Senate Counsel & Research

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 108 - Tobacco Use Permitted

Author: Senator Don Betzold

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

Date: February 18, 2005

S.F. No. 108 permits the administrator of a chemical dependency treatment program or mental health program to establish a policy that would permit smoking by patients in a separated ventilated area when prohibiting smoking would interfere with the patient's treatment.

KC:rdr

Senator Betzold introduced--

S.F. No. 108: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; permitting tobacco use in certain public institutions; amending Minnesota Statutes 2004, section 144.414, subdivision 3; repealing Minnesota Statutes 2004, section 246.0141.

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

Section 1. Minnesota Statutes 2004, section 144.414, subdivision 3, is amended to read:

Subd. 3. [HEALTH CARE FACILITIES AND CLINICS.] (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, or other health care-related facility, other than a nursing home, boarding care facility, or licensed residential facility, except as allowed in this subdivision.

(b) Smoking by patients in a chemical dependency treatment program or mental health program may be allowed in a separated well-ventilated area pursuant to a policy established by the administrator of the program that identifies circumstances in which prohibiting smoking would interfere with the treatment of persons recovering from chemical dependency or mental illness.

(c) Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

Sec. 2. [REPEALER.]

Minnesota Statutes 2004, section 246.0141, is repealed.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective the day following final enactment.

APPENDIX
Repealed Minnesota Statutes for 05-0981

246.0141 TOBACCO USE PROHIBITED.

No patient, staff, guest, or visitor on the grounds or in a state regional treatment center, the Minnesota Security Hospital, the Minnesota sex offender program, or the Minnesota extended treatment options program may possess or use tobacco or a tobacco-related device. For the purposes of this section, "tobacco" and "tobacco-related device" have the meanings given in section 609.685, subdivision 1. This section does not prohibit the possession or use of tobacco or a tobacco-related device by an adult as part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

Senator ..... moves to amend S.F. No. 108 as follows:

Page 1, line 14, before "Smoking" insert "Notwithstanding section 246.0141,"

Page 2, delete section 2

Page 2, line 4, delete "Sections 1 and 2" and insert "Section 1 is"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Hennepin County Medical Center
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Psychiatry

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Michael K. Popkin, M.D.
Chief of Psychiatry

October 21, 2003

Senator Donald R. Betzold
111 State Capital
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606

Dear Senator Betzold,

I write to indicate my strong opposition to the bill recently passed by the Senate and currently before the House requiring inpatient psychiatric units to be smoke-free beginning January, 2004.

Previous experience with such a policy on our inpatient psychiatric units convincingly demonstrated significant negative impacts on patient care, including increased elopements, aggression towards staff and other patients, and decreased cooperation with treatment.

Though a non-smoking policy may be well-intentioned, I believe it is unwise to further challenge a patient attempting to deal with an episode of psychiatric illness severe enough to have required hospitalization. Smoking issues can better be addressed after stabilization and discharge, likely with greater cooperation from the patient. I urge you to oppose the legislation.

Sincerely,

Michael K. Popkin, MD
Chief of Psychiatry
Hennepin County Medical Center

Professor of Psychiatry and Medicine
University of Minnesota Medical School

MKP/sr

Sen.Don Betzold

Dear Senator Betzold

I am a psychiatric nurse at Hennepin County Medical Center and I am writing to express my strong opposition to the recent legislation passed by the senate and currently before the House requiring psychiatric units to be smoke free beginning January, 2004.

I have worked inpatient psychiatry at HCMC since 1988 which includes approximately 1 1/2 years smoke-free in the inpatient psychiatry units. While the smoke-free intention may be good, is it reasonable to ask adults who are experiencing acute psychiatric crisis to quit smoking. It is simply one more stressor for the patient who is already experiencing significant and overwhelming psychiatric symptoms. Our last debacle with being smoke free was a resounding fiasco. Patients became pitted against staff, would sign themselves out of the hospital early against medical advice, smuggle in cigarettes and lighters and also light cigarettes using a paperclip stuck into an electrical outlet and the resulting sparks would be caught on paper or toilet paper causing the paper to ignite and then that to light a cigarette. During this time patients were more irritable angry and assaultive towards staff and other patients and patient cooperation with treatment was markedly diminished.In effect we (staff) became the "cigarette police."

It is important to keep in mind the severity of the mental illness of the patients we treat and the resistance many have to psychiatric treatment. We take their smokes and it creates an instant adversarial relationship. The therapeutic relationship is in jeopardy immediately as we stand over them and demand they be smoke free to receive treatemnt.For many patients smoking is the only enjoyment they have in a very bleak and tragic existence. And then we take that away from them, it is as though they were being punished for being mentally ill? And the only way to avoid this particular punishment is to avoid treatment. Which I can tell you in the vast majority of cases is a really bad idea.

Lastly many "well" people struggle mightily to stop smoking, but we compel these very mentally ill people to stop smoking and they have no choice because they are on court holds, 72 hour holds or committed. What little power or control of their lives they have we further erode by taking this. Many people would see this smoking issue as a small thing, but to these people, my patients, it is huge-bigger than you can imagine. To know you should come see us, talk to those of us who will be affected by your actions. Please oppose this legislation
Sincerely
Sandy Klein-Hegge R.N.

FORCE OF HABIT

Smoke and Mirrors

You have to be crazy to light up in a Minnesota hospital. Thank goodness for small favors!

