to Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;
(2) support practical nursing programs in regions of high need;
(3) address the shortage of nursing faculty; and
(4) provide accessible learning opportunities to students through distance education and simulation experiences.

Assumptions

Assumes spending levels consistent with MnSCU request to Governor: $4.8 million in FY2006 and $5.2 million in FY2007 for a biennial total of $10 million.

Expenditure and/or Revenue Formula

Expand Nursing Enrollment and Nurse Educator Programs	$5.4 million
Healthcare Education Simulation Equipment and Digital Learning Library	$1.1 million
Nursing Online	$2.7 million
Strategic Partnerships	$0.8 million
Total	$ 10 million

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: JUDY BORGEN
Date: 04/18/05 Phone: 296-3544

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: JAYNE RANKIN
Date: 04/18/05 Phone: 296-7316

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:** 04/18/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

Agency Name: Health Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		137	129	162	216
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		137	129	162	216
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		137	129	162	216
Total Cost <Savings> to the State		137	129	162	216

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	0.25		
Total FTE		1.00	0.25		

Bill Description
Sections of this bill affecting MDH:

Sec. 1 – Premium Rate Restrictions
Requires the Commissioners of Commerce and Health to apply the premium growth limits established under Minnesota Statutes, section 62J.04, subd. 1b, when approving the individual market rates.

Sec. 3 – Premium Growth Limits
Requires the Commissioner to set annual premium growth limits for health plan companies. Between 2005 and 2010, limits are set at the regional CPI for urban consumers for the previous year plus two percentage points and an additional percentage point to finance the establishment of electronic medical records systems. Requires the Commissioner to ensure that the additional one percent is being used for that purpose. Beyond 2010, the additional percentage point for electronic medical record systems can be continued on the recommendation of the Commissioners of Health and Commerce. The Commissioner may add additional percentage points in the case of major disasters or emergency events effecting health care costs. Premium growth limits are to be published in the State Register by January 31 of the year in which they are to be in effect. This section also adds employee health plans offered by self-insured employers to definition of health plan company.

Sec. 4 – Cost Containment
Directs the Commissioner to monitor statewide achievement of premium growth limits.

Sec. 5 – Health Plan Company Expenditure Limits
Directs the Commissioner, beginning in calendar year 2006, to establish annual health care expenditure limits, which are not to exceed the premium limits. Requires the commissioner to publish in the State Register by July 1, 2007 and every year thereafter a list of all health plan companies that exceed their health care expenditure limit for the previous calendar year. This section defines health care expenditures as all incurred claims or expenditures on health care services. Health plan companies are to report information on health care expenditures by April of each year for the preceding calendar year.

Sec. 6 – Health Risk Information Sheet
Requires the Commissioner to develop and post on the Web an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and smoking.

Sec. 7, Sec. 8 – Data collection
Specifies data to be collected from group purchasers for the purposes of setting premium growth limits and monitoring premium growth limit compliance. Specifies that data including premium revenue, information on aggregate enrollment, and data on member months is to be broken down by large group market, small group market, and individual market.

Section 9 – MERC
Amends the MERC statute to require providers of clinical medical education for pediatricians, in order to be eligible for MERC funds, to include in their curriculum training in case management and medication management for children suffering from mental illness.

Section 10 - application of premium growth limits
Requires the Commissioners of Health and Commerce to apply premium growth rates established under section 62J.04, subdivision 1b when approving small employer market rates.

Sec. 12 and 13 – Loan Forgiveness
Modifies Minnesota Statutes 2003 Supplement, section 144.1501, subdivision 4, to further distribute loan forgiveness fund for physicians to include 25% allocated to pediatric psychiatry residents. Appropriation in **Section 31, subd. b.**

Sec. 29 – Task Force on Childhood Obesity
Requires the commissioner of health, in consultation with the commissioners of human services and education, to convene a task force to study and make recommendations on in reducing the rate of childhood obesity in Minnesota. Areas to address are specified, as is the membership of the task force. The task force would be governed by M.S. 15.059, subd. 6. The recommendations are to be submitted by January 15, 2007.

Sec. 30 – Implementation of an Electronic Health Records System
Requires the commissioner of health, in consultation with the electronic health record planning work group established in Laws 2004, chapter 288, article 7, section 7 to develop a statewide plan for implementation of electronic health records. This section specifies certain factors to be considered by the commissioner in developing the plan and to provide certain reports to the legislature.

