Senate Counsel, Research, and Fiscal Analysis

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75 Rev. Dr. Martin Luther King, Jr. Blvd.
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(651) 296-4791
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Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 2521 - Fergus Falls Hospital Moratorium Exception

Author: Senator Cal Larson

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

Date: March 15, 2006

S.F. No. 2521 authorizes an exception to the hospital construction moratorium to allow the addition of two rehabilitation beds at a Fergus Falls hospital that closes its separately licensed 13-bed skilled nursing facility.

DG:rdr

Senator Larson introduced–

S.F. No. 2521: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing an exception to hospital restricted construction or modification; 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 an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility.

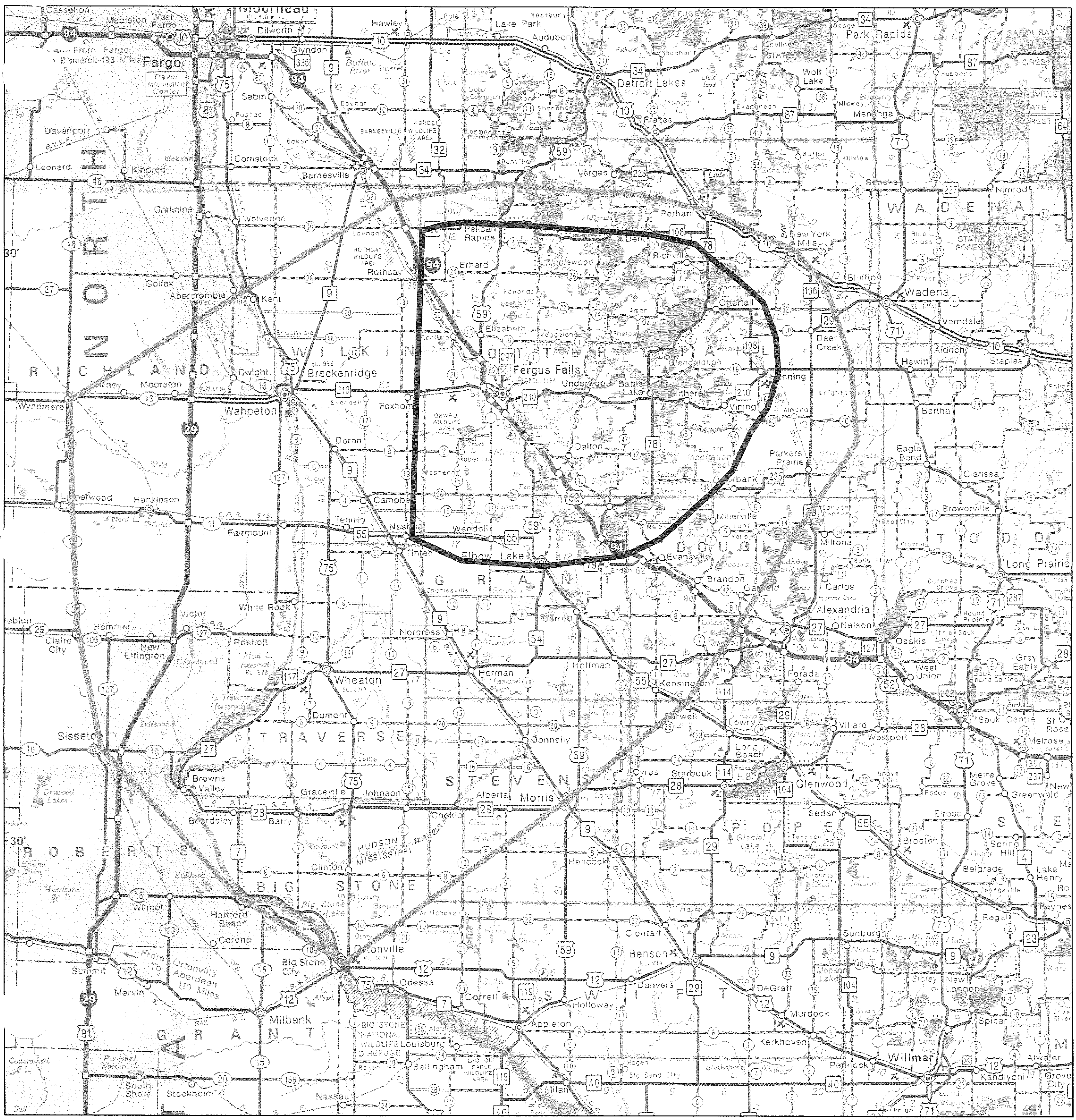
Lake Region Healthcare Corporation

Center for Rehabilitation

Fergus Falls, Minnesota

Service Area

Primary and Secondary Markets



LRH Lake Region Healthcare Corporation

712 S. Cascade • Fergus Falls, MN • www.lrhc.org • 218 736-8000 (V/TDD)

WE SPECIALIZE IN YOU!

H.F. No. 2854, as introduced - 84th Legislative Session (2005-2006) Posted on Feb 16, 2006

A bill for an act

relating to health; providing an exception to hospital restricted construction or modification;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:

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(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;

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(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;

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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;

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(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;

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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~~

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(20) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility.

Pioneer
RETIREMENT
COMMUNITY

- Pioneer Care Center
- Pioneer Pointe
- Pioneer Main
- Pioneer Senior Cottages
- Pioneer Adult Day Care
- Pioneer Therapies
- Pioneer Auxiliary
- Pioneer Foundation

1006 Sheridan St. S., Fergus Falls, MN 56537 *Telephone: 218-739-7700* *Fax: 218-739-7707*

March 15, 2006

Senator Cal Larson
153 State Office Building
100 Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155-1206

Representative Bud Nornes
175 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155

IN RE: Lake Region Healthcare Corporation
Legislative Request

Dear Gentlemen:

Pioneer Home, Inc. operates a number of facilities in Fergus Falls which serve the housing and care needs of elderly persons. The Pioneer Care Center is a skilled nursing home facility serving 105 residents, and providing 24-hour skilled nursing care, restorative therapies, and daily activities, among other services, to its residents. The Pioneer Senior Cottages provides a secure care environment for residents suffering from Alzheimer's and other memory loss issues. It is common for residents of Pioneer Home facilities to be in need of medical care and inpatient hospitalization. Pioneer Home, Inc. relies on Lake Region Healthcare Corporation to primarily deliver inpatient hospitalization.

Pioneer Home, Inc. is aware that Lake Region Healthcare Corporation is requesting legislative approval to expand its inpatient rehabilitation beds by an additional two beds, increasing the capacity to sixteen beds total. Pioneer Home, Inc. is in support of the request by Lake Region Healthcare Corporation, and believes it is appropriate for Lake Region to expand its rehabilitation unit beds.

Lake Region Healthcare Corporation operates the only hospital in Fergus Falls, and operates the only inpatient rehabilitation unit in this area. It is important that Lake Region Healthcare Corporation have sufficient capacity in its inpatient rehabilitation unit in order to fully serve the needs of the Fergus Falls community. As a member of the medical community in which Lake Region Healthcare operates its hospital, Pioneer Home,

Inc. would benefit from the increased bed capacity in the rehabilitation unit, which would serve to provide additional access for rehabilitation services that are not otherwise available to our community. The type of care provided by Lake Region in the rehabilitation unit is not offered by other medical providers in the community, so the public will certainly benefit from the expansion of this unit.

I think you for your consideration to this matter. Please share my comments with your peers in the Legislature.

Sincerely,

John Richards, CEO

LUTHERAN BRETHREN HOMES
Fergus Falls

BROEN MEMORIAL HOME

824 SOUTH SHERIDAN
FERGUS FALLS, MINNESOTA 56537
Phone 218-736-5441
We are an Equal Opportunity/Affirmative Action Employer

Senator Cal Larson
153 State Office Building
100 Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155-1206

Representative Bud Nornes
175 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155

March 15, 2006

Lutheran Brethren Homes, Inc. operates Broen Memorial Homes in Fergus Falls, which consists of a 153-bed skilled nursing home facility providing nursing care, residence services, and other affiliated services to the elderly population in Fergus Falls and the surrounding area. I am well familiar with the hospital operations of Lake Region Healthcare Corporation in Fergus Falls, and in particular, their rehabilitation care unit. When the residents of Broen Memorial Home need inpatient hospital care, Lake Region Healthcare is the primary provider of services to our residents.

Lutheran Brethren Homes, Inc. wishes to communicate its support to the Minnesota Legislature of the request by Lake Region Healthcare Corporation to add two beds to its inpatient rehabilitation unit. There is no other facility in Fergus Falls or Otter Tail County that serves the same type of patients that are served by the Lake Region Healthcare Rehabilitation Unit. I believe there is a demand for the type of services provided in the Rehabilitation Unit. Based on my knowledge of the community healthcare needs, the demand for the type of rehabilitation services provided by Lake Region will increase in the future.