For decades now, cigarettes and hospitals have not mixed. Long before any clean-air act or tobacco settlement, there were islands of exiles—many of them standing sheepishly in scrubs—outside the whispering doors of the ER. Paradoxically, smoking persists in one place inside the hospital: the psych ward. There are reasons. When smoking is banned in psychiatric units, there frequently are outbursts of violence, anger, and resentment.

John Gray is the nursing supervisor for inpatient psychiatry at Hennepin County Medical Center. His unit provides patients with a smoking room, which is more or less a well-ventilated closet. Gray is old enough to remember a time not too long ago when it was common for a doctor to light up with a patient during a psychiatric interview. He also remembers the dark days when his unit adopted a strict nonsmoking policy, in 1994. The results were nerve-racking, to say the least. "During that year, the doctors were all for the nonsmoking policy," Gray said. "And the same doctors decided it wasn't a good idea after dealing with the patients." An exemption was granted.

On the whole, people are comfortable with the current policy, which allows smoking in designated areas during restricted times. It is a singular liberty and a comfort to troubled souls. Gray has received only one complaint from the family of a patient, but has received quite a bit of appreciative feedback. In fact, one family whose son was a patient shows its appreciation by donating cartons of cigarettes a few times a year. Not a smoker himself, Gray is careful to clarify that the unit does not endorse smoking. It's a hospital, after all, and alternatives are available. "We have offered tobacco cessation. But it's a rare patient that has any interest."

From her comfortable office over on Nicollet Mall, Dr. Maureen Hackett disagreed. She is a forensic psychiatrist in private practice, who specializes in legal issues in psychiatry. She teaches classes at William Mitchell College of Law. Hackett believes that most people who smoke want to quit and that it's medically irresponsible to allow smoking in any health care facility. As a result of her convictions, she launched what she called a "one-person campaign" seeking legislation that would explicitly require all health-care facilities, including psychiatric units, to be smoke-free. With the support of the Minnesota Medical Association, her efforts were successful. "A bill was signed and is going into action in 2004 that will eliminate smoking on hospital grounds," she said. According to Hackett, this will include the HCMC psychiatric unit. She anticipates grumbling from both the staff and the patients, but feels education will change the minds of many health-care workers. "These nurses are clueless," said Dr. Hackett. "And I'm not being disrespectful, because I was clueless too. There is a perception on the part of the staff that hostility is going to grow, and really it lessens." There are plenty of studies, she said, where this has been shown. "I think the unit needs to offer other options. The smoking room could be turned into a place that offers time out, maybe with running water, a fountain, or mood music." Perhaps they'll also consider punching bags.—*Sarah Sawyer*

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ILLUSTRATION BY MARY FALLON

MN House Health and Human Services Policy Committee MN State Capitol
St. Paul, MN

3/6/04

Dear Legislators:

Dr. Maureen Hackett informed me that the law banning smoking in hospitals and on hospital grounds was being reviewed and could possibly be rescinded. Given the deadly nature of tobacco, I think this would be indeed a step backwards for the community's health.

As an inpatient psychiatrist at Regions Hospital for the last 24 years I have worked on the wards both when we allowed smoking and after it was banned. For over 8 years now we have not allowed smoking on the inpatient psychiatric wards. When we first instituted this policy, many people were convinced it would fail and that the patients would become more agitated and dangerous. This in fact has not been the case. We provide nicotine replacement in the form of gum or the patch which work just fine. Many patients are delighted with their newfound ability to stay off cigarettes. It has been said that one would have to adjust med doses once patients started smoking again after discharge. I have not found this to be of clinical significance and I treat outpatients after their hospital stays. I cannot remember a single instance where I had to adjust meds due to a change in smoking habits.

Now that smoking is banned on the hospital grounds as well, it has become even less of an issue with patients who want passes to smoke. We simply tell them that we are a healthcare facility interested in helping them to become and stay as healthy as possible, and that smoking is not a part of that picture. Knowing that the state hospitals also maintain this posture makes for a consistent health-oriented partnership between the community hospitals and the long-term care facilities that helps patients deal with their tobacco addiction.

I sincerely hope that this very progressive law is not undone. Tobacco addiction is an incredibly difficult problem for anyone who has been trapped by it, not to mention for those of us exposed to secondhand smoke. This law is a small step in this battle, but a very important one. It helps the hospitals in their efforts to lead people to healthier lifestyles which is good for our community.

Thank you for your consideration. Due to technical and time constraints I cannot personally sign this letter; please accept it.

Janet Zander, M.D.
Inpatient Psychiatry Director
Regions Hospital
St. Paul, MN

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S.F. No. 826 - Child Care Centers Licensing Fee Reductions

Author: Senator Cal Larson

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

Date: February 17, 2005

S.F. No. 826 reduces by 25 percent the annual license fees paid by child care providers for a child care license.

JW:rdr

Senator Larson introduced--

S.F. No. 826: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying child care center license fees; amending Minnesota Statutes 2004, section 245A.10, subdivision 4.

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

Section 1. Minnesota Statutes 2004, section 245A.10, subdivision 4, is amended to read:

Subd. 4. [ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITH LICENSED CAPACITY.] (a) Child care centers and programs with a licensed capacity shall pay an annual nonrefundable license or certification fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee	Other Program License Fee
1 to 24 persons	~~$300~~ $225	$400
25 to 49 persons	~~$450~~ $340	$600
50 to 74 persons	~~$600~~ $450	$800
75 to 99 persons	~~$750~~ $565	$1,000
100 to 124 persons	~~$900~~ $675	$1,200
125 to 149 persons	~~$1,200~~ $900	$1,400
150 to 174 persons	~~$1,400~~ $1,050	$1,600
175 to 199 persons	~~$1,600~~ $1,200	$1,800
200 to 224 persons	~~$1,800~~ $1,350	$2,000
225 or more persons	~~$2,000~~ $1,500	$2,500

(b) A day training and habilitation program serving persons

with developmental disabilities or related conditions shall be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. When a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

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S.F. No. 873 - Child Care Assistance Provider Reimbursement

Author: Senator Cal Larson

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

Date: February 17, 2005

The child care assistance rates were frozen in 2003, and the Department of Human Services subsequently modified the reimbursement rates for providers based on a regional maximum rate, which resulted in a decrease in some provider rates. S.F. No. 873 requires that the commissioner restore the rate for those providers who received a decrease in reimbursement after the rates were frozen in 2003.

JW:rdr

Senator Larson introduced—

S. F. No. 873 Referred to the Committee on Health & Family Security

A bill for an act

relating to human services; modifying child care reimbursement rates.

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

Section 1. [CHILD CARE REIMBURSEMENT RATES; DIRECTION TO COMMISSIONER.]

The commissioner of human services shall modify the child care assistance provider reimbursement rate setting methodology used to implement the provider reimbursement rate freeze under Laws 2003, First Special Session chapter 14, article 9, section 34. Any child care provider who received a reimbursement rate decrease due to the creation of regional or statewide maximum reimbursement rates must have their reimbursement rate restored to the level at which it was set as of June 30, 2003.

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

Senate Counsel, Research,
and Fiscal Analysis

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Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

S.F. No. 223 - Emergency Medical Services

Author: Senator Gary Kubly

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

Date: February 21, 2005

S.F. No. 223 increases the amount of income a volunteer ambulance attendant may earn and still be defined as a volunteer, authorizes Indian tribes to be licensed to operate ambulance services under certain conditions, and makes other modifications in Minnesota Statutes, chapter 144, governing the Emergency Medical Services Regulatory Board (EMSRB).

Section 1 (144E.001, subdivision 8) expands the definition of ambulance service "licensee" to include Indian tribes.

Section 2 (144E.001, subdivision 15) allows a volunteer ambulance attendant to earn up to $6,000 annually and still be considered a volunteer. The current limit is $3,000 in this definitional section, but is $6,000 plus inflation for purposes of the ambulance service personnel longevity award and incentive program.

Section 3 (144E.10, subdivision 3) authorizes federally recognized Indian tribes to be licensed to operate ambulance services if they agree to (1) comply with all legal requirements governing ambulance services; (2) be subject to liability for claims arising out of the ambulance service operation and to waive sovereign immunity with respect to any claims; and (3) be subject to applicable data practice requirements. The board and the tribe must enter into a joint powers agreement to govern a tribal ambulance service.

Section 4 (144E.266) suspends portions of Chapter 144E during a declared national security emergency, peacetime emergency, or local emergency.

Sections 5 to 9 add the requirement that the applicant complete a board-approved application form to various personnel certification statutes.

- **Section 5 (144E.27, subdivision 2)** adds the requirement to the first responder registration statute.

- **Section 6 (144E.28, subdivision 1)** adds it to the emergency medical technician (EMT) certification statute.

- **Section 7 (144E.28, subdivision 3)** adds it to the statute governing EMT certification through reciprocity.

- **Section 8 (144E.28, subdivision 7)** adds it to the EMT renewal process.

- **Section 9 (144E.28, subdivision 8)** adds it to the EMT reinstatement process.

DG:rdr

Senators Kubly, Kierlin, Senjem, Lourey and Vickerman introduced--
S.F. No. 223: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying ambulance service provisions; modifying requirements for first responders and emergency medical technicians; providing for emergency suspension of certain requirements; amending Minnesota Statutes 2004, sections 144E.001, subdivisions 8, 15; 144E.10, by adding a subdivision; 144E.27, subdivision 2; 144E.28, subdivisions 1, 3, 7, 8; proposing coding for new law in Minnesota Statutes, chapter 144E.

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

Section 1. Minnesota Statutes 2004, section 144E.001, subdivision 8, is amended to read:

Subd. 8. [LICENSEE.] "Licensee" means a natural person, partnership, association, corporation, Indian tribe, or unit of government which possesses an ambulance service license.

Sec. 2. Minnesota Statutes 2004, section 144E.001, subdivision 15, is amended to read:

Subd. 15. [VOLUNTEER AMBULANCE ATTENDANT.] "Volunteer ambulance attendant" means a person who provides emergency medical services for a Minnesota licensed ambulance service without the expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though the individual receives an hourly stipend for each hour of actual service provided, except for hours on standby alert, or other nominal fee, and even though the hourly stipend or other nominal fee is regarded as

taxable income for purposes of state or federal law, provided that the hourly stipend and other nominal fees do not exceed ~~$3,000 within one year of the final certification examination~~ $6,000 annually.

Sec. 3. Minnesota Statutes 2004, section 144E.10, is amended by adding a subdivision to read:

Subd. 3. [TRIBAL LICENSING.] (a) As used in this chapter, "tribe" means a federally recognized Indian tribe, as defined in United States Code, title 25, section 450b, paragraph (e), located within the state of Minnesota.

(b) A tribe may be licensed by the board to operate an ambulance service if the tribe agrees:

(1) to comply with all requirements of this chapter and applicable rules;

(2) to be subject to liability for its torts and those of its officers, employees, and agents acting within the scope of their employment duties arising out of the operation of an ambulance service licensed by the board, to the same extent as a municipality under chapter 466, and the tribe further agrees, notwithstanding section 16C.05, subdivision 7, to waive its sovereign immunity with respect to claims arising from the liability; and

(3) to be subject to chapter 13 and any other laws of the state relating to data practices of ambulance services licensed by the board.

(c) To coordinate, define, and regulate the provision of ambulance service and to provide for mutual aid and cooperation, a tribe and the board shall enter into agreements under section 471.59. For purposes of section 471.59, a tribe shall be considered a "governmental unit."

Sec. 4. [144E.266] [EMERGENCY SUSPENSION OF AMBULANCE SERVICE REQUIREMENT.]

(a) The requirements of sections 144E.10; 144E.101, subdivisions 1, 2, 3, 6, 7, 8, 9, 10, 11, and 13; 144E.103; 144E.12; 144E.121; 144E.123; 144E.127; and 144E.15, are suspended:

(1) throughout the state during a national security emergency declared under section 12.31;

(2) in the geographic areas of the state affected during a peacetime emergency declared under section 12.31; and

(3) in the geographic areas of the state affected during a local emergency declared under section 12.29.

(b) For purposes of this section, the geographic areas of the state affected shall include geographic areas where one or more ambulance services are providing requested mutual aid to the site of the emergency.

Sec. 5. Minnesota Statutes 2004, section 144E.27, subdivision 2, is amended to read:

Subd. 2. [REGISTRATION.] To be eligible for registration with the board as a first responder, an individual shall complete a board-approved application form and:

(1) successfully complete a board-approved initial first responder training program. Registration under this clause is valid for two years and expires at the end of the month in which the registration was issued; or

(2) be credentialed as a first responder by the National Registry of Emergency Medical Technicians. Registration under this clause expires the same day as the National Registry credential.

Sec. 6. Minnesota Statutes 2004, section 144E.28, subdivision 1, is amended to read:

Subdivision 1. [REQUIREMENTS.] To be eligible for certification by the board as an EMT, EMT-I, or EMT-P, an individual shall:

(1) successfully complete the United States Department of Transportation course, or its equivalent as approved by the board, specific to the EMT, EMT-I, or EMT-P classification; and

(2) pass the written and practical examinations approved by the board and administered by the board or its designee, specific to the EMT, EMT-I, or EMT-P classification; and

(3) complete a board-approved application form.

Sec. 7. Minnesota Statutes 2004, section 144E.28,

subdivision 3, is amended to read:

Subd. 3. [RECIPROCITY.] The board may certify an individual who possesses a current National Registry of Emergency Medical Technicians registration from another jurisdiction if the individual submits a board-approved application form. The board certification classification shall be the same as the National Registry's classification. Certification shall be for the duration of the applicant's registration period in another jurisdiction, not to exceed two years.

Sec. 8. Minnesota Statutes 2004, section 144E.28, subdivision 7, is amended to read:

Subd. 7. [RENEWAL.] (a) Before the expiration date of certification, an applicant for renewal of certification as an EMT shall:

(1) successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director; ~~and~~

(2) take the United States Department of Transportation EMT refresher course and successfully pass the practical skills test portion of the course, or successfully complete 48 hours of continuing education in EMT programs that are consistent with the United States Department of Transportation National Standard Curriculum or its equivalent as approved by the board or as approved by the licensee's medical director and pass a practical skills test approved by the board and administered by a training program approved by the board. The cardiopulmonary resuscitation course and practical skills test may be included as part of the refresher course or continuing education renewal requirements. Twenty-four of the 48 hours must include at least four hours of instruction in each of the following six categories:

(i) airway management and resuscitation procedures;

(ii) circulation, bleeding control, and shock;

(iii) human anatomy and physiology, patient assessment, and medical emergencies;

(iv) injuries involving musculoskeletal, nervous, digestive, and genito-urinary systems;

(v) environmental emergencies and rescue techniques; and

(vi) emergency childbirth and other special situations; and

(3) complete a board-approved application form.

(b) Before the expiration date of certification, an applicant for renewal of certification as an EMT-I or EMT-P shall:

(1) for an EMT-I, successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director and for an EMT-P, successfully complete a course in advanced cardiac life support that is approved by the board or the licensee's medical director; and

(2) successfully complete 48 hours of continuing education in emergency medical training programs, appropriate to the level of the applicant's EMT-I or EMT-P certification, that are consistent with the United States Department of Transportation National Standard Curriculum or its equivalent as approved by the board or as approved by the licensee's medical director. An applicant may take the United States Department of Transportation Emergency Medical Technician refresher course or its equivalent without the written or practical test as approved by the board, and as appropriate to the applicant's level of certification, as part of the 48 hours of continuing education. Each hour of the refresher course, the cardiopulmonary resuscitation course, and the advanced cardiac life support course counts toward the 48-hour continuing education requirement; and

(3) complete a board-approved application form.

(c) Certification shall be renewed every two years.

(d) If the applicant does not meet the renewal requirements under this subdivision, the applicant's certification expires.

Sec. 9. Minnesota Statutes 2004, section 144E.28, subdivision 8, is amended to read:

Subd. 8. [REINSTATEMENT.] (a) Within four years of a certification expiration date, a person whose certification has

expired under subdivision 7, paragraph (d), may have the certification reinstated upon submission of:

(1) evidence to the board of training equivalent to the continuing education requirements of subdivision 7; and

(2) a board-approved application form.

(b) If more than four years have passed since a certificate expiration date, an applicant must complete the initial certification process required under subdivision 1.

Senator ..... moves to amend S.F. No. 223 as follows:

Page 1, after line 16, insert:

"Sec. 2. Minnesota Statutes 2004, section 144E.001, is amended by adding a subdivision to read:

Subd. 14a. [TRIBE.] "Tribe" means a federally recognized Indian tribe, as defined in United States Code, title 25, section 450b, paragraph (e), located within the state of Minnesota."

Page 2, delete lines 5 to 30

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senate Counsel & Research

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Senate
State of Minnesota

S.F. No. 24 - Cervical Cancer Elimination Study

Author: Senator Yvonne Prettner Solon

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

Date: February 18, 2005

S.F. No. 24, paragraph (a), requires the Commissioner of Health to develop a statewide integrated and comprehensive cervical cancer prevention plan. The plan must include activities that identify and implement methods that would improve the cervical cancer screening rates, including: (1) identifying and disseminating appropriate evidence-based cervical cancer screening guidelines; (2) increasing the use of appropriate screening based on these guidelines for patients seen by medical groups and monitoring results of these medical groups; and (3) reducing the number of women who should but have not been screened.

Paragraph (b) requires the Commissioner to identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment.

Paragraph (c) authorizes the Commissioner to work with a nonprofit quality improvement organization to identify evidence-based guidelines for cervical cancer screening and to identify methods to improve the cervical cancer screening rates among medical groups. The Commissioner may also work with a nonprofit health care result reporting organization to monitor results by medical groups.

Paragraph (d) authorizes the Commissioner to convene an advisory committee to assist in developing the prevention plan.

Paragraph (e) requires the Commissioner to submit a report to the Legislature by January 15, 2006, on: (1) the statewide plan; (2) methods for monitoring the results by medical groups and by the entire state of the screening improvement activities; and (3) recommended changes to existing laws, programs, or services for reducing the occurrence of cervical cancer by improving insurance coverage.

KC:vs

Senators Solon, Higgins and Moua introduced--

S.F. No. 24: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; establishing the Cervical Cancer Elimination Task Force.

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

Section 1. [CERVICAL CANCER ELIMINATION TASK FORCE.]

Subdivision 1. [GOAL.] It is the goal of the state to decrease the morbidity and mortality rates from cervical cancer by establishing a statewide comprehensive, coordinated plan to improve cervical cancer prevention, diagnosis, and treatment in Minnesota. The Cervical Cancer Elimination Task Force is created to achieve this goal.

Subd. 2. [MEMBERSHIP.] Appointments to the Cervical Cancer Elimination Task Force shall be coordinated by the commissioner of health to ensure ethnic and racial representation and to ensure that the geographic areas of the state are represented in proportion to each area's population. The Cervical Cancer Elimination Task Force consists of 21 members, as follows:

(1) the commissioners of health, human services, commerce, and education;

(2) the state epidemiologist;

(3) four members representing health care providers: one member appointed by the Minnesota Nurses' Association, one member appointed by the American Academy of Pediatrics, one member appointed by the American Academy of Family Practice, and

one member appointed by the American College of Gynecology;

(4) one member representing the American Cancer Society;

(5) two members representing health plan companies: one member appointed by the Minnesota Council of Health Plans and one member appointed by the Insurance Federation of Minnesota;

(6) one member representing the University of Minnesota Academic Health Center appointed by the university provost;

(7) two members representing community health boards as defined in Minnesota Statutes, section 145A.02;

(8) four members of the legislature: two members appointed under the rules of the senate and two members appointed under the rules of the house of representatives; and

(9) two members representing the general public interested in women's health issues: one member appointed under the rules of the senate and one member appointed under the rules of the house of representatives.

Subd. 3. [ADMINISTRATION.] (a) The Cervical Cancer Elimination Task Force is governed by Minnesota Statutes, section 15.059.

(b) The task force shall elect a chair from its membership. The commissioner of health shall provide staff and administrative support for the task force.

Subd. 4. [DUTIES.] The task force shall:

(1) examine, both statistically and qualitatively, the prevalence and cost to the state due to cervical cancer;

(2) develop a statewide integrated and comprehensive cervical cancer prevention plan, including strategies for promoting and implementing the plan. In developing the plan, the task force must consider reports and testimony from individuals, local health departments, community-based organizations, and other public and private organizations statewide regarding contributions and ideas for improving cervical cancer prevention, diagnosis, and treatment;

(3) develop a statewide public awareness campaign on the causes and nature of cervical cancer, including personal risk factors, and the value of prevention and early detection;

(4) identify new technologies, tests, and vaccines, which may be effective in preventing and controlling the risk of cervical cancer, and develop a plan to raise public awareness and educate physicians about the identified advancements that prove to be effective; and

(5) identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment, including but not limited to medical care reimbursement, treatment costs, and the availability of insurance coverage, and make recommendations on any necessary changes to existing laws, programs, or services in terms of improving coverage for screening and treatment services.

Subd. 5. [REPORT.] The task force shall submit a report to the legislature by January 15, 2006, and annually thereafter until the expiration of the task force addressing:

(1) progress being made in fulfilling the duties of the task force and in developing the cervical cancer prevention plan; and

(2) recommended strategies or actions to reduce the occurrence of cervical cancer and to improve prevention, diagnosis, and treatment for cervical cancer.

Subd. 6. [EXPIRATION.] The task force expires upon submission of the final report on January 15, 2008.

Senator ..... moves to amend S.F. No. 24 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [CERVICAL CANCER ELIMINATION STUDY.]

(a) The commissioner of health shall develop a statewide integrated and comprehensive cervical cancer prevention plan, including strategies for promoting and implementing the plan. The plan must include activities that identify and implement methods to improve the cervical cancer screening rates in Minnesota, including, but not limited to:

(1) identifying and disseminating appropriate evidence-based cervical cancer screening guidelines to be used in Minnesota;

(2) increasing the use of appropriate screening based on these guidelines for patients seen by medical groups in Minnesota and monitoring results of these medical groups; and

(3) reducing the number of women who should but have not been screened.

(b) In developing the plan, the commissioner shall also identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment, including, but not limited to, medical care reimbursement, treatment costs, and the availability of insurance coverage.

(c) The commissioner may work with a nonprofit quality improvement organization in Minnesota to identify evidence-based guidelines for cervical cancer screening and to identify methods to improve the cervical cancer screening rates among medical groups; and may work with a nonprofit health care result reporting organization to monitor results by medical groups in Minnesota.

(d) The commissioner may convene an advisory committee that includes representatives of health care providers, the American Cancer Society, health plan companies, the University of Minnesota Academic Health Center, community health boards, and the general public.

(e) The commissioner shall submit a report to the legislature by January 15, 2006, on:

(1) the statewide cervical cancer prevention plan, including a description of the plan activities and strategies developed for promoting and implementing the plan;

(2) methods for monitoring the results by medical groups and by the entire state of cervical cancer screening improvement activities; and

(3) recommended changes to existing laws, programs, or services in terms of reducing the occurrence of cervical cancer by improving insurance coverage for the prevention, diagnosis, and treatment for cervical cancer."

Senate Counsel & Research

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 795 - Coverage for Interpreter Services

Author: Senator Linda Higgins

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

Date: February 21, 2005

S.F. No. 795 requires a health plan to cover language interpreter services provided to non-English-speaking enrollees. These services may be provided in person or by telephone. A health plan company may provide these services directly or may require the provider or health care facility to provide or arrange interpreter services. In either case, the person providing the interpreter service must bill the health plan company and not the provider. Providers or health care facilities that employ or contract with interpreters shall be reimbursed directly by the health plan company. A health plan company, upon request, must provide to enrollees the policies and procedures for addressing the needs of non-English-speaking enrollees.

KC:vs

Senators Higgins, Kleis, Senjem and Johnson, D.E. introduced--
S.F. No. 795: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; requiring coverage for or provision of language interpreter services for enrollees; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. [62Q.40] [LANGUAGE INTERPRETER SERVICES.]

A health plan must cover language interpreter services provided to a non-English-speaking enrollee in order to facilitate the provision of health care services by a provider or health care facility. For purposes of this section, "provider" has the same meaning as provided under section 62J.03, subdivision 8; and "health plan" includes coverages excluded under section 62A.011, subdivision 3, clauses (7), (9), and (10). Language interpreter services may be provided in person or by telephone. A health plan may provide language interpreter services directly to a non-English-speaking enrollee. Where a provider or health care facility is required to provide or arrange for language interpreter services for an enrollee, a health plan shall reimburse the party providing interpretive services directly for the costs of language interpreter services provided to the enrollee. Persons providing language interpreter services that are reimbursed by a health plan must bill the health plan for such services and may not bill the provider or health care facility providing or

arranging for such services. Providers and health care facilities that employ or contract with language interpreters may bill and shall be reimbursed directly by health plan companies for such services. A health plan company shall provide to enrollees, upon request, the policies and procedures for addressing the needs of non-English-speaking enrollees.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment and applies to plans issued or renewed to provide coverage to Minnesota residents on or after that date.

Senator ..... moves to amend S.F. No. 795 as follows:

Page 1, line 9, after "enrollee" insert "or an enrollee who is deaf or deafblind"

Page 1, line 16, before the period, insert "or other accessible technology" and after "plan" insert "company"

Page 1, lines 20 and 24, after "plan" insert "company"

Page 2, line 6, before the period, insert "and enrollees who are deaf or deafblind"

February 22, 2003

Senator Linda Higgins, Dist. 58
328 State Capitol
St. Paul, MN 55155

Dear Senator Higgins,

Thank you for introducing S.F. 795 requiring health plans to cover payments for language interpreter services. This is a real problem for our member practices across the state, especially where we have high populations of workers that speak a language other than English.

S.F. 795 places the responsibility for payment of interpreters where it should be, at the plan level. Chiropractic services are often times billed at the $35 to $85 range depending on the service being provided. The interpretive service we are billed currently is in the range of $150 - $200. You can see we cannot even cover the costs of the interpreter. Something must be done to correct this problem or providers will no longer be able to accept these patients.

The Minnesota Chiropractic Association has joined with the Minnesota Provider Coalition to lobby in support of S.F. 795. Please let us know how we can support your efforts to resolve this problem.

Sincerely,

Dr. Matt Caron
President

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Burnsville, MN 55337
952 882-9411 • FAX 952 882-9397

Language Interpreter Services

Support for S.F. 795

Health care evaluation and treatment requires clear communication between the patient and doctor, nurse or therapist to be effective. Language barriers impede this essential communication and may even result in an inaccurate diagnosis or poor patient compliance with treatment recommendations.

Minnesota has been the destination for immigrants seeking new opportunities throughout its history. Recent waves of immigration largely from Somalia, Laos, Viet Nam and numerous Spanish-speaking countries is enriching our communities in many ways but also impacting how we provide services. Because many recent immigrants speak little or no English it is essential that qualified interpreters be available when non-English speakers require health care services. Federal law also requires health care providers to arrange for interpreter services.

Minnesota law currently requires many payers to either provide translators or reimburse clinics and hospitals for these important services.

- **PMAP requires participating health plans to provide language interpreters and they all comply by keeping a roster of trained interpreters who are available on request.**
- **Workers' Compensation insurance carriers are required to pay for language interpreter services.**
- **No-fault Auto Insurance Carriers are required to pay for language interpreter services for the benefit of persons injured in auto accidents.**
- **Medical Assistance pays a small fee ($25/hour) for language interpreter services for eligible individuals.**

The balance of payers, including health plans such as Medica, Blue Cross and Blue Shield and HealthPartners, are currently not required to reimburse for language interpreter services. They should be required to cover interpreter services and include these costs in the calculation of premiums.

The unreimbursed costs for language interpreter services fall disproportionately on clinics and hospitals located in communities with substantial numbers of recent immigrants. Placing the obligation to pay for these services on all health care payers is the most appropriate way to comply with federal law and insure consistent services for non-English speakers who require access to our health care system.

Please support S.F. 795.

☑ VOTE YES!

HF 757 (Abeler)/SF 795 (Higgins)
Language Interpreter Services

- Health care evaluation and treatment requires clear communication between the patient and doctor, nurse or therapist to be effective.

- Language barriers impede this essential communication and may even result in an inaccurate diagnosis or poor patient compliance with treatment recommendations.

- Minnesota has been the destination for immigrants seeking new opportunities throughout its history. Recent waves of immigration largely from Somalia, Laos, Vietnam and numerous Spanish-speaking countries is enriching our communities in may ways, but also impacting how we provide services. Because many immigrants speak little or no English, it is essential that qualified interpreters be available when non-English speakers require health care services.

- Federal law, the Civil Rights Act of 1964 Title VII, requires health care providers to arrange for interpreter services, yet provides no payment mechanism.

- Minnesota law currently requires many payers to either provide translators or reimburse clinics and hospitals for these important services.

  - PMAP requires participating health plans to provide language interpreters and they all comply by keeping a roster of trained interpreters who are available on request.

  - Workers' Compensation insurance carriers are required to pay for language interpreter services.

  - No-Fault Auto insurance carriers are required to pay for language interpreter services for the benefit of persons injured in auto accidents.

  - Medical Assistance pays a small fee ($25/hour) for language interpreter services for eligible individuals.

- The balance of payers, including health plans such as Medica, Blue Cross and Blue Shield, and HealthPartners, are currently not required to reimburse for language interpreter services. They should be required to cover interpreters.

- Unreimbursed costs for language interpreter services falls disproportionately on clinics and hospitals located in communities with substantial numbers of recent immigrants.

- Placing the obligation to pay for translator services on all health care payers is the most appropriate way to comply with federal law and insure consistent services for non-English speakers who require access to our health care system.

MINNESOTA
PODIATRIC
MEDICAL
ASSOCIATION

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February 22, 2005

Chairwoman Becky Lourey
Health and Family Security Committee
G-24 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

Re: Senate File 795 - Language Interpreter Services

Dear Senator Lourey and Committee Members:

The Minnesota Podiatric Association (MPMA) consisting of 130 Podiatric Physicians and Surgeons supports Senate File 795 which requires payers, including health plans, to reimburse for language interpreter services.

Podiatric Physicians and Surgeons provide quality and cost effective foot care services to patients who are non-English speaking but there is a need for reimbursement costs for language interpreter services. Currently the Podiatric Physician and Surgeon must pay out of their pocket for the full costs of the interpreter services. Placing the obligation to pay for these services on all health care payers is the fairest way for Podiatrists to comply with federal law and to insure consistent quality services for non-English speakers who require foot care.

Please vote yes for this bill which will assure that language barriers will not impede important communication between the patient and the Podiatrist.

Very truly yours,

Michael Joyce (mmB)

Michael Joyce, D.P.M.
MPMA Board Member

Please join these organizations
in supporting the

Language Interpreter Services Bill
SF 795 (Higgins)/HF 757 (Abeler)

Minnesota Medical Group Management Association

Minnesota Medical Association

Minnesota Academy of Ophthalmology

Hennepin Medical Society

Ramsey Medical Society

Minnesota Provider Coalition

Minnesota Society of Anesthesiologists

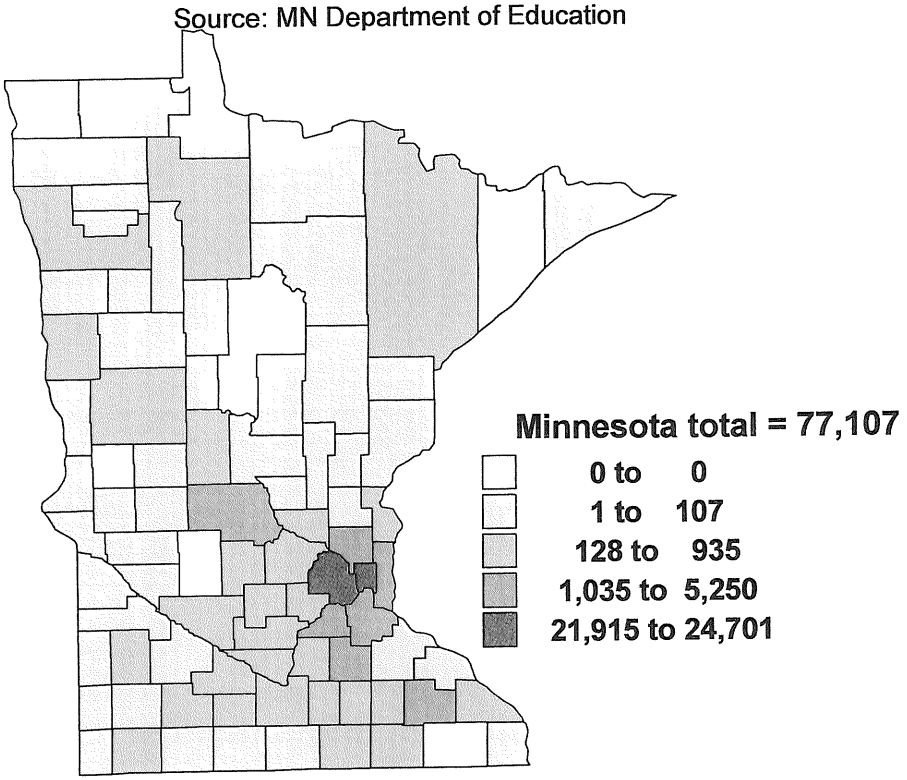
Hennepin Faculty Associates

Hennepin County Medical Center

Students Who Do Not Speak English at Home

2003-2004 School Year

Source: MN Department of Education



Concerns regarding SF 795: Requiring Health Plans to reimburse providers for interpreter services

Increased Health Care Costs

- Currently **interpreter services are considered part of the cost of doing business as a provider.** If clinic staffs are to be considered a medical expense, **this will represent an increased financial shift onto the health plans and, ultimately, those who purchase health care coverage.**

- Health plans would be responsible for reimbursing any interpreter agency that provided services to its members. **This would be problematic when it comes to controlling quality, costs, and abuse.**

- **Existing health plan contracts with providers would have to be expanded** to cover the commercial populations, since they currently do not. Amendments to the contracts would need to be made.

Broad Scope

- **This new requirement would apply not only to health insurance but also to categories of insurance normally excluded from mandates, including Medicare supplement policies.** This would also mandate benefits for a Medicare supplement policy at 100 percent coverage (not the typical 80/20), resulting in a significant premium increase to seniors.

- The **definition of "provider" includes any person or entity whose services would be reimbursed under the Medical Assistance program.** This means that a health plan would have to pay for interpreter services for commercial fully insured members even when the service involved is not covered in the fully-insured benefit set (e.g., non-skilled home care, special transportation, pharmacy dispensing).

- **The inclusion of long-term care insurance in the bill's applicability seems to conflict with the exclusion of Skilled Nursing Facilities from the definition of "provider"** in 62J.03 Subd 8.

Quality Issues

- **There is no licensure or recognized certification for foreign language interpreters in Minnesota.** There are no uniform minimum standards or requirements in order to become an interpreter. Health plans have developed their own processes for verifying the quality standards of the agencies with which they contract. **In signing agreements, providers accept responsibility for the quality of services furnished to our members.**

- **Under this bill, health plans would have to reimburse not only contracted providers, where members have this quality assurance, but for non-participating providers where the same level of quality is not assured.**

- **There have been cases of fraud**, including family members "interpreting" for each other and billing providers or health plans. There has been at least one lawsuit against a provider by a patient claiming poor quality interpretation. **This bill would exacerbate these problems and expose health plans to an uncontrollable and unfair level of liability.**

Mandates and Applicability

- **Providers must already furnish interpretation for patients under federal LEP (Limited English Proficiency) regulations.** Creating state legislation to shift financial responsibility for federal mandates sets a bad precedent.

- **Federal LEP regulations include limits on the services required** ("reasonability" standard). This bill places no such limits.

- **State mandates such as this push more employers either to become self-insured in order to avoid the mandates, or to stop offering health insurance altogether because of unsustainable costs. This bill is more likely than most to worsen this situation because of its broad applicability and potentially high cost for fully insured groups.**

- **Since any eventual mandate would not apply when the patient is an ERISA plan member, providers would still be obligated to provide interpretation for ERISA members, as they do now, under federal mandates for LEP (Limited English Proficiency.) This split will create even more confusion that we have already on these services.**