Assumptions

Assumes no fiscal impact from Sections 1, 3, 7,8, and 10. Data collection under Sections 7 and 8 can be accomplished through the use of existing data collection instruments. Costs related to monitoring of premium growth limits and expenditure limits in Sections 4 and 5 will be minimal and will be absorbed through the use of existing staff.

The change to MERC program eligibility in Section 9 can be achieved without any significant changes in the application process or in staff time related to determining eligibility. There is no fiscal impact to this change.

Sec. 6 – Health Risk Information Sheet
Assumes that existing staff will absorb development of the information sheets and posting them on the department's Web site.

Sec. 12 and 13 – Loan Forgiveness
Assumes that existing staff will absorb administration of the increased distribution of pediatric physicians to the existing health professions loan forgiveness program and assumes that 25% of the program's budget of total awards to physicians will go to pediatric psychiatrists. The program currently receives more applications than it can fund from currently included professions, one of which is psychiatry in general. In the past this profession has not submitted any applications and no awards have been given. One can assume that additional marketing efforts targeting pediatric psychiatry residents (PPR) will yield additional applications, but there is no experience base to estimate the interest from these professions, the number of applications resulting, or the proportion of applications it would be equitable to fund should any new funds be made available. Based on the average number of general psychiatry residents (6 per year) and PPR each year (3 per year), and the number graduating each year, 2-3 annual awards are assumed.

Sec. 29 – Task Force on Childhood Obesity
- Assumes that a half-time Epidemiologist Senior would be needed for one year to a) analyze existing data sources to estimate the number of children who are obese and b) assist the task force to set a goal and measurable outcomes for reducing the rate of childhood obesity.
- Assumes the task force would meet six times, at a cost of $1,000 per meeting for photocopying, postage, member travel expenses, and refreshments.
- Assumes a half-time Planner Principal State for eighteen months to review existing literature, provide staff support for the task force's deliberations, and prepare the task force's recommendations for submission.

Sec. 30 – Implementation of an Electronic Medical Records System
Requires the commissioner of health, in consultation with the electronic health record planning work group established in Laws 2004, chapter 288, article 7, section 7 to develop a statewide plan for implementation of electronic health records. This section specifies certain factors to be considered by the commissioner in developing the plan and to provide certain reports to the legislature. The department has been absorbing the costs of supporting the electronic health record planning work group since it began in 2004, and will continue to do so. The plans and reports called for in Section 30 are consistent with the efforts of the electronic health record planning work group. No new costs for this part of the bill.

Expenditure and/or Revenue Formula

Sec. 6 – Health Risk Information Sheet. No fiscal impact.

Sec. 12 and 13 – Loan Forgiveness - Fund 100

Pediatric psychiatry loan forgiveness	**FY2006**	**FY2007**	**FY2008**	**FY2009**

Loan Forgiveness Grants (3 $18,000 4-year awards awarded each year)	$54,000	$108,000	$162,000	$216,000
Operation support services @ 9.7%	0	0	0	0
Total	**$54,000**	**$108,000**	**$162,000**	**$216,000**

Sec. 29 – Task Force on Childhood Obesity – Fund 100

EXPENDITURES	**SFY06**	**SFY07**
Salary – Epi Senior (.5 FTE for 12 months)	$26,784	
Salary – Plnr Prin State (.5 FTE for 18 months)	25,818	$12,909
Fringe 29%	15,255	3,744
Subtotal Sal & Fringe	$67,857	$16,653
Supplies & Expenses	2,600	1,300
Task Force Meetings	5,000	1,000
Operation Support Services 9.7%	7,319	1,838
TOTAL EXPENSES	**$82,776**	**$20,791**
FTEs	**1.0**	**0.25**

Sec. 30 – Implementation of an Electronic Medical Records System. No fiscal impact.

Long-Term Fiscal Considerations

Section 6: None

Section 13: $216K will needed as an appropriation to consistently fund the program with current debt assumptions. Since awards are based upon average student debt from year to year, over time the number of awards will decrease without additional funding to the base budget.

Section 31: None

Local Government Costs

None

References/Sources

Minnesota Department of Health staff
Department of Psychiatry, University of Minnesota
American Academy of Child & Adolescent Psychiatry
Association of American Medical Colleges
Minnesota Psychiatric Society Task Force Report, 9/2002

I have reviewed the content of this fiscal note and believe it is a reasonable estimate of the expenditures and revenues associated with this proposed legislation.