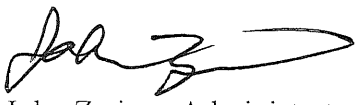
Lutheran Brethren Homes is also aware that Lake Region Healthcare Corporation is closing its separately-licensed 13-bed skilled nursing facility located in Fergus Falls. Accordingly, we do not view the request for additional inpatient rehabilitation beds as a gain of any sort in terms of the amount of beds available for inpatient care in Fergus Falls, but instead view the number of beds at Lake Region actually decreasing. Lutheran Brethren Homes has been working with Lake Region Healthcare to transition out of its nursing home facility, and certain of the patients that would otherwise be served by Lake Region's skilled nursing facility will now be provided care at

the Broen Memorial Home. Accordingly, we think it is important for the Legislature to consider that while the Rehabilitation Unit bed capacity will increase by 2, the actual bed capacity at Lake Region Healthcare will be less.

It is also important to point out that the providers of nursing and medical care in the Fergus Falls area are very few, primarily consisting of the Fergus Falls Medical Group, Lake Region Healthcare Corporation, Lutheran Brethren Homes, and Pioneer Home, Inc. Lake Region Healthcare Corporation provides rehabilitation services beyond those served by the other medical providers, so there is no duplication of service that would be realized as a result of increasing the rehabilitation bed capacity at Lake Region Healthcare Corporation.

In closing, based upon my knowledge of the healthcare community in which Lake Region Healthcare operates, I believe there is a demand for additional inpatient rehabilitation services of the nature provided by Lake Region Healthcare in its rehabilitation unit, and I fully support the request of Lake Region for additional inpatient rehabilitation beds.

Sincerely yours,



John Zwiers, Administrator

FERGUS FALLS MEDICAL GROUP, P.A.

615 SOUTH MILL STREET -- FERGUS FALLS, MINNESOTA 56537-2796 FAX 218-739-5501 218-739-2221
800-247-1066

March 15, 2006

Cal Larson
State Senator
153 State Office Building
100 Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155-1206

Bud Nornes
State Representative
175 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155

IN RE: Lake Region Healthcare Corporation
Legislative Request

Dear Senator Larson and Representative Nornes:

Lake Region Healthcare Corporation is requesting legislative authority to increase its rehabilitation unit bed capacity from 14 beds to 16 beds. This letter is provided to you and the other members of the Minnesota Legislature as an expression of support by Fergus Falls Medical Group, P.A. for the Lake Region Healthcare legislation, and is a request that the Minnesota legislature approve the legislation and the increased bed capacity.

Fergus Falls Medical Group, P.A. is a Fergus Falls based group of 41 physicians. The Fergus Falls Medical Group, P.A. operates an independent clinic and is a different legal and operating entity than Lake Region Healthcare Corporation. All of our medical group physicians have privileges at Lake Region Healthcare Corporation's hospital. Lake Region Healthcare Corporation is the primary hospital to which our group's physicians refer patients for care and treatment. As you likely are aware, the only other medical clinic in town is a husband and wife podiatry clinic, who also have privileges at Lake Region Healthcare Corporation and who primarily refer patients to Lake Region. For all practical purposes, the physicians of Fergus Falls Medical Group, P.A. are all the physicians comprising the medical community in which Lake Region operates its hospital. For these reasons, Fergus Falls Medical Group is intimately familiar with the medical care demands of the community in which Lake Region Healthcare operates.

It is also important to note that the medical staff of the Lake Region Healthcare Center for Rehabilitation is comprised of certain members of the Fergus Falls Medical Group, led by Dr. James Andrews, who specializes in physical medicine and rehabilitation. For these reasons, the Fergus Falls Medical Group is uniquely positioned to understand the needs for increased rehabilitation beds at Lake Region Healthcare and in our community.

The Lake Region Healthcare rehabilitation unit is the only in-patient rehabilitation unit in the City of Fergus Falls, Otter Tail County, and the surrounding area. If the rehabilitation unit did not exist at Lake Region Healthcare Corporation, our physicians would be forced to refer patients in need of comprehensive rehabilitation services either to Fargo, 60 miles away, or St. Cloud, 110 miles away. Therefore, the existence of the rehabilitation unit at Lake Region Healthcare is critical in order to fully serve the medical needs of the population of Fergus Falls and Otter Tail County. Our physicians directly know that the demand for the types of rehabilitation services provided by the Lake Region Healthcare rehabilitation unit is currently high, and the physicians also firmly believe that the demand in the future for rehabilitation services will continues to increase. For these reasons, the Fergus Falls Medical Group, and the medical staff of the rehabilitation unit fully see the need for increased bed capacity as requested by Lake Region Healthcare Corporation.

In closing, the Fergus Falls Medical Group, P.A., which includes the medical staff of Lake Region Healthcare Corporation, gives full an unqualified support to Lake Region Healthcare Corporation's request to increase its rehabilitation unit beds from 14 to 16. Expansion of the Rehabilitation Unit through addition of these beds will very well serve the interests of the public and will increase access to rehabilitation services in the medical community served by Lake Region Healthcare Corporation.

Respectfully yours,

FERGUS FALLS MEDICAL GROUP, P.A.

James Wilkus, CEO

Fergus Falls Medical Group, P.A.
615 SOUTH MILL • FERGUS FALLS, MINNESOTA 56537-2706 FAX 218 739 5501 218 739 2021 800 247 1066

Battle Lake
Good Samaritan
Center
In Christ's Love , Everyone Is Someone.

105 Glenhaven Dr
Battle Lake, MN 56515-4010

218-864-5231 *phone*
218-864-5498 *fax*

March 14, 2006

Senator Cal Larson
153 State Office Building
100 Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155-1206

Representative Bud Nornes
175 State Office Building
100 Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155

Dear Gentlemen,

I am the Administrator of the Battle Lake Good Samaritan Center, a 55 bed Medicare Certified long term care facility located in Battle Lake, Minnesota. This facility is located approximately 20 miles from Lake Region Healthcare Corporation, which operates the only hospital facility in Fergus Falls. In addition to nursing home care, our facility offers in-patient and out-patient physical, speech, and occupational therapy.

The Battle Lake Good Samaritan Center is aware of the request by Lake Region Healthcare Corporation for legislative approval to expand its current rehabilitation-bed capacity from 14 beds to 16 beds, which will occur concurrently with Lake Region Healthcare Corporation closing its separately licensed 13-bed skilled nursing care facility. This letter is an expression by Battle Lake Good Samaritan Center of its support for the Lake Region Healthcare Corporation request.

The Battle Lake Good Samaritan Center routinely refers our residents to Lake Region Hospital for services when our residents are in need of acute care that is beyond the scope provided by our facility. If the acute care rehabilitation unit is expanded to additional capacity, residents within the Fergus Falls community, and in greater Ottertail County will benefit from the increased capacity to provide rehabilitation services. Within the Fergus Falls community, and in Ottertail County, there is no other healthcare facility that provides the acute care rehabilitation services provided by Lake Region Healthcare Corporation in its rehabilitation unit. If Lake Region Healthcare expands its rehabilitation beds, access to the types of services provided in the rehabilitation unit will be increased and improved.

As a member of the regional healthcare community in which Lake Region Healthcare Corporation operates, the Battle Lake Good Samaritan Center believes it is in the best interest of the public to permit Lake Region Healthcare Corporation to increase the number of its acute care rehabilitation beds. I respectively urge both the Minnesota Senate and the Minnesota House of Representatives to approve the requested legislation.

Sincerely,

Jim Wolf,
Administrator

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
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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

Senators Sams, Higgins, Lourey and Ruud introduced–

S.F. No. 2630: Referred to the Committee on Health and Family Security.

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:

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(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;

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(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;

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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;

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(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.

To Make A Referral

Pre-admission screening is provided to all potential patients within 4 hours of the referral by one of the members of the rehabilitation team. This is to determine if the patient's specific condition may benefit from a comprehensive rehabilitation program. The Medical Director of **Lake Region Center for Rehabilitation** is responsible for authorizing a patient's admission the program.

If you wish to make a referral, please contact **Lake Region Center for Rehabilitation** and ask for the program director. In order to provide prompt service, the following information will be helpful:

- Patient's name, location or home address, date of birth, and social security number
- Name of the patient's referring or family physician
- History of present illness
- Insurance/Medicare information

Lake Region Center for Rehabilitation is covered by most major medical insurance carriers, including Medicare. Benefits will be verified prior to admission.

road to recovery

Patients Served

Lake Region Center for Rehabilitation provides services for patients who have suffered functional loss due to a disabling illness or injury, which may include the following:

- Stroke (CVA)
- Amputation
- Congenital deformities
- Debilitating arthritic conditions
- Major multiple trauma
- Spinal cord injury
- Brain injury
- Orthopedic dysfunction
- Degenerative neurological disorders including:
  - Multiple Sclerosis (MS)
  - Polyneuropathy
  - Muscular Dystrophy
  - Parkinson's Disease
  - Guillain Barre
  - Other progressive neurological impairments

CARF Accreditation

Choosing CARF-accredited program services gives you the assurance that:

- Our programs and services actively involve the patient in selecting, planning, and using services.
- Our programs and services have met consumer-focused, state-of-the-art national standards of performance.
- These standards were developed with the involvement and input of consumers.
- We are focused on assisting each person in achieving his or her chosen goals and outcomes.

