SENATE
STATE OF MINNESOTA
EIGHTY-FOURTH LEGISLATURE

S.F. No. 2630

(SENATE AUTHORS: SAMS, Higgins, Lourey, Ruud and Solon; Companion to H.F. No. 2574)

DATE	D-PG	OFFICIAL STATUS
03/01/2006	3808	Introduction and first reading
03/01/2006		Referred to Health and Family Security
03/08/2006	3839	Author added Solon
03/20/2006		Committee report: To pass
03/20/2006		Second reading

A bill for an act

relating to health; providing an exception to the hospital construction moratorium for a facility in Cass County; amending Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1.

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

Section 1. Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex

operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; ~~or~~

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law; or

(20) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board.

Senate Counsel, Research, and Fiscal Analysis

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

Senate

State of Minnesota

S.F. No. 2630 - Cass County Hospital Moratorium Exception

Author: Senator Dallas Sams

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

Date: March 15, 2006

S.F. No. 2630 authorizes an exception to the hospital construction moratorium to allow the construction of a 25-bed hospital in Cass County within 20 miles of the state Ah-Gwah-Ching facility, provided the license holder is approved by the county board.

DG:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S2630-0 **Complete Date:** 03/24/06

Chief Author: SAMS, DALLAS

Title: CASS CTY HOSPITAL MORATORIUM EXCEPT

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

Agencies: Human Services Dept (03/24/06) Health Dept (03/20/06)

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					
-- 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					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/24/06 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S2630-0 **Complete Date:** 03/24/06

Chief Author: SAMS, DALLAS

Title: CASS CTY HOSPITAL MORATORIUM EXCEPT

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 2574

Bill Description
This bill modifies the list of hospital construction or modification moratorium exceptions by adding a project in Cass County for up to 25 beds to be constructed within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the license holder is approved by the Cass County Board.

Assumptions
A change to the moratorium that increases inpatient hospital beds does not increase MHCP costs because all medically necessary inpatient services are already being provided, but at a different location. An increase in service availability does not increase demand for inpatient services.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 03/23/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/24/06 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S2630-0 **Complete Date:** 03/20/06

Chief Author: SAMS, DALLAS

Title: CASS CTY HOSPITAL MORATORIUM EXCEPT

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

Agency Name: Health 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					

Bill Description

Section 1
Amends Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1, to allow for the construction of a hospital with up to 25 beds in Cass County, within a 20-mile radius of the Ah-Gwah-Ching state facility, subject to approval of the facility's license holder by the county board.

Assumptions

Section 1
Approval of increased bed capacity for this project would require no additional responsibilities for the Department and have no fiscal impact. A public interest review is currently being conducted for this project pursuant to Minnesota Statutes 144.552, which will entail some additional costs to the Department. Those costs will be covered by revenues from the filing entity, as required by Minnesota Statutes 144.552, leaving no net fiscal impact.

Expenditure and/or Revenue Formula

No fiscal impact to the Department.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Scott Leitz (651-282-6361)
FN Coord Signature: MARGARET KELLY
Date: 03/16/06 Phone: 201-5812

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/20/06 Phone: 282-5065

Board of Commissioners

Our mission is to deliver quality public services to the citizens in an effective, professional and efficient manner.

PO Box 3000, 303 Minnesota Avenue, Walker, MN 56484-3000
Phone: 218-547-7419 Facsimile: 218-547-7455 TDD: 218-547-1424
E-Mail: robert.yochum@co.cass.mn.us Web site: www.co.cass.mn.us

To: Julie Sonier, Director of Health Economics Program
Minnesota Department of Health
85 East 7th Place Suite # 300
St. Paul, Minnesota 55101 By overnight mail

From: John Warren, Chairman Critical Access Hospital Task Force
Michael Hedrix, Vice President, Acute Care Operations, Benedictine Health System
Robert H. Yochum, Cass County Administrator

Date: March 9, 2006

Re: Public interest review – proposed rural community hospital at Ah-Gwah-Ching, Walker MN

Pursuant to Minnesota Statutes Chapter 144 the Cass County Board of Commissioners respectfully submit the following information in support of a hospital moratorium exemption as proposed in Senate File 2630 and House File 2574 currently under consideration by the 2006 Minnesota Legislature (see attachment #1).

A. PROJECT DESCRIPTION

1. Briefly describe the overall project, objectives, phases and timelines.

The State of Minnesota DHS plans to abandon the Ah-Gwah-Ching long-term-care facility near Walker in north-central Cass County as early as January 2007. Cass County is authorized by existing law to assume ownership, and plans to do so after State operations cease contingent upon 2006 legislative initiatives including this public interest review. Working closely with the State, the County has adopted an integrated medical campus reuse plan – see attachment #2. The 5-10-year vision for the reuse of the Ah-Gwah-Ching campus is made up of 3 integrated components: 1) up to a 25 bed Critical Access Hospital, all new medical/surgical beds, 2) an attached provider-based clinic ambulatory center to house the two existing physician clinics (Dakota Clinic and Merit Care Clinic), outreach physicians, as well as other providers, specialties and systems as coordinated or deemed needed, and 3) a senior housing and services campus with approximately 60 long term care beds, 30 assisted living beds and 30 independent living units. This informational submittal will focus on the hospital bed need based upon the DOH provided format.

- **Please list any potential partnerships, health system affiliations, and the role of each participant.**
  The proposed rural community hospital will be private investment by a non-profit organization and may include partnerships with other surrounding providers, who will be given the opportunity to participate in the health care campus. All existing providers are aware of our current efforts.

- **How will the new facility benefit the community?**
  Currently there are no hospitals located within Cass County. A large portion of the 19,000 residents in the proposed hospital's Primary Service Area (see attachment #3) live well beyond 35 miles to existing hospitals in the region whereas the distance to a hospital at Ah-Gwah-Ching would be just 20 miles. Only modest physician office services are available, very little in the way of procedures, and no evening or weekend services of any kind. Access to improved health care and livable wage jobs are documented priorities of the Cass County Comprehensive Plan (see attachment #4) – reuse of Ah-Gwah-Ching, as a health care campus will have a major impact on both. The health care campus development will also provide employment for many Ah-Gwah-Ching personnel laid off by close of that facility.

2. List the hospital-based services to be provided, for both acute and non-acute care.
The proposed hospital will start with a modest combination of acute and non-acute care services, and will grow to meet the growing population and aging needs of north-central Cass County. Hospital services will include general medical inpatient and swing bed/transition care services. As the medical community grows, hospital services will grow accordingly, including surgical inpatient services.

- **Describe any imaging, ambulatory surgery, cancer treatment, or dialysis service arrangements.**
  Outpatient services will include, observation beds, diagnostic and treatment services (high-complex lab, imaging, including radiology, CT, ultrasound, mammography, nuclear medicine, and mobile MRI, and therapies to include PT, OT, ST), ambulatory services (appropriate same-day procedures, urgent care), support services (governance, IT, operations, etc.), management and educational services.

- **Provide an overview of new or improved services to be offered in the primary service area.**
  Any hospital based service beyond existing day clinics are new to the primary service area.

- **If an emergency department is planned, describe the likely trauma designation.**
  Level IV, 24-hour emergency services.

3. Please provide detail on the number of hospital beds to be requested and describe whether these will be new beds of drawn from within the affiliated hospital system(s) or partnership's existing licensed bed capacity.
The referenced moratorium exemption legislation provides for up to 25 beds. Cass County anticipates that the beds will be an addition to the primary service area and will not be drawn from the unused capacity of other State license holders.

4. Describe provider groups affiliated with, or committed to, the hospital project.
The Cass County Critical Access Hospital Task Force (see attachment #5) and the lead provider for the project, Benedictine Health System, Duluth, MN, have kept hospital and clinic providers in the region informed about the project and have stated they are open to partnerships. To date, no providers in the region oppose the hospital project. In accordance with the proposed legislation Cass County will select the provider after an additional "open process". Resolutions of support are included as attachment #6.

- **To the extent possible, please provide information on where these provider groups currently hospitalize patients.**
  St. Joseph's Hospital, Park Rapids; North Country Hospital, Bemidji, St. Joseph's Hospital, Brainerd; Cuyuna Regional Medical Center, Crosby; Lakewood Health System, Staples; Deer River Hospital, Deer River; Grand Rapids Hospital, Grand Rapids, and Indian Health Services, Cass Lake.

5. Describe the site for the proposed project.
The site is Ah-Gwah-Ching located in Shingobee Township near Walker, MN. The site reuse plan includes a future County government campus, health care campus and an aquatic management area managed by Mn DNR – see attachment #7. The project does not propose to reuse any existing buildings at this time, but rather, assumes new construction. Historical significance and environmental issues have been documented by the State – see attachments #8 & #9. If County efforts to obtain critical access hospital designation (see attachment #10) are not successful at Ah-Gwah-Ching, CAH qualifying sites are available within 20 miles of Ah-Gwah- Ching as proposed in the moratorium exemption legislation.

6. What is the approximate cost of the entire project and what proportion of the total cost is specific to the proposed hospital.
The total construction, equipment, financing, and working capital costs for the new hospital component of the health care campus, is estimated at $28,250,000. This does not include costs for land acquisition, demolition of current Ah-Gwah-Ching buildings, utilities, medical office and senior housing facilities. Other phases of the health care campus may exceed $16,000,000. These projects would be the largest single private investment in our County in the last 10 years.

B. NEED FOR PROJECT

1. Define the Primary Service Area for the proposed hospital. Please describe the rationale and methods for selecting this area.
The Primary Service Area encompasses most of north-central Cass County and includes 35 townships and the cities of Walker, Hackensack, Akeley, Remer, Longville, Backus and Pine River. The rationale/method for selecting the Primary Service Area was done by calculating the equal-distance point between the proposed hospital and the nearest existing hospital - where the distance to an existing hospital becomes less than the distance to the Ah-Gwah-Ching site. See attachment #3.

2. Provide a summary of the Primary Service Areas demographic projections and the data sources, methods and assumptions used to make these population estimates and projections.
Cass County demographic information shows the total population of the Primary Service Area is 19,000. The population more than doubles during the summer months. According to the Mannix Study (see attachment #10), it is also one of the fastest growing regions in the state, with an estimated population growth of 22% by 2010 and another 26.8% by 2030. Cass County's population is older than the statewide average, with 41% of the population over age 45 compared to 30% statewide. Those age 60+ represent 10% of the population, compared to just over 12% statewide. Furthermore, north-central Cass County had nearly twice the percentage of those age 65+, as did the northern or southern areas of the county. The county's per capita income is 44% below the statewide average and its unemployment rate is higher than the statewide average.

3. Provide the Primary Service Area utilization estimates for the proposed hospital.

The need for a new hospital is primarily due to 3 factors: 1) In this area of Minnesota, there is an unusually large area of square miles where there is no hospital, 2) the population residing in this vast area is growing at a rapid pace, and will continue to do so, and 3) this growing population is also aging and living longer.

To reach these estimates, inpatient and outpatient utilization levels, payer mix, and operational expenses of the new hospital, were benchmarked to national CAH's, a 53-hospital peer group (1,800 – 2,500 acute inpatient days), and a 30-hospital peer group (500 – 800 acute inpatient days). It is estimated that by 2013, the new hospital will generate 722 acute discharges, or 20.7% of the projected 3,497 discharges from Cass County per the Table below:

Cass County	South	North	Central	Total
Population				
M&P Service Area Population (2005) (a)	13,273	4,953	12,184	30,410
Market				
Use rate per 1,000 (a)	115	115	115	
Market Discharges (a)	1,526	570	1,401	3,497
Estimated Market Share				
Estimated Market Share (2013 Potential)	5.0%	15.0%	40.0%	20.7%
Projected Inpatient Demand				
Discharges	76	86	560	722
ALOS	3.00	3.00	3.00	3.00
Patient Days	229	257	1,681	2,167
ADC				5.9

(a) Source: Mannix & Partners Report - see attachment #11.

4. Provide measures of current access for services within the proposed Primary Service Area:

- **Timeliness:** According to the Mannix Study, the average driving time to the nearest existing hospital is well over one hour and the average distance is 51.7 miles. North-central Cass County is sparsely settled and is served by state, county and local township roads only. There are no federal highways, expressways or four-lane highways within the Primary Service Area. The Walker Ambulance Service made 812 runs in 2005, with an average distance of 26.3 "loaded" miles from point of pickup to hospital delivery. The Longville Ambulance Service, which serves the eastern portion of the Primary Service Area, made 232 runs in 2005. Nearly 70% of its "loaded" runs from point of pickup to hospital delivery were 40 miles in length. As an example of the benefits of a hospital on the Ah-Gwah-Ching site, a "loaded" run from Rogers Point to the nearest existing hospital (Bemidji) in 2005 was 52.1 miles in length but only 15 miles to Ah-Gwah-Ching.

- **Care for low income and uninsured:**
  Estimates for uncompensated care were included in projections per benchmarking database described above, and reflect a typical Minnesota rural hospital serving a population in a HPSA and MUA area.

C. MARKET ANALYSIS

1. Describe how persons who live in the Primary Service Area currently receive hospital services. List the market shares, as measured by inpatient admissions, of hospitals that have a 5% share of more of this market.

Residents must drive an average of nearly 52 miles to their nearest existing hospital. The Minnesota Department of Health's most current data available for all of Cass County shows where residents received hospital inpatient acute care for the year 2000:

St. Joseph's Medical Center, Brainerd (Crow Wing County)	34.3%
North Country Hospital, Bemidji (Beltrami County)	22.1%
St. Joseph's Health Services, Park Rapids (Hubbard County)	07.4%
Abbott-Northwestern Hospital, Minneapolis (Hennepin County)	06.3%
Cuyuna Regional Medical Center, Crosby (Crow Wing County)	05.6%

Indian Health Services, Cass Lake provides services to Native Americans and their descendants.

- **For each facility listed above, list the percentage of admissions and patient days that originate from the Primary Service Area for this project.**
  This information is not currently available to Cass County.

2. Describe the anticipated financial impact of the proposed hospital on the facilities listed above.

The projected inpatient financial impact for area hospitals will be approximately $322 per admission to the new hospital (5% net income on average $6,400 net inpatient revenue per admission).

3. For the major service categories proposed for the new hospital, describe how persons who live in the Primary Service Area currently receive these services. Please list the market shares, as measured by admissions, of hospitals that have 50% share or more of the market for each major service category.

This information is not currently available to Cass County.

4. What is the anticipated impact of the new hospital on existing hospitals in a 25-mile radius that provide uncompensated care?

Although there are no other hospitals within a 25 mile radius, it is anticipated that there will be a reduction of uncompensated care at surrounding hospitals as the new hospital begins to provide more of the emergency, and other hospital services, to local residents directly, rather that traveling to other surrounding hospitals for services. The possibility of an Indian Health Service presence at the Ah-Gwah-Ching site would expand service to Native Americans and potentially increase Federal costs.

5. Please provide information on the staffing needs of the proposed hospital and the estimated impact on existing facilities in the region.

The Ah-Gwah-Ching/Walker area has been accustomed to requiring its own health care workers over many decades, nurses, lab and x-ray techs, business office, maintenance, and other health care professionals, as it has always had health care facilities in the community. Therefore, there will be very little or no impact in this regard on other surrounding hospitals.

- **To the extent possible, estimate impact of the new hospital on vacancy rates, length of time to fill positions, and wage for staff, particularly for nurses, pharmacists and radiological technicians.**

  This information is not currently available to Cass County.

6. Other information

The Cass County Board has facilitated a very public process over a long period of time regarding related issues. "Public interest reviews" at a local level have included, among other things, the 33 occasions that the Board has taken formal action on Ah-Gwah-Ching (see attachment #12).

The development of an integrated health care campus anchored by a hospital at or near Ah-Gwah-Ching accomplishes:

- Improved access to health care for an area with a well documented need
- Economic development consistent with decades of local planning
- Concludes reuse of the former State facility (although we might come back some other day)

List of original attachments sent by overnight mail:

1. Text of Senate File 2630 and, House File 2574
2. Critical Access Committee news release dated January 11, 2006 "Vision Statement for Integrated Health Care Campus at Ah-Gwah-Ching"
3. Map of existing hospitals, proposed primary service area, and population densities. Table of distances comparing existing services to proposed.
4. Cass County Comprehensive Plan.
5. Critical Access Hospital Task Force membership and contact information.
6. Resolutions of support from the Counties of Beltrami, Cass, Crow Wing, & Itasca, the Townships of Shingobee, Pine Lake, & Leech Lake, the City of Walker & the Leech Lake Band of Ojibwe.
7. Topographic survey of Ah-Gwah-Ching site with intended reuse.
8. Ah-Gwah-Ching Center Reuse Study dated July 2003 by the MN Historical Society.
9. Environmental Assessment Worksheet dated November 15, 2004 by the MN Department of Administration.
10. The Critical Access Hospital Task Force case statement for critical access hospital designation submitted to the MN Congressional delegation dated March 7, 2006.
11. Ah-Gwah-Ching Center Campus Reuse Master Plan Report (including Mannix and Partners report) dated March 3, 2005 by the MN Department of Human Services.
12. Summary of Cass County Board action related to Ah-Gwah-Ching for the years 2002 through 2005.

We respectfully request your assessment that this submittal:

- Meets the public interest review requirements, and
- Warrants a favorable recommendation to the 2006 Legislature in that the hospital bed moratorium exemption we seek is consistent with the priorities of several State of Minnesota Departments.

Thank you.

On behalf of the Cass County Board of Commissioners
Robert H. Yochum
Cass County Administrator
PO Box 3000, 303 Minnesota Avenue, Walker, MN 56484
Phone (218) 547-7419 Fax (218) 547-7455
robert.yochum@co.cass.mn.us

Copy by e-mail without attachments:

Cass County Board of Commissioners
State Senator, Carrie Ruud
State Representative, Larry Howes
State Representative, Frank Moe
Critical Access Hospital Task Force members
State of Minnesota Departments of:
- Administration, Wayne Waslaski
- Health, Scott Leitz
- Health, Mark Schoenbaum
- Human Services, Wes Kooistra
- Human Services, Mike Tessneer
- Human Services, Alan Van Bus Kirk
- Natural Resources, Harlan Firestine

The Case for A 25-Bed Hospital at Ah-Gwah-Ching in North-Central Cass County

The Need

Cass County is one of the fastest growing counties in the State of Minnesota, primarily because its natural resources of lakes and forest attract people at or near retirement age who choose to become permanent or seasonal residents. During the summer season, alone, the county's population nearly triples to 80,000+. The county's rapid population growth is expected to continue, growing at the rate of 38.5% by year 2030. Yet the county is the largest in both size and population of only seven counties in Minnesota currently without a hospital within their borders (with the exception of an Indian Health Services hospital in Cass Lake). An eleven bed hospital in Walker provided health care services to residents and visitors in the heart of the lakes area of north-central Cass County for nearly 70 years before closing its doors in 1975. Without a hospital, residents and visitors in north-central Cass County have to travel up to an hour or more out of the county to hospitals in Bemidji, Park Rapids, Deer River, Crosby, Staples or Brainerd to seek urgent care in emergency rooms and other hospital-based services. With the high rate of population growth in north-central Cass County predicted to grow by 26.8% by year 2030, a hospital in the area will be needed more than ever.

The Facts

- The Walker Ambulance PSA (service area) has a permanent population of approximately 5,000 and a seasonal high population of 15,000.

- Cass County's grew 20% from 1990-2000 to 27,150. It is projected to grow an additional 19% by 2010 to 33,630, 29% by 2015 to 36,960, and 38.5% by 2030 to 41,380. This makes Cass County one of the fastest growing counties in Minnesota and the fastest growing in a nine-county area.

- Central Cass County makes up 50% of the county's total population. It grew 26% from 1990-2000 to 13,739. It is projected to grow an additional 22% by 2010 to 16,875, and 26.8% by 2030 to 21,397.

- Cass County's population is older than the statewide average, with 41% of the population over age 45 in year 2000 compared to 30% statewide. Those age 60+ represent nearly 25% of the population compared to just over 12% statewide. Those age 65+ represent 18% of the population compared to 12% statewide. This is significant because an older population is the highest users of healthcare services.

- Central Cass County had nearly twice the percentage (24%) of those age 65+, as did the northern or southern areas of the county in year 2000.

- Cass County's per capita income of $17,189 is 44% below the statewide average of $30,742. The unemployment rate in the county is currently 4.0% compared to 3.4% statewide. In 2004 the county unemployment rate was 7% compared to 4.7% statewide.

- There are no hospitals or urgent care centers located in Cass County, with the exception of the Indian Health Services (HIS) facility in Cass Lake (which provides service dedicated to Native Americans and their descendants). Regional hospitals currently serving Cass County are located Bemidji, Park Rapids, Deer River, Staples, Brainerd and Crosby.

- Health care services (primarily clinics) made up only 6% of the county's workforce in year 2003. Cass County had 657 employees in the healthcare sector, generating a payroll of $14,507,000 and expenditures for goods and services of $12,181,020 for a total economic impact of $26,688,020.

- Ah-Gwah-Ching, with 100 employees in 2005, has an annual payroll of $5,745,000. A 25-bed hospital serving north-central Cass County would have a staff of approximately 100 employees with a payroll of $9,000,000.

- In the year 2000, there were 2,987 Cass County residents discharged from hospitals outside of the county.

- With no hospital emergency room facilities located in Cass County, patients are forced to use emergency rooms outside of the county for the types of illness or trauma that could be handled by a hospital in north-central Cass County.

- EMS ambulance runs in all of Cass County in 2004 were 2,813, plus 46 air transfers and 140 other ambulance runs by crews outside of Cass County. The demand for ambulance service is growing throughout Cass County, particularly in the north-central region with the fast growth of an older population base. The Walker Ambulance service, for example, had over 800 runs in 2004 and is expected to exceed 1,200 runs in 2005.

- According to the Mannix Study conducted for the state and county in 2004-2005:

    1. Distance: The average miles traveled to reach a regional acute care hospital from central Cass County were: 46 miles to Brainerd, 47 miles to Park Rapids, 58 miles to Bemidji and 66 miles to Staples.

    2. Physician shortfall: Only 12 physicians are currently employed by clinics located in all of Cass County. The report states that 42 physicians will be needed to serve the county's projected population in 2010, of which over 20 will be needed in Central Cass County alone.

    3. 2010 Bed Need: Anywhere from 18 to 34 acute care beds will be needed by 2010. While this low volume would challenge the operating efficiency of a freestanding acute care facility, Critical Access Designation and/or integrating beds with a long-term care facility could improve financial performance of the proposed 25-bed hospital serving north-central Cass County.

The Opportunity

The State of Minnesota plans to abandon the Ah-Gwah-Ching long-term-care facility by January 1, 2007, and turn the 170-acre campus near Walker over to Cass County and DNR. The county's long range vision for an 88-acre portion of the property is the establishment of an integrated medical campus, anchored by a 25 bed hospital, and possibly including a medical clinic, Indian Health Services satellite clinic, long-term care, assisted living and other ancillary health care services. The state, meantime, has earmarked $4 million in bonding money for redevelopment and/or demolition of existing structures. Ah-Gwah-Ching currently has a staff of 100 employees, many of whom would be employable by a hospital located on the campus. The Ah-Gwah-Ching site, therefore, presents an excellent opportunity for an existing hospital provider in the region to establish and operate a small rural hospital facility as the "anchor" of an integrated health care campus.

The Obstacles

1. Critical Access Hospital Designation: Because Critical Access Hospitals (CHA) receive higher Medicare and Medicaid reimbursements, CHA designation is often critical to the financial feasibility and operation of rural hospitals like the one being proposed at Ah-Gwah-Ching. The hospital being proposed at Ah-Gwah-Ching, serving north-central Cass County, meets most – but not all – federal and state requirements for CHA designation. The criteria it would meet are:

- Being the sole hospital in a county.
- Being a hospital in a county with a designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA).
- Located in a county with population density less than the state average.
- Located in a county with a higher percentage of residents over the age of 65 as compared to the state average.
- Located in a county with a lower per capita income than the state average.
- Located in a county with a higher unemployment rate the state average.
- Participates in a rural health network with patient referral and transfer, use of telemetry and electronic sharing of patient data with at least one full-service acute care hospital.

However, according to the Minnesota Department of Health's Office of Rural Health and Primary Care, the Ah-Gwah Ching site fails to meet two criteria for CHA designation:

- A CHA must be located a minimum of 35-miles from the nearest hospital and the Ah-Gwah-Ching site is just over 28 miles (or 32.35 miles on state highways, if you don't use the township road) from the hospital in Park Rapids. Federal law allows states to make an exception to the 35-mile rule by designating hospitals within 20-34 miles of the nearest hospital as "necessary providers in order to achieve CHA designation. This provision, however, "sunsets" on December 31, 2005.

- For a hospital to receive "necessary provider" (and, ultimately, CHA) designation, it must be up and running – staffed, licensed and inspected – by December 31, 2005. There is no provision for granting "necessary provider" or CHA designations for hospitals that are on the drawing board, as is the case with a facility at Ah-Gwah-Ching.

2. Hospital Bed Moratorium: In addition, an exemption is also needed from the Minnesota Department of Health and/or the Minnesota Legislature to the current moratorium on new hospital beds in the state. While procuring the exemption poses a significant challenge to the project, we believe the merits of and need for locating a 25-bed hospital on the Ah-Gwah-Ching campus in north-central Cass County support approval of an exemption by the state.

The Leadership Plan

Hospital access in the region was the top priority of a Cass County Health Task Force that met in the fall of 2004 and January of 2005. The priority was based on numerous studies and data compiled by the state and county consultants that showed many area residents are an hour or more away from the nearest hospital, the so-called "Golden Hour" when a life is most at risk following an accident, heart attack or stroke. The Cass County Health Task Force recommended creation of the Critical Access Hospital Task Force to address this need.

The task force visited with all five-hospital providers in the region (St. Joseph's Health Services, Park Rapids; North Country Regional Hospital, Bemidji; Cuyuna Regional Medical Center, Crosby; Lakewood Health System, Staples; and the Benedictine Health System (BHS), a Minnesota non-profit health system) and invited them to submit proposals for leading the project. Three providers said they were interested and two declined. The three providers presented their proposals to the task force on August 30, 2005, and BHS was selected. It is important to note that the four providers not selected or who declined have all indicated their support for the project. BHS, meantime, is contacting the four to see if any are interested in a collaborative project with shared ownership similar to BHS's collaborative ownership arrangement at St. Francis Regional Hospital in Shakopee, MN.

BHS currently owns and/or manages more than 60 health care facilities – hospitals, nursing homes, assisted and independent living facilities - in nine states, including St. Joseph's Medical Center, Brainerd. Six of BHS' nine hospitals are designated as Critical Access Hospitals serving primarily rural areas. The project also calls for BHS to complete a financial feasibility study to construct a 24-bed hospital with a 24-hour emergency room on the Ah-Gwah-Ching campus. BHS is charged with developing the plans for hospital construction, governance, management and operation in addition to examining the financial feasibility of a long term care facility as part of the new medical campus. With the selection of BHS, the project can move forward without the prerequisite of first attempting to establish a hospital-taxing district to support construction and operations. The hospital is expected to provide a minimum of 100 jobs to help offset jobs losses from the closure of the Ah-Gwah-Ching facility by the state.

Members of the task force are Chairman John Warren, Walker Area Foundation; Terri Bjorkland, Walker City administrator; Jim Dowson, Cass County commissioner; Jennifer Jenkins, Indian Health Services director, Cass Lake; Gail Leverson, Cass County Economic Development Corporation; Steve Michel, retired Walker City administrator; Dorothy Opheim, Cass County Health & Human Services director; Steve Rogness, retired Minnesota Hospital Association CEO; Brad Walhof, mayor of Walker; and Bob Yochum, Cass County administrator.

For more information, contact:

Michael Hedrix, VP Acute Care Operations
Benedictine Health System
(763) 689-1162

John Warren, Chair
Critical Access Hospital Task Force
(218) 547-2865

Bob Yochum, Administrator
Cass County
(218) 547-7419

A bill for an act

relating to human services; modifying chemical use assessments; imposing duties on the commissioner of human services related to chemical health; proposing coding for new law in Minnesota Statutes, chapter 254A.

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

Section 1. **[254A.20] CHEMICAL USE ASSESSMENTS.**

Subdivision 1. **Persons arrested outside of home county.** When a chemical use assessment is required under Minnesota Rules, parts 9530.6600 to 9530.6655, for a person who is arrested and taken into custody by a peace officer outside of the person's county of residence, the assessment must be completed by the person's county of residence no later than three weeks after the assessment is initially requested. If the assessment is not performed within this time limit, the county where the person is to be sentenced shall perform the assessment. The county of financial responsibility must be determined under chapter 256G.

Subd. 2. **Probation officer as contact.** When a chemical use assessment is required under Minnesota Rules, parts 9530.6600 to 9530.6655, for a person who is on probation or under other correctional supervision, the assessor, either orally or in writing, shall contact the person's probation officer to verify or supplement the information provided by the person.

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference; or

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2006, except for subdivision 3, which is effective July 1, 2008.

Sec. 2. **[254A.25] DUTIES OF COMMISSIONER RELATED TO CHEMICAL HEALTH.**

The commissioner shall:

(1) annually distribute information to chemical health assessors on best practices in assessments, including model instruments for adults and adolescents;

(2) monitor the compliance of local agencies with assessment and referral rules;

(3) develop a directory that identifies key characteristics of each licensed chemical dependency treatment program;

(4) work with the commissioner of health to develop guidelines and training materials for health care organizations on the use of brief interventions for alcohol abuse;

(5) provide local agencies with examples of best practices for addressing needs of persons being considered for repeat placements into publicly funded treatment;

(6) identify best practices to help local agencies monitor the progress of clients placed in treatment;

(7) periodically provide local agencies with statewide information on treatment outcomes; and

(8) post copies of state licensing reviews at an online location where they may be reviewed by agencies that make client placements.

Sec. 3. **RECOMMENDATIONS ON CHANGING THE CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND.**

The commissioner shall report to the legislature by January 15, 2007, on recommendations which analyze the merits of changing the statutory maintenance of effort provisions in the chemical dependency treatment fund and the feasibility of posting treatment program peer reviews at an online location where they can be viewed by agencies that make client placements.

Sec. 4. **PLAN FOR IMPROVING COMMUNITY-BASED SUBSTANCE ABUSE TREATMENT.**

The commissioner of human services shall present a plan to the legislature by January 15, 2007, for improving the availability of community-based substance abuse treatment.

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3307-1A **Complete Date:**

Chief Author: RANUM, JANE

Title: EXPAND CHEMICAL USE ASSESSMENTS REQ

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

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					

Fiscal Note Request Worksheet

Bill #: SF3307 Title: Chemical use assessments husman services study & duties

Companion #: HF3678 Author: Ranum Agency: Human Services

Urgent: Due Date: Committee: Health & Human Services Budget Division

Consolidated: Lead Agency: Human Services Contact Person: Wayne Raske 431-2464 Don Allen 431-2325

What version of the bill are you working on? 1E
(Changing the version of the bill will automatically create a new fiscal note request.)

(The following four fiscal impact questions must be answered before an agency can sign off on a fiscal note.)

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund			558	388	388
Fund					
Fund					
Less Agency Can Absorb					
Fund			0	0	0
Fund					
Fund					
Net Expenditures			558	388	388
Fund					
Fund					
Fund					
Revenues					
General Fund			223	155	155
Fund					
Fund					
Net Cost <Savings>			335	233	233
Fund					
Fund					
Fund					
Total Cost <Savings> to the State			335	233	233

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents					
Fund			4	4	4
Fund					
Fund					
Total FTE			4	4	4

Bill Description

The bill provides for changes in county chemical use assessment requirements. The bill also creates additional duties for the commissioner to provide assessment and placement best practice information to counties, including model assessment instruments; monitor county compliance with assessment requirements; develop a directory of chemical dependency programs; develop guidelines and training materials for HMOs; provide counties with best practice information and methods for monitoring client progress during treatment; provide counties periodic information on treatment outcomes; and post copies of chemical dependency DHS licensing reviews online for county agency information. The commissioner is also to provide a report to the 2007 Legislature on the merits of changing CCDTF maintenance of effort provisions; the feasibility of placing the results of program peer reviews online for county agency review; and plans for improving the availability of community based treatment.

Assumptions

- **County monitoring:** This will require implementation of a web-based system that can capture county chemical use assessment activity in detail, including assessments that do not result in a treatment placement (estimated development cost of $100,000). In addition to implementation costs for a web-based system, this will require one position for system analysis and two positions to actively review county practices, generate reports on county compliance, and provide technical assistance to counties with compliance issues.

- **CD treatment directory:** It is assumed that this will also be a web-based directory that will have program characteristics from the DAANES and other information sources. This will require development and maintenance of the web based site. (Estimate $30,000 development cost. Ongoing system maintenance estimated at $15,000 annually)

- **Online posting of chemical dependency program license information:** Requires ongoing technical support of $15,000 annually and $20,000 for scanning of information into the system.

- The **additional assessment related duties**, including dissemination of best practice in assessment, development of standard model assessment instruments, dissemination of repeat placement best practice, guidelines for monitoring client progress while in treatment, and use of treatment outcome information will require one more position.

- The **three reports** required in the bill require analysis that is a normal part of operations, and can be completed with existing staff and budgets as augmented here.

Expenditure and/or Revenue Formula

Costs were estimated based on personnel cost projections for similar level staff and from Licensing and PMQI Divisions' experience in developing similar reporting and accountability systems.

	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Monitoring County Assessments				
Web application development	$0	$100,000	$0	$0
1 FTE Systems Analyst Salary & Benefits (30%)	$0	$76,700	$76,700	$76,700
2 FTE County Monitor Salary & Benefits (30%)	$0	$127,400	$127,400	$127,400
Non-salary costs (3 positions)	$0	$78,000	$48,000	$48,000
Subtotal	$0	$382,100	$252,100	$252,100
Licensing Information System				
Technical Support	$0	$15,000	$15,000	$15,000
Document Scanning	$0	$20,000	$20,000	$20,000
Subtotal	$0	$35,000	$35,000	$35,000

Substance Abuse Program Directory				
Web application Development	$0	$30,000	$0	$0
Technical Support	$0	$15,000	$15,000	$15,000
Subtotal	$0	$45,000	$15,000	$15,000
County Technical Assistance Duties				
1 FTE Pgrm. Consultant Salary & Benefits (30%)	$0	$70,200	$70,200	$70,200
Non-salary costs	$0	$26,000	$16,000	$16,000
Subtotal	$0	$96,200	$86,200	$86,200
Total Administrative Costs	$0	$558,300	$388,300	$388,300
Non-dedicated General Fund Revenue (40%)	$0	$223,320	$155,320	$155,320
Net Administrative Costs	$0	$334,980	$232,980	$232,980

Summary by Budget Activity

Continuing Care Management	$0	$275,600	$245,600	$245,600
Legal & Regulatory Operations	$0	$35,000	$35,000	$35,000
Health Care Administration	$0	$247,700	$107,700	$107,700
Subtotal	$0	$558,300	$388,300	$388,300
General fund revenue	$0	$223,320	$155,320	$155,320
Net General Fund cost	$0	$334,980	$232,980	$232,980

Long-Term Fiscal Considerations

These costs will be continued in future years.

Local Government Costs

None

References/Sources

Information from Licensing Division, PMQI Division, and from MAPS Personnel Cost Projection Reports.

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: _____

Senator Dille introduced–

S.F. No. 2675: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; increasing the rate reimbursement for a day training and habilitation provider.

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

Section 1. **PROVIDER RATE INCREASE.**

A day training and habilitation provider in Meeker County providing services to up to 110 individuals shall have a rate reimbursement increase that equals eight percent of the provider's current reimbursement rate.

Fiscal Note – 2005-06 Session

Bill #: S2675-0 **Complete Date:** 03/16/06

Chief Author: DILLE, STEVE

Title: DAY TNR & HAB PROV RATE REIMB INCR

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			39	37	37
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund			39	37	37
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund			39	37	37
Total Cost <Savings> to the State			39	37	37

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

NARRATIVE: SF 2675/HF 3208

Bill Description

Section 1 of the bill increases the daily reimbursement rate of a day training and habilitation provider in Meeker County by an additional eight percent.

Assumptions

1. Effective date of the rate increase is July 1, 2006
2. The federal participation rate for the medical assistance program is 50% of the total costs. The state share is the difference between the total costs and federal share.
3. The rate increase is in addition to the COLA increases for this programs appropriated by the 2005 Legislature.

Expenditure and/or Revenue Formula

	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Number of Recipients	77	77	77	77
Funded by Medical Assistance	60	60	60	60
Funded by Counties	17	17	17	17
Program Days per year	245	245	245	245
Daily Program Rate-Current Law	60.75	62.12	62.12	62.12
Average Weighted Daily Rate (with October 1 COLA increase)	60.75	61.78	62.12	62.12
Proposed Rate Change- 7/1/06		1.08	1.08	1.08
Daily Program Rate-Proposed	60.75	67.09	67.09	67.09
Total Cost	$ -	$ 100,173	$ 93,759	$ 93,759
Medical Assistance	-	78,057	73,059	73,059
Federal	-	39,029	36,530	36,530
State	-	39,029	36,530	36,530
County Funded	-	20,700	20,700	20,700
State Budget(000's) MA Waivers		39	37	37

Long-Term Fiscal Considerations

This proposal would result in an additional $37,000 on-going expenditure of state funds annually.

Local Government Costs

This proposal would result in additional county costs of 20,700 per year.

References/Sources

February 2006 Forecast
2004 DHS Survey of Day Training Programs
Continuing Care Research and Analysis

Agency Contact Name: Bob Meyer 431-2383
FN Coord Signature: STEVE BARTA
Date: 03/16/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/16/06 Phone: 286-5618

SF 2675
Dille

To: ProWorks Employees

From: Dale Miller

Subject: ProWorks Survival

Date: March 6, 2006

I was certainly hoping that I did not need the bearer of bad news, but we have come to a point where I need to let you know that ProWorks' financial situation is not good – I wish I could say that our program will survive, but the truth is that it may not.

How did we come to this point?

1) In 2001, our work comp premium was under $7,000; in 2006 our premium exceeds $43,000; all other insurance premiums have increased significantly as well, but not so ridiculously dramatic as work comp.

2) In 2003, the State of Minnesota decreased our program/transport per diem by 1%; this decrease was not only a loss of about $15,000, but we also did not receive a cost of living adjustment (COLA); the COLA usually increased our per diem by 2% or 3% on July 1st of each year. In 2004, the State of Minnesota gave no per diem increases, and in 2005, we received a 2.2553% on October 1st. An additional rate increase of 2.2553% is scheduled for October 1st of 2006.

3) In December of 2003, I submitted a **Request for a Rate Variance** to Meeker County Social Services; I requested a rate increase of 5%; the request was denied.

4) The cost of gasoline has risen sharply, and whether people are transported by ProWorks' or Meeker County Public Transit – we absorb the increased cost.

5) ProWorks vehicles need to be replaced; in 2005, we spent $20,000 on vehicle repair.

6) In December of 2005, I asked Meeker County Social Services to approve a **Request for a Rate Variance**; I requested a rate increase of 6%; the request was denied.

7) We have lost consumers; most, not all, have left because they were unable to find residential services in Meeker County; for every person receiving DT&H services, ProWorks receives approximately $14,500.

Since August 2005, we have transferred $45,450 from our reserves to cover payroll; we presently have about $70,000 in reserves, and we are transferring

between $5,000 and $8,000 every pay period.

As difficult as this situation appears to be, I am asking everyone to remain positive; we serve 77 wonderful people; our work contracts are increasing, and I think there is not a single person that doesn't realize what a fantastic program we have created. We have met with Meeker County Social Services and the Meeker County Board of Commissioners; we have met with Senator Steve Dille and Representative Dean Urdahl; Senator Dille will introduce a **ProWorks' Bill**; this legislation gives us an 8% rate increase.

In the meantime, we need to make further adjustments to decrease our costs. We need to hold on until the cavalry arrives. If you have suggestions, whether they involve you personally, or the entire program, I welcome your input. I appreciate working with each and every one of you, and I don't want that to end.

I would like to have a staff meeting on Tuesday, March 14th at 5pm. This will give me an opportunity to better answer your questions, and perhaps we can develop a workable survival strategy.

Minnesota Day Training & Habilitation Programs - 2004 per diems

Region	Program Name	Service Days	Service Units	Per Diem	Rank
11	Chrestomathy Center	242	0	$138.55	1
11	Solstice Vocational Services	248	511	$137.76	2
7	Rum River Ornamental Products	242	9,002	$132.17	3
11	Aurora Products & Services	244	5,960	$130.00	4
11	Midwest Special Services, INC.-Eagan	246	2,831	$129.58	5
11	CCP-Gorham	254	9,972	$128.78	6
11	Rise-Creative Partnership South	250	6,371	$127.70	7
11	Chrestomathy II	242	8,509	$126.63	8
11	Opportunity Services-Anoka Behavior Services	250	1,018	$126.62	9
11	Opportunity Services-Anoka Community Living	250	4,799	$126.62	10
3	Range Area Vocational Supports	250	3,106	$126.60	11
10	Straight River Enterprises	248	6,049	$126.47	12
10	Turtle Creek Industries	248	4,905	$126.45	13
11	Rise-Anoka CIP	250	7,061	$125.32	14
11	Chrestomathy III-Dakota County	242	5,763	$125.00	15
11	Kaposia-Hennepin	250	4,727	$124.89	16
11	Midewest Special Services, INC.-Plymouth	245	10,849	$124.17	17
10	Opportunity Services-Behavior Support Services	250	488	$123.16	18
11	Midwest Special Services, INC.-Burnsville	246	6,660	$123.05	19
3	Duluth Socs DT&H-Airpark	247	7,770	$121.28	20
3	Moose Tracks	250	2,195	$121.21	21
11	CIP-Hoover	234	9,869	$120.33	22
11	CIP-Northeast	234	0	$120.33	23
11	Phoenix Alternatives-Site II Linden	244	8,784	$120.31	24
11	MetroTech Industries	249	7,272	$119.98	25
11	Lifeworks North Life Enrichment	246	0	$118.61	26
11	Rise-Creative Partnership North	250	15,973	$116.57	27
11	Metro Resources Unlimited-Westwood	248	9,698	$113.99	28
11	Metro Resources Unlimited-City West	248	7,465	$113.72	29
11	Kaposia-Plus	244	2,664	$112.68	30
4	Willows	245	4,212	$111.84	31
9	Step Of Fairmont II	245	2,280	$110.97	32
11	Merrick, INC. (White Bear Lake)	244	16,859	$110.56	33
10	Cannon River Enterprises	245	11,870	$109.65	34
11	East Suburban Resources-Stillwater II	252	0	$107.67	35
3	Options Program	240	6,363	$106.71	36
10	Opportunity Services-Dodge Community Living	250	0	$106.58	37
9	MRCI-Highland Plaza	249	9,020	$105.91	38
11	Lifeworks-Mendota Heights II	246	1,613	$103.65	39
7	Phase-South	245	5,391	$99.27	40
3	Duluth Socs DT&H-West End	247	5,901	$99.21	41
10	ProAct, INC.-Zumbrota	250	3,819	$97.95	42
11	Phoenix Alternatives-Commerce	244	10,973	$96.90	43
11	Phoenix Alternatives-Site I	244	13,409	$96.90	44
11	Phoenix Alternatives-Site IV	244	7,252	$96.90	45
4	Broadway Industries	240	841	$95.89	46

11	Workahead-Metro Community Mental Health	244	6,283	$93.85	47
6	Sparks Industries DT&H	250	3,538	$93.04	48
5	Lakes Employment Opportunities	240	6,000	$92.70	49
5	Quality Enterprises II	240	0	$92.70	50
7	Wright Connections III	240	3,534	$92.43	51
9	Valley Enterprises	250	7,940	$91.29	52
10	Possabilities-Life Enrichment II	245	4,391	$91.22	53
11	CCP- Brooklyn Park	253	0	$89.12	54
11	CCP-Champlin	253	26,707	$89.12	55
11	CCP-Plymouth	253	0	$89.12	56
11	CCP-VTS-Core	253	0	$89.12	57
11	CCP-VTS-Satellite	253	0	$89.12	58
11	Choice, INC.-St. Boniface	230	8,745	$88.80	59
4	Heartland Industries Moorhead	245	6,576	$88.51	60
3	Access To Employment Too, INC. (Virginia)	255	1,237	$88.30	61
11	New Options	242	14,513	$87.96	62
11	Workabilities, INC.	240	31,629	$86.29	63
11	Midwest Special Services, INC.-St. Paul	244	18,141	$86.12	64
11	Midwest Special Services, INC.-Shoreview	244	12,547	$85.83	65
1	EGF Polk County DAC	222	5,631	$85.24	66
11	Access To Employment Too, INC. (Minneapolis)	254	5,688	$84.98	67
9	Lifeworks-Mankato	245	4,484	$84.84	68
8	Progess INC. Of Edgerton	240	793	$84.83	69
11	Opportunity Partners-Anoka	247	3,463	$84.74	70
11	CCP-Cooperative Options	253	4,435	$83.38	71
9	MRCI-Front Street	249	5,205	$83.31	72
10	Possabilities-Life Enrichment	245	7,141	$83.22	73
11	Partnership Resources, INC. (Minneapolis)	242	15,977	$83.10	74
11	Partnership Resources, INC. (St. Louis Park)	242	16,673	$83.10	75
9	MRCI-Map Drive	249	10,135	$82.94	76
7	Independence CTR, INC.-ST. Cloud	240	8,869	$82.54	77
6	Heartland Industries Of Dawson, INC.	240	1,460	$82.22	78
11	Opportunity Partners	247	94,080	$81.75	79
11	Opportunity Partners-Asplin Center	247	0	$81.75	80
11	Opportunity Partners-Karlins Center	247	0	$81.75	81
2	Clearwater DAC	240	4,638	$81.45	82
11	MRCI Chaska II	249	5,290	$81.24	83
11	CIP-Bloomington	234	13,873	$80.93	84
3	Lake County DAC, INC.	250	7,219	$80.81	85
11	ProAct, INC.	245	28,711	$80.78	86
11	Lifeworks-Apple Valley	246	0	$80.75	87
11	Lifeworks-Burnsville	246	0	$80.75	88
11	Lifeworks-Hastings	246	0	$80.75	89
11	Lifeworks-Mendota Heights Center	246	59,200	$80.75	90
11	MRCI-Burnsville	246	13,152	$80.72	91
11	MRCI-Lakeville	246	3,477	$80.72	92
11	Zenith Services	251	3,737	$79.49	93
1	Red Lake County Habilitation And Training	250	2,303	$79.13	94
7	Wacosa-Waite Park North	240	9,650	$78.95	95
11	Lifeworks-Bloomington	246	45,557	$78.55	96
11	Lifeworks-Bloomington/North Employment	246	0	$78.55	97

10	Cedar Branch DAC	250	3,951	$78.53	98
9	Le Sueur County DAC II	245	7,180	$78.44	99
9	Le Sueur-Recycling Center	245	0	$78.44	100
1	Polk County DAC	222	8,905	$78.38	101
1	East Polk County DAC	225	4,226	$77.80	102
10	Cedar Valley Services-Albert Lea Division	251	0	$77.74	103
10	Cedar Valley Services-Alpha Program	251	14,517	$77.74	104
9	Madelia Enterprise	248	4,356	$77.69	105
3	Choice Program	240	6,154	$76.89	106
5	Wadena County DAC	232	9,369	$76.60	107
1	Focus Corporation-Minnesota	235	5,205	$76.33	108
11	Equality-Pathways To Potential	247	5,782	$76.01	109
11	Opportunity Services- Anoka Community Work	250	10,052	$75.77	110
9	Step Of Fairmont I	245	7,018	$75.51	111
11	Kaposia Hennepin Employment Services	250	0	$75.16	112
11	Accessablility, INC.	246	30,351	$74.26	113
7	Wright Connections I	247	10,933	$74.25	114
7	Wright Connections II	240	0	$74.25	115
10	ProAct, INC.-Red Wing	250	20,351	$74.14	116
7	Options, INC.	240	19,954	$73.73	117
11	TSE-Lakeridge	244	12,143	$73.52	118
11	TSE-Mccarrons	244	15,321	$73.52	119
11	TSE-Roselawn	244	13,875	$73.52	120
2	Hubbard County DAC	252	10,332	$73.45	121
10	Ability Enterprises, INC.	254	23,272	$72.93	122
11	Metro Work Center, INC.-Site I	242	12,944	$72.72	123
5	The Rising Phoenix, INC.	232	0	$72.65	124
11	Opportunity Services-Woodbury	250	10,659	$72.49	125
3	East Range DAC	232	19,743	$72.25	126
9	Step Of Blue Earth	245	3,971	$72.13	127
4	Pope County DT&H	240	3,577	$71.03	128
1	Norman County DAC	210	5,150	$70.41	129
11	Midway Training Services, INC.	244	26,601	$70.07	130
11	MTS-McKnight (North St. Paul)	244	1,998	$70.07	131
11	MTS-Outreach	244	8,462	$70.07	132
5	Employment Enterprises, INC.	230	14,136	$70.03	133
5	Employment Enterprises, INC. Senior Program	230	0	$70.03	134
5	Employment Enterprises, INC.-The Clothes Hanger	230	0	$70.03	135
4	Stevens County DAC	235	11,828	$70.02	136
10	Opportunity Services-Kasson Community Work	250	3,347	$69.94	137
10	Possabilities-Senior Program	245	5,438	$69.75	138
11	Achieve Services, INC.	240	25,773	$69.74	139
6	Swift County DAC	229	3,898	$69.18	140
3	Aitkin County DAC	240	7,900	$68.96	141
3	Aitkin County DAC-DAC Mart	240	370	$68.96	142
11	Pillsbury United Community (PUC)	247	1,137	$68.79	143
11	Choice, INC.-Excelsior	230	12,158	$68.74	144
8	Jackson County DAC	249	3,229	$68.64	145
10	Wabasha County DAC	251	7,789	$68.59	146
6	Crossroads DT&H	251	10,706	$68.55	147
10	Winona County DAC	260	10,762	$68.50	148

10	Opportunity Services-Red Wing	250	7,799	$68.42	149
9	Step Of Fairmont III	245	2,577	$68.30	150
10	Possabilities-Supported Employment Program	245	8,982	$67.99	151
7	Mille Lacs County Area DAC-Milaca	240	9,233	$67.93	152
7	Mille Lacs County Area DAC-Princeton	240	10,723	$67.93	153
9	Enterprise North	248	8,638	$67.86	154
9	Jobs Plus, INC.	249	14,161	$67.82	155
4	Heartland Industries Moorhead II	245	0	$67.60	156
7	Chisago County DAC	250	19,796	$67.31	157
3	Floodwood Services & Training, INC.	232	6,552	$67.28	158
11	Rise-CIP	250	24,945	$67.22	159
10	Possabilites-Work Services Program	245	6,022	$67.16	160
8	Rock County DAC	236	7,343	$67.06	161
11	Northeast Contemporary Services, INC.-Adult	244	14,459	$67.02	162
7	Rise-Employment Innovations	251	5,313	$66.73	163
10	Fillmore County DAC-Crafty Corner	220	0	$66.63	164
10	Fillmore County DAC	220	10,340	$66.36	165
10	Fillmore County DAC II	220	0	$66.36	166
1	Kittson County DAC, Inc.	220	3,305	$66.17	167
5	Thread Shed I	230	0	$65.76	168
5	Thread Shed II	230	0	$65.76	169
5	Todd County DAC	230	0	$65.76	170
5	Todd County DAC-Senior Program	230	0	$65.76	171
7	Thread Shed III	230	0	$65.76	172
6	Heartland Industries II	260	4,830	$65.59	173
11	Kaposia-Retirement Service	244	7,382	$65.52	174
11	Merrick, INC. (Maplewood)	244	42,423	$65.28	175
1	Habilitation And Training CTR-Warren	253	5,915	$65.11	176
11	East Suburban Resources	252	38,385	$65.01	177
11	East Suburban Resources-Forest Lake Products	252	0	$65.01	178
11	East Suburban Resources-Stillwater I	252	0	$65.01	179
10	Rice County Activity Center	240	13,553	$64.94	180
10	Epic Enterprises, INC.	240	13,321	$64.93	181
11	Choice, INC.-Plymouth	230	9,745	$64.74	182
2	DAC-Bemidji	248	13,427	$64.58	183
8	Progress, INC.	240	6,806	$64.16	184
8	Ecco	235	0	$64.14	185
8	Hope DAC	235	7,580	$64.14	186
9	Enterprise Thrift Shoppe	248	0	$64.04	187
4	Becker County DAC-Annex	220	0	$63.96	188
4	Becker County DAC, INC.	220	12,834	$63.96	189
10	Career Options	260	5,849	$63.78	190
3	UDAC, INC.	240	30,920	$63.63	191
5	Quality Enterprises	240	15,282	$63.43	192
4	Wilkin County DAC	240	3,792	$63.18	193
7	Industries, INC.-Cambridge	245	4,623	$63.17	194
7	Industries, INC.-Mora	245	5,696	$63.17	195
6	Adult Training & Habilitation Center	245	14,914	$63.00	196
6	ATHC-West	245	6,463	$63.00	197
11	Kaposia, INC.	244	24,592	$62.82	198
4	Productive Alternatives, INC.	245	8,860	$62.68	199

4	Productive Alternatives, INC.	245	3,191	$62.68	200
4	Productive Alternatives, INC.-Perham Branch	245	8,049	$62.68	201
1	Falls DAC	245	7,313	$62.29	202
8	Cottonwood County DAC	220	12,085	$62.27	203
8	Cottonwood County DAC-Satellite	220	0	$62.27	204
4	Grant County DAC	245	7,058	$61.72	205
7	Wacosa	240	31,325	$60.73	206
7	Wacosa-Seniors	240	5,720	$60.73	207
7	Wacosa-Sauk Centre	240	3,708	$60.73	208
9	Sibley County DAC	220	6,020	$60.70	209
9	Sibley County Seconds	220	0	$60.70	210
6	West Central Industries DT&H	250	6,110	$60.33	211
4	Connections Of Moorhead, INC.	245	14,821	$60.25	212
2	Mahnomen County DAC	210	3,168	$59.69	213
6	Pro-Works, Inc.	245	13,542	$59.41	214
6	Pro-Works Red Rooster	245	0	$59.41	215
6	Pro-Works Annex	245	0	$59.41	216
3	Itasca DAC	250	8,024	$59.33	217
6	ACTS	239	9,241	$59.12	218
6	Kandi Works	240	20,422	$58.25	219
6	Kandi Works DAC	240	0	$58.25	220
5	Northern Cass DAC	240	6,105	$57.41	221
8	Nobles County DAC	240	6,303	$57.11	222
3	Habilitation And Training CTR-Grand Rapids	250	3,216	$57.08	223
4	Alexandria Opportunities Center, INC.	252	14,809	$56.56	224
5	Pine River Area DAC, INC.	225	6,856	$56.54	225
8	Lyon County DAC	248	0	$56.25	226
7	Phase	240	10,910	$55.93	227
6	Canby DAC	240	12,257	$55.47	228
9	Le Sueur County DAC I	245	5,903	$55.04	229
9	Le Sueur-Potential Unlimited	245	0	$55.04	230
6	Chippewa Enterprises, INC.	225	8,250	$54.70	231
8	Fulda DAC	245	0	$53.40	232
8	Murray County DAC	245	9,048	$53.40	233
9	MRCI-Center	249	7,512	$53.08	234
6	Main Street Industries	225	4,408	$52.90	235
1	Habilitation And Training CTR-Thief River Falls	250	5,909	$52.80	236
3	Northland DAC	250	8,380	$52.14	237
8	Service Enterprises-East BLDG.	250	1,363	$51.48	238
8	Service Enterprises-West BLDG.	250	16,945	$51.48	239
3	Ita Bel Koo DAC	236	4,481	$51.47	240
3	Deer River Hired Hands	250	3,760	$51.17	241
6	Lac Qui Parle County DAC	210	1,795	$50.35	242
9	MRCI-Fairmont	247	6,084	$49.94	243
4	Douglas County DAC	240	12,868	$49.50	244
9	MRCI-New Ulm	249	6,501	$48.85	245
3	Range Center DAC	248	15,191	$48.81	246
11	Midwest Special Services, INC.-Employment Services	244	10,762	$40.45	247
9	MRCI-Mankato	249	8,806	$38.56	248
11	MRCI-Chaska I	249	4,252	$36.14	249
11	Northeast Contemporary Services, INC.-Senior	244	7,449	$11.88	250

3	Access To Employment Too	0	0	$0.00	251
11	Access To Employment DAC	0	0	$0.00	252

A bill for an act

relating to human services; developing training requirements for postadoption search services; directing the commissioner of human services to promulgate rules relating to postadoption search services; amending Minnesota Statutes 2004, section 259.87; proposing coding for new law in Minnesota Statutes, chapter 259.

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

Section 1. **[259.86] POSTADOPTION SEARCH SERVICES.**

(a) The commissioner of human services shall develop a specialized curriculum to train department, county agency, and social service agency staff in performing and complying with the postadoption search services developed in the best practices guidelines reported to the legislature in 2006.

(b) All department and county social service agency staff providing adoption services, including postadoption search services, shall complete postadoption search services training as a component of the mandatory child welfare training.

(c) All private agency staff providing adoption services, including postadoption search services, shall complete at least six hours of postadoption search services training.

Sec. 2. Minnesota Statutes 2004, section 259.87, is amended to read:

259.87 RULES.

The commissioner of human services shall make rules as necessary to administer sections 259.79 ~~and~~, 259.83, and 259.86.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 3208 - Postadoption Search Services Training (First Engrossment)

Author: Senator Ann H. Rest

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

Date: April 5, 2006

S.F. 3208 relates to training for postadoption search services.

Section 1, paragraph (a), requires the commissioner of human services to develop a specialized curriculum to train department, county agency, and social service agency staff in performing and complying with the postadoption search services developed in the best practices guidelines reported to the legislature in 2006.

Paragraphs (b) and (c) require all staff listed in paragraph (a) to complete postadoption search services training.

Section 2 authorizes the commissioner of human services to make rules as necessary to administer the requirements in section 1.

JW:mvm

Fiscal Note – 2005-06 Session

Bill #: S3208-1A **Complete Date:** 04/04/06

Chief Author: REST, ANN

Title: POST ADOPTION SEARCH SVCS TRAINING

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	15	12	12
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	15	12	12
Revenues					
General Fund		0	6	5	5
Net Cost <Savings>					
General Fund		0	9	7	7
Total Cost <Savings> to the State		0	9	7	7

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

Narrative: SF 3208-1A

Bill Description
This bill as amended requires the commissioner of human services to develop a specialized training curriculum for department, county agency and social service agency staff to comply with the postadoption search services developed in the best practices guidelines report due to the legislature February 1, 2006.

Also, the bill requires the commissioner to make rules as needed to administer these provisions.

Assumptions
Under this bill, the department would need to develop a curriculum and provide a six-hour training to comply with the *Post Adoption Search Services Practice Guide* which was provided with the best practices report submitted to the legislature in 2006. Currently, mandatory training is only required for the child protection area. A one-day, six-hour course would be developed by the Minnesota Child Welfare Training System.

The department assumes that provisions in this bill could be administered through department policy bulletins so costs associated with establishing rules are not included in this fiscal estimate.

Expenditure and/or Revenue Formula

Costs to develop and implement mandatory training – four sessions/ year to be held in metro and out-state areas

	First Year	2nd Year and Ongoing
Write Curricula	$ 1,890	0
Trainer Cost @ $1,275/session	$ 5,100	$ 5,100
Site/Equipment/Materials @ $855/ session	$ 3,420	$ 3,420
Admin (one-time)	$ 960	0
Admin (ongoing) @ $964/ session	$ 3,856	$3,856
Total	**$15,226**	**$12,376**
FFP	**$ 6,090**	**$ 4,950**
Net State Cost	**$ 9,136**	**$ 7,426**

Long-term Fiscal Considerations

Local Government Costs

References/Sources
Connie Caron
Children & Family Services, Child Safety & Permanency Division
MN Dept of Human Services
651. 651.282.3793

Agency Contact Name: Jenny Ehrnst 282-2595
FN Coord Signature: STEVE BARTA
Date: 04/03/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/04/06 Phone: 286-5618

Senators Koering, Solon, Higgins, Sams and Berglin introduced–

S.F. No. 3240: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; establishing a pharmacy payment reform advisory committee; providing for a study; requiring a report to the legislature.

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

Section 1. **PHARMACY PAYMENT REFORM ADVISORY COMMITTEE.**

Subdivision 1. **Definitions.** For purposes of this section, the following words, terms, and phrases have the following meanings:

(a) "Department" means the Department of Human Services.

(b) "Commissioner" means the commissioner of the Department of Human Services.

(c) "Cost of dispensing" includes, but is not limited to, operational and overhead costs; professional counseling as required under the Omnibus Budget Reconciliation Act of 1990, excluding medication management services under Minnesota Statutes, section 256B.0625, subdivision 13h; salaries; and other associated administrative costs, as well as a reasonable return on investment. In addition, cost of dispensing includes expenses transferred by wholesale drug distributors to pharmacies as a result of the wholesale drug distributor tax under Minnesota Statutes, sections 295.52 to 295.582.

(d) "Additional costs" include, but are not limited to, costs relating to coordination of benefits, bad debt, uncollected co-pays, payment lag times, and high rate of rejected claims.

(e) "Advisory committee" means the Pharmacy Payment Reform Advisory Committee established by this section.

Subd. 2. **Advisory committee.** The Pharmacy Payment Reform Advisory Committee is established under the direction of the commissioner of human services. The commissioner, after receiving recommendations from the Minnesota Pharmacists Association, the Minnesota Retailers Association, the Minnesota Hospital Association,

and the Minnesota Wholesale Druggists Association, shall convene a pharmacy payment reform advisory committee to advise the commissioner and make recommendations to the legislature on implementation of pharmacy reforms contained in title VI, chapter IV, of the Deficit Reduction Act of 2005. The committee shall be comprised of three licensed pharmacists representing both independent and chain pharmacy entities, one of whom must have expertise in pharmacoeconomics, two individuals representing hospitals with outpatient pharmacies, and two individuals with expertise in wholesale drug distribution. The committee shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the committee. The department's pharmacy program manager shall also serve as an ex officio, nonvoting member of the committee. The committee is governed by Minnesota Statutes, section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee members shall serve a two-year term and the advisory committee will expire on January 31, 2008.

Subd. 3. **Cost of dispensing study.** The department shall conduct a prescription drug cost of dispensing study to determine the average cost of dispensing Medicaid prescriptions in Minnesota. The department shall contract with an independent third party in the state that has experience conducting business cost allocation studies, such as an academic institution, to conduct a prescription drug cost of dispensing study. If no independent third-party entity exists in the state, the department may contract with an out-of-state entity. The cost of dispensing study shall be completed by an independent third party no later than October 1, 2006, and reported to the department and the advisory committee upon completion.

Subd. 4. **Content of study.** The study shall determine the cost of dispensing the average prescription and any additional costs that might be incurred for dispensing Medicaid prescriptions. The study shall include the current level of dispensing fees paid to providers and an estimate of revenues required to adequately adjust reimbursement to cover the cost to pharmacies.

Subd. 5. **Methodology of study and publishing requirement.** The independent third-party entity performing the cost of dispensing research shall submit to the advisory committee the entity's proposed research methodology and shall publish the collected data to allow other independent researchers to validate the study results. The data shall be published in a manner that does not identify the source of the data.

Subd. 6. **Recommendations.** The advisory committee shall use the information from the cost of dispensing study and make recommendations to the commissioner on implementation of pharmacy reforms contained in title VI, chapter IV, of the Deficit Reduction Act of 2005. The commissioner shall report the findings of the study and

the recommendations of the advisory committee to the legislature by January 15, 2007. The department shall conduct a cost of dispensing study every three years following the initial report. The commissioner, in consultation with the advisory committee, shall make recommendations to the legislature on how to adequately adjust reimbursement rates to pharmacies to cover the costs of dispensing and additional costs to pharmacies. Reports shall include the current level of dispensing fees paid to providers and an estimate of revenues required to adequately adjust reimbursement to ensure that:

(1) reimbursement is sufficient to enlist an adequate number of participating pharmacy providers so that pharmacy services are as available for Medicaid recipients under the program as for the state's general population;

(2) Medicaid dispensing fees are adequate to reimburse pharmacy providers for the costs of dispensing prescriptions under the Medicaid program;

(3) Medicaid pharmacy reimbursement for multiple-source drugs included on the federal upper reimbursement limit is set at the level established by the federal government under United States Code, title 42, section 1396r-8(e)(5);

(4) the combined Medicaid program reimbursement for prescription drug product and the dispensing fee provides a return adequate to provide a reasonable profit for the participating pharmacy; and

(5) the new payment system does not create disincentives for pharmacists to dispense generic drugs.

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

RESPONDING TO FEDERAL MEDICAID REFORMS: PHARMACY REIMBURSEMENT

>>>ISSUE BRIEF<

MEDICAID PHARMACY REIMBURSEMENT

Minnesota has 1,586 pharmacies and roughly 485,400 people on Medicaid. Minnesota loses on average 12-13 pharmacies per year and has a shortage of approximately 400 pharmacists. Pharmacists in rural Minnesota also serve many nursing homes, hospitals and other entities by providing medication reviews for patients and ordering and delivering medications.

- FEDERAL CHANGES TO MEDICAID PHARMACY REIMBURSEMENT FORMULAS COULD UNINTENTIONALLY CREATE DISINCENTIVES FOR DISPENSING GENERIC DRUGS AND HARM PATIENTS' ACCESS TO MEDICATIONS AND ACCESS TO THE KNOWLEDGE OF A PHARMACIST. THIS IS PARTICULARLY LIKELY IF STATES DO NOT ADJUST REIMBURSEMENT TO ADDRESS STATE SPECIFIC CONDITIONS THAT ALTER THE COST OF DISPENSING.

  Average pharmacy profit margins are in the range of 1.8% - 2.2%. Further reductions in reimbursement will put pharmacists' profit margin below the cost of dispensing in many cases.

- IN ORDER TO ENSURE THAT THE FEDERAL REFORMS ARE IMPLEMENTED IN A WAY THAT DOES NOT BRING ABOUT THESE UNINTENDED CONSEQUENCES:
  - A study should be conducted to determine the cost of dispensing a prescription to Medicaid patients in Minnesota.
  - An advisory committee should be formed to review the new drug product reimbursement mechanism created and the cost of dispensing study results to make recommendations to the legislature on how to implement the federal reforms.
  - The cost of dispensing study must take state-specific policies that increase cost into consideration. For example expenses associated with the Minnesota Wholesale Drug Distributor Tax. **NO OTHER STATE HAS THIS TAX.**

MINNESOTA PHARMACISTS ASSOCIATION • 1935 West County Road B-2, Suite 165 • Roseville, MN 55113
651-697-1771 *metro* • 800-451-8349 *mn* • 651-697-1776 *fax* • Liz@mpha.org • Abbie@mpha.org

Fiscal Note – 2005-06 Session

Bill #: S3240-0 **Complete Date:** 04/06/06

Chief Author: KOERING, PAUL

Title: PHARMACY PYMT REFORM ADVISORY COMM

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	100	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	100	0	0
Revenues					
General Fund		0	40	0	0
Net Cost <Savings>					
General Fund		0	60	0	0
Total Cost <Savings> to the State		0	60	0	0

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

Senate Counsel, Research, and Fiscal Analysis

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

Senate

State of Minnesota

S.F. No. 3240 - Pharmacy Payment Reform Advisory Committee

Author: Senator Paul E. Koering

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

Date: March 28, 2006

S.F. No. 3240 establishes the Pharmacy Payment Reform Advisory Committee to advise the Commissioner of Human Services and make recommendations to the Legislature in implementing federal charges.

Subdivision 1 defines the following terms: "department," "commissioner," "cost of dispensing," "additional costs," and "advisory committee."

Subdivision 2 establishes the advisory committee. Describes the makeup of the committee. States that the committee expires on January 31, 2008.

Subdivision 3 requires the commissioner to conduct a prescription drug cost of dispensing study to determine the average cost of dispensing prescriptions under the medical assistance program. Requires the commissioner to contract with an independent third party to conduct the study.

Subdivision 4 requires the study to determine the cost of dispensing the average prescription and any additional costs that may be incurred for dispensing prescriptions under the medical assistance program. Requires the study to include the current level of dispensing fees paid to providers and an estimate of revenues required to adequately adjust reimbursement to cover the cost to pharmacies.

Subdivision 5 requires the third-party entity to submit to the advisory committee the entity's proposed research methodology and publish the collected data to allow other researchers to validate the study results. States that any data published shall not identify the source of the data.

Subdivision 6 requires the advisory committee to use the information from the study and make recommendations to the commissioner on implementation of pharmacy reforms. Requires the commissioner to report the findings of the study and recommendations of the advisory committee to the Legislature by January 15, 2007. Requires the commissioner to conduct a cost of dispensing study every three years following the initial report. Requires the commissioner to make recommendations to the Legislature on how to adequately adjust reimbursement rates to pharmacies to cover the costs of dispensing and additional costs to pharmacies.

KC:ph

NARRATIVE: HF 3590/SF 3240

Bill Description

This bill requires the commissioner to convene an advisory group that would, through a DHS funded study, identify the costs associated with filling a prescription in Minnesota. By January 15, 2006, the commissioner would report the committee's findings to the legislature.

Assumptions

If this bill is passed DHS will be responsible for the following:
1.) Begin meeting with committee members.
2.) Create an RFP for the cost study, distribute the RFP and select a vendor.
3.) Communicate vendor study methodology to the committee to obtain approval.
4.) Publish study data and findings for review by other researchers to validate findings.
5.) Communicate study results to committee by Oct 1, 2006.
6.) By January 15, 2007 the commissioner will report the findings and the committee recommendations to the legislature.
7.) This analysis addresses only the cost of the study, not the implementation of study results.

Expenditure and/or Revenue Formula

Study Cost = $100,000.00

Long-Term Fiscal Considerations
None

Local Government Costs
None

References/Sources

MPhA for cost of study.

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 03/28/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/06/06 Phone: 286-5618

Senators Rosen, Lourey and Koch introduced–

S.F. No. 3265: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; creating a state-level methamphetamine coordinator; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **[144.90] STATE-LEVEL METHAMPHETAMINE COORDINATOR.**

Subdivision 1. **Establishment; purpose; appointment.** A state-level, statewide methamphetamine coordinator is created in the Department of Health. The purpose of the methamphetamine coordinator is to coordinate Minnesota's efforts related to reducing the incidence of methamphetamine addiction and the related consequences, by working with various state agencies, local units of government, law enforcement, the courts, the chemical dependency treatment community, the federal government, other states, and other interested individuals and parties in order to coordinate the state's resources to provide and oversee education, research, and training related to methamphetamine. To the extent possible, the coordinator must also coordinate efforts with tribal governments. The coordinator shall be appointed by the governor.

Subd. 2. **Duties.** The duties of the methamphetamine coordinator include, but are not limited to:

(1) providing health-based information and safety training materials to law enforcement, first responders, and others exposed to methamphetamine use and manufacturing;

(2) promoting and tracking first responder training provided by the Minnesota Bureau of Criminal Apprehension, the United States Drug Enforcement Agency, and others;

(3) providing train-the-trainer materials for state and local agencies and community groups working to respond to methamphetamine problems in their communities;

(4) serving as a clearinghouse for information and materials on all aspects of methamphetamine response, including treatment and treatment providers, law enforcement, corrections and drug courts, education, prevention, children's issues, staff training and safety, and K-12 curricula;

(5) tracking of grant and other funding opportunities available to Minnesota agencies, organizations, and communities;

(6) coordinating media-based prevention opportunities, including methamphetamine and other antidrug materials available for use by local communities;

(7) establishing a speaker's bureau of experts on methamphetamine and other addictions;

(8) fielding methamphetamine-related calls;

(9) maintaining current knowledge and understanding of methamphetamine-related research in the areas of remediation, children's health, health of users, best prevention and treatment practices, and other issues;

(10) tracking trends in use, manufacturing, incidence of methamphetamine labs and seizures, costs, incarcerations, and child involvement nationwide and for Minnesota specifically;

(11) making recommendations to the legislature for methamphetamine policy changes and funding;

(12) serving as coordinator or point-of-contact for a Minnesota drug endangered children's alliance; and

(13) coordinating prevention information efforts related to methamphetamine with the Minnesota Prevention Resource Center.

Subd. 3. **Annual update.** The methamphetamine coordinator shall provide to the legislature an annual update by January 15 of each year, summarizing goals that have been established and met, and plans for the upcoming year.

Subd. 4. **Office space.** The commissioner of health shall provide the coordinator with adequate office space and administrative services.

Sec. 2. **APPROPRIATION.**

$..... is appropriated to the commissioner of human services from the federal chemical health block grant funds, and transferred to the commissioner of health for the fiscal year ending June 30, 2007, to implement section 1.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 3265 - Methamphetamine Coordinator

Author: Senator Julie A. Rosen

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

Date: April 4, 2006

Section 1, subdivision 1, establishes a state-level, statewide methamphetamine coordinator in the Department of Health. The purpose of the coordinator is to coordinate the state's efforts related to reducing the incidence of methamphetamine addiction and the related consequences, by working with various agencies, local units of government, law enforcement, the courts, the chemical dependency treatment community, the federal government, other states, and other interested individuals.

Subdivision 2 specifies the duties of the methamphetamine coordinator.

Subdivision 3 requires the coordinator to provide an annual update to the legislature by January 15, summarizing goals that have been established and met, and plans for the upcoming year.

Subdivision 4 requires the commissioner of health to provide the coordinator with adequate office space and administrative services.

Section 2 provides a blank appropriation to the commissioner of human services from the chemical health block grant fund, to be transferred to the commissioner of health for the fiscal year ending June 30, 2007, to implement section 1.

JW:mvm

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3265-0 **Complete Date:** 04/03/06

Chief Author: ~~BERGLIN, LINDA~~ ROSEN

Title: METHAMPHETAMINE COORDINATOR ESTD

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

Agency Name: Health 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					
Federal Fund			82	205	205
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Federal Fund			82	205	205
Revenues					
Federal Fund			82	205	205
Net Cost <Savings>					
Federal Fund			0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Federal Fund			2.00	2.00	2.00
Total FTE			2.00	2.00	2.00

Preliminary

Bill Description

This bill calls for appointment by the Governor of a statewide methamphetamine coordinator in the Department of Health who will coordinate Minnesota's efforts related to reducing incidence of methamphetamine addiction and related consequences, by working with state, local and federal agencies and individuals in order to coordinate the state's methamphetamine response resources.

This bill requires the methamphetamine coordinator to perform a variety of duties ranging in complexity from fielding individual citizen calls to maintaining current knowledge and understanding of methamphetamine-related research. In summary, the bill requires the coordinator to: 1) collect, analyze and collate information from a variety of sources on meth-related topics including environmental remediation, potential for harm to human health and best treatment practices, 2) to collect statistics on trends related to methamphetamine use, addiction, manufacturing, 3) to serve as a clearinghouse for data, funding opportunities, information and materials, 4) to provide these data, materials and resources throughout the state, and 5) to help coordinate state and local efforts toward methamphetamine response.

The coordinator is required to provide and annual update summarizing plans and activities. The Commissioner of Health is required to provide housing for this position.

Assumptions

This fiscal note assumes the addition of two positions to the existing MDH Methamphetamine Program. The additional duties imposed by the language of this bill will require extensive broadening and formalization of existing functions, as well as numerous additional duties. Performing these tasks will require 1.0 FTE State Program Admin Coordinator to assume the coordinator position, as well as 1.0 FTE Office Administrative Specialist to provide administrative support, clerical and communication assistance and website maintenance. Total staffing costs related to establishment of this position would be $81,642 for the second half of FY07 and $204,968 in subsequent years.

Expenditure and/or Revenue Formula

EXPENDITURES	SFY06	SFY07	SFY08	SFY09
Salaries 2.0 FTE		64,323	128,644	128,644
Operating costs		10,100	18,200	18,200
Meth conferences			40,000	40,000
Administrative support		7,219	18,124	18,124
TOTAL EXPENSES		81,642	204,968	204,968

Long-Term Fiscal Considerations

These costs will be ongoing.

Local Government Costs

None.

Agency Contact Name: John Stine (651-201-4675)
FN Coord Signature: MARGARET KELLY
Date: 03/31/06 Phone: 201-5812

EBO Comments

The appropriations language in the bill is not necessary. The federal funds specified in the bill are already appropriated to the Commissioner of Human Services. Funds would need to be transferred to the Department of Health, but appropriating them and then transferring is an unnecessary step.

EBO Signature: CRAIG WIEBER

Preliminary

Date: 04/03/06 Phone: 282-5065

A bill for an act

relating to human services; establishing a reverse mortgage incentive program; establishing eligibility standards, benefits, and other requirements; appropriating money; amending Minnesota Statutes 2004, sections 47.58, subdivision 8; 256.01, by adding a subdivision; 256.975, subdivision 7; 256B.0911, subdivision 3a; 256B.0913, by adding a subdivision; 256B.15, by adding a subdivision; 462A.05, by adding a subdivision; Minnesota Statutes 2005 Supplement, section 256B.0911, subdivision 1a.

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

Section 1. Minnesota Statutes 2004, section 47.58, subdivision 8, is amended to read:

Subd. 8. **Counseling; requirement; penalty.** A lender, mortgage banking company, or other mortgage lender not related to the mortgagor must keep a certificate on file documenting that the borrower, prior to entering into the reverse mortgage loan, received counseling as defined in this subdivision from an organization that meets the requirements of section 462A.209 and is a housing counseling agency approved by the Department of Housing and Urban Development. The certificate must be signed by the mortgagor and the counselor and include the date of the counseling, the name, address, and telephone number of both the mortgagor and the organization providing counseling. A failure by the lender to comply with this subdivision results in a $1,000 civil penalty payable to the mortgagor. For the purposes of this subdivision, "counseling" means the following services are provided to the borrower:

(1) a review of the advantages and disadvantages of reverse mortgage programs;

(2) an explanation of how the reverse mortgage affects the borrower's estate and public benefits;

(3) an explanation of the lending process;

(4) a discussion of the borrower's supplemental income needs; ~~and~~

(5) an explanation of the provisions of sections 256B.0913, subdivision 17, and 462A.05, subdivision 42; and

(6) an opportunity to ask questions of the counselor.

Sec. 2. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 23. **Reverse mortgage information and referral.** The commissioner, in cooperation with the commissioner of the Minnesota Housing Finance Agency, shall:

(1) establish an information and referral system to inform eligible persons regarding the availability of reverse mortgages and state incentives available to persons who take out certain reverse mortgages. The information and referral system shall be established involving the Senior LinkAge Line, county and tribal agencies, community housing agencies and organizations, reverse mortgage counselors and lenders, senior and elder community organizations, and other relevant entities; and

(2) coordinate necessary training for Senior LinkAge Line employees, mortgage counselors, and lenders regarding the provisions of sections 256B.0913, subdivision 17, and 462A.05, subdivision 42.

Sec. 3. Minnesota Statutes 2004, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance; Senior LinkAge.** (a) The Minnesota Board on Aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; ~~and~~

(8) provide information and assistance to inform older adults about reverse mortgages, including the provisions of sections 47.58; 256B.0913, subdivision 17; and 462A.05, subdivision 42; and

(9) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 4. Minnesota Statutes 2005 Supplement, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan, which may include the use of reverse mortgage payments to pay for services needed to maintain the individual in the person's home;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

Sec. 5. Minnesota Statutes 2004, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment. <u>If the person chooses to obtain a reverse mortgage</u>

under section 47.58 as part of the community support plan, the plan must include a spending plan for the reverse mortgage payments.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner containing the following information:

(1) the purpose of preadmission screening and assessment;

(2) information about Minnesota health care programs and about reverse mortgages, including the provisions of sections 47.58; 256B.0913, subdivision 17; and 462A.05, subdivision 42;

(3) the person's freedom to accept or reject the recommendations of the team;

(4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 6. Minnesota Statutes 2004, section 256B.0913, is amended by adding a subdivision to read:

Subd. 17. **Services for persons using reverse mortgages.** (a) Alternative care services are available to a person who satisfies the following criteria:

(1) the person qualifies for the reverse mortgage incentive program under section 462A.05, subdivision 42, and has received the final payment on a qualifying reverse mortgage, or the person satisfies the criteria in section 462A.05, subdivision 42, paragraph (b), clauses (1) to (5), and has otherwise obtained a reverse mortgage and payments from the reverse mortgage for a period of at least 24 months or in an amount of at least $15,000 are used for services and supports, including basic shelter needs, home maintenance, and modifications or adaptations, necessary to allow the person to remain in the home as an alternative to a nursing facility placement; and

(2) the person satisfies the eligibility criteria under this section, other than age, income, and assets, and verifies that reverse mortgage expenditures were made according to the spending plan established under section 256B.0911, if one has been established.

(b) In addition to the other services provided under this section, a person who qualifies under this subdivision shall not be assessed a monthly participation fee under subdivision 12 nor be subject to an estate claim under section 256B.15 for services received under this section.

(c) The commissioner shall require a certification of loan satisfaction or other documentation that the person qualifies under this subdivision.

Sec. 7. Minnesota Statutes 2004, section 256B.15, is amended by adding a subdivision to read:

Subd. 9. **Recovery of alternative care and certain reverse mortgages.** The state and a county agency shall not recover alternative care paid for a person under section 256B.0913, subdivision 17, under this section.

Sec. 8. Minnesota Statutes 2004, section 462A.05, is amended by adding a subdivision to read:

Subd. 42. **Reverse mortgage incentive program.** (a) The agency shall, within the limits of appropriations made available for this purpose, establish, in cooperation with the commissioner of human services, a program to encourage eligible persons to obtain reverse mortgages to pay for eligible costs of maintaining the person in the home as an alternative to a nursing facility placement.

(b) The incentive program shall be made available to a person who has been determined by the commissioner of human services or the commissioner's designated agent to meet all of the following criteria:

(1) is age 62 or older;

(2) would be eligible for medical assistance within 365 days of admission to a nursing home;

(3) is not a medical assistance recipient, is not eligible for medical assistance without a spenddown or waiver obligation, is not ineligible for the medical assistance program due to an asset transfer penalty, and does not have income greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guidelines effective July 1 in the year for which program eligibility is established, who would be eligible for the elderly waiver with a waiver obligation;

(4) needs services that are not funded through other state or federal funding for which the person qualifies;

(5) obtains a reverse mortgage loan under section 47.58 on a home with an estimated market value not to exceed $150,000. This limit shall be adjusted annually on April 1 by the percentage change for the previous calendar year in the housing component of the United States Consumer Price Index - All Urban Consumers; and

(6) agrees to make expenditures of reverse mortgage payments in accordance with a spending plan established under section 256B.0911, subdivision 3a, in which payments, services, and supports meet the following standards:

(i) payments received under the loan for a period of at least 24 months or in an amount of at least $15,000 are used for services and supports, including basic shelter needs, home maintenance, and modifications or adaptations, necessary to allow the person to remain in the home as an alternative to a nursing facility placement;

(ii) reimbursements for services, supplies, and equipment shall not exceed the market rate; and

(iii) if the person's spouse qualifies under section 256B.0913, subdivisions 1 to 14, the reverse mortgage payments may be used to pay client fees under that section.

(c) The incentives available under this program shall include:

(1) payment of the initial mortgage insurance premium for a reverse mortgage. The maximum payment under this clause shall be limited to $1,500. This limit shall be adjusted annually on April 1 by the percentage change for the previous calendar year in the housing component of the United States Consumer Price Index - All Urban Consumers;

(2) with federal approval, payments to reduce service fee set-asides, through an advance payment to the lender, an agreement to guarantee fee payments after 60 months if the set-aside is limited to 60 months, or through other mechanisms approved by the commissioner; and

(3) other incentives approved by the commissioner.

(d) After calculating the adjusted maximum payment limits under paragraphs (b) and (c), the commissioner shall annually notify the Office of the Revisor of Statutes in writing, on or before May 1, of the adjusted limits. The revisor shall annually publish in the Minnesota Statutes the adjusted maximum payment limits under paragraph (b).

Sec. 9. **APPROPRIATION.**

The following amounts are appropriated from the general fund to the commissioner of human services for the fiscal year beginning July 1, 2006:

(1) $..... for the purposes of section 2; and

(2) $..... to be transferred to the commissioner of the Minnesota Housing Finance Agency for the purposes of section 8.

Any money appropriated for these purposes that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 3322 - Establishing a Reverse Mortgage Incentive Program (The First Engrossment)

Author: Senator Linda Berglin

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

Date: April 3, 2006

S.F. No. 3322 establishes several incentives to encourage elderly persons to use reverse mortgage proceeds to pay for long-term care services in their own homes as an alternative to nursing facility placement.

Section 1 (47.58, subdivision 8) amends the existing statute regulating reverse mortgages by requiring the mandatory counseling a borrower must receive to include an explanation of the new reverse mortgage incentives established in this bill.

Section 2 (256.01, subdivision 23) requires the Department of Human Services (DHS), in cooperation with the Minnesota Housing Finance Agency (MHFA), to (1) establish an information and referral system to inform eligible persons about reverse mortgages and state incentives to use them, and (2) coordinate necessary training for Senior LinkAge Line employees, mortgage counselors, and lenders regarding these new incentives.

Section 3 (256.975, subdivision 7) requires the Senior LinkAge Line to provide information and assistance to older adults about reverse mortgages and about the new incentive program.

Section 4 (256B.0911, subdivision 1a) provides that a community support plan, which may be developed as part of long-term care consultation services, may include the use of reverse mortgage payments to pay for services needed to maintain a person at home.

Section 5 (256B.0911, subdivision 3a) provides that if a person chooses to obtain a reverse mortgage as part of the community support plan, the plan must include spending goals for the reverse

mortgage payments. This section also requires long-term care consultation teams to provide interested persons with information about reverse mortgages and incentives to use them.

Section 6 (256B.0913, subdivision 7) provides regular Alternative Care (AC) services and other benefits to persons meeting listed qualifications. To qualify, a person must (1) exhaust a reverse mortgage obtained under the incentive program established in section 8 or, if the mortgage was obtained through another avenue, use 24 months or $15,000 worth of payments for services and supports to maintain the person at home and (2) satisfy AC program eligibility requirements, other than age and income and asset limits, and verify that reverse mortgage expenditures were made according to a spending plan established in connection with long-term care consultation services, if a plan has been established. In addition to other AC services, persons who qualify under this subdivision are exempt from monthly AC fees and from estate claims for AC services received.

Section 7 (256B.15, subdivision 9) amends the Medical Assistance (MA) claims law to prohibit claims for AC services provided under section 6.

Section 8 (462A.05, subdivision 42) requires MHFA, in cooperation with DHS, to establish a reverse mortgage incentive program to help individuals pay costs necessary to maintain them in their homes as an alternative to nursing facility placement. To qualify a person must: (1) be age 62 or older; (2) be eligible for MA within 365 days of admission to a nursing facility; (3) not be eligible for MA or for the Elderly Waiver; (4) need services not paid for by government programs; (5) obtain a reverse mortgage on a home worth $150,000 or less; and (6) use the mortgage proceeds for at least 24 months or in the amount of $15,000 for qualifying services. Program incentives for eligible persons include: (1) payment of up to $1,500 of the initial mortgage insurance premium, (2) payments to reduce reverse mortgage service fee set-asides, and (3) other incentives approved by MHFA.

Section 9 is an appropriations section.

DG:rdr

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S3322-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: REVERSE MORTGAGE INCENTIVE PROGRAM

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

Agencies: Human Services Dept Housing Finance Agency (03/29/06)

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	238	153	153
Human Services Dept		0	238	153	153
Housing Finance Agency		0	0	0	0
Revenues					
General Fund		0	78	54	54
Human Services Dept		0	78	54	54
Housing Finance Agency		0	0	0	0
Net Cost <Savings>					
General Fund		0	160	99	99
Human Services Dept		0	160	99	99
Housing Finance Agency		0	0	0	0
Total Cost <Savings> to the State		0	160	99	99

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.00	0.60	0.60	0.60
Human Services Dept		0.00	0.50	0.50	0.50
Housing Finance Agency		0.00	0.10	0.10	0.10
Total FTE		0.00	0.60	0.60	0.60

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3322-1A **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: REVERSE MORTGAGE INCENTIVE PROGRAM

Agency Name: Human Services Dept

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

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		0	238	153	153
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	238	153	153
Revenues					
General Fund		0	78	54	54
Net Cost <Savings>					
General Fund		0	160	99	99
Total Cost <Savings> to the State		0	160	99	99

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

NARRATIVE: SF 3322-1A

Bill Description

This section modifies AC eligibility requirements by permitting individuals who have exhausted a qualifying reverse mortgage (or have used the proceeds for 24 months or in an amount of $15,000) to qualify for AC expanded criteria for age, income, and assets. It also permits them to be eligible without premiums or estate recoveries.

Assumptions

Given that the number of reverse mortgages is likely to be quite small, and given that the time necessary to implement this bill, take out reverse mortgages, and exhaust a mortgage (or meet the 24-month / $15,000 test) must pass before there can be an effect on the AC caseload, no consequential effect on AC caseload or costs is anticipated. Implementation date of July 1, 2006, with one provision pending federal approval process.

Expenditure and/or Revenue Formula

Human Services Administration:

.5 FTE: DHS will:

- develop an interagency agreement with Minnesota Housing Finance Agency (MHFA) and administer transfer and accounting of program funding dedicated to housing component.
- Provide a grant for development of training and consumer outreach materials and assistance through Senior LinkAge® Line (SLL).
- develop and coordinate changes to both the reverse mortgage incentive program and the alternative care program eligibility, access, and training for local lead agencies and partners, including MMIS programming and training.
- MMIS programming: moderate expenses for implementation, including RM and AC eligibility criteria, screening document activity, and related edits.

Interagency agreement with MHFA:

- Reverse Mortgage Incentive Program Expenditures: Estimated participation 25 loans per fiscal year, initial mortgage insurance premium limited to $1,500/loan, payments to reduce service set-asides uncertain based on need for federal approval.
- RFP for participating lenders and reverse mortgage counselors
- MHFA estimates 200 hours staff time for coordination with DHS on materials and training for consumers and reverse mortgage counselors, which the agency will absorb.

Admin Activity	BACT	FY06	FY07	FY08	FY09
DHS administrative costs					
AC program costs to manage interagency agreement/funding, RM and AC program eligibility, docs, MMIS, forms, and training – .5 FTE	85	$0	$57	$47	$47
RMI and AC program material costs; eligibility, docs, brochures, training	85	0	$100	$50	$50
SLL – client tracking system update	70	0	$25	$0	$0
Interagency agreement with MHFA					
Mortgage insurance	85	0	$38	$38	$38
MHFA coordination costs, training, materials, distribution (MHFA to absorb)		0	$0	$0	$0
MMIS systems costs	51		$18	$18	$18
Total General Fund		**$0**	**$238**	**$153**	**$153**
admin non-ded Rev for non-systems admin costs- @ 40%		$0	$78	$54	$54
TOTAL		**$0**	**$160**	**$99**	**$99**

Long-Term Fiscal Consideration
Unknown; determined by consumer response to available incentives.

Local Government Costs
None.

References/Sources
- National Council on Aging
- HUD
- MHFA

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3322-1A **Complete Date:** 03/29/06

Chief Author: BERGLIN, LINDA

Title: REVERSE MORTGAGE INCENTIVE PROGRAM

Agency Name: Housing Finance Agency

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	8	7	7
Less Agency Can Absorb					
General Fund		0	8	7	7
Net Expenditures					
General Fund		0	0	0	0
Revenues					
General Fund		0	0	0	0
Net Cost <Savings>					
General Fund		0	0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.00	0.10	0.10	0.10
Total FTE		0.00	0.10	0.10	0.10

Bill Description

This bill provides incentives for certain individuals to obtain a home equity conversion or reverse mortgage and to expend the proceeds for items and services necessary to remain in the home rather than a nursing home. The incentives are payment of initial mortgage insurance premiums and eligibility for alternative care services without regard to age, income, or assets, no payment of a monthly participation fee and an exemption from an estate claim for alternative care services. An additional incentive of reduced service fee set aside requires federal approval.

To be eligible, an individual must be:

- 62 years old or older;
- eligible for Medical Assistance within one year of admission in a nursing home;
- not eligible for Medical Assistance and meets certain income requirements;
- has a home valued at less than $150,000; and
- obtains a reverse mortgage and uses the proceeds for items and services that help the person remain in their home and avoid nursing home admission.

Assumptions

MHFA relies on DHS for the assumption about volume of loans.

Approximately three hours of staff time will be required per payment of mortgage insurance premium. Approximately 80 hours of staff time each year will be required to develop an RFP and related process to select lenders to participate in the incentive program.

Approximately 40 hours of staff time will also be needed to work with DHS on the development and implementation of the information and referral system.

The costs of training home equity conversion counselors on the incentive program will be covered from non-state resources.

Expenditure and/or Revenue Formula

The cost of the mortgage insurance premium incentive and marketing brochures is included in the fiscal note from DHS. Approximately 200 hours of staff time will be needed in the first year and approximately 160 hours the second year. Modifications to the web site will be required.

The expenditure reflects the average salary, benefits, direct and indirect costs of an employee at a support staff level.

Staffing requirements in the future will depend on the level of participation by borrowers.

Long-Term Fiscal Considerations

Costs related to payment processing and lender participation will be ongoing; the volume of loans is unknown.

Local Government Costs

References/Sources

Agency Contact Name: TONJA M. ORR (651-296-9820)
FN Coord Signature: JULIE STAHL
Date: 03/29/06 Phone: 296-2291

EBO Comments

Preliminary

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/29/06 Phone: 296-7642

Fiscal Note Request Worksheet

Bill #: S.F. 3322 Title: Reverse mortgage incentive program
Companion #: H.F. 3878 Author: Berglin Agency: DHS
Urgent: Due Date: 04/03/2006 Committee: Health and Family Security
Consolidated: Lead Agency: DHS Contact Person: Rotegard

What version of the bill are you working on? 3/10/06 w/ 3/27/06 A-1 amendment

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Fund General Fund – 100	-	$0	$238	$153	$153
Fund					
Fund					
Less Agency Can Absorb					
Fund	-	0	0	0	0
Fund					
Fund					
Net Expenditures					
Fund General Fund – 100	-	$0	$238	$153	$153
Fund	-				
Fund					
Revenues					
Fund REV- Administrative	-	$0	$78	$54	$54
Fund					
Fund					
Net Cost <Savings>					
Fund General Fund – 100		$0	$160	$99	$99
Fund					
Fund					
Total Cost <Savings> to the State		$0	$160	$99	$99

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents	0	0	.5	.5	.5
Fund					
Fund					
Fund					
Total FTE	0	0	.5	.5	.5

Bill Description

This section modifies AC eligibility requirements by permitting individuals who have exhausted a qualifying reverse mortgage (or have used the proceeds for 24 months or in an amount of $15,000) to qualify for AC expanded criteria for age, income, and assets. It also permits them to be eligible without premiums or estate recoveries.

Assumptions

Given that the number of reverse mortgages is likely to be quite small, and given that the time necessary to implement this bill, take out reverse mortgages, and exhaust a mortgage (or meet the 24-month / $15,000 test) must pass before there can be an effect on the AC caseload, no consequential effect on AC caseload or costs is anticipated. Implementation date of July 1, 2006, with one provision pending federal approval process.

Expenditure and/or Revenue Formula

Human Services Administration:

.5 FTE: DHS will:

- develop an interagency agreement with Minnesota Housing Finance Agency (MHFA) and administer transfer and accounting of program funding dedicated to housing component.
- Provide a grant for development of training and consumer outreach materials and assistance through Senior LinkAge® Line (SLL).
- develop and coordinate changes to both the reverse mortgage incentive program and the alternative care program eligibility, access, and training for local lead agencies and partners, including MMIS programming and training.
- MMIS programming: moderate expenses for implementation, including RM and AC eligibility criteria, screening document activity, and related edits.

Interagency agreement with MHFA:

- Reverse Mortgage Incentive Program Expenditures: Estimated participation 25 loans per fiscal year, initial mortgage insurance premium limited to $1,500/loan, payments to reduce service set-asides uncertain based on need for federal approval.
- RFP for participating lenders and reverse mortgage counselors
- MHFA estimates 200 hours staff time for coordination with DHS on materials and training for consumers and reverse mortgage counselors, which the agency will absorb.

Admin Activity	BACT	FY06	FY07	FY08	FY09
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admin non-ded Rev for non-systems admin costs- @ 40%		$0	$78	$54	$54
TOTAL		**$0**	**$160**	**$99**	**$99**

Long-Term Fiscal Consideration

Unknown; determined by consumer response to available incentives.

Local Government Costs
None.

References/Sources
- National Council on Aging
- HUD
- MHFA

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: _____

Minnesota Board on Aging

April 4, 2006

Senator Linda Berglin, Chair
Health and Human Services Budget Division
306 Capitol
St. Paul, MN 55155

Dear Senator Berglin:

I am writing on behalf of the Minnesota Board on Aging, a 25 member Governor appointed board, which is the designated State Unit on Aging under the Older Americans Act. The Minnesota Board on Aging has promoted personal responsibility and ways to pay privately for long-term care services to help individuals plan ahead for their future health care needs. The Board has been an advocate for long-term care reform for several years and we continue to increase public awareness of the aging of Minnesota.

The Minnesota Board on Aging supports the Reverse Mortgage Incentive Program contained in S.F. 3322 because it provides an additional voluntary option for private payment of home and community-based services. If an informed consumer chooses to convert their home equity into a lump-sum of money and/or a stream of monthly income they can provide themselves the resources to modify their home or purchase supportive services to extend the time that they can remain in their home. This program will help pay the considerable cost associated with a reverse mortgage, and if the need for support extends beyond the reverse mortgage the participant will receive certain special eligibility and cost sharing conditions if they apply to participate in the Alternative Care program

The Board believes that more options should be developed so that people have the flexibility to pay for these vital services. More incentives such as this will help our citizens in the future pay for the quality services and live at home. The Board will cooperate as provided in the legislation so that consumers can make an informed decision if a reverse mortgage is the right option for them.

Thank you for this opportunity to comment on this innovative piece of legislation.

Sincerely,

Kenneth Moritz
Co-Chair
Public Policy Committee

PO Box 64976
St. Paul, Minnesota 55164-0976
Phone: (651) 431-2500
Toll Free: (800) 882-6262
FAX: (651) 431-7453
www.mnaging.org

MEMORANDUM

TO: Senator Linda Berglin

FROM: Barbara Stucki, NCOA

DATE: March 24, 2006

SUBJ: Potential impact of incentives under the proposed Reverse Mortgage Incentive Program.

The following tables lay out the potential impact of incentives proposed under S.F. No. 3322, by age of the borrower and the value of the home. These tables were generated using the National Reverse Mortgage Lenders Association (NRMLA) reverse mortgage calculator (http://nrmla.edthosting.com/) to establish the specific costs associated with a HECM loan. The AARP reverse mortgage loan calculator (http://www.rmaarp.com/) was used to estimate the duration of the loan. The loan duration estimate presented here assumes that the borrower withdrew $800 per month from their line of credit. The loan interest rate used in these calculations was 6.10% - current for the week of February 7, 2006.

Note: All the data presented here are estimates. Actual amounts will vary based on interest rates and other factors such as the need for home repairs.

Table 1 shows the size, costs, and duration of HECM loans without any incentives for borrowers. Loan amounts were calculated for homes valued at $37,000, $75,000 and $150,000. These home values are representative of the median home values in different counties in Minnesota. The calculations assumed that there was no debt on the home. Loan values were also calculated for borrowers at age 75, 80, and 85.

Table 1 reveals many of the basic features of HECM loans:

- The amount that lenders are willing to lend (termed the loan principle limit) increases with age. For example, an 85 year old can get a loan that is 79.2% of the home equity, while a 75 year old can tap 68.9% of their home equity. These percentages reflect current interest rates. They are the same regardless of the value of the home.
- Because the closing costs associated with taking our a HECM loan are relatively fixed, the proportion of the loan principle limit devoted to paying for these costs (assuming that the borrower rolls costs into the loan), is significantly higher for elders with modest homes. An 85 year old borrower with a $37,000 home would devote 13.3% of the loan principle limit to these costs, compared to 7.1% of the principle limit for a borrower with a home worth $150,000.
- The servicing fee set-aside also reduces the net cash available to the borrower. The servicing fee set aside is the present value calculation of the total service fees ($30/month) that will be required over the life of the loan. Currently, this is based on the assumption that a borrower will live to age 100. Younger borrowers with modest homes are particularly hard hit by the servicing fee set-aside, which can eat up over 20% of the loan principle limit for a borrower age 75 with a $37,000 home.

- The net cash available, after closing costs have been paid and the serving fee set aside has been deducted, has a significant impact on the duration of the loan for people who need services to continue to live at home. For example, an 85-year-old with a $37,000 home would be able to make monthly withdraws of $800 from their line of credit for about 2.4 years before running out of loan funds. The same borrower in a $150,000 home would be able to get this monthly amount for up to 20 years (assuming constant interest rates).

Table 2 highlights some of the costs and benefits of providing incentives to reduce the closing costs associated with HECM loans under S.F. No. 3322. The table considers the impact of 1) paying for up to $1,500 of the upfront mortgage insurance premium (MIP), and 2) limiting the serving-fee set aside to 60 months (5 years).

Under the HECM program, the upfront FHA mortgage insurance premium (MIP) required for all HECM loans is calculated as a percentage (2%) of the value of the home. For a house appraised at $37,000 this amount would be $740, and would increase to $3,000 for a home worth $150,000. Reducing the MIP would be a cost that would be borne by the state.

The amount that is set aside to cover the total expected cost of servicing fees, over the life of the loan, can be considerable. This set-aside was created to protect lenders who could face many years of servicing costs, long after the borrower had used up the loan proceeds. The target population of the new reverse mortgage alternative care program is likely to present much less of a risk to lenders. Data from the Alternative Care program suggests that most of these clients are only able to continue to live at home for a few years.

The State may be able to negotiate with HUD and servicing lenders to allow a smaller servicing fee set-aside for this program. Table 2 assumes that the set-aside would be limited to 60 months (60 months x $30/month = $1,800), as proposed in S.F. No. 3322. A monthly servicing fee of $30 is the amount that lenders such as Wells Fargo charge borrowers in Minnesota. As a backup for lenders, under the proposed legislation, the State would pay the servicing fee for eligible borrowers who continue to stay at home for more than 60 months.

The potential impact of these changes to borrowers who take out a HUD HECM loan as part of the proposed Reverse Mortgages Incentive program could be substantial:

- Reducing the upfront MIP, and the servicing fee set-aside would significantly reduce the actual and perceived cost of HECM loans – by over 37% among 85 year old borrowers with homes worth $37,000, and 30% among borrowers age 85 with $150,000 homes.
- The proportion of the loan principle limit devoted to costs and servicing fee set-aside would become more reasonable for borrowers with modest homes – 16.9% under this scenario compared to 27% with no incentives (Table 1), for borrowers age 85 with $37,000 homes.
- Borrowers age 85 with $37,000 homes would be able to increase their net available cash by 13.9%, and increase the duration of the loan by about 17% (compared to no incentives – Table 1) which would enable them to pay $800 per month for services for an estimated 2.8 years.

Table 1. Funds available from a HECM loan, by home value and age of youngest borrower

	Home value= $37,000			Home value= $75,000			Home value= $150,000		
	Age			Age			Age		
	75	80	85	75	80	85	75	80	85
Loan principle limit[1]	$25,493	$27,417	$29,304	$51,675	$55,575	$59,400	$103,350	$111,150	$118,800
Costs and fees									
Origination fee	$2,000	$2,000	$2,000	$2,000	$2,000	$2,000	$3,000	$3,000	$3,000
Upfront mortgage ins. (MIP)	$740	$740	$740	$1,500	$1,500	$1,500	$3,000	$3,000	$3,000
Other closing costs	$1,163	$1,163	$1,163	$1,573	$1,573	$1,573	$2,383	$2,383	$2,383
Total costs	$3,903	$3,903	$3,903	$5,073	$5,073	$5,073	$8,383	$8,383	$8,383
Service fee set-aside[2]	$5,188	$4,701	$4,027	$5,188	$4,701	$4,027	$5,188	$4,701	$4,027
Total fees+costs	$9,091	$8,604	$7,930	$10,261	$9,774	$9,100	$13,571	$13,084	$12,410
Net cash available	$16,402	$18,813	$21,374	$41,414	$45,801	$50,300	$89,779	$98,066	$106,390
Loan as % home equity	68.9%	74.1%	79.2%	68.9%	74.1%	79.2%	68.9%	74.1%	79.2%
Loan structure									
% cash available	64.3%	68.6%	72.9%	80.1%	82.4%	84.7%	86.9%	88.2%	89.6%
% costs	15.3%	14.2%	13.3%	9.8%	9.1%	8.5%	8.1%	7.5%	7.1%
% set aside	20.4%	17.1%	13.7%	10.0%	8.5%	6.8%	5.0%	4.2%	3.4%
Duration of loan (yrs)[3]	1.8	2.1	2.4	5.1	5.7	6.4	14.6	17.0	20.0

Notes: 1 - Loan principle limit is the amount that the bank is willing to lend based on age and interest rates. 2 - The service fee set-aside is an amount that is put into an account to pay for monthly servicing fees ($25-$35) over the life of the loan. Borrowers are only charged as needed from this account. 3 - Based on a monthly withdrawal from the HECM credit-line of $800.

Table 2. Potential impact of reducing closing costs and service fee set-aside									
	Home value= $37,000			Home value= $75,000			Home value= $150,000		
	Age			Age			Age		
	75	80	85	75	80	85	75	80	85
Loan principle limit	$25,493	$27,417	$29,304	$51,675	$55,575	$59,400	$103,350	$111,150	$118,800
Costs and fees									
Origination fee	$2,000	$2,000	$2,000	$2,000	$2,000	$2,000	$3,000	$3,000	$3,000
MIP reduced $1500	$0	$0	$0	$0	$0	$0	$1,500	$1,500	$1,500
Other closing costs	$1,163	$1,163	$1,163	$1,573	$1,573	$1,573	$2,383	$2,383	$2,383
Total costs	$3,163	$3,163	$3,163	$3,573	$3,573	$3,573	$6,883	$6,883	$6,883
Service fee set-aside limit	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800
Total fees+costs	$4,963	$4,963	$4,963	$5,373	$5,373	$5,373	$8,683	$8,683	$8,683
% total reduction	45.4%	42.3%	37.4%	47.6%	45.0%	41.0%	36.0%	33.6%	30.0%
Net cash available	$20,530	$22,454	$24,341	$46,302	$50,202	$54,027	$94,667	$102,467	$110,117
% increase in cash	25.2%	19.4%	13.9%	11.8%	9.6%	7.4%	5.4%	4.5%	3.5%
Loan structure									
% cash available	80.5%	81.9%	83.1%	89.6%	90.3%	91.0%	91.6%	92.2%	92.7%
% costs	12.4%	11.5%	10.8%	6.9%	6.4%	6.0%	6.7%	6.2%	5.8%
% set aside	7.1%	6.6%	6.1%	3.5%	3.2%	3.0%	1.7%	1.6%	1.5%
Duration of loan (yrs)	2.3	2.6	2.8	5.8	6.4	7.0	15.0	17.5	20.5
% increase in duration	28%	24%	17%	14%	12%	9%	3%	3%	3%

U. S. Department of Housing and Urban Development
Washington, D.C. 20410-8000

March 8, 2000

OFFICE OF THE ASSISTANT SECRETARY
FOR HOUSING-FEDERAL HOUSING COMMISSIONER

MORTGAGEE LETTER 00-10

TO: ALL APPROVED MORTGAGEES

SUBJECT: Revisions to the Home Equity Conversion Mortgages (HECMs) Program

The Department is continuing its efforts to both promote the HECM program and deliver this valuable product more efficiently to seniors. Recently, Congress converted the HECM program from a temporary program to a permanent one and also increased the number of HECM loans that FHA can insure to 150,000. Congress also increased the maximum mortgage amounts available under this program. This Mortgagee Letter implements a number of changes to the HECM program to increase its availability and further streamline the process for mortgage lenders. These changes are effective immediately.

o Increase in Loan Origination Fee --- Must Cover Mortgage Broker or Loan Correspondent Fee

FHA permits a lender to charge a loan origination fee agreed upon by the borrower and lender. However, we are now capping the amount of the origination fee that can be charged the borrower and also permitting the borrower to finance the entire amount of the fee. The origination fee amount will now be limited to the greater of $2000 or 2 percent of the maximum claim amount on the reverse mortgage.

The financed origination fee is now the full amount that the borrower can pay for the origination and underwriting of the mortgage and must also include the full amount of any mortgage broker fee or loan correspondent fee. The borrower is not permitted to pay any additional origination fees of any kind to a mortgage broker or loan correspondent. Lenders are reminded that a mortgage broker fee can be included as part of the origination fee only if the mortgage broker is engaged independently by the homeowner and that a mortgage broker's fee is prohibited if there is any financial interest between the mortgage broker and lender. A copy of the agreement between the borrower and the mortgage broker to pay the broker fee must be submitted along with the loan application and other documents in the binder submitted to FHA. Consequently, the Home Equity Conversion Mortgage Loan Agreement section 2.2.1 is amended to:

2.2.1. Loan Advances shall be used by Lender to pay, or reimburse Borrower for, closing costs listed in the Schedule of Closing Costs (Exhibit 2) attached to and made a part of this Loan Agreement, provided that Loan Advances will only be used to pay origination fees in an amount not exceeding the greater of $2,000 or 2 percent of the maximum claim amount, nor shall the Lender charge the Borrower an origination fee in excess of this amount.

o Counseling Certificates

In all circumstances the borrower must receive reverse mortgage counseling. The Certificate of HECM Counseling includes a 180-day expiration period. Provided the homeowner applies for a HECM within 180 days of signing the certificate, there is no need to obtain an updated certificate. Further, when the loan is being applied for by more than one homeowner, as long as at least one homeowner's signature on the certificate is within the 180-day expiration period, the lender may consider the counseling certificate as being valid for all borrowers on the loan. In addition, those borrowers that received the counseling more than 180 days previously but do not believe that a second session would be useful may also waive the expiration date in writing.

o HECM Counseling Provided by Fannie Mae

On October 15, 1999, Fannie Mae began providing telephone counseling for homeowners contemplating using FHA's HECM loans. This service will be offered under a one-year pilot. Fannie Mae will provide counseling under any of the following circumstances:

- o HUD-approved counseling is not available within 50 miles of the homeowner's residence, or
- o The HUD-approved counseling agency has a waiting period of three weeks or more before it can see the homeowner, or
- o The local agencies do not provide reverse counseling in the homeowner's native language, or
- o The homeowner is unable to travel and the local agencies do not make home visits, or
- o The local agency charges a fee for reverse mortgage counseling.

o Face-to-Face Interview Requirement

In Mortgagee Letter 98-15 (March 16, 1998), FHA eliminated the face-to-face interview requirement. Those rules, which affected forward mortgages insured by FHA, now also apply to reverse mortgages under the HECM program *provided* that the homeowner has at least had a face-to-face interview with a HUD-approved reverse mortgage counseling agency. In other words, a face-to-face interview with an acceptable counseling agency may substitute for a

face-to-face interview with the mortgage lender. However, please note that the above telephone counseling provided by Fannie Mae cannot also substitute for the lender's face-to-face interview.

With or without a face-to-face interview, the lender remains completely accountable for positively identifying the applicant and assuring that the homeowner is eligible based on his or her age for the HECM loan.

o Revised Appraisal Disclosure Requirements

Mortgagee Letter 99-18 announced numerous changes to FHA's appraisal requirements. Please note, however, that the "Importance of Home Inspections" form is not required to be provided on HECM loans.

If you have any questions regarding this mortgagee letter, please contact your Homeowner Centers in Atlanta (888-696-4687), Denver (800-543-9378), Philadelphia (800-440-8647) or Santa Ana (888-527-5605).

Sincerely,

William C. Apgar
Assistant Secretary for Housing-
Federal Housing Commissioner

A bill for an act

relating to health; establishing a controlled substances reporting program; providing for disciplinary action; proposing coding for new law in Minnesota Statutes, chapter 152.

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

Section 1. **[152.126] ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.

(d) "Dispenser" means a person authorized by law to dispense, pursuant to a valid prescription, a controlled substance. A dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 2. **Establishment of a prescription electronic reporting program.** (a) The board shall establish by January 1, 2008, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, and maintenance of the electronic reporting system. The vendor's role shall be limited to providing technical support to the board concerning the software, databases, and computer systems required to interface with the existing systems currently used by pharmacies to dispense prescriptions and transmit prescription data to other third parties.

Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The board may convene an advisory committee. If the board convenes a committee, the committee must include at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association; and

(6) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

Subd. 4. **Reporting requirements.** (a) Each dispenser must submit the following data to the board or its designated vendor:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) name of the patient for whom the prescription was written;

(6) date of birth of the patient for whom the prescription was written;

(7) date the prescription was written;

(8) date the prescription was filled;

(9) name and strength of the controlled substance;

(10) quantity of controlled substance prescribed; and

(11) quantity of controlled substance dispensed.

(b) The dispenser must submit the required information by a procedure and in a format established by the board.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for individuals residing in licensed skilled nursing or intermediate care facilities.

Subd. 5. **Use of data by board.** The board shall develop and maintain a database of the data reported under subdivision 4 and shall use the database for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

Subd. 6. **Access to prescription electronic reporting program data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12.

(b) The board may provide data submitted under subdivision 4 for public research, policy or education purposes, to the extent that any information that is likely to reveal the identity of the patient or other person who is the subject of the data has been removed.

(c) The following persons may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber, to the extent the information relates specifically to a current patient of the prescriber, to whom the practitioner is prescribing or considering prescribing any controlled substance;

(2) a dispenser to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4;

(4) personnel of the board specifically assigned to conduct investigations related to controlled substances laws under the jurisdiction of the board;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities of their employment;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to test and maintain the system databases;

(7) a designated representative of a health-related licensing board responsible for the licensure, regulation, or discipline of prescribers or dispensers provided that the requested data relates to a bona fide investigation of a specific licensee;

(8) federal, state, and local law enforcement authorities engaged in a bona fide investigation of a specific person; and

(9) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

(d) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of healthcare data shall be subject to disciplinary action by the appropriate health-related licensing board.

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting program to determine if the program is cost-effective. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the program to the legislature by January 15, 2009.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the prescription electronic reporting program, whichever is later. In the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting program, the board is not required to implement section 1, without a subsequent appropriation from the legislature.

Sec. 2. **FEDERAL GRANTS.**

The Board of Pharmacy shall apply for any applicable federal grants or other nonstate funds to establish and fully implement the prescription electronic reporting program.

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

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 2899 - Controlled Substance Electronic Reporting System (Second Engrossment)

Author: Senator Linda Berglin

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

Date: March 27, 2006

S.F. No. 2899 establishes a controlled substances reporting system that would require dispensers of controlled substances to electronically report specified information to the Board of Pharmacy.

Section 1 (152.126) establishes the prescription electronic reporting system.

Subdivision 1 defines the following terms: "advisory committee," "board," "controlled substances," "dispense," "dispenser," "prescriber," and "prescription."

Subdivision 2 requires the Board of Pharmacy to establish by January 1, 2008, an electronic system for reporting prescribing information for all controlled substances dispensed within the state. Authorizes the Board to contract with a vendor for the purpose of obtaining technical assistance. Limits vendor's role to providing technical support.

Subdivision 3 authorizes the Board to convene an advisory committee of seven members appointed by the Board. Describes the members of the committee and the committee's duties, if convened by the Board.

Subdivision 4 requires each dispenser to submit the following data to the Board or the Board's designated vendor:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) name of the patient for whom the prescription was written;

(6) date of birth of the patient fro whom the prescription was written;

(7) date the prescription was written;

(8) date the prescription was filled;

(9) name and strength of the controlled substance;

(10) quantity of controlled substance prescribed; and

(11) quantity of controlled substance dispensed.

The dispenser is required to submit this data by a procedure and in the format established by the Board. A dispenser is not required to submit this data for individuals residing in a skilled nursing facility or a intermediated care facility.

Subdivision 5 requires the Board to develop and maintain a database of the reported data and use the data for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

Subdivision 6, paragraph (a), except as indicated in this subdivision, classifies the data submitted to the Board as private data on individuals, as defined in Minnesota Statutes, section 13.02, subdivision 12.

Paragraph (b) permits the Board to provide the data submitted for public research and policy or education purposes so long as any information that is likely to identify the patient or other person who is subject to the data has been removed.

Paragraph (c) authorizes the following persons to access to the data in the same or similar manner and for the same or similar purposes as those persons authorized to access similar private data on individuals under state and federal law:

(1) a prescriber to the extent the information relates to a current patient;

(2) a dispenser to the extent the information relates to a current patient;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted;

(4) personnel of the Board assigned to conduct investigations related to controlled substances laws;

(5) personnel of the Board engaged in the collection of controlled substance prescription information;

(6) authorizes personnel of a vendor under contract, provided that access is limited to the minimum amount necessary to test and maintain databases;

(7) a designated representative of a health-related licensing Board as it relates to an investigation of a specific licensee;

(8) law enforcement officials engaged in a bona fide investigation of a specific licensee; and

(9) personnel of the medical assistance program assigned to use the data collected to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

Paragraph (d) states that the Board may not release the data submitted unless it is provided with evidence that the person requesting the information is entitled to receive the data.

Subdivision 7 states that a dispenser who knowingly fails to submit data to the Board as required or who has access to the data and knowingly discloses the data in violation of state or federal law is subject to disciplinary action by the appropriate health-related licensing board.

Subdivision 8 requires the Board to evaluate the prescription electronic reporting program to determine if the program is cost effective and submit the evaluation to the Legislature by January 15, 2009. The Board may contract with a vendor to design and conduct the evaluation.

Effective date: The effective date of this section is dependent on receiving sufficient nonstate funds to implement the program.

Section 2 requires the Board of Pharmacy to apply for any applicable federal grants or other nonstate funds to establish and fully implement the program.

KC:ph

SF 2899

AMA
AMERICAN
MEDICAL
ASSOCIATION

July 25, 2005

The Honorable Edward Whitfield
United States House of Representatives
301 Cannon House Office Building
Washington, DC 20515

Dear Representative Whitfield:

On behalf of the American Medical Association (AMA) and its physician and medical student members, I offer our strong support for H.R. 1132, the "National All Schedules Prescription Electronic Reporting Act of 2005." We are pleased that this legislation recognizes both the vital role physicians play in preventing prescription drug abuse, as well as the importance of limiting access to confidential patient information.

Prescription drug abuse is one of the fastest growing public health problems facing our country. The nonmedical use of prescription drugs now ranks second behind marijuana as a category of illicit drug abuse among adults and youth. In 2002, the National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that an estimated 6.2 million persons in the U.S. over the age of 12 reported "past month" use of prescription stimulants, sedatives, tranquilizers, and analgesics for non-medical purposes. This compares to roughly 3.5 million and 1.6 million, respectively, in 2001 and 2000.

By providing physicians with access to important patient information, they can effectively treat their patients' pain or illness while helping to prevent the abuse and diversion of controlled substances. This principle of "balance" between access to necessary pain medication and the prevention of abuse has long been supported by the AMA. We are confident that H.R. 1132, through the provision of grants to states for the creation or expansion of voluntary, state-based controlled substance monitoring programs, will serve as a critical tool to preserve this balance.

We thank you for your strong leadership on this valuable legislation, and we look forward to working with you to ensure its enactment.

Sincerely,

Michael D. Maves, MD, MBA
Executive Vice President, CEO

S.F. 2899

Cody Wiberg

From: Cody Wiberg
Sent: Thursday, April 06, 2006 9:20 AM
To: 'Shannon.anderson@sen.mn'
Cc: katie.cavanor@senate.mn
Subject: GAO Report

In response to your request for technical assistance, I am providing information on the likelihood that drug diversion activities might increase in Minnesota if surrounding states enact a drug monitoring program and Minnesota does not. You can access a report put out by the federal U.S. General Accounting Office at:

http://www.gao.gov/new.items/d04524t.pdf

The report is titled: "Prescription Drugs - State Monitoring Programs May Help to Reduce Illegal Diversion"

On page 11 of the report (which is page 13 of the Adobe document) you will find this quote:

"Another indication of the effectiveness of a monitoring program is that its existence in one state appears to increase drug diversion activities in contiguous states without programs. When states begin to monitor drugs, drug diversion activities tend to spill across boundaries to states without programs. One example is provided by Kentucky, which shares a boundary with seven states, only two of which had programs in 2002—Indiana and Illinois. As drug diverters became aware of the Kentucky program's ability to trace their drug histories, they tended to move their diversion activities to nearby nonmonitored states. OxyContin diversion problems worsened in Tennessee, West Virginia, and Virginia—all contiguous states without programs—because of the presence of Kentucky's program, according to a 2001 joint federal, state, and local drug diversion report".

Iowa has already received a federal grant as follows:

Program FY 2004 Prescription Drug Monitoring (Harold Rogers) Program
Award Number 2004-PM-BX-0021
Office BJA
Grantee Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319
Award Date 7/6/2004
Award Amount $350,000

In Fiscal Year 2004, Congress appropriated funds to the U.S. Department of Justice to support the Harold Rogers Prescription Drug Monitoring Program. Prescription Drug Monitoring Programs are systems where controlled substance dispensing data are submitted to a centralized database administered by an authorized state agency. Designed to help prevent and detect the diversion and abuse of pharmaceutical controlled substances -- particularly at the retail level where no other automated information collection system exists -- these programs also involve law enforcement, health providers, and the community in: identifying drug abuse trends and possible sources of diversion, uncovering outmoded prescribing practices, and developing meaningful and appropriate educational programs for medical professionals. Initial program activities will include statewide training and troubleshooting programs to ensure that all pharmacists who will be required to submit prescription information to the Iowa Prescription Drug Monitoring Program (IPDMP) are prepared for that transmission. These training programs will be held throughout the state to facilitate attendance by at least one representative from each retail pharmacy in the state. The purpose of these sessions is to determine an effective means for each pharmacy to electronically transmit to the program controlled substances dispensing information and to identify and resolve any impediments to timely compliance. In addition, written training

materials will be prepared and delivered to each currently licensed nonresident pharmacy subject to program requirements. Nonresident pharmacies will be encouraged to initiate contact with program personnel to resolve any questions or issues relating to the timely submission of controlled substances dispensing information. The IPDMP will collect controlled substance dispensing information from all outpatient pharmacies providing these prescription medications to patients in Iowa, including pharmacies located instate and outside Iowa. Data collection/transmission will be accomplished by dial-up or broadband electronic communication or by submittal of data disk or tape. Data collected in this manner will be analyzed to identify patients whose usage is increasing and who may benefit from referral to a pain-management specialist or to substance abuse treatment. Program personnel may contact a prescriber to alert the prescriber to concerns regarding an individual patient or a prescriber may request a profile on an individual patient to aid in making appropriate treatment decisions for a patient requesting a controlled substance. Law enforcement and regulatory agencies may request information maintained by the program regarding an individual who is the subject of an abuse or diversion investigation. The IPDMP will include education of the public, prescribers, and pharmacists regarding appropriate controlled substance use, the extent of drug abuse, and treatment options available to abusers of diverted drugs. Information and trends identified by analyzing the data maintained by the program will be used to develop educational programs and brochures regarding controlled substances and activities relating to the distribution and dispensing of controlled substances.

Cody Wiberg, Pharm.D., R.Ph.
Executive Director
Minnesota Board of Pharmacy

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

April 5, 2006

Dear Senator/Representative:

The Minnesota Board of Medical Practice voted at its March 4th meeting to oppose SF 2899/HF 3264.

Reasons for our opposition are outlined in the bullet points attached. We are joined in opposition to this legislation by the Minnesota Provider Coalition (letter attached), the Minnesota Hospital Association (attached letter), and practicing pain specialists, Dr. A.V. Anderson, Dr. Miles, Belgrade, Dr. Thomas Elliott, Dr. Tom Flynn, Dr. Todd Hess, Dr. Burton Schwartz, and Dr. Andrew Will (copies of correspondence from these physicians are attached).

The bill has been amended somewhat as it moved through various Senate Committees, however, none of the amendments have lessened the Board's concerns, because this legislation has been constructed around several premises, which are, in fact, faulty:

- That someone can determine the legitimacy of a prescription based on the names of the prescribing physician, dispensing pharmacist, patient, drug, the amount and strength of the drug, and the dates on which the prescription was issued and filled. In fact, such a determination cannot be made without considerable clinical and medical data about the specific patient, such as medical history, diagnosis, response to treatment, and other factors, because each human being responds differently to disease, drugs, and other treatment modalities. Determination of the appropriateness of any single prescription can be made only after time consuming, expensive, and intrusive investigation to reconstruct the entire clinical context in which the prescription was written.
- That physicians need this data system in order to prevent patients from scamming them out of unneeded drugs. In fact, an overwhelming majority of patients are simply seeking relief from legitimate pain and suffering caused by disease and or trauma. The few who are, indeed, seeking drugs and not relief can be identified by the physician's use of clinical skills, which will identify drug seekers, and existing data readily available from pharmacies.
- That this data system will significantly reduce the amount of pharmaceutical drugs which appear in street traffic. In fact, the vast majority of pharmaceutical drugs appearing in street traffic are the result of theft, not diverted prescriptions written by doctors (see attached press release and study from *Journal of Pain and Symptom Management).* Further, it has been estimated that it would take 8,300 prescriptions at 60 pills each, diverted to the street market, in order to put 500,000 pills into the street trade. The actual amount of illegal prescription medication on the street in Minnesota is probably much higher.
- That there are no privacy concerns with regard to this legislation. In fact, others, with considerably more expertise in data privacy than the Board of Medical Practice, have raised significant privacy concerns. However, strictly from the perspective of medical community, this legislation creates yet another significant intrusion into an already crowded

physician/patient relations, and will result in a data base, which, over time, will include all, or nearly all living Minnesotans, since controlled substances are used to manage pain and conditions which result from disease and trauma, from which no one can escape completely over a lifetime.

- That this legislation will improve patient access to appropriate pain management. In fact, this legislation will have a chilling effect on the medical community's willingness to use controlled substances to manage pain and other medical conditions, because of fear of legal and regulatory retribution. During the late 80's and early 90's, the Board of Medical Practice participated in a project known as the Prescription Abuse and Diversion System (PADS). This was an interagency cooperative project among DHS, the Board of Pharmacy, the Board of Medical Practice, and the Office of the Attorney General. It drew the same data elements listed in the current legislation from prescription records of Minnesota's Medical Assistance patients. The Board of Medical Practice could not determine the legitimacy of these prescriptions from the raw data alone, for the reasons listed above, and had to open literally thousands of costly, time consuming, and disruptive investigations to determine the clinical and medical context for the prescriptions, by doctor, by individual patient. The results were:

    - A few doctors were disciplined, and required to take remedial training (approximately 25-50).
    - The practice community became unwilling to use controlled substances in their practice for fear of Board action.
    - Patients suffered degraded levels of pain management and management of other conditions, which require controlled substances for proper management.
    - The Board of Medical Practice has spent years and large amounts of effort and money educating and re-education the practice community on the proper and legitimate use of controlled substance.

Implementation of this legislation will simply undo the efforts of the Board, and many others in the Medical community, to convince practitioners that it is in fact OK to use these drugs. Alternatives to the use of controlled substances, especially for the management of pain, and certain mental health conditions are considerably more expensive, and would, if widely used as a substitute, increase the cost of health care substantially.

This legislation has a far-reaching impact on the delivery of health care, in the ways listed above, and unfortunately, because of its focus on the very heart of modern medical care, prescriptive authority, it may, indeed, have negative unintended consequences which are not foreseeable.

In summary, the Board of Medical Practice strongly urges you to oppose passage of SF 2899/HF 3264. If you would like any additional information, please contact Dr. A. V. Anderson, Board Member at 612-3280-6666, Mr. Rob Leach, Executive Director, Board of Medical Practice at 612-617-2149, or Dick Auld, Assistant Executive Director, Board of Medical Practice 612-617-2140.

Sincerely,

Robert A. Leach
Executive Director

Enclosures

SF 2899/HF 3264

- As written, this bill creates a quantitative database, showing physician, dispenser, patient, drug, and drug quantity, without any medical context regarding history, empirical findings, diagnosis, treatment plan, response to treatment or anything else.

  Without such context, it is impossible to make any judgment regarding the appropriateness of the care rendered by the physician, or the legitimacy of the patient's needs for medication.

  Determination of appropriateness of such care, based only on this quantitative data can be done only through extensive, costly, and intrusive investigations, which invariably are highly traumatic to physician and patient alike.

  As such, this system can only be used as a case finder for agencies looking for potential drug diversion.

- The bill requires the data be shared interstate, and that it be accessible to a broad spectrum of entities, including law enforcement, many of whom would have no capability of accurately assessing the appropriateness of the care, even if a medical context were present.

- This access represents a significant intrusion into the physician/patient relationship, and a significant compromise of physician/patient confidentiality.

- This legislation represents a potentially national, electronic version of a type of legislation enacted by some states in the late '80's, known as triplicate script legislation.

  States which implemented such law saw a significant chilling effect on the physician community's willingness to use controlled substances, even when medically appropriate, creating massive substandard pain management for patients suffering all types of pain.

Minnesota Provider Coalition

1300 Godward Street NE Suite 2000-2200 * Minneapolis, MN 55413

Jack Davis
Chief Executive Officer
Hennepin Medical Society
612-623-2899
jdavis@metrodoctors.com

Roger Johnson
Chief Executive Officer
Ramsey Medical Society
612-362-3799

MEMBERS

Acupuncture Association of Minnesota

Advocates for Marketplace Options for Mainstreet (AMOM)

Association of Community Mental Health Programs, Inc.

Hennepin Medical Society

.etropolitan Anesthesia Network LLP

Minnesota Academy of Ophthalmology

Minnesota Ambulatory Health Care Consortium

Minnesota Chapter American Physical Therapy Association

Minnesota Chiropractic Association

Minnesota Dental Association

Minnesota Medical Group Management Association

Minnesota Nurses Association

Minnesota Occupational Therapy Association

Minnesota Physician Patient liance

Minnesota Podiatric Medical Association

Minnesota Psychiatric Society

Minnesota Rural Health Cooperative

Northstar Physicians

Northwestern Health Sciences University

Ramsey Medical Society

April 4, 2006

Dear Senators and Representatives:

The Minnesota Provider Coalition whose member organizations are listed at the left is writing to you to communicate our opposition the National All Schedule Prescription Electronic Register (NASPER) as written in SF 2899 Berglin/ HF 3264 Abeler.

The main reasons for our opposition are:

(1) Significant impact on the patient/physician relationship and potential compromise of confidentially.
(2) The information specified has no link to medical context or appropriateness of care.
(3) Information would be available to a large number of agencies both within and outside Minnesota which have no way to judge the appropriateness of treatment.
(4) History tells us that similar legislation has had a negative impact on the physician's willingness to prescribe controlled substances when appropriate to patient suffering pain.
(5) There is little evidence to suggest that this legislation will reduce the availability of controlled substances diverted from patient. The fact is that most controlled substances on the street are there as a result of theft.

The Minnesota Provider Coalition urges you to appose passage of SF 2899/HF 3264.

Sincerely,

Jack G. Davis
Chair

Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900
phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

April 5, 2006

Dear Senators and Representatives:

The Minnesota Hospital Association, representing all of its member hospitals, is writing to express our concern and opposition to the National All Schedule Prescription Electronic Register as written in SF 2899 Berglin/HF 3264 Abeler. There are a number of reasons for our concern.

1. First and foremost, we are worried about the chilling effect that this legislation will have on pain management and a physician's willingness to prescribe controlled substances when medically appropriate for patients suffering pain. We know from past experience that similar legislation has had a negative impact.
2. The impact on the patient-physician relationship and confidentiality is of equal concern. The public policy in this state has been to protect patient privacy unless there is some compelling and overwhelming need to disclose confidential information, and there is no such need here.
3. Giving law enforcement and other non-medical personnel access to information of this sort when they have no way of determining the medical appropriateness of medical treatment, seems particularly unwise. For example, how is law enforcement to know if a patient's pain management needs are the driving factor in dosage decisions or if the patient is, as some suggest, selling excess medication. Without the patient's medical record and training, no one can know.
4. Finally, this legislation does nothing to address our number one drug problem, methamphetamine use. Nor does it take into account the fact that legally available controlled substances find their way to the addict through theft or internet sales. Further, the proposal does not address the issue of drug seekers using false identification.

Please join us and the Board of Medical Practice in opposing this legislation.

Respectfully,

David Feinwachs
General Counsel

MEDICAL PAIN MANAGEMENT

5775 Wayzata Blvd., Suite 110
St. Louis Park, MN 55416
Telephone: (952) 835-9777
Fax: (952) 835-9830

April 4, 2006

Richard Auld, Ph. D.
Assistant Executive Director
Minnesota Board of Medical Practice
University Park Plaza, Suite 400
2829 University Avenue SE
Minneapolis, MN 55414-3246

Dear Dr. Auld:

The SF 2899 and HF 3264 bills, which deal with a controlled substance reporting program. While it might be useful for a treating doctor to have the ability to track a patient who would abuse scheduled medication, these bills emphasize scrutiny over the prescribing doctor. I oppose these bills for the following reasons:

Subd 3 refers to "standards of prescribing" which are unwritten and undetermined due to the enormous variability of patient response to a given medication. Therefore, this could not be fairly assessed by the Advisory Committee.

Subd. 4. requires the information on the prescriber and the dispenser. These practitioners are already under scrutiny by regulatory agencies, Physicians, pharmacists, third party payers, patients, and family members of patients, are all able to report unprofessional prescribing to the appropriate agency. The board receiving the complaint then applies procedures based on complete information .These bills do not consider the specialty of the doctor, or the diagnosis of the patient, information which is necessary to determine appropriateness of prescribing.

Regarding the Advisory Committee, it appears to be dominated by members who would have no expertise in management of pain or medication required.

It was the understanding of the pain associations that this was to be a tool for the prescribing doctors, in which the doctor could call up the information on a specific patient. Since the patient is the only person who is not presently monitored regarding the chain of custody of a scheduled medication, this bill should deal specifically with that issue.

I am very concerned that these bills, if passed into law, would have chilling effect on the treatment of pain. This would encourage the use of invasive procedures such as implantable devises and the overuse of injection procedures for conditions which could be more effectively treated with scheduled medications.

Sincerely,

Alfred V. Anderson M.D.
Medical Director
Medical Pain Management
St Louis Park, Mn.

Richard Auld

From: Belgrade, Miles J [MBELGRA1@FAIRVIEW.ORG]
Sent: Wednesday, March 08, 2006 10:47 AM
To: Richard.Auld@state.mn.us
Cc: drenner@mnmed.org
Subject: Bill

I have reviewed the Bill to establish a controlled substances reporting program. While I am sure most physicians would welcome an ability to track their patients' use of controlled medicines, this bill is so problematic that I cannot support it.

First, the stated objectives for the all schedules prescription reporting program go way beyond patient care and physician tracking of their patients' meds. None of the five stated uses of the program are to aid physicians' care of patients or selection of patients for opioid prescriptions or continuation of prescriptions. The purposes as stated are to monitor physician and pharmacy prescribing practice and to identify unprofessional and unlawful prescribing or dispensing (uses 1-4); and to identify forged or altered prescriptions (use #5). It is not at all clear that such a reporting system would be able to identify forged prescriptions. Thus this data and the board are designed for law enforcement, and to catch physicians and pharmacies who are not adhering to some (yet unwritten or unidentified) guidelines of prescribing practice.

Secondly, The make-up of the "advisory" board consists of individuals who (with perhaps one exception) have no pain management knowledge or expertise, no knowledge or expertise about medications or clinical problems (e.g. members from: board of helath, dept of human services, the public, an advocate, members of licensing bodies, etc). Such individuals have no basis by which to judge the proper prescribing of opioids and other controlled medicines.

Thirdly, The database provides no clinical context by which to judge the prescribing process. Cancer, hospice, terminal patients, acute pain, chronic pain, mental illness, etc are all unidentified.

Finally, I am concerned that such a database and advisory board structure will definitely have a chilling effect on the use of opioid analgesics for all patients with pain. There is a serious question here of the intent of the individulas who are promoting this bill which will likely place interventional pain treatments at center stage when the medicine options create barriers. Are the promoters of this bill going to see an increase in their interventional business because there is greater reluctance to use medicine to treat pain? This is a secondary gain that needs to be addressed.

Sincerely,

Miles Belgrade, M.D.
Medical Director,
Fairview Pain & Palliative Care Center
University of Minnesota Medical Center, Fairview

Richard Auld

From: Elliott, Tom E. [telliott@smdc.org]
Sent: Tuesday, March 14, 2006 9:24 AM
To: 'Richard Auld'
Subject: RE:

Hi Dick,
Thank you for asking my opinion regarding the prescription electronic reporting program proposed by the Minnesota legislature. First, I agree completely with Miles Belgrade's assessment. This is a terribly flawed program that will not achieve its goals, serve patients or society, and will waste tax payers money.
Here are a few of my specific comments:

Line 2.19: "(2) Proper analysis and interpretation of prescription monitoring data." Unfortunately, this will not be possible without substantial clinical data.

Line 2.20: "(3) Standards for clinically appropriate prescribing and dispensing of controlled substances." Also, not possible. Without considerable clinical data this assessment is not possible. Furthermore, there are no 'standards for clinically appropriate' prescribing of opioids.

Lines: 3.12-13: "(2) Prescribes who may be prescribing controlled substances in an unprofessional or unlawful manner." The data will not make this goal possible.

Lines: 3.14-15: "(3) Dispensers who may be dispensing controlled substances in an unprofessional or unlawful manner." Again the data to be collected will not detect these behaviors.

Lines: 3.16-19: "(4) Individuals receiving prescriptions for controlled substances from prescribes who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances." The database will not permit detecting these goals either. Furthermore, there are no 'recognized standards of dosage' for these drugs. This is a terribly flawed approach.

In closing, I would be very disappointed if our government chooses to pursue this plan, which is frightfully flawed and a terrible waste of our tax payers money.
Best regards,
Tom

Testimony
SF 2899
Thomas P. Flynn, MD
Medical Oncologist, Minneapolis, MN

- Thank you for the opportunity to present my perspective to the committee
- I have been a practicing oncologist in MN for 25 years, and as such am involved in managing cancer-related pain on a nearly daily basis. I come to you as an individual practitioner, although I expect my views are held by many in my specialty.
- Much work has been done in recent years to educate physicians on the appropriate management of pain in cancer patients on both a national and local level. Such efforts have been stimulated, in part, by studies which have revealed that such pain is often under treated, and under treatment in part can be linked to physician concerns about outside scrutiny of the use of controlled substances.
- This bill has the potential to undo much of that effort.
- I oppose passage of SF 2899 for several reasons, as follows:
- The bill provides for monitoring of prescriptions for these medications on a purely numeric basis, devoid of any clinical information
- The specter of such outside monitoring, without any consideration of the clinical situation, and the potential for reporting of such incomplete data to law enforcement and regulatory agencies will, in my opinion, lead to under prescribing and thus under treatment of pain
- Such under treatment of pain will then lead to more patients coming to ERs and being hospitalized for the control of their pain, increasing the cost of health care.
- Other mechanisms already exist to monitor for inappropriate prescribing and use of medication, such as through the Board of Medical Practice and other licensing and regulatory boards. In these settings all the appropriate clinical information is considered.
- Particularly for cancer patients experiencing pain near the end of life, there is often a need to alter pain treatment regimens frequently, with increasing doses or changes to other narcotics. The monitoring as proposed in this legislation would take into account the number of days supply based on the directions for use. Physicians may then be reluctant to issue new prescriptions when needed before the prior Rx "runs out" leading to inadequate pain control
- The bill provides that an advisory committee, composed largely of individuals with no real expertise in pain management, be charged to provide advice on "standards for clinically

appropriate prescribing and dispensing of controlled substances". There is no way to come up with such standards based on a numeric monitoring system. The variability among patients in doses and schedules needed for the appropriate use of pain medications is enormous. I have had patients who required hundreds of milligrams of morphine every day for months to control their pain, where others may require a tiny fraction of that.

- As a physician practicing in my specialty, I think this bill creates a process which is an unnecessary intrusion into the physician-patient relationship.
- As I have outlined, there is good reason to believe that, while the reporting program may identify a few providers who are prescribing inappropriately or a few patients who are using these medications in inappropriate ways, the harm to patients who suffer from inadequate control of their pain will be too high a price to pay.
- Thank you for your attention.

-----Original Message-----
From: tmhessmd@aol.com [mailto:tmhessmd@aol.com]
Sent: Monday, March 27, 2006 9:16 AM
To: aanderson@medpainmanagement.com
Subject: Re: Bill Draft for legislation

Hey AL,
Thanks for the heads up.
What a terrible bill. It will make our lives miserable and our patients will suffer.
DO you need me to do anything at this point?
Let me know, and thanks again for the update.
Please keep me posted of all issues on this bill.
Thanks again Al!
Todd

Burton Schwartz M.D. F.A.C.P.
800 East 26th. Street
Piper Building, Suite 405
Minneapolis, Mn. 55407

April 3, 2006

Dear Senator;

Dear Representative;

I have been in practice for over 30 years as a cancer specialist. I have also been on the Board of Medical Practice and just finished my term as president.

I have throughout my career dealt with patients who have pain. I have also worked very hard in my practice and also for the Board of Medical Practice to increase the proper use of pain meds.

When I started in practice, physicians throughout the state were afraid to use pain meds (I have done outreach in Albert Lea and continue to do outreach in Faribault) The Board of Medical Practice has worked hard to increase the proper use of pain meds. This has been a successful endeavor. This has resulted in improved pain control for patients who need pain medication.

The proposed bills **SF 2899/HR 3264** will be a major deterrent to proper use of pain meds for patients who require pain control.

The bills do not take into account the type of patient, the physician, and the specialty for which and from which the prescription is written.

I could envision most of the oncologists in the state being investigated at some point because of the high number of prescription they write in order to control cancer pain. It should also be noted that pain medications, not invasive, procedures are the main approach to the control of pain, and the most cost effective. I do not want any physician to be afraid to write a prescription to take away pain for their patients. This would be a terrible consequence of these bills.

Thus these bills would not only have a negative effect on cancer patients but all patients who require proper pain management.

These bills would result in a series of unintended consequences:

1. Proper pain medication use would surely decrease as was the case when I started in practice
2. Harassment of physicians trying to give proper pain control for their patients.
3. Patients not having the relief of pain at a critical time in their life.

I am sure this was not the intent of authors of the bills. However, unfortunately what will result is a series of events that will result in poorer patient care and not necessarily a decrease in the illegal use of narcotics.

*Thus , I oppose **SF 2899/HF3264**. I would strongly urge that these bills not be adopted as written.*

Sincerely,

Burton Schwartz

Burt Schwartz M.D. F.A.C.P.

Richard Auld

From: Andrew Will [andrew.will@painmanagementandrehab.com]
Sent: Wednesday, April 05, 2006 6:49 AM
To: Richard.Auld@state.mn.us
Subject: sf 2899

Dear Richard Auld,

I received a copy of your email regarding the proposed legislation sf 2899 and read about how you would like input from pain management practitioners.

I am a full time practicing pain management physician in Edina, and operate a clinic that includes the services of physical therapy, injections, and medications (including controlled medications) for the management of pain. My primary board certification is in Physical Medicine and Rehabilitation and I am also board certified in the subspecialty of Pain Medicine. I am also the incoming President for the Minnesota Physiatric Association, which is the state medical organization of Physical Medicine and Rehabilitation physicians.

I have read the proposed legislation and have serious concerns about it in its proposed form. I do think it would be useful if physicians had access to the prescription history for certain patients, but I fear that this proposed legislation goes beyond that and causes further undue scrutiny of physicians and this would seriously limit patient access to these medications even in cases where they are necessary.

Just this week, I was speaking to a primary care physician who told me he was not going to prescribe opioids for any patients anymore and had told the rest of the physicians in his group that they should also stop. He told me that as a primary care physician, the scrutiny had become too threatening. Therefore, he said that the patients would have to go to a speciality pain clinic. Interestingly, the same physician group that proposed this legislation have on their website a statement saying that they are not willing to help primary care physicians take over the prescribing of opioids for patients that simply need chronic opioids for management of their pain. Therefore, it appears to me that the patients are being abandoned by the primary care physicians and the specialists, and this will only worsen if this legislation passes as it is currently written.

Also, I question the term "standards of prescribing" as it is written in Subd 3. There is not one official standard that we can all refer to. There are very few official written standards developed so far, partially because the appropriate need for these medications can vary so widely. Therefore, if practitioners were going to be held to some "standards of prescribing" , then I think these standards would need to be clarified further before the state passes this type of legislation and starts burdening the physicians with unnecessary investigations.

Furthermore, the proposed advisory committee appears to have few people on it who are actual experts in the practice of pain management.

I do applaud the attempt to reduce abuse of prescription medications, but I think this proposed legislation in its current form will miss this main goal, and just further restrict legitamate patient access to this type of medical care.

FOR IMMEDIATE RELEASE
November 3, 2005

CONTACT: David E. Joranson 608-263-7662
or Linda Dietrich 608-263-6585

Pharmacy theft is an overlooked source of abused pain medications

MADISON – A research letter published by the *Journal of Pain and Symptom Management* reports that every year, thousands of armed robberies and thefts from pharmacies, manufacturers and distributors result in millions of dosages of opioid pain medications being diverted into the illicit market. The medications are trafficked by drug dealers and then abused, often in combination with alcohol and other drugs, leading to overdose and death.

"Drug Crime is a Source of Abused Pain Medications in the United States" was written by David E. Joranson, MSSW, and Aaron M. Gilson, PhD, of the Pain & Policy Studies Group at the University of Wisconsin Comprehensive Cancer Center. The letter describes data received from the US Drug Enforcement Administration (DEA) under a Freedom of Information Act request. The request was for theft reports of prescription controlled substances that had been submitted to the DEA by DEA registrants on federal Form 106. The information provided contained analyzable data for only 22 Eastern states representing approximately one-half the US population.

In the four-year period from 2000 to 2003, nearly 28 million dosage units of all prescription controlled substances were diverted in 12,894 separate incidents primarily involving pharmacies, and averaging more than 3,000 incidents per year. In 2003, approximately 5.8 million dosages of opioid pain medications were diverted, including hydrocodone, oxycodone, morphine, methadone, meperidine, hydromorphone and fentanyl.

Diversion of this type occurs at places in the drug supply chain above the level of prescribing, dispensing and patient use, and involves individual and organized criminal activity by persons who are not licensed or registered to handle controlled substances, and therefore would not be detected by programs that monitor prescribing. The taking of controlled substances by force from DEA registrants became a federal felony in 1984; more information is needed about how law enforcement is addressing drug crimes against DEA registrants as a part of the national coordinated response to prescription drug diversion. Addressing pharmacy theft could become a model for achieving hoped-for "balanced" responses to diversion, because these sources of diversion can be identified and addressed with little if any risk of interfering in legitimate medical practice and patient care.

Future studies should examine trends and whether pharmacy thefts occur in particular states and metropolitan or rural areas, evaluate the causes and methods of preventing pharmacy crime, and determine what proportion of total diversion and abuse comes from pharmacy theft or from other sources such as fraudulent prescriptions or "pill mills." Existing national drug abuse databases should collect information on the source of abused drugs to a more evidence-based face on how abused prescription pain relievers are obtained.

Joranson DE, Gilson AM. Drug crime is a source of abused pain medications in the United States. *J Pain Symptom Manage.* 2005; 30(4):299-301. (Available at http://www.medsch.wisc.edu/painpolicy/publicat/05jpsm/05jpsm.pdf.)

Drug Crime Is a Source of Abused Pain Medications in the United States

Joranson DE, Gilson AM. Drug crime is a source of abused pain medications in the United States.
Journal of Pain and Symptom Management. 2005; 30(4):299-301.

To the Editor:

The International Narcotics Control Board consistently reports that, despite an extremely large number of transactions, little or no narcotic drugs are diverted from licit international trade into illicit channels.[1] Most diversion occurs within countries, where governments attempt to prevent diversion during the manufacture and distribution of controlled substances to the retail level (e.g., pharmacies and hospitals). In the United States, diversion occurs despite a closed distribution system of licensing, security, and record keeping.

Public dialogue about prescription drug abuse in the United States focuses largely on inappropriate physician prescribing and patient misuse.[2,3] National media reports and high-profile charges against physicians enhance the perception that physician prescribing for pain is the main cause of increases in opioid analgesic abuse.

An important but mostly overlooked diversion source involves thefts, including armed robberies, night break-ins, and employee and customer pilferage. The Controlled Substances Act makes thefts of controlled substances from Drug Enforcement Administration (DEA) registrants a federal crime, and requires pharmacists, manufacturers, and distributors to report significant thefts and losses.

The authors submitted a Freedom of Information Act request to the DEA to obtain data from Form 106 "Report of Theft or Loss of Controlled Substances." An electronic database was provided with annual data for 2000--2003. Each incident of theft/loss included the number of dosage units, as well as the generic name, trade name, dosage strength, and formulation of the controlled substance. We evaluated six opioid medications used for moderate to severe pain that we have studied previously:[4] fentanyl, hydromorphone, meperidine, methadone, morphine, and oxycodone.

The database contained analyzable data from registrants in only 22 Eastern states, representing 53% of the U.S. population. A total of 12,894 theft/loss incidents were reported in these states between 2000 and 2003. Theft/losses were primarily from pharmacies (89.3%), with smaller portions from medical practitioners, manufacturers, distributors, and some addiction treatment programs that reported theft/losses of methadone.

Over the 4-year period, almost 28 million dosage units of all controlled substances were diverted. The total number of dosage units for the six opioids is as follows:

- 4,434,731 for oxycodone
- 1,026,184 for morphine
- 454,503 for methadone
- 325,921 for hydromorphone
- 132,950 for meperidine
- 81,371 for fentanyl

The number of dosage units diverted varied considerably from year to year and from drug to drug (see **Table 1**). The greatest increase in theft/loss between 2000 and 2003 was for fentanyl (161.3%); however, fentanyl comprised the smallest amount compared to other opioids. The second largest increase (147.2%) was for hydromorphone, but represented only 2.45% of all dosage units lost in 2003. Morphine was the only opioid showing a decrease (257.4%). There was an 18.5% increase in losses of oxycodone; however, the proportion of oxycodone losses, compared to losses all controlled substances was slightly lower in 2003 than in 2000, as was the case for meperidine and methadone.

Comment

This exploratory study suggests that theft is an important source of prescription opioids diverted into the illicit market. In 2003 alone, a total of 7,652,099 dosage units of controlled substances were stolen/lost, of which 1,834,717 (24.0%) dosage units were the six opioid analgesics. As a comparison, hydrocodone, an opioid analgesic frequently prescribed but not indicated for moderate to severe pain, accounted for 3,995,402 dosage

Table 1

Number of Dosage Units for Selected Opioid Analgesics Listed in the U.S. DEA's Theft/Loss Database[a]

Year and Total Annual Dosage Units Lost or Stolen	Fentanyl	Hydromorphone	Meperidine	Methadone	Morphine	Oxycodone
2000, $n = 6,404,965$	17,644 (0.28)	75,965 (1.19)	32,447 (0.51)	99,073 (1.55)	491,356 (7.67)	1,052,305 (16.43)
2001, $n = 8,640,891$	5,759 (0.07)	28,400 (0.33)	36,966 (0.43)	82,521 (0.96)	172,387 (2.00)	979,683 (11.34)
2002, $n = 5,157,442$	11,867 (0.23)	33,739 (0.65)	25,850 (0.50)	166,288 (3.22)	153,222 (2.97)	1,155,471 (22.40)
2003, $n = 7,652,099$	46,101 (0.60)	187,817 (2.45)	37,687 (0.49)	106,621 (1.39)	209,219 (2.73)	1,247,272 (16.30)
Percentage change, 2000–2003	161.3	147.2	16.2	7.6	−57.4	18.5

[a]Values are expressed as number (percentage) of dosage units lost or stolen.

units (52.2%) lost or stolen in 2003 more than twice the amount of the six study drugs combined.

We conclude that pain medications, regardless of schedule, are being stolen from the drug distribution chain prior to being prescribed, contributing to their illicit availability, abuse, and associated morbidity and mortality. National discussion about pain medication abuse and diversion should be better informed by reliable information about whether abused drugs are coming from those registered to handle controlled substances lawfully or from those who engage in criminal activities.[5]

If we accept uncritically that drug diversion stems only from prescriptions, we risk distorting our view of the medical profession and patients through a lens of substance abuse, which further weakens physicians' desire to treat pain and worsens patient access to pain care. We must eliminate the impact of illegal actions on law-abiding physicians and patients.

The unchecked flow of pain medications diverted from nonmedical sources will not be addressed if diversion control focuses only on prescribers and patients. Instead, this may provoke greater scrutiny of the medical system rather than street level pharmacy crime. To achieve a positive regulatory environment for pain management and palliative care, diversion control efforts must target the correct sources and not subject law-abiding prescribers and patients to unwarranted scrutiny. Once identified, diversion sources should be addressed in a public health context, and in ways that are appropriate and proportional; vulnerabilities in the distribution system may require improved security, while responses to individual practitioners should be based on standards of professional conduct, reserving criminal prosecution for intentional diversion.

Better use must be made of existing national drug abuse databases[6] to put an evidence-based face on how abused prescription pain medications are obtained. A balanced response to diversion must be the goal, in which the collective resources of education, prescription monitoring, professional discipline, and law enforcement are correctly targeted without interfering with legitimate medical practice and patient care.

David E. Joranson, MSSW
Aaron M. Gilson, PhD
Pain & Policy Studies Group,
University of Wisconsin--Madison
Comprehensive Cancer Center;
and World Health Organization
Collaborating Center for Policy
and Communications
Madison, Wisconsin, USA

References

[1] International Narcotics Control Board. Report of the International Narcotics Control Board for 2004. New York: United Nations, 2005.

[2] Cicero TJ, Inciardi JA. Diversion and abuse of methadone prescribed for pain management [letter]. JAMA 2005;293(3):297--298.

[3] Drug Enforcement Administration - Office of Diversion Control. The diversion of drugs and chemicals - A descriptive report of the programs and activities of DEA's Office of Diversion Control. Washington, DC: Drug Enforcement Administration, 1999. Available from: http://www.deadiversion.usdoj.gov/pubs/program/activities/index.html. Accessed October 6, 2005.

[4] Gilson AM, Ryan KM, Joranson DE, Dahl JL. A reassessment of trends in the medical use and abuse of opioid analgesics and implications for diversion control: 1997--2002. J Pain Symptom Manage 2004; 28(2):176--188.

[5] Brushwood DB, Kimberlin CA. Media coverage of controlled substance diversion through theft or loss. J Am Pharm Assoc (Wash DC) 2004;44(4):439--444.

[6] The Council of State Governments. Trends alert: Drug abuse in America - Prescription drug diversion. The Council of State Governments, Lexington, KY, 2004.

FACT SHEET ON THE NEED FOR A STATE PRESCRIPTION DRUG MONITORING DATABASE

1. Diversion and abuse of legally manufactured prescription drugs is a pressing national issue. The Office of National Drug Control Policy (ONDCP) cites that in 2002, 6.2 million Americans abused prescription drugs. It is estimated that approximately 20% of pain clinic patients abuse prescription drugs.

2. Prescription drug abuse rank second behind marijuana.

3. Chronic pain is prevalent in 15% to 30% of the population. In the last several years there has been an increasing interest in the provision of better pain therapies.

4. This interest in managing chronic pain has led to the increased prescribing of controlled substances.

5. With the prevalence of chronic pain ranging from 15% to 30% in the United States (25 to 45 million people), the prescription drug abuse or misuse is seen in 18% to 24% (approximately 5 million to 9 million persons).

6. The diversion and abuse of prescription drugs are associated with incalculable costs to society in terms of addiction, overdose, death, and related criminal activities.

7. The DEA has stated that the diversion and abuse of legitimately produced pharmaceuticals constitute a multi-billion dollar illicit market nationwide. OxyContin sells on the street for about $40 - $100 per pill depending on the dose.

8. Patients may be receiving Schedule II, III, and IV prescriptions from multiple practitioners who are unaware that others are prescribing for the patient.

9. Drug spending is skyrocketing. Significant amounts of Medicaid funds are spent on drugs that are abused.

10. Significant amounts of state funds are being spent for drug abuse and addiction treatment.

11. The incidence of drug diversion is on the rise. According to the GAO, problems are shifting from states with monitoring programs to neighboring states without a monitoring program.

12. Physicians are becoming more hesitant to prescribe pain medications. Legitimate patients are being under-treated due to the hesitancy.

13. When a physician is able to review a patient's prescription history one of two things could result:

    a. Patients with a chemical dependency problem will benefit from earlier physician intervention.
    b. Patients who are appropriately seeking pain relief will benefit from physician's ability to feel more comfortable in prescribing what the patient needs for pain management.

14. Confidentiality and privacy appear to be a major concerns of this bill. Both physicians who legitimately prescribe prescription drugs and patients who legitimately use them are concerned that the information collected, maintained and monitored by state programs may be used inappropriately. All states, regardless of whether there is a state prescription monitoring program or not, have the authority under current laws to conduct investigations of records of individuals alleged to be involved in prescription drug diversion and abuse, including the records of prescribing physicians and dispensing pharmacies.

FACT SHEET ON NASPER

1. When the 109th session began in January 2005, National All Schedules Prescription Electronic Reporting Act (NASPER) was reintroduced in the Senate with eight co-sponsors and in the House with 35 co-sponsors. It unanimously passed the Senate's Health, Education, Labor and Pensions Committee on May 25, 2005, and the House Energy and Commerce Committee on July 20, 2005. The full House of Representatives unanimously passed the bill on July 27, 2005; and the Senate followed with unanimous approval on July 29, 2005.

2. The bill, H.R. 1132 was signed into law on August 11, 2005.

3. H.R. 1132, "the NASPER Act" calls for each state to establish a prescription drug monitoring program.

4. The purpose of the NASPER Act is to combat the abuse and diversion of prescription drugs by establishing a grant program that would support expansion, in number and effectiveness, of State prescription drug monitoring programs. The bill will also facilitate the interoperability of State systems to detect more rapidly drug diversion and abuse that crosses State lines.

5. The NASPER Act does not mandate that states implement a monitoring program. Rather, it gives each state the option to create such a program and the funding to do so.

6. The NASPER Act creates a set of standards for creating prescription-drug monitoring programs that will allow each state to share critical drug information with its neighbors in order to reduce drug abuse and the diversion of prescription drugs across state borders.

7. The NASPER Act authorizes grants to states from the Department of Health and Human Services ("HHS") to fund programs that create or update electronic monitoring programs for prescription drugs.

8. A state can become eligible for such a grant simply by passing legislation establishing a prescription drug monitoring program consistent with the parameters of the NASPER Act.

9. **NASPER authorizes $15 million to be appropriated in Fiscal Year 2006 and 2007. In each Fiscal Year 2008, 2009, and 2010, another $10 million is authorized.**

10. **The Minnesota legislation authorizing the creation of a drug monitoring program must be in place before we can apply for federal funding.**

Consolidated Fiscal Note – 2005-06 Session

Bill #: S2899-0 **Complete Date:** 03/21/06

Chief Author: BERGLIN, LINDA

Title: CNTRLD SUBST ELECTONIC RPT PRGM

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

Agencies: Pharmacy Board (03/21/06) Human Services Dept (03/21/06)

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					
-- 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					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/21/06 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S2899-0 **Complete Date:** 03/21/06

Chief Author: BERGLIN, LINDA

Title: CNTRLD SUBST ELECTONIC RPT PRGM

Agency Name: Pharmacy Board

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					

Bill Description

SF 2899 ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING PROGRAM. Requires the Board of Pharmacy to apply for any applicable federal grants or other nonstate funds to establish and fully implement the prescription electronic reporting program.

Assumptions

The bill states that in the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting program, the board is not required to implement section 1, without a subsequent appropriation from the legislature.

So, as written, the bill does not authorize the expenditure of state funds.

The work required to prepare grant applications can be done within the Board's current budget.

Expenditure and/or Revenue Formula

There will be no fiscal impact on the Board for the reasons described above.

Long-Term Fiscal Considerations

Unknown. The bill does mention the possibility of the Board seeking an appropriation from the legislature if sufficient nonstate funds are not available to adequately fund the program.

Local Government Costs

None

References/Sources

FN Coord Signature: JULI VANGSNESS
Date: 03/13/06 Phone: 201-2732

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/21/06 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S2899-0 **Complete Date:** 03/21/06

Chief Author: BERGLIN, LINDA

Title: CNTRLD SUBST ELECTONIC RPT PRGM

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 2899

Bill Description

This bill would establish a controlled substance reporting program, would provide program guidelines and would give the State Board of Pharmacy authority to apply appropriate legal or disciplinary action.

1.) The State Board of Pharmacy would have to establish the data capture, storage, protection and analyses systems; and the policies and protocols for managing this process- and on an on-going basis, review all of these imperatives.
2.) The Board would have to evaluate data outcomes and initiate appropriate responses to offenses.
3.) The Board would be required to communicate the content of this program.
4.) If an action is protested, the Board would have to respond. This may result in expensive legal steps.

Assumptions
To optimize the quality, cost effectiveness, and timely submission of data, reporting would be done electronically through the pharmacy adjudication system.
The electronic submissions would be delivered to the State Board of Pharmacy where the data base will be stored and reports generated identifying providers and patients with patterns of concern.
Based on their findings, the State Board of Pharmacy would have the authority to conduct an investigation and take appropriate action. They could also use the data for public policy recommendations and educational purposes.
An advisory committee would oversee the establishment of the reporting program.
All of these activities are conducted by the State Board, pharmacies, and system vendors.

This process would require no additional reporting or record keeping by DHS.
Expenditure and/or Revenue Formula
None for DHS

Long-Term Fiscal Considerations
If MA recipients are identified as controlled substance abusers, DHS would have to take the appropriate action but the incidence of this occurring and the cost of action taking is expected to be negligible.

Local Government Costs

References/Sources
Minnesota Board of Pharmacy

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 03/20/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/21/06 Phone: 286-5618

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 2899 as follows:

Page 3, line 21, after "persons" insert "shall be considered permissible users and "

Page 4, after line 13, insert:"

(d) Any permissible user identified in paragraph (c) that directly accesses the data electronically shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks."

Page 4, line 14, delete "(d)" and insert "(e)"

A bill for an act

relating to health; establishing a healthy biomonitoring program; requiring reports; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **[144.995] HEALTHY MINNESOTANS BIOMONITORING PROGRAM.**

Subdivision 1. **Citation.** Sections 144.995 to 144.999 may be cited as the healthy Minnesotans biomonitoring program.

Subd. 2. **Definitions.** (a) For purposes of sections 144.995 to 144.999, the following definitions apply.

(b) "Biomonitoring" means the process by which the presence and concentration of toxic chemicals and their metabolites are identified within a biospecimen as a means to assess the accumulation of pollutants in a human body.

(c) "Biospecimen" means a sample of human blood, hair, urine, breast milk, body fat, or other body tissue or any other biophysical substance that is reasonably available as a medium to measure the presence and concentration of toxic chemicals.

(d) "Commissioner" means the commissioner of health.

(e) "Panel" means the Healthy Minnesotans Biomonitoring Program Advisory Panel established under section 144.996.

(f) "Toxic chemical" means a chemical:

(1) for which data provided by scientific, peer-reviewed animal, cell, or human studies have demonstrated the chemical is known or strongly suspected to negatively impact human health by contributing to an increase in serious illness or mortality; and

(2) that has been identified according to section 144.997.

Subd. 3. **Establishment; duties.** (a) The commissioner shall establish the healthy Minnesotans biomonitoring program. The program shall provide community-based biomonitoring on a strictly voluntary and confidential basis by utilizing biospecimens, as appropriate, to identify toxic chemicals that may be present in the environment.

(b) Initially, to the extent that funds are available, the program shall examine breast milk in three economically, racially, and geographically diverse communities and identify any toxic chemical that is present in the breast milk. The commissioner shall expand the program, to the extent that funds are available, by examining other biospecimens in additional communities.

(c) When a toxic chemical is detected in a program participant, the commissioner, in consultation with the commissioners of agriculture, natural resources, and the Pollution Control Agency, and other public or private entities, as appropriate, shall examine the possible presence of the toxic chemical in the surrounding environment and possible routes of exposure and disease outcomes and shall develop recommendations to reduce or minimize possible contamination or exposure to the toxic chemical.

Subd. 4. **Participation.** (a) Participation in the biomonitoring program is voluntary. All participants shall be evaluated for the presence of toxic chemicals as a component of the biomonitoring process. Participants shall receive consultation, health care referrals, and follow-up counseling and shall be offered educational materials, including, but not limited to, information regarding possible routes of exposure, ways to reduce exposure, and the availability of state and local resources.

(b) Data collected under the biomonitoring program are health data for purposes of section 13.3805 and shall not be made public without the written and informed consent of the individual to whom it pertains.

Subd. 5. **Program guidelines.** (a) The commissioner, in consultation with the panel, shall develop:

(1) model protocols or program guidelines that address the science and practice of biomonitoring to be utilized and procedures for changing those protocols to incorporate new and more accurate or efficient technologies as they become available. The model protocols shall be developed utilizing a peer review process in a manner that is participatory and community-based in design, implementation, and evaluation;

(2) guidelines for ensuring confidentiality; informed consent; follow-up counseling and support; and communicating findings to participants, communities, and the general public;

(3) educational and outreach materials that are culturally appropriate for dissemination to program participants and communities. Priority shall be given to the development of materials specifically designed to ensure that parents are informed about all of the benefits of breastfeeding so that the program does not result in an unjustified fear of toxins in breast milk, which might inadvertently lead parents to avoid breastfeeding. The materials shall communicate relevant scientific findings; data on the accumulation of pollutants; possible routes of exposure; population-based health effects and toxicity; the benefits of linking the accumulation of pollutants to community health; and the required responses by local, state, and other governmental entities in regulating toxicant exposures;

(4) a training program that is culturally sensitive specifically for health care providers, health educators, and other program administrators; and

(5) a designation process for state and private laboratories that are qualified to analyze biospecimens and report the findings.

(b) The commissioner may enter into contractual agreements with health clinics, community-based organizations, or experts in a particular field to perform any of the activities described under this subdivision.

Sec. 2. **[144.996] HEALTHY MINNESOTANS BIOMONITORING PROGRAM ADVISORY PANEL.**

Subdivision 1. **Creation.** (a) The commissioner shall establish the Healthy Minnesotans Biomonitoring Program Advisory Panel. The panel shall be composed of two committees, the scientific committee and the community representative committee, with a membership of eight voting members on each committee. The community representative committee shall also include nonvoting members appointed according to subdivision 2, paragraph (d).

(b) The commissioner shall appoint, from the panel's membership, the chair of each of the committees, who shall also serve as cochairs of the panel.

(c) The panel shall meet as often as it deems necessary but at a minimum on a quarterly basis.

(d) Members of the panel and the committees shall serve without compensation but shall be reimbursed for travel and other necessary expenses incurred through performance of their duties under sections 144.995 to 144.997.

Subd. 2. **Membership.** (a) Eight of the voting members shall be appointed by the commissioner, four of the voting members shall be appointed under the rules of the senate, and four of the voting members shall be appointed under the rules of the house of representatives. Nonvoting members shall be appointed by the commissioner according

to paragraph (d). All members shall be appointed to the panel by July 1, 2006. Each voting member shall be appointed for a three-year term. All appointments made by the commissioner shall be approved by the governor.

(b) The scientific committee shall be composed of eight members with background or training in interpreting biomonitoring studies or in related fields or science, including, but not limited to, the fields of health tracking, social science, laboratory science, occupational health, industrial hygiene, toxicology, epidemiology, environmental health, environmental hazards, and public health.

(c) The community representative committee shall be composed of eight members from the following nongovernmental organizations:

(1) one member from a breast cancer awareness organization;

(2) one member from an organization with a focus on environmental health;

(3) one member from an organization with a focus on environmental justice;

(4) one member from an organization with a focus on child environmental health;

(5) one member from an organization promoting breastfeeding;

(6) one member from a labor organization;

(7) one member from private industry with a verifiable and consistent commitment to sustainable core business practices that reduce environmental toxins; and

(8) one member from a public health organization.

(d) The commissioner shall appoint the following additional nonvoting members to the community representative committee:

(1) one representative from the Maternal and Child Health Division of the Department of Health; and

(2) one member from each participating community.

Members appointed under this paragraph may be reappointed at any time and are not subject to the three-year term.

Subd. 3. **Committee duties.** (a) The scientific committee shall make recommendations to the panel on:

(1) chemicals that should be added to or deleted from the list of chemicals identified under section 144.997;

(2) priorities for biomonitoring in Minnesota;

(3) the adequacy and appropriate interpretation of biomonitoring investigations carried out under the program; and

(4) collecting and analyzing data, including the tracking of diseases for which there is scientific evidence of an environmental etiology.

(b) The community representative committee shall make recommendations to the panel on:

(1) study sites or communities for the program;

(2) identifying possible community partners;

(3) training programs and educational and outreach materials; and

(4) dissemination of findings to biomonitoring program participants and to the general public.

Sec. 3. **[144.997] TOXIC CHEMICALS.**

Subdivision 1. **Identification.** The commissioner shall identify and list toxic chemicals that shall be included within the scope of the healthy Minnesotans biomonitoring program. To be included on the list, all of the following criteria must be met:

(1) the chemical is recommended for inclusion by the scientific committee under section 144.996;

(2) the scientific, peer-reviewed data from animal, cell, or human studies have demonstrated the chemical is known or strongly suspected to negatively impact human health by contributing to an increase in serious illness or mortality;

(3) Minnesotans are exposed to the chemical; and

(4) the chemical is listed as a toxic chemical on either a state or federal list.

Subd. 2. **Implementation.** (a) The commissioner shall prioritize the toxic chemicals under subdivision 1 according to the threat the chemicals pose to public health.

(b) The commissioner shall initially implement the biomonitoring activities of the program with regard to the 20 toxic chemicals that present the greatest public health risk.

(c) The commissioner shall add additional chemicals in order of priority to the extent funds are available.

Sec. 4. **[144.998] BIOMONITORING FISCAL PROVISIONS.**

Subdivision 1. **Creation of account.** A healthy Minnesotans biomonitoring program account is established in the state government special revenue fund. The account consists of money appropriated by the legislature and any other funds identified for use by the healthy Minnesotans biomonitoring program. All interest earned on money deposited into the account shall be retained in the account. Money in the account is appropriated to the commissioner for the purpose of implementing the healthy Minnesotan biomonitoring program.

Subd. 2. **Other funding.** The commissioner shall seek funding from federal and private sources.

Sec. 5. **[144.999] BIOMONITORING REPORTS.**

(a) By January 15, 2008, the commissioner shall submit a report to the legislature summarizing the initial activities of the healthy Minnesotans biomonitoring program, including a program description, the methodology used, and the initial outcomes.

(b) Thereafter, the commissioner shall prepare a biennial report describing the effectiveness of the program, including analysis of the health and environmental exposure data collected to adequately monitor the activities under section 144.995. The report shall be made available to local public health departments and the general public in a summary format that protects the confidentiality of program participants. The commissioner shall disseminate the report via the Department of Health's Web site.

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0979-1E **Complete Date:**

Chief Author: LOUREY, BECKY

Title: HEALTHY MINNESOTANS BIOMONITORING

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					
State Govt Special Revenue Fund			287	678	1,085
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
State Govt Special Revenue Fund			287	678	1,085
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Govt Special Revenue Fund			287	678	1,085
Total Cost <Savings> to the State			287	678	1,085

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
State Govt Special Revenue Fund			4.00	5.30	5.30
Total FTE			4.00	5.30	5.30

Bill Description

This bill establishes a healthy Minnesotans biomonitoring program. It requires the commissioner of health to provide community-based biomonitoring on a voluntary and confidential basis using biospecimens to identify toxic chemicals in the environment. To the extent that funds are available, the program will examine breast milk in economically, racially, and geographically diverse communities to identify toxic chemicals present in breast milk and other biospecimens. Commissioners of health, agriculture, natural resources, and the pollution control agency will examine the possible presence of the chemicals in the environment and develop recommendations to reduce exposure to toxic chemicals identified in the biomonitoring program.

This bill requires the commissioner of health to establish a healthy Minnesotans biomonitoring program advisory panel and to establish scientific and community representative committees to identify and list toxic chemicals to be included in the biomonitoring program, prioritized according to their public health threat. Initial implementation of the program will focus on the 20 toxic chemicals with highest priority, and additional chemicals will be added to the program as funds become available.

This bill creates a healthy Minnesotans biomonitoring program account in the special revenue fund and appropriates money into the account to implement this program. The commissioner of health is required to submit an initial report and biennial reports to the legislature to summarize activities, program effectiveness, and the analysis of the health and environmental exposure data collected in this program.

Assumptions

1. Members of the advisory panel, including the scientific and community representatives, will not draw on funds from this program for travel, honoraria, and incidental expenses. The advisory panel will be supported administratively by program staff and will provide advice to the commissioner.

2. By the end of the first year (SFY07), the advisory panel and the commissioner will identify the top 20 toxic chemicals and lay the groundwork for biomonitoring activities (i.e. the examination of breast milk, blood and urine for toxic chemicals in selected volunteers).

3. In SFY08 (the first year of biomonitoring tests), breast milk from 10 volunteers in each of 3 communities will be analyzed for the top 20 toxic chemicals. In SFY09, breast milk, blood and urine from 10 volunteers from each of 3 communities will be analyzed for the top 25 chemicals.

4. Staff will be integral to fulfilling the following requirements in the bill:
   a. examine presence of the toxins in the environment and develop recommendations to reduce exposure;
   b. coordinate with clinics and community partners to enroll volunteers; collect, transport, and store biospecimens;
   c. provide consultation, health care referrals, and follow-up counseling to volunteers;
   d. develop and disseminate culturally-sensitive educational and outreach materials;
   e. compile relevant scientific findings, data on the accumulation of pollutants, possible routes of exposure, population-based health effects and toxicity, links to community health, and regulatory responses by government entities;
   f. assure confidentiality, informed consent, follow-up counseling and support, and reports for the volunteers;
   g. establish a training program for health care providers, health educators, and other program administrators;
   h. develop a designation process for laboratories that are qualified to perform biomonitoring analyses;
   i. establish an advisory panel, comprised of committees of scientific experts and community representatives;
   j. facilitate the advisory panel's charge to recommend: model laboratory protocols and guidelines for biomonitoring; the list of toxic chemicals in the program's scope; biomonitoring priorities for Minnesota; interpretation of biomonitoring activities and laboratory analytical data; communities for enrollment; possible community partners; training and educational materials; dissemination of findings to program participants and the general public;
   k. prioritize the identified toxic chemicals according to their public health threat;
   l. seek funding from federal and private sources;
   m. submit reports to the legislature, to include descriptions, evaluations, and outcomes;
   n. make reports available to local public health departments and the general public, being sure to protect the confidentiality of program participants.

5. The cost to health care entities for enrolling volunteers, then collecting and transporting blood and urine biospecimens is $500 per volunteer. In SFY09 blood and urine specimens will be collected in conjunction with health care professionals.

6. The cost for laboratory analysis of each biospecimen (e.g. breast milk, blood or urine) is estimated at $5,420. The suite of tests will include neurotoxins, specific pesticides, heavy metals, endocrine disruptors, carcinogens, and persistent bioaccumulative toxins (e.g. PCBs - poly-chlorinated biphenyls, PBDEs - poly-brominated diphenyl ethers, and PFOS - perfluoro-octanyl sulfonate. Although the costs will vary slightly for breast milk vs. blood vs. urine and will vary slightly for 20 vs. 25 chemicals, the cost is estimated at $5,420 for each biospecimen.

7. This cost analysis does not include metabolites (produced when the parent compound is converted via biochemical processes inside the living cell). The cost for detecting both the toxic chemicals and their metabolites may double the cost of laboratory analyses.

Expenditure and/or Revenue Formula

Expenditure formula: program management
MDH will either use contractual agreements or hire staff members to fulfill the requirements of the bill.

Research Scientist, environmental toxicologist (1 FTE) to provide expertise in health risk assessment, toxicology, environmental exposure, and recommendations for mitigating exposure routes; to compile relevant scientific findings, data on the accumulation of pollutants, possible routes of exposure, population-based health effects and toxicity, links to community health, and regulatory responses by government entities; prioritize the identified toxic chemicals according to their public health threat

Research Scientist, laboratory chemist (1 FTE) to provide technical expertise to develop or adapt methods that analyze toxic chemicals in the environment to be useful for measuring toxins or their metabolites in biospecimens (breast milk, blood and urine) at physiological levels

Public Health Nurse (0.3 FTE) to coordinate with community services, local public health agencies, and clinics that will enroll volunteers and collect, transport, and store biospecimens; to provide volunteers with access to follow-up counseling and support; assure confidentiality, informed consent, and reports for the volunteers

Health Educator (0.5 FTE) to develop and disseminate culturally sensitive educational and outreach materials; to establish and implement a training program for health care providers, health educators, and other program administrators

Environmental Analyst (0.3 FTE) to develop and implement a designation process for laboratories that are qualified to perform biomonitoring analyses

State Program Administrator (1 FTE) to create an advisory panel comprised of a scientific committee and a community representative committee; to facilitate the advisory panel's charge to recommend: model laboratory protocols and guidelines for biomonitoring; the list of toxic chemicals in the program's scope; biomonitoring priorities for Minnesota; interpretation of biomonitoring activities and laboratory analytical data; communities for enrollment; possible community partners; training and educational materials; dissemination of findings to program participants and the general public; to seek funding from federal and private sources;to submit reports to the legislature that include descriptions, evaluations, and outcomes

Office Administrative Specialist (1 FTE) to support the research scientist, public health nurse, health educator, environmental analyst, and state program administrator in performing their responsibilities;

Information Technology Specialist (0.2 FTE) to collect and manage data for the biomonitoring investigations; to aid in interpreting laboratory results, to apply statistical analysis to evaluation measures and outcomes; to support reports to the legislature, participants, affected communities, local public health agencies, and the general public.

Expenditure formula: Laboratory testing
For breast milk specimens, MDH recommends adapting methods developed by the US Centers for Disease Control and Prevention (CDC) for their use in measuring toxins and their metabolites in biological matrices (particularly blood and urine). Undoubtedly, some of the toxic chemicals that will be listed as a high priority for the

healthy Minnesotans biomonitoring program will not have published or validated methods available for assaying biospecimens. In those cases, methods will be developed and validated before use in these biomonitoring investigations.

It is anticipated that, for most kinds of toxic chemicals that would be identified for the healthy Minnesotans biomonitoring program, particular laboratory analyses would characterize several closely related chemicals in a single scan. For example, technology for measuring heavy metals will identify and quantitate up to 20 metals in a single spectrum. The estimated cost of laboratory analyses is detailed below for particular classes of toxins.

For many toxic chemicals that are under discussion for biomonitoring activities nationally, research investigations for analyzing metabolites are in their infancy. The cost analysis presented herein does not include metabolites (which are the breakdown products that are generated within the living cell; some metabolites are more toxic than the parent compounds). Laboratory costs could double for metabolites.

Test cost for a suite of toxic chemicals (and assuming 20-25 chemicals from the following classes):

$570	agricultural chlorinated pesticides
$545	agricultural organophosphate pesticides
$670	carcinogenic PAHs (poly-aromatic hydrocarbons)
$1,200	dioxins
$160	heavy metals
$730	PCBs (poly-chlorinated biphenyls)
$730	PBDEs (poly-brominated diphenyl ethers)
$622	PFOS/PFOA (perfluoro-octanyl sulfonate, perfluro-octanoic acid)
$193	volatile organic chemicals
$5,420	

Annual testing costs:

SFY07: 0
SFY08: 30 volunteers x 1 biospecimen/volunteer @ $5,420 per specimen = $162,600
SFY09: 30 volunteers x 3 biospecimens/volunteer @ $5,420 per specimen = $487,800

Expenditures	SFY06	SFY07	SFY08	SFY09
Salaries 4.0 – 5.3 FTE		236,070	394,920	394,920
Operating costs		3,400	7,900	7,400
laboratory tests		0	162,600	487,800
contracts to health care clinics		0	0	15,000
Administrative support		47,655	112,519	180,119
Total expenses	0	287,125	677,939	1,085,239

Revenue:
The bill creates an account for the healthy Minnesotans biomonitoring program, to be established in the state government special revenue fund. The account is to consist of money appropriated by the legislature and any other funds identified for use by the healthy Minnesotans biomonitoring program.

Long-Term Fiscal Considerations

The first year of the program would focus on identifying the top 20 toxic chemicals to be included in biomonitoring studies. Years 2, 3 and 4 would constitute a feasibility study (or pilot program). If the results from these first 4 years are successful, the healthy Minnesotans biomonitoring program would build toward population-based surveillance. Minnesota has 70,000 newborn infants each year. Biomonitoring of 1% of the mothers would translate to 700 volunteers, or 700 x 3 biospecimens = 2,100 laboratory tests annually. The cost of analyzing 20-25 toxic chemicals for 2,100 specimens would be $11 million annually. If the advisory panel would recommend that lab tests measure the toxic metabolites, then the laboratory cost of a mature program could be $22 million annually.

These calculations are based on surveillance of mothers of newborn infants. If the population-based screening were to analyze other vulnerable populations (e.g. very young children, the frail elderly, and immigrants or refugees), then the costs would be higher.

Local Government Costs

None

References/Sources

Centers for Disease Control and Prevention (CDC), "National Report on Exposure to Environmental Chemicals, Second Report" (2003)

Darnerud, P.O., et al, "Polybrominated diphenyl ethers: Occurrence, dietary exposure, and toxicology". *Environmental Health Perspectives*: 109 (S1); 49-68 (2001)

Hutchison, W, O'Rourke, P. University of Minnesota College of Agriculture, Food, and Environmental Sciences. "Pesticide-use table".

Minnesota Department of Health, "2005 Environmental Laboratory Handbook, (test costs for environmental toxins in water and soil)

Minnesota Pollution Control Agency. Statewide major sources of groundwater contamination http://www.pca.state.mn.us/water/groundwater

National Research Council, "Pesticides in the Diets of Infants and Children" Washington, D.C.: National Academy Press (1993)

Pirkle, JL et al., "Using biological monitoring to assess human exposure to priority toxicants". *Environmental Health Perspectives* 103 (S3): 45-48 (1995).

US Geological Survey, "Presence and Distribution of Organic Wastewater Compounds in Wastewater, Surface, Ground, and Drinking Waters, Minnesota, 2000-2002", (2004), http://water.usgs.gov/pubs/sir/2004/5138

Senator ..... moves to amend S.F. No. 979 as follows:

Page 6, after line 10, insert:

"Sec. 6. **EFFECTIVE DATE.**

Sections 1 to 5 are effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature."

A bill for an act

relating to human services; implementing long-term care service options; requiring an investment study and report on core county long-term care functions; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.096] LONG-TERM CARE SERVICE OPTIONS.**

(a) To guarantee a high-quality long-term care system, the commissioner shall ensure that the system meets the following objectives: the system must be sustainable and support self-determination; it must provide services that meet consumers' needs and preferences; it must provide high-quality care; and it must ensure efficiency and affordability.

(b) The system must ensure a range of options, including nursing facilities, housing with services, and home and community-based services and support that include, but are not limited to, the following:

(1) home health care services;

(2) living at home/block nurse programs;

(3) meals and nutrition services;

(4) chore, homemaker, transportation, assisted living programs, senior companionship, respite, and other caregiver support services;

(5) adult day services;

(6) technology facilitated care;

(7) end-of-life care; and

(8) care coordination.

(c) The system must be cost-effective and provide incentives for lower-cost quality options, fair compensation for services delivered, appropriate use of trained community

volunteers, and flexible funding streams, such as the alternative care, elderly waiver, Medicaid, and aging grants programs.

(d) The system must support high-quality services that meet contemporary standards, achieve positive outcomes, and are provided by a sufficient number of trained, competent staff.

(e) The system must incorporate policies, including incentives, to ensure the least restrictive alternative for each service recipient in order to minimize disruption to an older person's life while meeting the person's care needs.

(f) The system must minimize premature use of nursing facilities and support diversions from nursing facilities to the community when feasible.

(g) The system must support elder-friendly communities with family, government, faith communities, businesses, and other sectors working together to support vital aging and long-term care at home.

(h) The system must strengthen informal care networks that include family, friends, volunteers, and other community resources.

Sec. 2. **LONG-TERM CARE INVESTMENT STUDY AND REBALANCING GOALS DEVELOPMENT.**

(a) By February 15, 2007, the commissioner of human services, in consultation with the commissioner of health, shall report to the legislature:

(1) the results of the investment study conducted under paragraphs (b) to (f); and

(2) the balancing goals developed under paragraphs (g) and (h).

(b) The investment study shall include recommendations for a rebalanced allocation of public funding between nursing facility services and home and community-based services. The recommendations may include variations based on population density or other factors. The study shall also recommend a standard set of core services, utilizing culturally appropriate social models in an elder-friendly environment, to be reasonably accessible to older persons and family caregivers, irrespective of their community of residence.

(c) The investment study must:

(1) include proposals to implement the recommendations related to age-friendly communities and family caregiving in the 2005 report on financing long-term care for Minnesota baby boomers;

(2) gather and report community level and other data about the specific needs of older persons and of family caregivers of frail older persons within the existing long-term care system;

(3) determine the efficacy and efficiency of existing services and service models within varying economic, demographic, and social groups at the community level; and

(4) quantify the costs and benefits of existing services and service models, specifically including home and community-based services for older persons, their family caregivers, communities, and the state.

(d) The study shall be conducted in five Minnesota communities, including three in greater Minnesota, one of which must be conducted in a city of the first or second class, and two in the seven-county metropolitan area. The study must include one greater Minnesota community and one metropolitan community with a significant minority population.

(e) The study shall be conducted utilizing a community engagement process and a community planning advisory group in each community. A majority of the group members in each community must be community leaders age 65 and older, family caregivers of persons age 65 and older, and caregivers of persons age 85 and older. Each advisory group must also include representatives of counties; cities; health plans; nonprofit and for-profit health and social services providers; area agencies on aging; minority organizations; housing, transportation, community development, and economic development agencies; and the local business community.

(f) The study process shall include interviews, focus groups, opinion surveys, and other methods to obtain direct input from community members. The study shall also incorporate:

(1) existing, relevant local community and state agency data;

(2) other relevant data used in population models; and

(3) individual case studies, including those of family caregivers of frail older persons.

(g) The goals development report shall include recommended allocation goals for long-term care spending that reflect an increasing reliance on home and community-based services. The allocation goals shall:

(1) incorporate the findings and recommendations of the investment study described in paragraphs (b) to (f); and

(2) include a plan and timeline to achieve rebalancing goals by state fiscal year 2011, with progress measures, including specific allocations percentages, specified for each fiscal year beginning in fiscal year 2008.

(h) The 2007 report shall include data for fiscal year 2006 on state spending for nursing facility care and home and community-based services, including numbers of recipients, through medical assistance, the Older Americans Act, the elderly waiver, the alternative care program, state aging grants, and other funds administered by the state that pay for long-term care services for older Minnesotans.

(i) The commissioner shall select a contractor by August 15, 2006, to conduct the study.

Sec. 3. **LIST OF COUNTY LONG-TERM CARE FUNCTIONS.**

The commissioner of human services, in consultation with county organizations, shall develop and report to the legislature by February 15, 2007, a list of core county long-term care functions, the estimated future costs to counties to perform these functions, and an analysis of possible funding sources for these costs.

Sec. 4. **APPROPRIATION.**

$250,000 is appropriated from the general fund for the fiscal year ending June 30, 2007, to the commissioner of human services to hire a contractor to conduct the long-term care investment study under section 2.

Fiscal Note – 2005-06 Session

Bill #: S2080-1A **Complete Date:** 03/22/06

Chief Author: LOUREY, BECKY

Title: LONG TERM CARE TASK FORCE RECS

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	464	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	464	0	0
Revenues					
General Fund		0	186	0	0
Net Cost <Savings>					
General Fund		0	278	0	0
Total Cost <Savings> to the State		0	278	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.00	0.75	0.00	0.00
Total FTE		0.00	0.75	0.00	0.00

NARRATIVE: SF 2080-1A

Bill Description
This bill seeks a study of long term care investments, recommendations to "rebalance" institutional and community investments, and allocation goals to shift investment to the community. A study of core county long term care functions, future cost, and financing options is also required.

Assumptions
The studies are to be completed by February 15, 2007. SF2080 appropriates $250,000 for contractor services to complete the rebalancing study. One full-time staff is needed to develop and manage the contract and develop and implement the county study. This professional position would be needed for 9 months.

Expenditure and/or Revenue Formula

	SFY 2007	SFY 2008	SFY 2009
LTC Study (section 2)	250,000		
County LTC Role Study (section 3)	150,000		
Staff Support (sections 2 and 3)			
1 FTE	85,350		
Prorated for 9 months	0.75		
	64,013		
Total Costs-CC M	464,013		
Admin. FFP(.40)	185,605		
Net State Costs	278,408		

Long-Term Fiscal Considerations
None

Local Government Costs
None

References/Sources

Agency Contact Name: Jolene Kohn 431-2579
FN Coord Signature: STEVE BARTA
Date: 03/21/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/22/06 Phone: 286-5618

A bill for an act

relating to human services; establishing the Runaway and Homeless Youth Act; requiring a report on case management and other social services; requiring a report on the reduced Medicaid reimbursements; amending Laws 2005, First Special Session chapter 4, article 7, section 59; proposing coding for new law in Minnesota Statutes, chapter 256K.

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

Section 1. **[256K.60] RUNAWAY AND HOMELESS YOUTH ACT.**

Subdivision 1. **Definitions.** (a) The definitions of this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 21 years or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include youth exiting out-of-home placements, youth who previously were homeless, youth whose parents or primary caregivers are or were previously homeless, youth who are exposed to abuse and neglect in their homes, youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities, and runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 2. **Homeless and runaway youth initiative.** (a) The commissioner shall develop a comprehensive initiative for homeless youth, youth at risk of homelessness, and runaways. The commissioner shall contract with organizations and public and private agencies, including faith-based organizations, to provide street outreach, emergency shelter services, drop-in services, family mediation counseling and conflict resolution, transitional living services, case management services, life skills training, and family reunification services to youth, to the extent that funds exist or become available. The programs must be culturally competent to serve specific populations and must provide voluntary services to homeless youth, youth at risk of homelessness, and runaways in an appropriate and responsible manner.

(b) The commissioner shall plan for and coordinate services for homeless, runaway, and at-risk youth. The commissioner may provide support services required to achieve the objectives and goals of the initiative.

(c) Nothing in this section relieves counties from existing responsibilities to provide services for homeless youth, youth at risk of being homeless, or runaways under section 626.556, chapter 256E, or other applicable laws.

(d) Nothing in this section is intended to preclude homeless youth ages 18 to 21 from utilizing other services or programs available to homeless adults.

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and on-going supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support to services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) after-care services;

(9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency, short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day, and shall assist a runaway with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

(1) family reunification services;

(2) individual, family, and group counseling;

(3) assistance obtaining clothing;

(4) access to medical and dental care and mental health counseling;

(5) education and employment services;

(6) recreational activities;

(7) advocacy and referral services;

(8) independent living skills training;

(9) after-care and follow-up services;

(10) transportation; and

(11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and

related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

(1) educational assessment and referrals to educational programs;

(2) career planning, employment, work skill training, and independent living skills training;

(3) job placement;

(4) budgeting and money management;

(5) assistance in securing housing appropriate to needs and income;

(6) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(7) referral for medical services or chemical dependency treatment;

(8) parenting skills;

(9) self-sufficiency support services or life skill training;

(10) after-care and follow-up services; and

(11) homelessness prevention.

Sec. 2. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include draft legislation for case management changes that will:

(1) streamline administration;

(2) improve consumer access to case management services;

(3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;

(4) establish case management performance measures;

(5) provide for consumer choice of the case management service vendor; and

(6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

Sec. 3. **IMPACT ON REDUCED MEDICAID REIMBURSEMENTS.**

The commissioner of human services shall report to the chair of the house Health Policy and Finance Committee and the chairs of the senate Health and Family Security

Committee and Health and Human Services Budget Division by December 1, 2006, on the impact of reduced Medicaid reimbursements resulting from the federal Deficit Reduction Act of 2005. The report shall include options to restore lost revenues and ensure the continuation of targeted case management and other affected social services.

Sec. 4. **APPROPRIATION.**

$..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services for purposes of Minnesota Statutes, section 256K.50.

Sec. 5. **EFFECTIVE DATE.**

Sections 2 and 3 are effective the day following final enactment.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING. JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 2535 - Runaway and Homeless Youth Initiative and Reports on Case Management and Reduced Medicaid Reimbursements

Author: Senator Becky Lourey

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

Date: April 6, 2006

Section 1 establishes the Runaway and Homeless Youth Act.

Subdivision 1 defines the following terms; commissioner, homeless youth, youth at risk of homelessness, and runaway.

Subdivision 2 establishes the homeless and runaway youth initiative. This subdivision requires the commissioner of human services to develop a comprehensive initiative for homeless youth, youth at risk of homelessness, and runaways. The commissioner is required to provide funding to counties to contract with organizations and public and private agencies to provide street outreach, emergency shelter services, drop-in services, family mediation counseling and conflict resolution, transitional living services, case management services, life skills training, and family reunification services to youth. The commissioner is also required to plan for and coordinate services for homeless, runaway, and at-risk youth.

Subdivision 3 establishes a street and community outreach and drop-in program. This program must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. This subdivision also lists the information, referrals, and services that may be provided by the program.

Subdivision 4 establishes an emergency shelter program. These programs must provide homeless youth and runaways with referral and walk-in access to emergency, short term residential care, and safe, dignified shelter, including private shower facilities, beds, and at least one meal each day. The program must also assist runaways with reunification with their family or legal guardian

when required or appropriate. This subdivision lists the services that the emergency shelter may include.

Subdivision 5 establishes transitional living programs. This program must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may provide rental assistance and related supportive services, or refer youth to other organizations or agencies that provide such services. The program may also be available for up to 24 consecutive months. This subdivision lists the services the transitional living program may include.

Section 2 modifies the report to the legislature related to case management, by expanding the report to include other social services, in addition to case management. The bill requires findings and recommendations for improving quality of care case management and other social services, instead of draft legislation, and modifies the detailed list of issues the report must contain.

Section 3 requires the commissioner of human services to report on the impact of reduced medicaid reimbursements by December 1, 2006.

Section 4 provides a blank appropriation for purposes of section 1.

Section 5 makes section 2 and 3 effective the day following final enactment.

JW:mvm

Minnesota Youth Service Association

Committee on Public Policy and Advocacy

7601 42nd Avenue North, New Hope, MN 55427

phone (763) 592-5510, fax (763) 592-5550

"Pursuing public policy reform to increase opportunities and resources for homeless and runaway youth."

2006 CAPITAL HILL DAY TALKING POINTS

SUPPORT THE RUNAWAY AND HOMELESS YOUTH ACT

Support Senate File 2535 and House File 3204!

How and Why Do Youth Become Homeless?

Homeless youth are aged 12 to 21 years, unaccompanied by an adult, and often homeless due to physical abuse, sexual exploitation, neglect, or abandonment. Homeless youth are resilient and talented and want to succeed.

The Wilder Research Center's statewide survey of homeless youth in 2003 determined:

- there are between 500 and 600 youth who are homeless and without shelter on any given night;
- nearly half (46%) had been physically or sexually mistreated;
- nearly a third (30%) had experienced parental neglect;
- nearly one-third of all homeless girls have been sexually abused and nearly one-quarter (23%) have attempted suicide;
- disproportionate numbers are youth of color (65% were African American, American Indian, or bicultural).

Communities Don't Have Resources to Help Youth

Nonprofit organizations have seen no decrease in the number of homeless youth. The Twin Cities metropolitan area has seen an enormous amount of homeless and at-risk youth seeking shelter. In 2003 Twin Cities' nonprofit agencies served over 3,700 homeless and runaway youth. (However, please note that this is not an unduplicated count.) However, this is not just an urban issue. Greater Minnesota also reports an alarming supply of troubled teenagers: in Bemidji, outreach workers with Evergreen Shelter saw 145 homeless and at-risk youth on the streets and provided emergency shelter and family reunification services to 600 youth in 2003; and in Duluth, Lutheran Social Services' shelter assisted 554 youth in 2001 with street-based outreach reporting an additional 250 youth needing services each day.

Nonprofit community organizations struggle to serve every youth. **Community-based programs and agencies struggle to serve thousands of youth each year with only 100 shelter beds and just over 450 youth apartments.** During the winter, almost every night youth are turned away from shelter due to a lack of bed spaces.

We're losing progress!

Recent losses in federal, state, and local funding have impacted nonprofit organizations ability to serve homeless and runaway youth. **Since 2003 we have lost 16 emergency shelter beds, 137 units of supportive, transitional housing, and 48 youth case workers.** Some of the deepest cuts have been to small community programs in Greater Minnesota that served critical areas and offered diversion from mental health facilities.

How does the Runaway and Homeless Youth Act Help?

The Act would be Minnesota's first comprehensive policy initiative that defines and prioritizes the needs of Minnesota homeless youth.

- calls for the State to expand the supply of shelter, housing, outreach, and one-to-one case management to address the crisis of youth homelessness and protect vulnerable youth;
- recognizes a and establishes a state-wide grant program from the Department of Human Services to offer family- and community-centered services and interventions;
- defines of broad spectrum of services for youth, including: outreach, family reunification, emergency shelter, drop-in centers, life skills training, supportive and transitional housing;
- allows for local communities to articulate local needs and solutions through a competitive grant making process to the State; and
- recognizes the disparity of youth of color who experience homelessness and mandates culturally oriented and culturally competent services;

How much are we asking

$1.2 million dollars for the first year of this program. These funds will leverage additional support from Federal programs and private philanthropy.

It's a smart and good investment! It involves local community members in identifying local priorities. It helps the State achieve its Plan to End Long-term Homelessness. Investment in early intervention services and crisis support help keep youth safe and diverts youth from considerable time in costly out-of-home placements, in-patient treatment, or jail.

Minnesota must do better to protect and nurture older adolescents!

We know what works in protecting and nurturing youth! Youth need consistent and loving adults in their lives, opportunities to build their skills to increase their development, and stability in their housing and basic needs to grow up to be productive adults. Community-based programs offer at-risk youth hope for the future and routinely achieve positive outcomes with youth participants! A small community investment in youth-serving agencies can results in positive outcomes. Minnesota needs to start seeing and protecting its youth!

SUPPORTED AND ENDORSED BY: Minnesota Youth Service Association, Minnesota Coalition for the Homeless, HousingMinnesota, Lutheran Social Services, Family and Children Service, and Minnesota Center for Independent Living.

Prepared by:
Richard A. Hooks Wayman
Hookswayman@yahoo.com
(612) 730-7574

Lutheran Social Service
for changing lives

UNITED IN FAITH: for a Minnesota where
every child and youth has a safe, supportive place to live

In 2006 we in the state of Minnesota have a clear opportunity to put our values in action by caring for and positively supporting otherwise vulnerable young people – Minnesota's youth who lack safe places to live. This year we can take steps to contribute to healthy communities and prevent unnecessary and costly future crises by passing the Runaway and Homeless Youth Act.

RUNAWAY AND HOMELESS YOUTH ACT

SF 2535, HF 3204

Each night in Minnesota, young people experiencing homelessness are turned away from shelters. From the 2003 Wilder Research report on Homelessness in Minnesota we know that on any given night at least 500-600 homeless youth are on their own. Many youth find themselves homeless due to abuse or neglect, alcohol or drug problems in the home, or other unsafe situations, forcing them into dangerous situations on MN's streets in an attempt to escape dangers at home. Sadly, homeless youth face a new height of vulnerability – often falling victim to drug use and abuse, prostitution, crime and other exploitation.

Lutheran Social Service of Minnesota sees youth in Brainerd, Duluth, Willmar, the Metro area, and throughout the state of Minnesota who desperately need help, hope and supports to succeed. All youth in crisis need a safe place to stay to set in motion a process wherein they can: reunite with family, access long-term housing, enter educational programs, and mature into flourishing young adults.

Together, with concerned citizens, community and social service organizations, local and state government, we can turn the crisis of youth homelessness into a short term transition for youth – from precariousness into safe and supportive new places to thrive.

The Runaway and Homeless Youth Act

This comprehensive policy defines and prioritizes the needs of Minnesota homeless youth and establishes a state-wide program to offer family- and community-centered services and interventions. Anticipated funding for his act is $1.2 million. Provisions include:

- Supporting local programs statewide to provide: shelter, basic needs, outreach and supportive services for youth to gain new homes and hopeful futures.
- Serving and protecting homeless and at-risk youth.
- Support for family reunification.
- Provide homeless youth with safe, dignified housing when family reunification is not an option. Programs will offer youth support in education, employment and life skills training.

LUTHERAN SOCIAL SERVICE OF MINNESOTA
For additional information contact: advocacy@lssmn.org,
Kirsten Anderson-Stembridge 651.969.2354, or Kate Maher 651.969.2285

A bill for an act

relating to human services; allowing the commissioner of human services to contract with Medicare-approved special needs plans to provide medical assistance services to persons with disabilities; creating a stakeholder group; requiring legislative approval; appropriating money; amending Minnesota Statutes 2004, section 256B.69, subdivision 9, by adding a subdivision; Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23.

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

Section 1. Minnesota Statutes 2004, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection ~~from county advocacy activities~~ in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Nonpersonally identifiable health plan encounter data, aggregate spending data, and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan;

(2) total aggregate medical assistance spending for major categories of service as reported to the commissioner of commerce under section 62D.08, subdivision 3,

paragraph (a), in a form that the commissioner can report by age, eligibility group, and health plan; and

(3) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

Sec. 2. Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner

must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover

the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until January 1, 2008, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

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

Sec. 3. Minnesota Statutes 2004, section 256B.69, is amended by adding a subdivision to read:

Subd. 28. **Medicare special needs plans and medical assistance basic health care for persons with disabilities.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d);

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group; and

(3) the commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

Sec. 4. **STAKEHOLDER PARTICIPATION.**

The commissioner of human services shall establish one or more stakeholder groups of interested persons, including representatives of recipients, advocacy groups, counties, providers, and health plans to provide information and advice on the development of any proposals for changes in the medical assistance program authorized by the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

Sec. 5. **LEGISLATIVE AUTHORIZATION REQUIRED.**

Any changes to the medical assistance program proposed as a result of the federal Deficit Reduction Act of 2005, Public Law 109-171, which affect cost sharing, co-payments, premiums, eligibility, covered services, service limitations, or benefit set changes, must receive legislative approval prior to being implemented or submitted to the Centers for Medicare and Medicaid Services.

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

Sec. 6. **APPROPRIATION; OMBUDSMAN FOR MANAGED CARE.**

$200,000 is appropriated from the general fund to the commissioner of human services in fiscal year 2007 to increase staff for the development and management of contract requirements associated with enrolling persons with disabilities in managed care and for the ombudsman for managed care office in order to assist persons with

disabilities on issues involving health coverage under Minnesota Statutes, section 256B.69, subdivision 28.

Request for Expansion of Integrated Disability Care Projects

S.F. No. 3399 (Lourey)/H.F. No. 3591 (Finstad)

PrimeWest Health System and South Country Health Alliance

bout PrimeWest and South Country.

- PrimeWest Health System and South Country Health Alliance are county-based purchasing health plans that provide health coverage to persons residing in their participating counties who are eligible for government health care programs, including:
  - Persons who receive their Medical Assistance or General Assistance Medical Care coverage through Minnesota's Prepaid Medical Assistance Program (PMAP);
  - Seniors who receive both Medicare and Medicaid coverage, including Medicare Part D benefits, through Minnesota Senior Health Options (MSHO);
  - Seniors who receive their Medical Assistance and Elderly Waiver Home and Community-Based Services coverage through Minnesota Senior Care.
- PrimeWest also will and South Country has begun to serve Medicare enrollees with disabilities as a Medicare-approved "Special Needs Plan" (SNPs).
- PrimeWest serves Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse counties.
- South Country Health Alliance serves Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha and Waseca counties.

Request to Serve Persons with Disabilities.

- Current state law exempts people with disabilities from participating in PMAP, with the exception of two Twin Cities-based pilot projects: one for persons with a physical disability; and another for persons with a developmental disability.
- The pilot projects are known as "MnDHO" (Minnesota Disability Health Options) and provide integrated health coverage to persons eligible for both Medicare and Medical Assistance.
- The Twin Cities integrated disability care pilot projects have been successful and are popular with consumers:
  - Creates locally based, integrated coverage -- consumers can receive all their health care and social services from a single source and the services are well coordinated
  - Offers greater flexibility than the traditional Medical Assistance fee-for-service program
  - Consumers receive personalized care coordination help and can receive some types of equipment and services that are not covered under the Medical Assistance programs
  - Results in fewer emergency room visits and hospitalizations
- Because of the success of MnDHO and its popularity with consumers, PrimeWest and South Country request the authority to offer this option in rural communities, too.

Reasons to Permit Rural Communities to Establish a MnDHO Program:

- Fewer health care resources in rural areas require an individualized, local care coordination approach to assist consumers in finding and accessing appropriate care in a timely manner
- This option will likely result in higher reimbursement for providers than traditional Medical Assistance
- When provided through a county-based purchasing approach, this model will improve access to care and effectiveness of care through *community-based* coordination of local health and social services around the individual's needs
- PrimeWest and South Country have been highly successful in serving PMAP participants and cost-effectively managing the Medical Assistance resource for the State at the local level
- This approach caps the state's financial liability under the Medical Assistance program

We urge you to support S.F. No. 3399 and H.F. No. 3591

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3399-1A **Complete Date:**

Chief Author: LOUREY, BECKY

Title: MEDICARE-APPROVED SPEC PLN CONTRACT

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	936	573	590
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	936	573	590
Revenues					
General Fund		0	80	80	80
Net Cost <Savings>					
General Fund		0	856	493	510
Total Cost <Savings> to the State		0	856	493	510

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.00	2.00	2.00	2.00
Total FTE		0.00	2.00	2.00	2.00

Preliminary

Narrative: SF 3399-1A

Bill Description

Sections 2 and 3 of this bill allows expansions of Minnesota Disability Health Options (MnDHO) projects. It allows DHS to contract with Medicare approved Special Needs Plans (SNPs) to provide Medicaid services, including basic health care, home care, NF and home and community-based services. It lifts the current statutory limit on serving persons with developmental disabilities. It requires stakeholder participation in the development process.

Section 4 requires the department to establish one ore more stakeholder groups to provide information and advise to the department on any proposals for changes in the medical assistance program authorized by the federal Deficit reduction Act of 2005.

Assumptions

One impact of this bill is that there may be an expansion of access to home and community based waivered services beyond the current caps.

See spreadsheet

Expenditure and/or Revenue Formula

FISCAL NOTE SUMMARY
General Fund (dollars in thousands)

BACT	Description	FY07	FY08	FY09
50-HC Admin.	2 FTEs and related admin	200	200	200
51-HC Operations	MMIS costs	24	0	0
42-MA Basic HC Grants E&D	Program costs	712	373	390
Total General Fund Costs		936	573	590
Non-Dedicated FFP @ 40%		80	80	80
Net Cost to State:		856	493	510

ADMINISTRATIVE COSTS

One FTE for the Ombudsman to help consumers navigate the new system.
One FTE to oversee the stakeholder group(s) and to oversee rate cell assignment, set program specs, and et cetera under Special Needs Purchasing.

In addition, systems costs would be needed as described below:
3 months, total costs of $67,200 (State share costs of $24,000).

*qualifier - we will also need data warehouse staff time that is not included above. This would require a new process to identify and send education and enrollment information, identification of people in the waiting period for Medicare and work to establish a new product. Adding a new product includes EVS changes, ratable reduction logic changes, rate changes and health plan test files.

PROGRAM COSTS

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Allow DHS to Contract with Medicare Special Needs Plans
To Provide Coverage for People with Disabilities
Senate File 3399 -1A

Section 2 places limits on the expansion of Minnesota disability health options (MnDHO) projects. Since no expansion is included in the current forecast, the limitations are assumed to have no fiscal effect.
Section 3 permits DHS to contract with Medicare special needs plans to provide coverage of persons with disabilities. This language is added to a section authorizing demonstration projects, so we assume that the expansion of capitation arrangements permitted under this change would be limited in scope. We assume 1000 additional enrollees in managed care effective January 2007, 500 more effective January 2008, and 500 more effective January 2009. Managed care enrollment is assumed to be voluntary.

Because of voluntary enrollment, we assume the disabled individuals with higher needs will choose to enroll and that the average capitation payment will be twice the average fee-for-service cost expected for MA disabled basic care.

The fiscal effect of the added capitation is the cash-flow cost for one month of payments for each additional recipient capitated. The effect would be two months but for the general requirement in current law that the capitation payment for June is delayed to July.

Enrollment Projections	FY 2006	FY 2007	FY 2008	FY 2009
Newly capitated recipients as of January	0	1,000	1,500	2,000
Average monthly recipients		500	1,250	1,750
Average monthly capitation rate		$1,425	$1,492	$1,561
Factor for delay of June payment		83.33%	100.00%	100.00%
Total MA capitation payments	0	7,123,072	22,379,309	32,779,105
Cash Flow Costs				
Incremental capitated recipients		1,000	500	500
Average monthly capitation rate		$1,425	$1,492	$1,561
Total MA cost		1,424,614	745,977	780,455
Federal share	0	712,307	372,988	390,227
State share	0	712,307	372,988	390,227

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 04/03/06 Phone: 431-2916

A bill for an act

relating to human services; establishing the Runaway and Homeless Youth Act; requiring a report on case management and other social services; requiring a report on the reduced Medicaid reimbursements; amending Laws 2005, First Special Session chapter 4, article 7, section 59; proposing coding for new law in Minnesota Statutes, chapter 256K.

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

Section 1. **[256K.60] RUNAWAY AND HOMELESS YOUTH ACT.**

Subdivision 1. **Definitions.** (a) The definitions of this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 21 years or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include youth exiting out-of-home placements, youth who previously were homeless, youth whose parents or primary caregivers are or were previously homeless, youth who are exposed to abuse and neglect in their homes, youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities, and runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 2. **Homeless and runaway youth initiative.** (a) The commissioner shall develop a comprehensive initiative for homeless youth, youth at risk of homelessness, and runaways. The commissioner shall contract with organizations and public and private agencies, including faith-based organizations, to provide street outreach, emergency shelter services, drop-in services, family mediation counseling and conflict resolution, transitional living services, case management services, life skills training, and family reunification services to youth, to the extent that funds exist or become available. The programs must be culturally competent to serve specific populations and must provide voluntary services to homeless youth, youth at risk of homelessness, and runaways in an appropriate and responsible manner.

(b) The commissioner shall plan for and coordinate services for homeless, runaway, and at-risk youth. The commissioner may provide support services required to achieve the objectives and goals of the initiative.

(c) Nothing in this section relieves counties from existing responsibilities to provide services for homeless youth, youth at risk of being homeless, or runaways under section 626.556, chapter 256E, or other applicable laws.

(d) Nothing in this section is intended to preclude homeless youth ages 18 to 21 from utilizing other services or programs available to homeless adults.

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and on-going supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support to services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) after-care services;

(9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency, short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day, and shall assist a runaway with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

(1) family reunification services;

(2) individual, family, and group counseling;

(3) assistance obtaining clothing;

(4) access to medical and dental care and mental health counseling;

(5) education and employment services;

(6) recreational activities;

(7) advocacy and referral services;

(8) independent living skills training;

(9) after-care and follow-up services;

(10) transportation; and

(11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and

related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

(1) educational assessment and referrals to educational programs;

(2) career planning, employment, work skill training, and independent living skills training;

(3) job placement;

(4) budgeting and money management;

(5) assistance in securing housing appropriate to needs and income;

(6) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(7) referral for medical services or chemical dependency treatment;

(8) parenting skills;

(9) self-sufficiency support services or life skill training;

(10) after-care and follow-up services; and

(11) homelessness prevention.

Sec. 2. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include draft legislation for case management changes that will:

(1) streamline administration;

(2) improve consumer access to case management services;

(3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;

(4) establish case management performance measures;

(5) provide for consumer choice of the case management service vendor; and

(6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

Sec. 3. **IMPACT ON REDUCED MEDICAID REIMBURSEMENTS.**

The commissioner of human services shall report to the chair of the house Health Policy and Finance Committee and the chairs of the senate Health and Family Security

Committee and Health and Human Services Budget Division by December 1, 2006, on the impact of reduced Medicaid reimbursements resulting from the federal Deficit Reduction Act of 2005. The report shall include options to restore lost revenues and ensure the continuation of targeted case management and other affected social services.

Sec. 4. **APPROPRIATION.**

$..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services for purposes of Minnesota Statutes, section 256K.50.

Sec. 5. **EFFECTIVE DATE.**

Sections 2 and 3 are effective the day following final enactment.

A bill for an act

relating to human services; allowing the commissioner of human services to contract with Medicare-approved special needs plans to provide medical assistance services to persons with disabilities; creating a stakeholder group; requiring legislative approval; appropriating money; amending Minnesota Statutes 2004, section 256B.69, subdivision 9, by adding a subdivision; Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23.

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

Section 1. Minnesota Statutes 2004, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection ~~from county advocacy activities~~ in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Nonpersonally identifiable health plan encounter data, aggregate spending data, and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan;

(2) total aggregate medical assistance spending for major categories of service as reported to the commissioner of commerce under section 62D.08, subdivision 3,

paragraph (a), in a form that the commissioner can report by age, eligibility group, and health plan; and

(3) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

Sec. 2. Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner

must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover

the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until January 1, 2008, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

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

Sec. 3. Minnesota Statutes 2004, section 256B.69, is amended by adding a subdivision to read:

Subd. 28. **Medicare special needs plans and medical assistance basic health care for persons with disabilities.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d);

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group; and

(3) the commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

Sec. 4. **STAKEHOLDER PARTICIPATION.**

The commissioner of human services shall establish one or more stakeholder groups of interested persons, including representatives of recipients, advocacy groups, counties, providers, and health plans to provide information and advice on the development of any proposals for changes in the medical assistance program authorized by the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

Sec. 5. **LEGISLATIVE AUTHORIZATION REQUIRED.**

Any changes to the medical assistance program proposed as a result of the federal Deficit Reduction Act of 2005, Public Law 109-171, which affect cost sharing, co-payments, premiums, eligibility, covered services, service limitations, or benefit set changes, must receive legislative approval prior to being implemented or submitted to the Centers for Medicare and Medicaid Services.

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

Sec. 6. **APPROPRIATION; OMBUDSMAN FOR MANAGED CARE.**

$200,000 is appropriated from the general fund to the commissioner of human services in fiscal year 2007 to increase staff for the development and management of contract requirements associated with enrolling persons with disabilities in managed care and for the ombudsman for managed care office in order to assist persons with

disabilities on issues involving health coverage under Minnesota Statutes, section 256B.69, subdivision 28.

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. 3399 as follows:

Page 1, line 17, after the second "data" insert " for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3"

Page 1, line 23, after the semicolon, insert "and"

Page 1, line 24, delete everything after "(2)"

Page 1, delete line 25

Page 2, delete lines 1 and 2

Page 2, line 3, delete "(3)"

Page 5, line 32, after the period, insert " Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year."

Page 6, line 15, delete "establish" and insert "confer with"

Page 6, line 17, after "any" insert "substantial"

Deficit

Page 6, line 19, after the period, insert " In addition, for any substantial ~~Deficient~~ Reduction Act-related medical assistance change that affects recipients and that is proposed outside of the legislative or rulemaking process, the commissioner shall convene a stakeholder meeting and provide a 30-day comment period before the change becomes effective. If the time frame required to comply with a federal mandate precludes the 30-day advance notice, notice shall be given to the stakeholder group as soon as possible."

Page 6, delete section 5

Page 6, line 28, delete "; OMBUDSMAN FOR MANAGED CARE"

Page 6, line 29, delete "$200,000" and insert "$124,000"

Page 6, line 32, delete everything after the first "care" and insert a period

Page 7, delete lines 1 and 2

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

A bill for an act

relating to human services; implementing long-term care service options; requiring an investment study and report on core county long-term care functions; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.096] LONG-TERM CARE SERVICE OPTIONS.**

(a) To guarantee a high-quality long-term care system, the commissioner shall ensure that the system meets the following objectives: the system must be sustainable and support self-determination; it must provide services that meet consumers' needs and preferences; it must provide high-quality care; and it must ensure efficiency and affordability.

(b) The system must ensure a range of options, including nursing facilities, housing with services, and home and community-based services and support that include, but are not limited to, the following:

(1) home health care services;

(2) living at home/block nurse programs;

(3) meals and nutrition services;

(4) chore, homemaker, transportation, assisted living programs, senior companionship, respite, and other caregiver support services;

(5) adult day services;

(6) technology facilitated care;

(7) end-of-life care; and

(8) care coordination.

(c) The system must be cost-effective and provide incentives for lower-cost quality options, fair compensation for services delivered, appropriate use of trained community

volunteers, and flexible funding streams, such as the alternative care, elderly waiver, Medicaid, and aging grants programs.

(d) The system must support high-quality services that meet contemporary standards, achieve positive outcomes, and are provided by a sufficient number of trained, competent staff.

(e) The system must incorporate policies, including incentives, to ensure the least restrictive alternative for each service recipient in order to minimize disruption to an older person's life while meeting the person's care needs.

(f) The system must minimize premature use of nursing facilities and support diversions from nursing facilities to the community when feasible.

(g) The system must support elder-friendly communities with family, government, faith communities, businesses, and other sectors working together to support vital aging and long-term care at home.

(h) The system must strengthen informal care networks that include family, friends, volunteers, and other community resources.

Sec. 2. **LONG-TERM CARE INVESTMENT STUDY AND REBALANCING GOALS DEVELOPMENT.**

(a) By February 15, 2007, the commissioner of human services, in consultation with the commissioner of health, shall report to the legislature:

(1) the results of the investment study conducted under paragraphs (b) to (f); and

(2) the balancing goals developed under paragraphs (g) and (h).

(b) The investment study shall include recommendations for a rebalanced allocation of public funding between nursing facility services and home and community-based services. The recommendations may include variations based on population density or other factors. The study shall also recommend a standard set of core services, utilizing culturally appropriate social models in an elder-friendly environment, to be reasonably accessible to older persons and family caregivers, irrespective of their community of residence.

(c) The investment study must:

(1) include proposals to implement the recommendations related to age-friendly communities and family caregiving in the 2005 report on financing long-term care for Minnesota baby boomers;

(2) gather and report community level and other data about the specific needs of older persons and of family caregivers of frail older persons within the existing long-term care system;

(3) determine the efficacy and efficiency of existing services and service models within varying economic, demographic, and social groups at the community level; and

(4) quantify the costs and benefits of existing services and service models, specifically including home and community-based services for older persons, their family caregivers, communities, and the state.

(d) The study shall be conducted in five Minnesota communities, including three in greater Minnesota, one of which must be conducted in a city of the first or second class, and two in the seven-county metropolitan area. The study must include one greater Minnesota community and one metropolitan community with a significant minority population.

(e) The study shall be conducted utilizing a community engagement process and a community planning advisory group in each community. A majority of the group members in each community must be community leaders age 65 and older, family caregivers of persons age 65 and older, and caregivers of persons age 85 and older. Each advisory group must also include representatives of counties; cities; health plans; nonprofit and for-profit health and social services providers; area agencies on aging; minority organizations; housing, transportation, community development, and economic development agencies; and the local business community.

(f) The study process shall include interviews, focus groups, opinion surveys, and other methods to obtain direct input from community members. The study shall also incorporate:

(1) existing, relevant local community and state agency data;

(2) other relevant data used in population models; and

(3) individual case studies, including those of family caregivers of frail older persons.

(g) The goals development report shall include recommended allocation goals for long-term care spending that reflect an increasing reliance on home and community-based services. The allocation goals shall:

(1) incorporate the findings and recommendations of the investment study described in paragraphs (b) to (f); and

(2) include a plan and timeline to achieve rebalancing goals by state fiscal year 2011, with progress measures, including specific allocations percentages, specified for each fiscal year beginning in fiscal year 2008.

(h) The 2007 report shall include data for fiscal year 2006 on state spending for nursing facility care and home and community-based services, including numbers of recipients, through medical assistance, the Older Americans Act, the elderly waiver, the alternative care program, state aging grants, and other funds administered by the state that pay for long-term care services for older Minnesotans.

(i) The commissioner shall select a contractor by August 15, 2006, to conduct the study.

Sec. 3. **LIST OF COUNTY LONG-TERM CARE FUNCTIONS.**

The commissioner of human services, in consultation with county organizations, shall develop and report to the legislature by February 15, 2007, a list of core county long-term care functions, the estimated future costs to counties to perform these functions, and an analysis of possible funding sources for these costs.

Sec. 4. **APPROPRIATION.**

$250,000 is appropriated from the general fund for the fiscal year ending June 30, 2007, to the commissioner of human services to hire a contractor to conduct the long-term care investment study under section 2.

ATTACHMENT "D"

Senator ..... moves to amend S.F. No. 2080 as follows:

Page 4, delete lines 5 to 7 and insert "shall provide a status report to the legislature that includes a list of core county long-term care functions and an analysis of existing and potential funding sources for these functions."

Page 4, delete section 4 and insert:

"Sec. 4. **APPROPRIATION.**

$175,000 is appropriated from the general fund to the commissioner of human services for the fiscal year beginning July 1, 2006, to hire a contractor to conduct the long-term care investment study under section 2. This appropriation shall not be made available until the commissioner receives 50 percent matching funds from nonstate sources for this purpose."