Fiscal Note Coordinator Signature: _____ Date: _____

Agency Contact Name: Mark Schoenbaum (651-282-3859)
FN Coord Signature: DAVE HOVET
Date: 04/18/05 Phone: 215-0389

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/18/05 Phone: 282-5065

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:** 04/12/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

Agency Name: Commerce

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: MICHAEL F. BLACIK
Date: 04/12/05 Phone: 297-2117

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 04/12/05 Phone: 296-7642

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0065-2A **Complete Date:** 04/07/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CARE COST CONTAINMENT PROV

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

Agency Name: Employee Relations

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					
State Employees Insurance Fund	0	4,510	9,020	9,020	9,020
Less Agency Can Absorb					
State Employees Insurance Fund	0	0	0	0	0
Net Expenditures					
State Employees Insurance Fund	0	4,510	9,020	9,020	9,020
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Employees Insurance Fund	0	4,510	9,020	9,020	9,020
Total Cost <Savings> to the State	0	4,510	9,020	9,020	9,020

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

Bill Description

Relating to health care; regulating health insurance premium growth rates and numerous sections which address various aspects of health care reform. DOER is primarily addressing the impact of: Sections 1 through 5 which set annual premium growth limits and create health plan company expenditure limits.

Fiscal Considerations:
Senate File 65, sections 1 - 3 sets annual premium growth limits for health plan companies. Section 5 sets health plan company health care expenditure limits. The premium growth limits may not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of an electronic medical record system. The health plan company expenditure limits have been set to not exceed the proposed premium growth limits. The term "health care expenditures" is defined in Section 5, subd. 1 of the bill as "incurred claims or expenditures on health care services." The section also defines "consumer cost-sharing or subscriber liability," although it does not explain whether subscriber liabilities are included in the expenditure calculations.

The State Employee Group Insurance Program (SEGIP) is a self-funded program that contracts with licensed carriers for administrative services and aggregate stop-loss protection.

According to the bill, SEGIP is subject to both premium and expenditure limits as other health plan companies. However, SEGIP would be a smaller health plan company with fewer resources. Although the bill directs the health plan companies contracting with DOER to reduce provider reimbursement to meet premium targets, SEGIP would still be subject to claim cost fluctuations due to increased utilization, catastrophic claims, technology improvements, and higher administrative costs. The difficulty of projecting claim cost increases could lead to premium deficiencies, reserve depletions, increased administrative burdens, and lawsuits. Because SEGIP does not have the same reserve levels or ability to cut internal costs as the health plans, annual claim cost fluctuations could have a significant impact on SEGIP's financial solvency.

If the expenditure limits are enforceable, and SEGIP is required to pay claim costs within strict budget limitations, unexpected increases in utilization could lead to the denial of services at the end of the year unless reserves are used to pay for services. If health care services have to be denied it would lead to a rush to services in the early months of the following year, which could increase costs beyond the allowable annual premium increases for that year, as well. Denial of services could also lead to lawsuits and a general, preventable decrease in employee health. If services were not denied, the unexpected cost overages would likely be taken out of the reserves. If this happens over multiple years, and the reserves are depleted to the point where solvency is jeopardized, health care services may ultimately be denied or delayed leading to the problems listed above.

Other cost considerations -

Because the bill does not explicitly include the subscriber liability in the expenditure limits, there could be significant cost increases incurred by employees. If health plan companies are unable to negotiate appropriate provider reimbursement they will likely increase cost sharing provisions to meet their expenditure limits. In effect, the cost increases over the expenditure limits would be paid by employees in the form of greater co-payments and coinsurance. As a health plan company, SEGIP would have to be able to shift costs to employees to meet its expenditure limitations in a similar manner. However, changes in cost sharing need to be made through the collective bargaining process, which would limit SEGIP's ability to react quickly to changes in claim utilization and would likely affect the amount SEGIP would be able to collect in premiums.

It is reasonable to assume that as a result of the considerations above, expenditures could exceed revenues by 2% or greater each year.

Assumptions

Sections 1-5:
DOER has assumed:

- Provisions in the Advantage Health plan are continued until a new labor contract is negotiated, consequently, the status quo is projected out
- Expenditures exceed premiums by 2% each year, and DOER does not deny or delay services to meet expenditure limits

If SEGIP is unable to negotiate favorable provider contracts, or there is an unexpected change in member utilization, the expenditures will be greater than the premiums collected. The SEGIP premium projected for calendar year 2005 is approximately $451,000,000. An under-funding of 2.0% would require a $9,020,000 expenditure of reserves in calendar year 2005 to balance the program revenues and expenditures, unless SEGIP denied or delayed services.