LRH Lake Region Center for Rehabilitation
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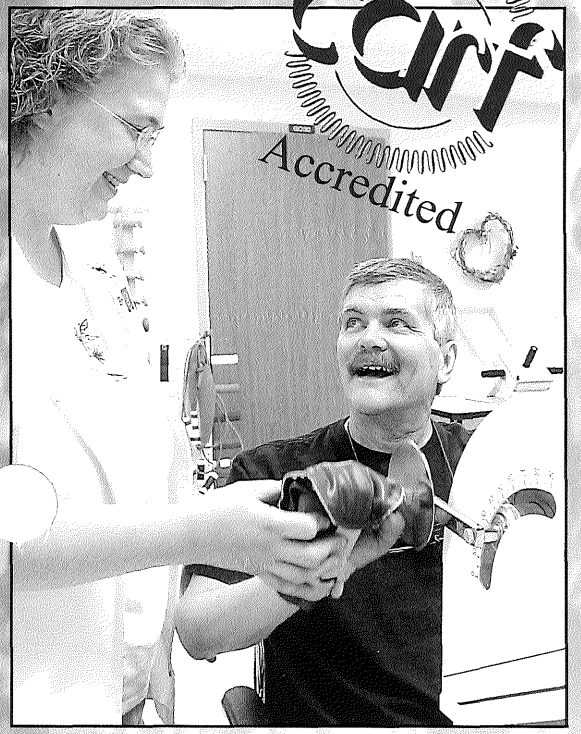
When you are in need of Inpatient Acute Rehabilitation

CARF Accredited



the road to recovery

LRH Lake Region Center for Rehabilitation
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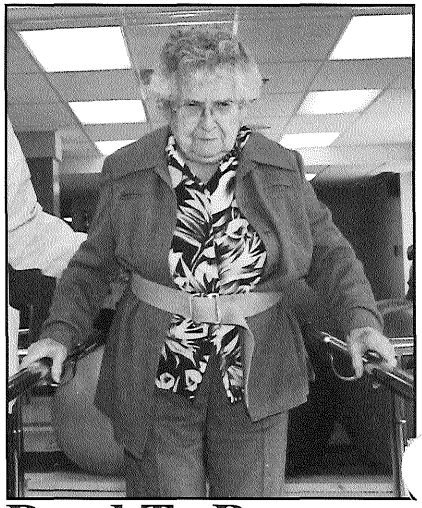
Individuals who have been impaired by an injury or illness have a lot of questions and face an uncertain future. We want to help alleviate those fears and frustrations by providing a supportive, caring environment and always placing emphasis on patients' abilities rather than disabilities. This positive approach to rehabilitation helps instill in patients the confidence they need for optimal recovery.



Road To Recovery

Our rehabilitation program is an inpatient program that provides ongoing care for the patient and prepares the patient for attaining the greatest level of independence.

- Self-care skills
- Mobility skills
- Communication abilities, as needed
- Effective discharge planning
- Maximizing the ability to enjoy life

Benefits of Rehabilitation

Potential candidates are patients who, as a result of injury or illness, have difficulties, which may include:

- alance and coordination problems
- Difficulty swallowing
- Difficulty moving in bed or from one place to another
- Weakness or limited motion in arms, legs, or trunk
- Difficulty performing activities of daily living such as eating, grooming, dressing, bathing, and homemaking
- Memory difficulties
- Speech or language problems

Admission Criteria

Patients can be referred and admitted from home, a hospital or other facility. **Lake Region Center for Rehabilitation** welcomes referrals from doctors, social workers, family members, insurance representatives, case managers, and patients themselves. Usually the referral process is initiated by a written order from the patient's physician. To be eligible for admission, the individual must:

- Be medically stable
- Need at least two forms of therapy
- Have the potential to improve function or achieve independence
- Have an identified discharge placement
- Be willing to participate with the team in the rehabilitation program

Rehabilitation Program

Our program consists of rehabilitation in an inpatient setting with comprehensive services including:

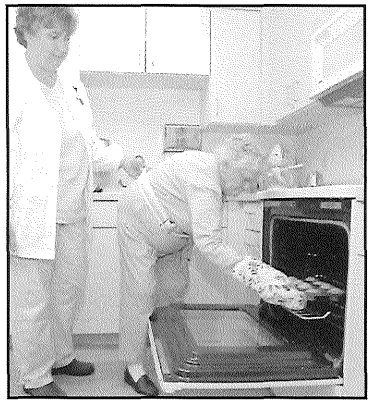
- Rehabilitation Medicine
- Rehabilitation Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Social Work
- Psychology
- Spiritual Services

Education and Training

Family education and training for discharge is an important part of the program and may include:

- Methods to conserve energy
- Therapeutic exercises
- Use of adaptive equipment
- Adjustment to changing life roles
- Management of medical complications

Planning for discharge includes preparation for ongoing care and rehab followup. Other services such as home health and outpatient therapy may be planned on an as needed basis.



Board of Commissioners

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

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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

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Senate Counsel, Research, and Fiscal Analysis

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DIRECTOR

Senate
State of Minnesota

S.F. No. 2582 - Waivered Services Overspending (as Amended by the A-1 Amendment)

Author: Senator Yvonne Prettner-Solon

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

Date: March 15, 2006

S.F. No. 2582 provides that a county that overspends its calendar year allotment under the waivered services program for persons with developmental disabilities is not required to pay back the overspending if the net spending by all counties does not exceed the total appropriation for the program.

DG:rdr

Senator Solon introduced–

S.F. No. 2582: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; establishing allowances for counties that overspend certain waivered services allotments under certain circumstances; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.492] WAIVERED SERVICES OVERSPENDING.**

Subdivision 1. **Waivered services for persons with developmental disabilities.** A county that overspends its allowed amounts in a calendar year under the waivered services program for persons with developmental disabilities shall not be required to pay back the amount of overspending when the net amount spent by all counties for these waivered services is within the limits of appropriations for these services by all counties.

Subd. 2. **Community alternatives for disabled individuals.** (a) A county that overspends its allowed amounts in a calendar year under the community alternatives for disabled individuals waivered services program shall not be required to pay back the amount of overspending when the net amount spent by all counties for these waivered services is within the limits of appropriations for these services by all counties.

(b) A county that authorizes more than the allowed appropriations amount for these waivered services but whose expenditures are equal to or less than the allowed amount shall not be required to pay back the difference between the allowed amount and the authorized amount.

Subd. 3. **Traumatic brain injury waivered services.** (a) A county that overspends its allowed amounts in a calendar year under the traumatic brain injury waivered services program shall not be required to pay back the amount of overspending when

the net amount spent by all counties for these waivered services is within the limits of appropriations for these services by all counties.

(b) A county that authorizes more than the allowed appropriations amount for these waivered services but whose expenditures are equal to or less than the allowed amount shall not be required to pay back the difference between the allowed amount and the authorized amount.

Senator ..... moves to amend S.F. No. 2582 as follows:

Page 1, delete line 7 and insert "A"

Page 1, delete subdivisions 2 and 3

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S.F. No. 2080 - Long-Term Care Service Options (the A-4 Delete-Everything Amendment)

Author: Senator Becky Lourey

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

Date: March 15, 2006

S.F. No. 2080 requires the Commissioner of Department of Human Services (DHS) to ensure that the state's long-term care system meets certain listed objectives. It also requires the commissioner to conduct a long-term care investment study and develop goals for rebalancing long-term care spending. It appropriates $250,000 to hire a contractor to conduct the investment study.

Section 1 (256B.0918) requires DHS to ensure that the long-term care system is sustainable, supports self determination, provides services that meet consumers' needs and preferences, provides high-quality care, and is efficient and affordable. The system must ensure a range of service options. Other system requirements are listed.

Section 2 requires DHS, in consultation with the Minnesota Department of Health, to report to the Legislature by February 15, 2007, on (1) the results of a long-term care investment study, and (2) goals developed to rebalance long-term care spending.

The investment study must include proposals to implement the recommendations related to age-friendly communities and family caregiving from a 2005 report on financing long-term care. The study must gather and report needs data and determine the efficiency of existing services and service models. The study must be conducted in five communities, three in greater Minnesota and two in the seven-county metro area. A planning advisory group must be appointed in each community being studied.

The goals development report must include recommended allocation goals for long-term care spending that reflect increased reliance on home and community-based services. The allocation

goals must incorporate the findings of the investment study and must include a plan and timeline to reach rebalancing goals by state fiscal year 2011.

DHS must select a contractor by August 15, 2006, to conduct the study.

Section 3 appropriates $250,000 to DHS to hire a contractor to conduct the investment study.

DG:rdr

Senators Lourey, Higgins and Kiscaden introduced--

S.F. No. 2080: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; implementing the recommendations of the tripartisan Long-Term Care Task Force; reducing excess capacity of nursing facility beds; allocating resultant savings to home and community-based services for elderly persons and family caregivers; expanding home and community-based services for elderly persons and family caregivers; establishing a demonstration project.

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

Section 1. [PURPOSE.]

Minnesota's long-term care system serving older Minnesotans supports self-determination, provides services that meet consumers' needs and preferences, provides high quality care, and ensures efficiency and affordability.

Sec. 2. [LONG-TERM CARE SERVICE OPTIONS.]

To ensure the availability of long-term care service options for older persons, the commissioner shall develop service options that meet the following objectives:

(1) choice to ensure a range of options including nursing facilities, housing with services establishments, and home and community-based services and support that include, but are not limited to, home health care, living at home block nurse programs, home-delivered meals, congregate dining, chore assistance, transportation, homemaker assistance, assisted living programs, senior companionship, respite and other caregiver support services, adult day health services,

technology, and care coordination;

(2) cost-effectiveness methodologies that ensure 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, and aging grants programs;

(3) high quality and good outcomes with assurances that services are provided by sufficient, trained, and competent staff that meet industry standards;

(4) least restrictive alternatives to minimize disruption to an older person's life while still meeting the person's assistance needs;

(5) avoidance of premature use of nursing facilities and diversion from nursing facilities to community supports when feasible;

(6) elder-friendly communities with family, government, faith communities, businesses, and other sectors working together to support vital aging and long-term care at home; and

(7) strengthening informal care systems that include family, friends, volunteers, and existing community resources.

Sec. 3. [ALLOCATION OF STATE AND FEDERAL FUNDS.]

By 2010, at least 60 percent of state and federal funds for long-term care for elderly persons shall be allocated to home and community-based services developed according to section 2, through the alternative care, elderly waiver, medical assistance home care, and aging grants programs, and other relevant programs and demonstration projects. The commissioner of human services shall establish a baseline for fiscal year 2005 and shall measure progress each fiscal year thereafter and report on the status of achieving the allocation of funds under this section to the legislature by January 31 of each year.

Sec. 4. [BED CLOSURES AND REALLOCATION OF FUNDS.]

The commissioner of human services, in consultation with nursing facilities, shall establish and implement a program by December 31, 2005, to close at least 3,000 nursing facility beds in fiscal years 2006 and 2007 and at least 3,000 additional beds

in fiscal years 2008 and 2009 through incentives or other measures determined by the commissioner. All of the cost savings shall be tracked by the commissioner and used to fund home and community-based services in section 2, the demonstration project in section 6, and the regional planning process in section 5, subdivision 2.

Sec. 5. [EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.]

Subdivision 1. [EXPANSION OF SERVICES.] The commissioner shall expand services to elderly persons and caregivers and provide ongoing funding for home and community-based services in section 2 through the alternative care, elderly waiver, medical assistance home care, and aging grant programs. Additional categories of services, such as transportation, may be developed and funded under the aging grant programs if determined necessary through the regional planning process under section 5, subdivision 2, and with the agreement of the commissioner.

Subd. 2. [EXPANSION PRIORITIES.] Service expansion priorities shall be determined by December 31, 2005, through a coordinated regional planning process conducted jointly by area agencies on aging, counties, health plans that hold contracts as MSHO or elderly waiver administrators, and nursing facilities.

Subd. 3. [CAREGIVER SUPPORT.] The commissioner, in partnership with the Minnesota Board on Aging, shall develop and implement access to caregiver support using the Internet to provide family caregivers information and tools to support the caregiver's ability to provide care longer and to identify and engage service providers such as respite workers, caregiver consultants, and adult day health services. Respite, caregiver consultation, adult day health, and other services shall be expanded in underserved areas according to subdivisions 1 and 2.

Sec. 6. [TARGETED CASE MANAGEMENT RELOCATION DEMONSTRATION PROJECT.]

Subdivision 1. [CASE MANAGEMENT.] The commissioner shall develop and implement, through a request for proposal process, a relocation demonstration project by July 1, 2006, of case management targeted at elderly persons currently residing in

nursing facilities with care needs that could be met in the community. The priority focus shall be on elderly persons during their first 60 days of residence in a nursing facility.

Subd. 2. [PERSONS SERVED.] The demonstration project shall serve 500 persons by June 30, 2007, and shall be implemented in at least one urban market area and one rural market area. Elderly persons are eligible for targeted relocation if enrolled in medical assistance or will spend down to medical assistance eligibility within 180 days.

Subd. 3. [PROVIDERS.] Providers eligible for the targeted case management demonstration project are county health and human service agencies, area agencies on aging, or other nonprofit or for profit entities that do not have a conflict of interest and meet medical assistance or other federal and state requirements. Counties in the demonstration area have the first right of refusal. Targeted case management providers must have:

(1) the legal authority to provide case management services;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by elderly persons;

(3) a financial management system that provides accurate documentation of and billing for services and costs; and

(4) the capacity to document and maintain individual case records.

Subd. 4. [COVERED SERVICES AND ACTIVITIES.] Targeted case management services eligible for reimbursement of state funds and federal funds under the demonstration for a nine-month period are:

(1) in-person assessments;

(2) written individual service plan development, completion, and regular review that is based on the older person's needs and preferences, and which ensures access to community-based long-term care services, medical care, and other related services and supports;

(3) routine contact and support for the elderly person, the

person's family, and any primary caregiver, and routine communication with service providers or other persons necessary to develop and implement the goals of the individual service plan;

(4) coordination and monitoring of overall service delivery to ensure quality of services, appropriateness, and continued need;

(5) maintenance of records and documentation that supports and verifies the activities in this subdivision;

(6) travel necessary to conduct one or more visits with the elderly person to develop or implement the goals of the individual service plan;

(7) coordination with the nursing facility discharge planner; and

(8) performance of the administrative activities of the demonstration project.

Sec. 7. [TRANSITIONAL SUPPORT GRANT.]

A cash grant of up to $3,000 shall be available to elderly persons participating in the demonstration project who are moving from a nursing facility to a community setting with a onetime payment to cover the costs, not covered by other sources, associated with moving into a community setting. Covered costs include, but are not limited to:

(1) lease or rent deposits;

(2) security deposits;

(3) utility setup costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

Sec. 8. [APPROPRIATIONS.]

Subdivision 1. $..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services to fund the expansion of home and community-based services under section 5.

Subd. 2. $..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of

human services to fund the targeted case management relocation demonstration project under section 6.

Subd. 3. $..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services to fund comparable cost-of-living increases for state-funded home and community-based service providers not covered under the cost-of-living provisions granted to nursing facility providers.

Senator ..... moves to amend S.F. No. 2080 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **[256B.0918] 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 supports 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. **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."

Delete the title and insert:

"A bill for an act

relating to human services; establishing long-term care system objectives; requiring a long-term care investment study and rebalancing goals development; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 256B."

Senator ..... moves to amend the delete-everything amendment (SCS2080A-4) to S.F. No. 2080 as follows:

Page 3, after line 33, insert:

"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."

Renumber the sections in sequence and correct the internal references

March 13, 2006

Minnesota Leadership Council on Aging
Long-term Care Investment Study

SF 2080 (Senators Lourey, Higgins and Kiscaden)

MN Leadership Council on Aging

The MN Leadership Council on Aging (MNLCOA) is a collaboration of non-profit organizations formed in 2004, representing more than 240,000 seniors and family caregivers. A primary goal of the Council is to assure that older persons have access to services that enable them to live in the community when they may have traditionally been placed in nursing homes.

Re-balancing Long-term Care

Minnesota's efforts to reform and rebalance its long-term care system from one of over-reliance on institutional care began with outstanding efforts of the Long-term Care Task Force and Project 2030. Counties have played a strong role in identifying service needs through their Gaps Analyses reports which has helped to increase home and community-based care options for seniors. Through the counties' service gaps reports, the Minnesota Board on Aging's Survey of Older Minnesotans, and the Transform 2010 initiative of the Department of Human Services (DHS) there is a general understanding of need for home and community-based services and of the broad expectations of older people.

Proposed Long-term Care Investment Study

It is imperative that Minnesota structures a planned approach to rebalancing its long-term care system as the current system is financially unsustainable. DHS reports that one of every four Minnesotans will be 65 and older by 2030 and that the number of seniors needing long-term care will double. In its January 2005 report to the Legislature on financing long-term care for baby boomers, DHS states that it is necessary "to increase efforts to support family caregivers" and "increase the number of age-friendly communities in Minnesota." The report states that 91% of long-term care for elders is provided by family members, and that this care is valued at $4.58 billion annually. In addition, the report notes that for every 1% decline in family caregiving, the cost to Minnesota is $30 million annually in public funding.

While the demographic trends are well documented and the financial costs of institutional long-term care well known, *there is a critical lack of community level data on which to base goals to reallocate public funding for long-term care and to guide investments in community care.* The following information is needed to shape Minnesota's investments in home and community-based long term care:

1. specific information about the needs of family caregivers of frail seniors;

2. costs and benefits of home and community-based care, including informal support;

3. efficacy and efficiency of existing service models within varying economic, demographic and social groups at the community level; and

4. recommendations for a core set of services accessible by seniors and caregivers.

Summary

The MNLCOA's proposal is to collect and report community level data from five communities that are representative of rural and urban communities and are of diverse racial and socioeconomic status. The Long-Term Care Investment Study will complement existing information and provide a solid base which Minnesota can use to develop a comprehensive plan to effectively rebalance its long-term care system with an overall vision to support quality of life for all in age-friendly communities.

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S.F. No. 3064 - Medical Assistance Coverage for Medicare Part D Enrollees

Author: Senator Linda Berglin

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

Date: March 14, 2006

S.F. No. 3064 provides medical assistance coverage for medical assistance recipients who are either enrolled in a Medicare Part D plan or eligible for a Medicare Part D plan.

Section 1 (256B.0625, subdivision 13i) extends medical assistance coverage to:

(1) co-payments over $12 per month paid under a Medicare Part D prescription drug plan or Medicare Advantage special needs plan;

(2) prescription drugs that are not covered under a Medicare Part D plan so long as the Board of Aging has determined that the plan that the recipient is in enrolled in is the most comprehensive plan in terms of covering the recipient's drug needs; and

(3) prescription drugs for recipients who are eligible for Medicare Part D but are not enrolled. Coverage under this instance is limited to 60 days from the date of application to Medicare Part D.

KC:ph

Senators Berglin and Koering introduced–

S.F. No. 3064: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; providing limited medical assistance coverage for individuals eligible for Medicare Part D; amending Minnesota Statutes 2004, section 256B.0625, by adding a subdivision.

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

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

Subd. 13i. **Medicare Part D.** (a) Notwithstanding subdivision 13, paragraph (d), for recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare Advantage special needs plan, medical assistance covers the following:

(1) co-payments which the recipient is responsible for under a Medicare Part D prescription drug plan or Medicare Advantage special needs plan, once the recipient has paid $12 per month in prescription drug co-payments, in accordance with the requirements of the plan; and

(2) any prescription drug that is not covered by the Medicare Part D prescription drug plan or Medicare Advantage special needs plan in which the recipient is enrolled but only after a determination has been made by the Board on Aging that the recipient is enrolled in the plan that provides the most comprehensive prescription drug coverage in terms of the recipient's prescription drug needs.

(b) Notwithstanding subdivision 13, paragraph (d), for recipients who are eligible for Medicare Part D but who are awaiting enrollment into a Medicare Part D prescription drug plan or Medicare Advantage special needs plan, medical assistance covers prescription drugs as required under subdivision 13, paragraph (a), for a period of 60 days beginning the date the Medicare Part D application was submitted.

(c) Medical assistance coverage under paragraphs (a) and (b) shall be provided in accordance with the requirements of subdivisions 13 to 13h.

Senator Berglin moves to amend S.F. No. 3064 as follows:

Page 1, line 13, delete "paid"and insert "incurred"

Page 1, delete lines 15 to 19 and insert:

"(2) any prescription drug that is not included in the drug formulary used by the Medicare Part D prescription drug plan or Medicare Advantage special needs plan in which the recipient is enrolled. Coverage under this clause shall only occur upon a determination by the Board of Aging that the recipient is enrolled in the plan that provides the most comprehensive prescription drug coverage in terms of the recipient's prescription drug needs and meets the low-income premium benchmark set for Minnesota. Once a determination has been made by the Board of Aging, the commissioner shall not require the recipient to pursue the plan's exception and appeal process before providing coverage under this clause."

Page 2, after line 2, insert:

"Sec. 2. **FEDERAL GOVERNMENT CHANGES.**

The commissioner of human services shall seek reimbursement from the federal government for funds expended by the state to provide drug coverage to medical assistance recipients who are enrolled or in the process of enrolling in Medicare Part D. The commissioner shall also continue to pursue federal changes to Medicare Part D to address lapses in drug coverage for medical assistance recipients who are also enrolled or eligible for Medicare Part D."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senate Counsel, Research, and Fiscal Analysis

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S.F. No. 2888 - Establishing Requirements for Assisted Living Services

Author: Senator Linda Berglin

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

Date: March 15, 2006

S.F. No. 2888 establishes minimum requirements for assisted living services in a new chapter of state law, Chapter 144G. It allows assisted living services to be provided only in a registered housing with services establishment. It modifies the home care bill of rights for assisted living clients with respect to certain advance notice requirements. It establishes a Class F home care provider category and eliminates the Class E assisted living program license. These provisions are effective January 1, 2007.

Section 1 (144A.441) modifies the home care bill of rights to require that assisted living clients receive 30 days of advance notice, rather than ten days, regarding the termination of a service by a provider, except in certain unusual circumstances.

Section 2 (144A.442) requires that when a non-Medicare-certified provider of home care services terminates services to an assisted living client, the provider must give the client a written notice that includes certain required information, including the date of termination, reason for termination, contact information for other service providers, and an offer to coordinate the transfer of care.

Section 3 (144A.4605) changes the title of licensed providers that offer home care services to residents of housing with services establishments. These providers are referred to as "class F home care providers" rather than "assisted living home care providers."

Section 4 (144D.01, subdivision 2a) adds a definition of "arranged home care provider" to the statute regulating housing with services establishments.

Section 5 (144D.015) clarifies the definition of "assisted living facility" and "assisted living residence" for purposes of consistency with long-term care insurance terminology.

Section 6 (144D.02) deletes outdated language.

Section 7 (144D.03, subdivision 2) deletes outdated language.

Section 8 (144D.04) modifies the contents of a housing with services contract. It clarifies language and requires the contract to include contact information for long-term care consultation services.

Section 9 (144D.045) outlines the information a housing with services establishment must provide to prospective residents regarding assisted living service providers that offer services in the establishment.

Section 10 (144D.05) deletes outdated language.

Section 11 (144D.065) corrects terminology.

Sections 12 to 17 establish a new Chapter 144G regulating assisted living services.

Section 12 (144G.01) defines terms.

Section 13 (144G.02) prohibits a person or entity from using the phrase "assisted living" to advertise or describe itself unless the entity is a housing with services establishment that meets the requirements of Chapter 144G or the person or entity provides some or all components of assisted living that meet these requirements. An establishment that only offers assisted living services in a portion of its housing units must identify the number or location of those units and may not use the term "assisted living" in its name. This section also authorizes the Commissioner of the Minnesota Department of Health (MDH) to enforce this chapter.

Section 14 (144G.03) requires that assisted living services be provided only to individuals living in a registered housing with services establishment. This section also establishes minimum requirements for assisted living services. A housing with services establishment using the phrase "assisted living" to identify or market itself must register annually with MDH to verify compliance with this chapter. Minimum assisted living service requirements include:

- the provision of health-related services, including medication administration or assistance with self-administration and assistance with at least three of seven listed activities of daily living;
- provision of necessary client assessments by a registered nurse;
- a system to supervise and evaluate the delegation of health care activities to unlicensed health care personnel;

- staff access to an on-call registered nurse at all times;
- a system to check at least daily on each client;
- a person available at all times to respond to client requests who is awake, located in the same building or nearby, and capable of understanding and responding to requests for assistance;
- the provision of, or offer to provide, two meals each day, weekly housekeeping and laundry service, and assistance in accessing other services; and
- provision of a consumer information guide as required under section 17.

This section also regulates the provision of nurse assessments prior to move in, the provision of information to help a resident who has concerns about assisted living services being provided, and the provision of notice to a resident when the establishment terminates the client's housing contract.

Section 15 (144G.04) protects a client from having to utilize any assisted living services made available in the establishment and protects the rights of the establishment to terminate contracts under certain circumstances; to decline to serve a client whose needs cannot be met; to refuse to fundamentally alter the operation of the establishment to accommodate a resident; and to require a resident, as a condition of residency, to pay for a package of assisted living services even if the client chooses not to utilize every service.

Section 16 (144G.05) allows providers who do not meet the requirements of this chapter to continue to receive payment for assisted living services under the Elderly Waiver program if they continue to satisfy federal standards.

Section 17 (144G.06) requires MDH, after receiving the recommendations of an advisory committee, to adopt a uniform format and required components for a consumer information guide and make them available to assisted living providers.

Section 18 is a Revisor's instruction.

Section 19 is a repealer.

DG:rdr

Senator Berglin introduced–

S.F. No. 2888: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; establishing requirements for assisted living services; limiting use of the term assisted living; specifying procedures for terminating services for assisted living clients; modifying the home care bill of rights for purposes of assisted living; establishing the Class F home care provider category; eliminating the Class E assisted living programs license; requiring the provision of information on assisted living and the legal rights of assisted living clients; amending Minnesota Statutes 2004, sections 144A.4605; 144D.01, by adding a subdivision; 144D.015; 144D.02; 144D.03, subdivision 2; 144D.04; 144D.05; 144D.065; proposing coding for new law in Minnesota Statutes, chapters 144A; 144D; proposing coding for new law as Minnesota Statutes, chapter 144G; repealing Minnesota Rules, part 4668.0125.

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

Section 1. **[144A.441] ASSISTED LIVING BILL OF RIGHTS ADDENDUM.**

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 2. **[144A.442] TERMINATION OF HOME CARE SERVICES FOR ASSISTED LIVING CLIENTS.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 4668.0050;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (17);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) contact information for the Office of Ombudsman for Older Minnesotans;

(8) a copy of the home care bill of rights; and

(9) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 3. Minnesota Statutes 2004, section 144A.4605, is amended to read:

144A.4605 ~~ASSISTED LIVING HOME CARE~~ CLASS F PROVIDER.

Subdivision 1. **Definitions.** For purposes of this section, the term "~~assisted living~~ class F home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments registered under chapter 144D.

Subd. 2. ~~Assisted living~~ **Class F home care license established.** A home care provider license category entitled ~~assisted living~~ class F home care provider is hereby established. A home care provider may obtain ~~an assisted living~~ a class F license if the program meets the following requirements:

(a) nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications under the ~~assisted living~~ class F license are provided solely for residents of one or more housing with services establishments registered under chapter 144D;

(b) unlicensed personnel perform home health aide and home care aide tasks identified in Minnesota Rules, parts 4668.0100, subparts 1 and 2, and 4668.0110, subpart 1. Qualifications to perform these tasks shall be established in accordance with subdivision 3;

(c) periodic supervision of unlicensed personnel is provided as required by rule;

(d) notwithstanding Minnesota Rules, part 4668.0160, subpart 6, item D, client records shall include:

(1) daily records or a weekly summary of home care services provided;

(2) documentation each time medications are administered to a client; and

(3) documentation on the day of occurrence of any significant change in the client's status or any significant incident, such as a fall or refusal to take medications.

All entries must be signed by the staff providing the services and entered into the record no later than two weeks after the end of the service day, except as specified in clauses (2) and (3);

(e) medication and treatment orders, if any, are included in the client record and are renewed at least every 12 months, or more frequently when indicated by a clinical assessment;

(f) the central storage of medications in a housing with services establishment registered under chapter 144D is managed under a system that is established by a registered nurse and addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications; and

(g) in other respects meets the requirements established by rules adopted under sections 144A.45 to 144A.47.

Subd. 3. **Training or competency evaluations required.** (a) Unlicensed personnel must:

(1) satisfy the training or competency requirements established by rule under sections 144A.45 to 144A.47; or

(2) be trained or determined competent by a registered nurse in each task identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, when offered to clients in a housing with services establishment as described in paragraphs (b) to (e).

(b) Training for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall use a curriculum which meets the requirements in Minnesota Rules, part 4668.0130.

(c) Competency evaluations for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, must be completed and documented by a registered nurse.

(d) Unlicensed personnel performing tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall be trained or demonstrate competency in the following topics:

(1) an overview of sections 144A.43 to 144A.47 and rules adopted thereunder;

(2) recognition and handling of emergencies and use of emergency services;

(3) reporting the maltreatment of vulnerable minors or adults under sections 626.556 and 626.557;

(4) home care bill of rights;

(5) handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints;

(6) services of the ombudsman for older Minnesotans;

(7) observation, reporting, and documentation of client status and of the care or services provided;

(8) basic infection control;

(9) maintenance of a clean, safe, and healthy environment;

(10) communication skills;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

(e) Unlicensed personnel who administer medications must comply with rules relating to the administration of medications in Minnesota Rules, part 4668.0100, subpart 2, except that unlicensed personnel need not comply with the requirements of Minnesota Rules, part 4668.0100, subpart 5.

Subd. 4. **License required.** (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain ~~an assisted living~~ a class F home care license according to this section or a class A or class ~~E~~ B license according to rule. A housing with services establishment that obtains a class ~~E~~ B license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5f, paragraph (b), and 256B.0915, subdivision 3d.

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.47, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

~~(c) An adult foster care provider licensed by the Department of Human Services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.~~

~~(d) An assisted living~~ (c) A class F home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

Subd. 5. **License fees.** The license fees for ~~assisted living~~ class F home care providers shall be as follows:

(1) $125 annually for those providers serving a monthly average of 15 or fewer clients, and for ~~assisted living~~ class F providers of all sizes during the first year of operation;

(2) $200 annually for those providers serving a monthly average of 16 to 30 clients;

(3) $375 annually for those providers serving a monthly average of 31 to 50 clients; and

(4) $625 annually for those providers serving a monthly average of 51 or more clients.

Subd. 6. **Waiver.** Upon request of the home care provider, the commissioner may waive the provisions of this section relating to registered nurse duties.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 4. Minnesota Statutes 2004, section 144D.01, is amended by adding a subdivision to read:

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under Minnesota Rules, chapter 4668, that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 5. Minnesota Statutes 2004, section 144D.015, is amended to read:

144D.015 ASSISTED LIVING FACILITY OR ASSISTED LIVING RESIDENCE DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or ~~contracts~~ makes arrangements with an individual or entity that holds~~, a~~ any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence."

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 6. Minnesota Statutes 2004, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain ~~an elderly~~ a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 7. Minnesota Statutes 2004, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity

of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into ~~an elderly~~ a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; and

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 8. Minnesota Statutes 2004, section 144D.04, is amended to read:

144D.04 ~~ELDERLY~~ HOUSING WITH SERVICES CONTRACTS.

Subdivision 1. **Contract required.** No ~~elderly~~ housing with services establishment may operate in this state unless a written ~~elderly~~ housing with services contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

Subd. 2. **Contents of contract.** ~~An elderly~~ A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

~~(9) fee schedules outlining the cost of any additional services;~~

~~(10)~~ (9) a description of the process through which the contract may be modified, amended, or terminated;

~~(11)~~ (10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Older Minnesotans;

~~(12)~~ (11) the resident's designated representative, if any;

~~(13)~~ (12) the establishment's referral procedures if the contract is terminated;

~~(14) criteria~~ (13) requirements of residency used by the establishment to determine who may reside or continue to reside in the ~~elderly~~ housing with services establishment;

~~(15)~~ (14) billing and payment procedures and requirements;

~~(16)~~ (15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement; ~~and~~

~~(17)~~ (16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Subd. 3. **Contracts in permanent files.** ~~Elderly~~ Housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.72, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 9. **[144D.045] INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.**

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

(1) the name, mailing address, and telephone number of the arranged home care provider;

(2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1) ;

(3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;

(4) the arranged home care provider's billing and payment procedures and requirements; and

(5) any limits to the services available from the arranged provider.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 10. Minnesota Statutes 2004, section 144D.05, is amended to read:

144D.05 AUTHORITY OF COMMISSIONER.

The commissioner shall, upon receipt of information which may indicate the failure of the ~~elderly~~ housing with services establishment, a resident, a resident's representative, or a service provider to comply with a legal requirement to which one or more of them

may be subject, make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the ~~elderly~~ housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 11. Minnesota Statutes 2004, section 144D.065, is amended to read:

144D.065 ESTABLISHMENTS THAT SERVE PERSONS WITH ALZHEIMER'S DISEASE OR RELATED DISORDERS.

(a) If a housing with services establishment registered under this chapter markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the ~~facility's~~ establishment's direct care staff and their supervisors must be trained in dementia care.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 12. **[144G.01] DEFINITIONS.**

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 13. **[144G.02] ASSISTED LIVING; PROTECTED TITLE; RESTRICTION ON USE; REGULATORY FUNCTIONS.**

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under sections 144A.45 and 144A.46 and with respect to housing with services establishments

under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 14. **[144G.03] ASSISTED LIVING REQUIREMENTS.**

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service, service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health related services under a class A or class F home care license. At a minimum, health related services must include:

(i) assistance with self-administration of medication as defined in Minnesota Rules, part 4668.0003, subpart 2a, or medication administration as defined in Minnesota Rules, part 4668.0003, subpart 21a; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed assistive health care personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, to respond to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other

identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service agreement or service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285 with respect to the provision of a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 4. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 5. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any;

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination; and

(7) contact information for the Office of Ombudsman for Older Minnesotans.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 15. **[144G.04] RESERVATION OF RIGHTS.**

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 16. **[144G.05] REIMBURSEMENT UNDER ELDERLY WAIVER ASSISTED LIVING SERVICE PACKAGES.**

Notwithstanding the provisions of this chapter, the requirements for the Elderly Waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91).

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 17. **[144G.06] UNIFORM CONSUMER INFORMATION GUIDE.**

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in Minnesota Statutes, section 144G.01, that includes information about services offered by that provider, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in Minnesota Statutes, section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 18. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall strike all references to the "Class E assisted living home care programs license, "Class E license," and similar terms in Minnesota Rules, chapters 4668 and 4669. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

(b) The revisor of statutes shall change the term "assisted living home care provider," "assisted living license," and similar terms to "Class F home care provider," "Class F license," and similar terms to "Class F home care provider," "Class F license," and similar terms, in Minnesota Rules, chapter 4668. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 19. **REPEALER.**

Minnesota Rules, part 4668.0125, is repealed, effective January 1, 2007.

Senator ..... moves to amend S.F. No. 2888 as follows:

Page 2, delete lines 28 and 29 and insert:

"(7) a copy of the home care bill of rights; and"

Page 2, line 30, delete "(9)" and insert "(8)"

Page 11, line 15, after "housing" insert a comma

Page 15, line 28, after the semicolon, insert "and"

Page 15, line 31, delete "; and" and insert a period

Page 15, delete line 32

Page 16, line 19, delete "ELDERLY WAIVER"

Page 16, line 25, after "for" insert "assisted living and"

Page 16, after line 27, insert:

"Providers of assisted living for the community alternatives for disabled individuals and traumatic brain injury waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved ~~community alternatives for disabled individuals and traumatic brain injury~~ waiver plans."

Page 17, line 27, delete "4668.0125" and insert "4668.0215"

Joan Lipe

2006 Legislative Proposal for Assisted Living

The following proposal is a result of the work of many stakeholder groups over nearly two years, including AARP, the Alzheimer's Association, Care Providers of Minnesota, ElderCare Rights Alliance, the Minnesota Health & Housing Alliance, the Minnesota Home Care Association, and the Minnesota Nurses Association. This bill accomplishes two goals: title protection for providers and clearer expectations for consumers.

1. **Requirements for Use of the Term "Assisted Living".** The bill establishes requirements that must be met by any building or program that markets itself as "Assisted Living". In addition to the other requirements in this summary:
    - Assisted Living must be provided in a registered housing-with-services establishment.
    - A housing-with-services establishment that does not make assisted living available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

2. **Required Health Related Services** to be made available to all clients include:
    - RN assessment to be offered to all assisted living clients
    - Supervision of unlicensed staff by licensed nurses
    - Assistance with self-administration of medications or administration of medications

3. **Activities of Daily Living (ADL's)** – Assisted Living must offer to provide or make available assistance with at least three of the following ADL's:
    - Bathing
    - Dressing
    - Grooming
    - Eating
    - Toileting
    - Transferring
    - Continence care

4. **Response System:** Assisted Living must have:
    - An RN on-call 24 hours per day, 7 days per week for staff
    - A means for clients to request assistance for health and safety needs 24 hours per day, 7 days per week.
    - A staff person available to respond to health and safety requests 24 hours per day, 7 days per week, who is awake; located in the same building, in an attached building, or on a contiguous campus; capable of communicating with clients, capable of recognizing the need for assistance; capable of providing the assistance required, or summoning the appropriate assistance, and capable of following directions.

5. **Supportive Services** – Assisted Living must offer to provide or make available:
    - At least two meals per day
    - At least weekly housekeeping
    - At least weekly laundry service
    - Reasonable assistance with arranging transportation to medical and social services appointments and a designated person or title for providing this assistance
    - Reasonable assistance with accessing community resources and social services available in the community and a designated person or title for providing this assistance
    - Periodic opportunities for socialization

6. **Consumer Information** - A Uniform Consumer Information Guide will be developed to provide consumers with consistent information to compare Assisted Living providers.

7. **Accountability for Services**
    - All Assisted Living must provide a contact person within the housing establishment that clients may look to for resolving concerns about their home care provider.
    - Minnesota Department of Health has authority to survey home care providers in Assisted Living and seek injunctive relief against housing providers in the event of violations, consistent with current law.

8. **Notice of Termination of Services.** If a provider terminates either a housing or home care services agreement with an assisted living client, the provider will provide a termination notice that contains specified explanations and information.

alzheimer's association

Testimony in support of SF2888
Karen Anderson, Minnetonka, MN
March 16, 2006

As a volunteer for the Alzheimer's Association Information Helpline, I take calls from those caring for or concerned about loved ones with Alzheimer's disease. Most of these callers want to keep their affected loved ones in their own homes for as long as possible. One of our primary tasks is to provide these callers with information, tips and strategies for doing so.

But the sad truth is that Alzheimer's is a progressive disease, and no matter how hard family members try, the time inevitably comes when the person with Alzheimer's or other forms of dementia, can no longer live by themselves or their caregiver (often a spouse) can no longer care for them. This is when we receive calls from family members wondering when and where to place their loved one in a care facility.

It will not surprise you that callers are usually looking for an assisted living facility. And it also will not surprise you that callers are asking us to make specific recommendations, which we cannot do because we do not have the means to monitor and make assurances.

If all things were equal, family members would usually select facilities located close to where they live - simply for convenience sake. But it is never that simple. Care facilities vary greatly in what they offer and in the type and quality of the care they provide. "Assisted Living" and "Memory Care" are terms that can have many different interpretations.

Ultimately, family members select a facility which they believe will provide the care their loved one needs at a price they hope they can afford as long as necessary. With a sigh of relief, family members believe their problems are solved and they can get on with their lives. Again, it's never that easy.

Another type of call we frequently receive regarding residential care is from a very distraught family member who has just learned that the care facility either has not or cannot provide the continued care for their loved one that

family had understood would be available. This might be due to a staffing problem or due to some apparent change in the resident's behavior or medical condition. This is very frustrating to the family who thought they had contracted for services which appeared at the outset to be geared to an Alzheimer's patient whose needs change over time, services that would allow their loved one to "age in place."

Again, we offer support and tips for dealing with the changing situation. And once again family members must take many hours of time away from family and work to try to find the appropriate facility. It is not uncommon for this cycle to happen several times to a family. I, myself, placed my father in six different facilities – three in California and three here in Minnesota. I know personally how difficult, confusing and exhausting this process can be.

We at the Alzheimer's Association have made a steady commitment to helping families understand choices in care. But that's a very difficult task when Assisted Living has no definition of basic services and safety. The Association asks you to pass this law because it will provide guidance to families by giving them consistent information, a standard for basic services, and an expectation of accountability. It will also be an important reference tool for those of us on the Information Helpline who are trying to help callers at some of the toughest moments in their lives.

Thank you very much.

Minnesota Nurses Association

United nurses in vision and voice

March 13, 2006

Senator Becky Lourey, Chair
Senate Health and Family Security Committee
Minnesota Senate
75 Dr Martin Luther King Jr Blvd
St. Paul, MN 55155

Dear Senator Lourey
and Members of the Senate Health and Family Security Committee:

The Minnesota Nurses Association is writing to urge your support of Senate File 2888, authored by Senator Berglin. This legislation both defines Assisted Living and establishes standards for Assisted Living. It is the product of two years' work with a variety of stakeholders including our association, the industry and consumer advocacy groups. We are pleased with the outcome.

We believe this legislation addresses the concerns our members expressed regarding both quality of care and clarity around the role and responsibilities of the Registered Nurse in Assisted Living. It does this by requiring the following provisions:

- An RN assessment must be offered to all assisted living clients.
- An RN on-call 24 hours a day & 24 hour-a-day/7days a week awake staff
- Clarity around the role of the RN
- Definition of a minimum health benefit

An RN assessment must be offered to all assisted living clients.
Under current law an RN assessment is only required prior to initiation of services. We believe with this change, both residents and families will be in a better position to choose the Assisted Living Facility or program that best meets their needs. Also, RN's and other care providers will have a better understanding upfront of the resident's care needs.

An RN is on-call 24 hours a day & 24 hour-a-day/7days a week awake staff
By requiring a Registered Nurse to be on call 24-hours-a- day to unlicensed staff, RNs will be able to better direct staff in the care of residents for both patient safety purposes and to prevent unnecessary hospitalization or nursing home placement. Also, the awake-staff will assist residents with health and safety needs.

Professional Distinction

Personal Dignity

Patient Advocacy

Minnesota Nurses Association 100 Years A Legacy of Caring 1905 · 2005

1625 Energy Park Drive
Suite 200
St ' MN 55108
T 651-646-4807
800-536-4662
Fax: 651-647-5301
Email: mnnurses@
mnnurses.org

Web: www.mnnurses.org

ANA American Nurses Association
UAN United American Nurses, AFL-CIO

S 66

Clarity around the role of the RN
This bill clarifies that the Registered Nurse is the only person authorized to supervise and delegate services to unlicensed personnel as defined in the Nurse Practice Act. We often find that nurses and employers are unclear as to their responsibilities in assessment of the care needs of the client and delegation to and supervision of the unlicensed assistive personnel who are providing that care.

Definition of a minimum health benefit
The bill also requires Assisted Living to offer a minimum package of health related services that include at least three activities of daily living as well as help with medication administration. Studies show, the average resident uses1-3 Aides to Daily Living and need assistance with medication. By setting forth a minimum package of services consumers will have clearer role of what additional services they may have to purchase beyond the minimum.

Thank you in advance for your support this legislation. Please feel free to contact us if you have any questions.

Sincerely,

Erin Murphy

Erin Murphy, RN, MA
Executive Director
Minnesota Nurses Association

CC: Mary Jo George and Carrie Mortrud, Staff Specialists, Governmental Affairs

AARP Minnesota

TESTIMONY OF LOIS MCCARRON,
CO-CHAIR OF AARP MINNESOTA'S HEALTH AND
LONG-TERM CARE ISSUES TEAM
BEFORE THE
SENATE HEALTH AND FAMILY SECURITY COMMITTEE

MARCH 16, 2006

Thank you for the opportunity to testify today in support of Senate File 2888. I am Lois McCarron, Co-Chair of AARP Minnesota's Health and Long-term Care Issue Team. AARP Minnesota represents more than 650,000 Minnesotans over the age of 50.

AARP would like to thank you, Senator Lourey, for holding this hearing on such an important topic to older Minnesotans and their families and to thank you Senator Berglin for agreeing to author this important legislation. For almost two years, AARP has been working alongside other advocates and representatives from the provider community to develop a standard definition of "assisted living." We are pleased to bring this collaborative work before you today.

As other testifiers have stated, as we plan our future long-term care needs, more Minnesotans are turning to assisted living in order to retain independence and a high quality of life. While often a good choice for consumers, Minnesota law has not kept up with the increased demand for these facilities. As a result, the quality and services offered by those that call themselves assisted living varies, and consumers sometimes enter into living arrangements without a clear idea of the exact level of services offered.

This legislation creates a standard definition of assisted living and adds some basic consumer protections to Minnesota law. For example, any building or program that calls itself assisted living must provide for twenty-four hour awake staff. They must also offer to provide assistance with things such as laundry, meals, transportation services, and activities of daily living.

AARP believes that this legislation will help protect Minnesota's consumers by giving consumers a clear understanding of what is and isn't offered in facilities through the development of the Uniform Consumer Information Guide.

This legislation is a good example of the work that can be done on behalf of consumers and providers when we come together around a common goal. Our intent as a consumer advocate was to give consumers that reside in assisted living some very basic, common sense protections – and to provide their families necessary assurance and clear communication that will help them help their loved ones find the right living situation. We believe that this legislation will help provide those assurances.

Thank you again for the opportunity to testify here today.

AARP Minnesota

March 15, 2006

Senator Berglin
309 State Capitol
St. Paul, MN 55155

Dear Senator Berglin:

On behalf of more than 650,000 Minnesotan's over the age of 50, thank you for authoring the Assisted Living Legislative Proposal, Senate File 2888. This is an important topic not only to our members, but also for their families.

As we plan our future long-term care needs, more Minnesotans are turning to assisted living in order to retain independence and a high quality of life. While often a good choice for consumers, the quality and services offered by those that call themselves assisted living varies, and consumers sometimes enter into living arrangements without a clear idea of the exact level of services offered.

This legislation creates a standard definition of assisted living and adds basic consumer protections to Minnesota law. For example, any building or program that calls itself assisted living must provide for twenty-four hour awake staff. They must also offer to provide assistance with things such as laundry, meals, transportation services, and activities of daily living.

Additionally, AARP believes that this legislation will help protect Minnesota's consumers by giving consumers a clear understanding of what is and isn't offered in facilities through the development of the Uniform Consumer Information Guide.

This legislation is a good example of the work that can be done on behalf of consumers and providers when we come together around a common goal. Our intent as a consumer advocate was to give consumers that reside in assisted living some very basic, common sense protections – and to provide their families necessary assurance and clear communication that will help them help their loved ones find the right living situation. We believe that this legislation will help provide those assurances.

Thank you again for authoring this important legislation. If you have any questions or concerns, please feel free to contact our Advocacy Director, Heidi Holste at 651-726-5645.

Sincerely,

Michele H. Kimball

Michele H. Kimball
State Director

30 E. 7th Street, Suite 1200 | St. Paul, MN 55101 | toll-free 866-554-5381 | 651-221-2636 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/mn

ElderCare Rights Alliance

advocacy & education since 1972

March 10, 2006

Senator Linda Berglin
309 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1606

RE: Support for Senate File 2888 – Assisted Living legislation

Dear Senator Berglin:

The ElderCare Rights Alliance is a non-profit advocacy and education organization with a thirty year history of advocating for elders and persons with disabilities in the long-term care system. Our agency mission is to advance the principles of justice and dignity in long-term care through education, advocacy and action.

Our agency supports Senate File 2888, Assisted Living legislation, and encourages the legislature to enact it into law this session. A stakeholders group, consisting of advocates, providers, and state agency personnel met regularly for over a year to develop the proposal. We believe the proposed legislation offers adequate safeguards, protections, and services for the elderly and persons with disabilities who desire to live and receive services in assisted living facilities. Further, the proposed legislation clearly delineates the requirements to be met for any facility in Minnesota that chooses to market itself as providing assisted living services.

We strongly support the passage of Senate File 2888, Assisted Living.

Sincerely,

Mary Ellen Kennedy,
Board Chair

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MINNESOTA
HOMECARE
ASSOCIATION

1711 West County Road B, Suite 211 S, St. Paul, MN 55113
651/635-0607 • Fax 651/635-0043 • Toll-Free 866/607-0607
www.mnhomecare.org

March 15, 2006

To Whom It May Concern:

The Minnesota HomeCare Association urges you to support House File 3144 and Senate File 2888, the Assisted Living Legislative Proposal for 2006. This proposal has been generated by a coalition of advocacy groups and provider organizations over the last two and a half years. The legislation is intended to develop parameters around the term "assisted living" and provide a clearer understanding of what is "assisted living".

This new legislation is not intended to prohibit any existing provider from delivering services in a "housing with services" establishment. It will require the agency to declare whether or not the facility has staff awake 24-hours, 7 days a week in order to call itself "assisted living". If they do not have awake staff, providers may continue to deliver services under this new class of licensure; however, they may not call themselves "assisted living".

It is our understanding that public programs (i.e., MA home and community-based waivers) will continue to allow both "housing with services" and "assisted living". This will assure no interruption for current clients on MA who live in facilities throughout the State.

We are pleased that all parties have been able to come together and reach a viable compromise.

Sincerely,

T. Jeff Bangsberg
Director of Government Relations

Minnesota – North Dakota
www.alzmndak.org
1-800-232-0851 24/7

alzheimer's association

March 14, 2006

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Western Minnesota Office
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Eastern North Dakota Office
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701-277-9757
701-277-9785 fax

Western North Dakota Office
1223 South 12th Street
Suite 7
Bismarck, ND 58504
701-258-4933
701-258-4914 fax

The Honorable Linda Berglin
Chair, Health, Human Services and Corrections
Budget Division
309 State Capitol
St. Paul, MN 55155

Dear Senator Berglin:

The Alzheimer's Association thanks you for being the Chief Author of SF2888, a bill to define and set basic standards for Assisted Living.

Assisted Living settings are quickly becoming the first choice in residential care for people with Alzheimer's and related dementias. Yet, families who call our Information Helpline run into problems as they try to navigate the system and make the best choices for their loved ones.

Families are under pressure to reach a decision when home care is no longer possible. Although, there is an array of choices, neither the term "assisted living" nor descriptors like "memory care" have a standard meaning.

Safety is always an issue, as dementia typically attacks memory and judgment long before it saps physical strength. But there is no bottom line requirement for security in Assisted Living in Minnesota.

Families are often faced with making repeated changes as the promise of "aging in place" turns out not to be realistic.

The Association has been actively committed to the work of the Assisted Living Stakeholder Group and commends the product of its extensive work.

Sincerely,

Jane Ochrymowycz
Secretary, Board of Directors
Chair, Public Policy Committee

The
Long-Term Care
IMPERATIVE

A Minnesota Collaboration for Changes in Older Adult Services

March 15, 2006

The Honorable Linda Berglin
Minnesota Senate
309 Capitol
St. Paul, MN 55155

Dear Senator Berglin:

This letter expresses our strong support for Senate File 2888, a bill that will provide protections and increase clarity for providers and consumers with respect to the services offered in assisted living housing.

Since August 2004, Minnesota Health & Housing Alliance, Care Providers of Minnesota, and a group of nearly 20 stakeholders have worked together to develop legislation that will clarify "assisted living" services. The Assisted Living Stakeholders Group included state agencies, consumer advocacy groups, county representatives and other interested organizations. The result of their hard work is SF 2188.

Care Providers of Minnesota and Minnesota Health & Housing Alliance , in a coalition called the Long-Term Care Imperative, strive to transform older adult services in Minnesota to meet the needs of an aging population while preserving choice for consumers. The associations convened the Assisted Living Stakeholders Group to identify and address the issues and concerns of both providers and consumers. The group sought to place some parameters around assisted living, while preserving provider flexibility and consumer choice. The proposed legislation builds on Minnesota's unique and consumer-centered framework of the Housing with Services Contract Act, with a continued focus on disclosure of important information that consumers need to make good decisions and to enforce their rights.

This existing framework, along with the Minnesota Department of Health's enforcement of licensure requirements for the health related/home care services delivered by assisted living providers, will be strengthened by the additional clarifications and protections included in Senate File 2888. We are confident that consumers, providers and regulatory agencies will all benefit

by setting standards that providers must meet in order to market themselves as "assisted living" providers, by addressing the need for more consumer information related to assisted living, and by clarifying consumer rights in this area.

Thank you for supporting SF 2888 on behalf of your constituents.

Sincerely,

Lori Meyer
Acting Vice President of Public Affairs
Minnesota Health & Housing Alliance

Patti Cullen
Vice President
Care Providers of Minnesota

make copies + file with bill

ElderCare Rights Alliance

advocacy & education since 1972

March 10, 2006

Senator Linda Berglin
309 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1606

RE: Support for Senate File 2888 – Assisted Living legislation

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Our agency supports Senate File 2888, Assisted Living legislation, and encourages the legislature to enact it into law this session. A stakeholders group, consisting of advocates, providers, and state agency personnel met regularly for over a year to develop the proposal. We believe the proposed legislation offers adequate safeguards, protections, and services for the elderly and persons with disabilities who desire to live and receive services in assisted living facilities. Further, the proposed legislation clearly delineates the requirements to be met for any facility in Minnesota that chooses to market itself as providing assisted living services.

We strongly support the passage of Senate File 2888, Assisted Living.

Sincerely,

Mary Ellen Kennedy

Mary Ellen Kennedy,
Board Chair

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