Under the scenario described above, an average annual premium shortfall of $9,020,000 could be expected, beginning in calendar year 2006. DOER assumed SEGIP reserves would be used to fund the shortfall. Given the current level of SEGIP reserves, the program would be insolvent before the end of calendar year 2011.

Projected SEGIP Medical Reserves, December 31, 2005	$41,000,000
Less Reserves required in CY 2006	$9,020,000
Less Reserves required in CY 2007	$9,020,000
Less Reserves required in CY 2008	$9,020,000
Less Reserves required in CY 2009	$9,020,000
Less Reserves required in CY 2010	$9,020,000
Reserves available January 1, 2011	($4,100,000)

Expenditure/Revenue Formula

Section 1 through 5: Expected 2005 annual premium – Minnesota Advantage Health Plan	$451,000,000
Average annual premium shortfall calculated by retrospective Application of premium growth limitation	2.0%
Annual expected premium shortfall, Minnesota Advantage Health Plan (estimated annual impact to SEGIP reserves)	$9,020,000
Cost by Fiscal Year Calculation: FY 06 –1/2 year x annual expected premium shortfall of $9,020,000	$4,510,000
FY 07 and subsequent years –Annual expected premium shortfall	$9,020,000

Long Term Fiscal Considerations

Based on the illustration above, SEGIP reserves would be depleted before the end of calendar year 2011, rendering the program insolvent.

Local Government Costs

N/A

References

- Developed with assistance from Deloitte Consulting, LLP, providing actuarial and consulting services to DOER for the administration of SEGIP benefit plans.
- SEGIP historical premium information from Annual Premium Payment Summary.

Agency Contact Name: Liz Houlding (651-296-6287)
FN Coord Signature: MIKE HOPWOOD
Date: 04/07/05 Phone: 297-5220

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 04/07/05 Phone: 215-0595

Minnesota Nurses Association Testimony In Support of Sen. Berglin's Health Bill (Senate File 65)

Madam Chair Members of the committee, my name is Mary Jo George, Government Affairs Staff Specialist with the Minnesota Nurses Association. The Minnesota Nurses Association represents over 18,000 nurses statewide. We are here today to support SF65, Sen. Berglin's health care bill. We support this bill because we believe it takes a comprehensive approach to reducing rising costs in health care. Rising health care costs are a concern to all of us, and nurses have become particularly concerned about the impact of rising health care costs on their patient's ability to afford health care insurance. Senate 65 reducing the cost of health care in many ways including the following:

1) The bill creates financial incentives to encourage providers to implement the use of best practices in medical care. Best practice guidelines, are a scientific proven method of providing the right care to the right patient at the right time. The literature from the Agency for Healthcare Research and Quality at the US Department of Health and Human Services indicates that significant savings can be found in our health care system if best practice guidelines are implemented.

2) The bill will also reduce health care costs by addressing the nursing shortage. Studies have shown that improved RN staffing can lead to better patient

outcomes, which means shorter stays in the hospital and reduces the likelihood of patients being readmitted to the hospital.

3) The third way that this bill reduces health care costs is by moving us toward a system wide use of electronic medical records. Electronic medical records will greatly improve efficiencies within our health care system, decrease administrative duplication and reduce medical errors as a result of a paper system.

4) Fourth, the bill improves access to health care coverage by allowing small employers to buy into Minnesotacare. This is an excellent idea for expanding the risk pool for small employers who often face huge increases in health premiums if one employee gets sick.

5) Fifth, the bill begins to address high cost drivers in our health system by establishing a Task Force on Childhood obesity and giving more information to consumers on the health risks and costs associated with smoking and obesity. Finally we support this bill because it places premium caps on insurers and HMO's. The bill requires that the savings we reap by changing our health care practices-- many that we illustrated above-- be shared with those who are purchasing health care. We believe this is a very fair approach and will encourage change in our health care practices. Thank you.

ATTACHMENT "E"

04/18/05 [COUNSEL] KC SCS0065A10

Senator ..... moves to amend S.F. No. 65 as follows:

Page 5, delete lines 17 to 22 and insert:

"(g) A health plan company may reduce reimbursement to providers in order to meet the premium growth limitations required by this section."

Page 7, lines 6 and 7, delete the new language and insert "This definition does not include the state employee health plan offered under chapter 43A"

Page 17, line 17, after "provider" insert "conducting the review" and after "follow" insert "coverage policies adopted by the health plan company that are based upon"

Page 17, line 19, after "organization" insert ", a nationally recognized guideline development organization,"

Page 18, line 27, after "physician" insert "conducting the review" and after "follow" insert "coverage policies adopted by the health plan company that are based upon"

Page 18, line 29, after "organization" insert ", a nationally recognized guideline development organization,"

Page 22, line 15, after "used" insert "coverage policies adopted by the health plan company that are based upon published"

Page 22, line 17, after "determination" insert "unless the recipient can show by clear and convincing evidence that the determination should be overturned"

Page 27, delete section 18

Page 28, after line 16, insert:

"Sec. 19. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25a. [PRIOR AUTHORIZATION FOR CERTAIN SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the services described in paragraph (c) for reimbursement under this chapter, chapters 256D, and 256L. Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in paragraph (c) unless the prepaid health plan is otherwise using evidence-based practices to address these services.

(b) Prior authorization shall be conducted by the medical

director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director or medical policy advisory council in place, the commissioner shall contract prior authorization to a Minnesota-licensed utilization review organization.

(c) The following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) chiropractic visits beyond ten visits;

(5) circumcision; and

(6) orthodontia.

(d) No new medical device, brand drug, or medical procedure shall be included in the benefit sets under this chapter, chapter 256D, or 256L until a technology assessment has been completed and the potential benefits are proven to outweigh the additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations."

Page 30, line 13, after the period, insert "A new eligibility certification form must be signed by the recipient's attending physician and the recipient every time a new face-to-face assessment or service update is made."

Page 30, line 20, delete the new language

Page 30, delete lines 21 and 22

Page 30, line 36, after "(e)" insert "Eligibility certification form" means a document based on the assessment,

approved by the commissioner, signed by the recipient's attending physician and the recipient, that describes:

(1) the specific type of personal care assistant services that are to be provided;

(2) the specific amount, in hours and number of days, of personal care assistant services that are to be provided; and

(3) the length of time, not to exceed 12 months, that the personal care assistant services are to be provided.

(f)"

Page 31, line 3, strike "(f)" and insert "(g)"

Page 31, line 12, strike "(g)" and insert "(h)"

Page 31, line 17, strike "(h)" and insert "(i)"

Page 31, line 19, strike "(i)" and insert "(j)"

Page 31, line 35, strike "and"

Page 31, line 36, after "(6)" insert "maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7)"

Page 32, line 2, strike "(j)" and insert "(k)"

Page 32, line 22, after "requirements" insert "; the organization must maintain documentation to ensure that the personal care assistant has complied with the requirements of section 256B.0627, subdivision 1, paragraph (j), clause (6), and the organization must:

(i) obtain the recipient's attending physician's signature on the eligibility form; and

(ii) obtain the recipient's signature on the eligibility certification form"

Page 32, line 23, strike "(k)" and insert "(l)"

Page 32, lines 35 and 36, reinstate the stricken "who is not the personal care assistant"

Page 33, line 5, after the period, insert "The delegated responsible party is not required to reside with the recipient while serving as the responsible party if adequate supervision and monitoring are provided for as part of the person's

individual service plan under a home- and community-based waiver program or in conjunction with a home care targeted case management service provider or other case manager."

Page 33, line 17, strike "(l)" and insert "(m)"

Page 33, line 27, strike "(m)" and insert "(n)"

Page 34, line 5, strike "(n)" and insert "(o)"

Page 34, line 19, after the period, insert "To be eligible for payment, these services must not exceed the service guidelines and dollar limits in the personal care limit decision tree as required by this section."

Page 34, line 23, after "amount" insert ", length," and after "authorized" insert "by the recipient's attending physician in the eligibility certification form"

Page 36, line 24, after "criteria" insert "which is documented with substantiating financial documentation" and after "and" insert "upon review of this documentation"

Page 37, line 6, strike "and"

Page 37, line 8, before the period, insert "; and

(15) services not certified by the recipient's attending physician in an eligibility certification form"

Page 37, line 24, after the period, insert "The audit process must include, at a minimum, a requirement that (1) each personal care assistant be assigned an identification number; (2) each bill submitted by an agency or individual must include the identification numbers of each personal care assistant providing services to the client; and (3) the documentation of hours of care provided must include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified. The commissioner shall use an eligibility certification form signed by the recipient's attending physician and the recipient that certifies that the recipient requires personal care assistant services. The eligibility certification form shall contain a penalty notice indicating that any person who obtains certification by misrepresentation or fraud shall be guilty of a misdemeanor.

(g) The commissioner shall maintain a personal care limit decision tree that sets forth the maximum number of hours that may be applied to a particular type of personal care assistant service. The commissioner shall establish guidelines for each type of personal care assistant service based on need and dependency. In order to be eligible for payment, adherence to the service and dollar limitations by the personal care provider organization and personal care assistant shall be required beginning July 1, 2005. Any county public health nurse or certified public health nurse under contract with the county or with a prepaid health plan who conducts assessments for personal care assistant services shall follow these guidelines."

Page 37, strike lines 33 to 35 and insert "Authorized services must be used within a calendar month and shall not be carried over to the following month. If rolling eligibility is reinstated under chapter 256B, flexible use hours may be used over a six-month period."

Page 38, lines 8 to 27 delete the new language

Page 38, line 28, delete "(d)"

Page 39, line 1, delete "(e)" and insert "(c)"

Page 39, line 4, delete "(f)" and insert "(d)"

Page 48, after line 7, insert:

"(p) Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in section 256B.0625, subdivision 25a, unless the prepaid health plan is otherwise using evidence-based practices to address these services.

Sec. 28. [256L.036] [PRIOR AUTHORIZATION OF SERVICES.]

Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in section 256B.0625, subdivision 25a, unless the prepaid health plan is otherwise using evidence-based practices to address these services."

Page 53, line 36, delete everything before "established" and insert "Health Information Technology and Infrastructure Advisory Committee"

Page 54, line 21, delete "2005" and insert "2015"

Page 54, after line 23, insert:

"Sec. 34. [TRAINING REQUIRED.]

Effective July 1, 2005, the commissioner of human services shall develop a plan for increased training of physicians, public health nurses, personal care assistants, and enrollees or persons acting as responsible parties who are interested in hiring a personal care assistant under the self-directed option:

(1) training for physicians shall include information on the personal care assistant benefit, the requirements for participation and the guidelines for services developed by the commissioner;

(2) training for public health nurses shall include ensuring that level of need determinations and guidelines for services as developed by the commissioner are understood and consistently applied;

(3) training for personal care assistants, particularly nonagency employed personal care assistants, should include which services are appropriate for a personal care assistant to provide. A personal care assistant shall attend at least four hours of training annually; and

(4) training for those interested in hiring a personal care assistant under the self-directed option should be conducted by a nurse and include how to employ a personal care assistant, what services are appropriate for a personal care assistant, and what responsibilities are included in managing a personal care assistant.

Training must begin no later than October 1, 2005.

Sec. 35. [RATE REDUCTION.]

(a) Effective for the services identified in Minnesota Statutes, section 256B.0625, subdivision 25a, paragraph (c), rendered on or after July 1, 2005, the payment rate shall be reduced by ... percent from the rate in effect on June 30, 2005.

(b) This section shall expire on June 30, 2006, or upon the completion of the prior authorization system required under Minnesota Statutes, section 256B.0625, subdivision 25a,

paragraph (b), whichever is later."

Page 54, delete lines 25 to 35

Page 54, line 36, delete "(b)"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "F"

Senator ..... moves to amend S.F. No. 65 as follows:

Page 54, after line 23, insert:

"Sec. 33. [AIDS PREVENTION INITIATIVE FOCUSING ON AFRICAN-BORN RESIDENTS.]

The commissioner of health shall award grants in accordance with Minnesota Statutes, section 145.924, paragraph (b), for a public education and awareness campaign targeting communities of African-born Minnesota residents. The grants shall be designed to promote knowledge and understanding about HIV and to increase knowledge in order to eliminate and reduce the risk for HIV infection; to encourage screening and testing for HIV; and to link individuals to public health and health care resources. The grants must be awarded to collaborative efforts that bring together nonprofit community-based groups with demonstrated experience in addressing the public health, health care, and social service needs of African-born communities."

Page 55, after line 3, insert:

"(c) $300,000 is appropriated for fiscal year 2006 from the general fund to the commissioner of health for the purpose of a public education and awareness campaign targeting communities of African-born Minnesota residents. This appropriation is a onetime appropriation and shall not become part of the base-level funding for the 2006-2007 biennium."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly