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

Senate
State of Minnesota

S.F. No. 3302 - Mental Health Services Reimbursement Expansion

Author: Senator Yvonne Prettner Solon

Prepared by: Joan White, Senate Counsel (651/296-3814)
Katie Cavanor, Senate Counsel (651/296-3801)

Date: March 27, 2006

Sections 1 and 8 (256B.0623, subdivision 8 and 256B.0943) require that diagnostic assessments for adult rehabilitative mental health service and children's therapeutic services and supports, respectively, must be reimbursed at the same rate as a diagnostic assessment under the home and community-based service waivers for persons with disabilities.

Section 2 (256B.0625, subdivision 38) provides MA payments for mental health services provided at a community mental health center by an individual who has completed all requirements for licensure as a mental health professional except for the supervised experience to be at the same rate as if the service was provided by a licensed mental health professional employed by a community mental health center. This section also provides MA coverage for the clinical supervision of an unlicensed practitioner when clinical supervision is required as part of other medical assistance services.

Section 3 (256B.0625, subdivision 43) states that MA coverage for mental health provider travel time includes the time in which the provider is traveling as well as reimbursement for mileage.

Section 4 (256B.0625, subdivision 46) states that MA coverage for mental health telemedicine includes payment for the originating facility fee and the cost of broadband connections.

Section 5 (256B.0625) defines the term "Intensive mental health outpatient treatment" for purposes of making it a covered service under medical assistance.

Section 6 (256B.0943, subdivision 1) modifies the statute relating to children's therapeutic service and supports, by defining the term "family psycho-education".

Section 7 (256B.0943, subdivision 2) adds family psycho-education as a covered service under children's therapeutic services and supports.

Section 9 (256B.761) states that MA payment rates for mental health services provided by mental health professionals are to be determined using the average usual and customary charges of doctoral prepared professionals only.

Section 10 (256B.763) increases payment rates for services provided on or after July 1, 2006, for community mental health center services and services provided by mental health clinics and centers or provided by outpatient psychiatric departments at hospitals that are designated as an ECP by 20 percent over the rates that were in effect on January 1, 2005. States that this increase does not apply to any service where rates are negotiated with the county or that received an increase between January 1, 2005, and January 1, 2006. Requires the prepaid health plan rates to be adjusted to reflect this increase and requires the plans to pass the increase to the providers.

Section 11 (256L.035) adds outpatient mental health services to the MinnesotaCare limited benefit set and authorizes mental health professionals to provide the services.

JW:KC:mvm

Minnesota Association of Community Mental Health Programs, Inc.

Improving quality through education, public policy advocacy, and member services

1821 University Avenue West, Suite 350-S, St. Paul, Minnesota (651) 642-1903; FAX (651) 645-1399

March 27, 2006 **Mental Health Reimbursement: S.F. 3302/H.F. 3818** *Ron Brand, Executive Director*

S.F. 3302 (Solon, Berglin, Lourey, Koering, Foley); H.F. 3818 (Grilling, Huntley, Abler)
This bill addresses several issues in mental health reimbursement that seriously affect access to appropriate care and viability of crucial community providers. These provisions were identified and supported by a MMHAG workgroup and the Mental Health Legislative Network, a coalition of 17 mental health organizations that supports proposals when there is a consensus among the group.

Section 1. Diagnostic Assessment for Adult Mental Health Rehab. Services. Amends the Medical Assistance statute (256B.0623, subd. 8) on adult mental health rehabilitation services (ARMHS) to specify that the reimbursement rate for diagnostic assessment for this purpose should be paid at the same level as the nursing assessment used to authorize and plan home health and CADI waiver services.

Discussion: This provision increases the payment and the expectation for clinical leadership and individual treatment planning for services that are typically provided by unlicensed practitioners. This helps assure compliance with quality standards.

Section 2. Payment for training new Board-eligible professionals. (a) Amends Medical Assistance statute (256B.0625, subd. 38) to increase reimbursement for services provided by individuals who are employed by a community mental health center and who is completing the hours of supervised experience required by the licensing Board. The rate would be increased to 100% of the rate paid to the clinical supervisor.

Discussion: This provision will help support an important training function necessary to develop new mental health professionals experienced working in settings committed to public services.

Section 2 (b) Clinical Supervision. Amends MA statute (256B.0625, subd. 38) to cover clinical supervision of unlicensed mental health practitioners when the supervision is required as part of the other covered service.

Discussion: This helps defray the added program cost related to clinical supervision necessary for compliance and quality services.

Section 3. Travel time. Amends MA statute (256B.0625, subd. 43) to increase reimbursement for travel time necessary to deliver covered mental health services.

Discussion: Current rate covers about one-half of the cost of travel (mileage and staff time). The current payment rate harms all providers, but especially discriminates against rural providers who must travel distances.

Section 4. TeleHealth Facility Fee. Amends MA statute (256B.0625, Subd. 46) on tele-mental health services to add a payment to the "originating clinic site for the facility and broadband connection expenses.

Discussion: Payment for the originating facility site is provided by private healthplans and Medicare. This is important as a way to support the added ongoing expenses of delivering services remotely through virtual presence TeleHealth/telemedicine.

Section 5. Intensive Mental Health Outpatient Treatment. Amends MA statute (256B.0625, new subdivision). Defines intensive outpatient mental health services as a concentrated, structured treatment and rehab. service that combines components of already covered services into a coordinated package that will support several evidenced-based practices. Defines payment as 90% of rate paid for partial hospitalization.

Discussion: This adds a cost-effective level of care that is critical to intensive earlier intervention and aftercare—something between outpatient clinic services and inpatient hospital. Defines eligible providers as licensed or certified to provide all aspects of the services.

Section 6. Family Psycho-education. Amends MA statute Child Therapeutic Services and Supports (CTSS) (256B.0943, subd. 1) to cover family psycho-education services. Defines family psycho-education as a multi-modal outpatient and rehabilitative service for the benefit of the identified patient. Specifies eligible providers as certified to provide outpatient therapy and CTSS. Also clarifies that CTSS covers skills training provided to parents/caregivers without child present.

Discussion: Services help families understand, assist with treatment goals, and address problems posed by mental illness. Supports/strengthens family's role in treatment process for client's benefit.

Section 7. Family Psycho-Education. Adds family psycho-education as covered in Children's therapeutic services and supports.

Section 8. Diagnostic Assessment for Children's Therapeutic Services and Supports (CTSS). Amends the MA statute (256B.0943, new subd.) to specify that the reimbursement rate for diagnostic assessment use for this purpose should be paid at the same level as the nursing assessment used to authorize and plan home health and CADI waiver services.

Discussion: This provision increases the payment and the expectation for clinical leadership and individual treatment planning for services that are typically provided by unlicensed practitioners. This helps assure compliance with quality standards.

Section 9. Reimbursement Rate calculation. Amends MA to specify that reimbursement rates for mental health services will be calculated based on submitted charges from doctoral-level mental health professionals.

Discussion. This corrects a problem in the rate setting procedure in which submitted charges for each service <u>from all providers</u> are used to calculate the median charge. The full rate is then set as the median, minus a 24.6% discount. An additional discount is subtracted for masters-level professionals. The proposal would calculate the initial rate using charges from doctoral level providers only and then apply the discounts. The current method results in a double discount.

Section 10. Mental Health Centers and Clinics—Critical Access Providers. This would increase MA reimbursement rates for certain "critical access providers" who provide a disproportionate amount of uncompensated care and services under government programs.

Discussion: Similar reimbursement adjustments have been in place for hospitals, community health centers, and dentists. This strengthens key safety-net providers and draws Federal financial participation. A similar provision is in MHAG/Governor's mental health initiative bill (SF-3290).

Section 11. MinnesotaCare Limited Benefit for Adults without children. Amends MnCare Limited so that outpatient mental health would be covered the same as other MnCare programs.

Discussion. Strengthens the outpatient benefit, adding services by mental health professionals, partial hospitalization and day treatment, services often necessary for disease management or to avoid hospitalization.

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

S.F. No. 3302: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; expanding reimbursement for mental health services;
1.3 amending Minnesota Statutes 2004, sections 256B.0623, subdivision 8;
1.4 256B.0625, subdivision 43, by adding a subdivision; 256B.0943, subdivisions
1.5 1, 2, by adding a subdivision; 256B.761; Minnesota Statutes 2005 Supplement,
1.6 sections 256B.0625, subdivisions 38, 46; 256L.035; proposing coding for new
1.7 law in Minnesota Statutes, chapter 256B.

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

1.9 Section 1. Minnesota Statutes 2004, section 256B.0623, subdivision 8, is amended to
1.10 read:

1.11 Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health
1.12 services must complete a diagnostic assessment as defined in section 245.462, subdivision
9, within five days after the recipient's second visit or within 30 days after intake,
1.14 whichever occurs first. A diagnostic assessment must be reimbursed at the same rate
1.15 as a diagnostic assessment under section 256B.49, subdivision 14. In cases where a
1.16 diagnostic assessment is available that reflects the recipient's current status, and has been
1.17 completed within 180 days preceding admission, an update must be completed. An
1.18 update shall include a written summary by a mental health professional of the recipient's
1.19 current mental health status and service needs. If the recipient's mental health status
1.20 has changed significantly since the adult's most recent diagnostic assessment, a new
1.21 diagnostic assessment is required. For initial implementation of adult rehabilitative mental
1.22 health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's
1.23 current status and has been completed within the past three years preceding admission
is acceptable.

Sec. 2. Minnesota Statutes 2005 Supplement, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. **Payments for mental health services.** (a) Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. ~~For purposes of reimbursement of mental health professionals under the medical assistance program, all~~

(b) Payments for mental health services covered under the medical assistance program that are provided by social workers who:

(1) have received a master's degree in social work from a program accredited by the Council on Social Work Education;

(2) are licensed at the level of graduate social worker or independent social worker; ~~and~~

(3) are practicing clinical social work under appropriate supervision, as defined by chapter 148D; and

(4) meet all requirements under Minnesota Rules, part 9505.0323, subpart 24, ~~and shall be paid accordingly~~

shall be paid in accordance with Minnesota Rules, part 9505.0323, subpart 24, unless paragraph (c) is applicable.

(c) Payments for mental health services covered under the medical assistance program that are provided by an individual who is employed by a community health center and who has completed all requirements for licensure or board certification as a mental health professional except for the requirements for supervised experience in the delivery of mental health services or by an individual who is a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional shall be reimbursed at 100 percent of the rate paid to a doctoral-prepared professional. The individual providing the service must be under the clinical supervision of a fully qualified mental health professional.

(d) Medical assistance covers clinical supervision of unlicensed practitioners by a mental health professional when clinical supervision is required as part of other medical assistance services.

Sec. 3. Minnesota Statutes 2004, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** Medical assistance covers provider travel time plus reimbursement for mileage if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. ~~This~~ Reimbursement under this subdivision does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Sec. 4. Minnesota Statutes 2005 Supplement, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health telemedicine.** Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service and shall include payment for the originating facility fee and the cost of broadband connections. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 5. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 51. **Intensive mental health outpatient treatment.** Intensive outpatient treatment is a concentrated, nonresidential, coordinated, structured, multimode treatment and rehabilitative service that is at least two hours per day, and nine to 20 hours per week, designed to address a mental disorder as indicated in the treatment plan. The service provides an opportunity to combine existing covered services, in order to deliver the necessary intensity and frequency of individual, family or multifamily group psychotherapy, psycho-educational services, and adjunctive services such as medical monitoring, family psycho-education, behavioral parent training, rehabilitative services, medication education, relapse prevention, illness management and recovery services, care coordination, and service coordination and referral arrangements for medical care or social services necessary to support the individual treatment plan. During transition into or from services, intensive outpatient treatment may include time-limited services in multiple settings as clinically necessary. The service must be paid as a per diem based on

4.1 90 percent of the rate paid for partial hospitalization. Eligible providers must be licensed
4.2 or certified to provide all aspects of the service.

4.3 Sec. 6. Minnesota Statutes 2004, section 256B.0943, subdivision 1, is amended to read:
4.4 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
4.5 the meanings given them.
4.6 (a) "Children's therapeutic services and supports" means the flexible package of
4.7 mental health services for children who require varying therapeutic and rehabilitative
4.8 levels of intervention. The services are time-limited interventions that are delivered using
4.9 various treatment modalities and combinations of services designed to reach treatment
4.10 outcomes identified in the individual treatment plan.
4.11 (b) "Clinical supervision" means the overall responsibility of the mental health
4.12 professional for the control and direction of individualized treatment planning, service
4.13 delivery, and treatment review for each client. A mental health professional who is an
4.14 enrolled Minnesota health care program provider accepts full professional responsibility
4.15 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
4.16 and oversees or directs the supervisee's work.
4.17 (c) "County board" means the county board of commissioners or board established
4.18 under sections 402.01 to 402.10 or 471.59.
4.19 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.
4.20 (e) "Culturally competent provider" means a provider who understands and can
4.21 utilize to a client's benefit the client's culture when providing services to the client. A
4.22 provider may be culturally competent because the provider is of the same cultural or
4.23 ethnic group as the client or the provider has developed the knowledge and skills through
4.24 training and experience to provide services to culturally diverse clients.
4.25 (f) "Day treatment program" for children means a site-based structured program
4.26 consisting of group psychotherapy for more than three individuals and other intensive
4.27 therapeutic services provided by a multidisciplinary team, under the clinical supervision
4.28 of a mental health professional.
4.29 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
4.30 11.
4.31 (h) "Direct service time" means the time that a mental health professional, mental
4.32 health practitioner, or mental health behavioral aide spends face-to-face with a client
4.33 and the client's family. Direct service time includes time in which the provider obtains
4.34 a client's history or provides service components of children's therapeutic services and
4.35 supports. Direct service time does not include time doing work before and after providing

direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Family psycho-education" is a multimodel outpatient therapy and rehabilitative service that involves parents, families, and others as resources in the treatment, recovery, and improved functioning of a person with mental illness or emotional disturbance, in which families learn about the illness, family reactions, and types of treatment and supports. Families learn to develop skills to handle problems posed by mental illness including coping, managing stress, ensuring safety, creating social support, identifying resources, and supporting treatment and recovery goals. Services include family counseling, family treatment planning, and family support using cognitive, behavioral, problem-solving, and communication strategies, and may involve individual, family, and group intervention activities for consumers and families together, famlies-only, or brief or intermittent consultations at critical times in an episode of care. Eligible providers must be certified to provide both outpatient mental health services and rehabilitative services under sections 256B.0623 and 256B.0943.

~~(k)~~ (l) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

~~(l)~~ (m) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

~~(m)~~ (n) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (o) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and

6.1 supports provider to provide a structured treatment program to a child who is at least 33
6.2 months old but who has not yet attended the first day of kindergarten.
6.3 ~~(o)~~ (p) "Skills training" means individual, family, or group training designed to
6.4 improve the basic functioning of the child with emotional disturbance and the child's
6.5 family in the activities of daily living and community living, and to improve the social
6.6 functioning of the child and the child's family in areas important to the child's maintaining
6.7 or reestablishing residency in the community. Skills training must also be provided to the
6.8 parent, guardian, or caregiver of a child without the child present. Individual, family,
6.9 and group skills training must:
6.10 (1) consist of activities designed to promote skill development of the child and the
6.11 child's family in the use of age-appropriate daily living skills, interpersonal and family
6.12 relationships, and leisure and recreational services;
6.13 (2) consist of activities that will assist the family's understanding of normal child
6.14 development and to use parenting skills that will help the child with emotional disturbance
6.15 achieve the goals outlined in the child's individual treatment plan; and
6.16 (3) promote family preservation and unification, promote the family's integration
6.17 with the community, and reduce the use of unnecessary out-of-home placement or
6.18 institutionalization of children with emotional disturbance.

6.19 Sec. 7. Minnesota Statutes 2004, section 256B.0943, subdivision 2, is amended to read:
6.20 Subd. 2. **Covered service components of children's therapeutic services and**
6.21 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
6.22 children's therapeutic services and supports as defined in this section that an eligible
6.23 provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.
6.24 (b) The service components of children's therapeutic services and supports are:
6.25 (1) individual, family, ~~and~~ group psychotherapy, and family psycho-education;
6.26 (2) individual, family, or group skills training provided by a mental health
6.27 professional or mental health practitioner;
6.28 (3) crisis assistance;
6.29 (4) mental health behavioral aide services; and
6.30 (5) direction of a mental health behavioral aide.
6.31 (c) Service components may be combined to constitute therapeutic programs,
6.32 including day treatment programs and preschool programs. Although day treatment and
6.33 preschool programs have specific client and provider eligibility requirements, medical
6.34 assistance only pays for the service components listed in paragraph (b).

7.1 Sec. 8. Minnesota Statutes 2004, section 256B.0943, is amended by adding a
7.2 subdivision to read:

7.3 Subd. 11a. **Reimbursement of diagnostic assessments.** A diagnostic assessment
7.4 under this section must be reimbursed at the same rate as a diagnostic assessment under
7.5 section 256B.49, subdivision 14.

7.6 Sec. 9. Minnesota Statutes 2004, section 256B.761, is amended to read:

7.7 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

7.8 (a) Effective for services rendered on or after July 1, 2001, payment for medication
7.9 management provided to psychiatric patients, outpatient mental health services, day
7.10 treatment services, home-based mental health services, and family community support
7.11 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
7.12 50th percentile of 1999 charges.

7.13 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
7.14 services provided by an entity that operates: (1) a Medicare-certified comprehensive
7.15 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
7.16 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
7.17 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
7.18 when those services are provided within the comprehensive outpatient rehabilitation
7.19 facility and provided to residents of nursing facilities owned by the entity.

7.20 (c) Notwithstanding section 256B.03, subdivision 1, effective July 1, 2006, the
7.21 medical assistance payment rates for mental health services provided by mental health
7.22 professionals shall be determined by using the average usual and customary charge of
7.23 the doctoral prepared professionals only.

7.24 Sec. 10. **[256B.763] MENTAL HEALTH CENTERS AND CLINICS**
7.25 **REIMBURSEMENT.**

7.26 (a) Effective for services rendered on or after July 1, 2006, payment rates for: (1)
7.27 community mental health center services under section 256B.0625, subdivision 5; and (2)
7.28 services provided by mental health clinics and centers certified under Minnesota Rules,
7.29 parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are
7.30 designated as essential community providers under section 62Q.19, shall be increased by
7.31 20 percent over the rates in effect on January 1, 2005. This increase does not apply to
7.32 services with rates negotiated with the county or that received increases between January
7.33 1, 2005, and January 1, 2006. This reimbursement increase shall be in addition to any
7.34 other reimbursement increases enacted by the 2006 legislature.

8.1 (b) The commissioner shall adjust rates paid to prepaid health plans under contract
8.2 with the commissioner to reflect the rate increases provided in paragraph (a) effective for
8.3 services rendered on or after January 1, 2007. The prepaid health plan must pass this rate
8.4 increase to the providers identified in paragraph (a).

8.5 Sec. 11. Minnesota Statutes 2005 Supplement, section 256L.035, is amended to read:

8.6 **256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE**
8.7 **ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.**

8.8 (a) "Covered health services" for individuals under section 256L.04, subdivision
8.9 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty
8.10 guideline means:

8.11 (1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and
8.12 subject to an annual limitation of $10,000;

8.13 (2) physician services provided during an inpatient stay; and

8.14 (3) physician services not provided during an inpatient stay; outpatient hospital
8.15 services; freestanding ambulatory surgical center services; chiropractic services; lab and
8.16 diagnostic services; diabetic supplies and equipment; outpatient mental health services,
8.17 as defined under section 256L.03, subdivision 1; and prescription drugs; subject to the
8.18 following co-payments:

8.19 (i) $50 co-pay per emergency room visit;

8.20 (ii) $3 co-pay per prescription drug; and

8.21 (iii) $5 co-pay per nonpreventive visit.

8.22 The services covered under this section may be provided by a physician, physician
8.23 ancillary, chiropractor, ~~psychologist, or licensed independent clinical social worker~~ or a
8.24 mental health professional, as defined under section 256B.0625, subdivision 42, if the
8.25 services are within the scope of practice of that health care professional.

8.26 For purposes of this section, "a visit" means an episode of service which is required
8.27 because of a recipient's symptoms, diagnosis, or established illness, and which is delivered
8.28 in an ambulatory setting by any health care provider identified in this paragraph.

8.29 Enrollees are responsible for all co-payments in this section.

8.30 (b) Reimbursement to the providers shall be reduced by the amount of the
8.31 co-payment, except that reimbursement for prescription drugs shall not be reduced once a
8.32 recipient has reached the $20 per month maximum for prescription drug co-payments.
8.33 The provider collects the co-payment from the recipient. Providers may not deny services
8.34 to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

9.1 (c) If it is the routine business practice of a provider to refuse service to an individual
9.2 with uncollected debt, the provider may include uncollected co-payments under this
section. A provider must give advance notice to a recipient with uncollected debt before
9.4 services can be denied.

Minnesota Association of Community Mental Health Programs, Inc.
Improving quality through education, public policy advocacy, and member services
1821 University Avenue West, Suite 350-S, St. Paul, Minnesota (651) 642-1903; FAX (651) 645-1399

March 27, 2006 **Mental Health Reimbursement: S.F. 3302/H.F. 3818** *Ron Brand, Executive Director*

S.F. 3302 (Solon, Berglin, Lourey, Koering, Foley); H.F. 3818 (Grilling, Huntley, Abler)
This bill addresses several issues in mental health reimbursement that seriously affect access to appropriate care and viability of crucial community providers. These provisions were identified and supported by a MMHAG workgroup and the Mental Health Legislative Network, a coalition of 17 mental health organizations that supports proposals when there is a consensus among the group.

Section 1. Diagnostic Assessment for Adult Mental Health Rehab. Services. Amends the Medical Assistance statute (256B.0623, subd. 8) on adult mental health rehabilitation services (ARMHS) to specify that the reimbursement rate for diagnostic assessment for this purpose should be paid at the same level as the nursing assessment used to authorize and plan home health and CADI waiver services.

Discussion: This provision increases the payment and the expectation for clinical leadership and individual treatment planning for services that are typically provided by unlicensed practitioners. This helps assure compliance with quality standards.

Section 2. Payment for training new Board-eligible professionals. (a) Amends Medical Assistance statute (256B.0625, subd. 38) to increase reimbursement for services provided by individuals who are employed by a community mental health center and who is completing the hours of supervised experience required by the licensing Board. The rate would be increased to 100% of the rate paid to the clinical supervisor.

Discussion: This provision will help support an important training function necessary to develop new mental health professionals experienced working in settings committed to public services.

Section 2 (b) Clinical Supervision. Amends MA statute (256B.0625, subd. 38) to cover clinical supervision of unlicensed mental health practitioners when the supervision is required as part of the other covered service.

Discussion: This helps defray the added program cost related to clinical supervision necessary for compliance and quality services.

Section 3. Travel time. Amends MA statute (256B.0625, subd. 43) to increase reimbursement for travel time necessary to deliver covered mental health services.

Discussion: Current rate covers about one-half of the cost of travel (mileage and staff time). The current payment rate harms all providers, but especially discriminates against rural providers who must travel distances.

Section 4. TeleHealth Facility Fee. Amends MA statute (256B.0625, Subd. 46) on tele-mental health services to add a payment to the "originating clinic site for the facility and broadband connection expenses.

Discussion: Payment for the originating facility site is provided by private healthplans and Medicare. This is important as a way to support the added ongoing expenses of delivering services remotely through virtual presence TeleHealth/telemedicine.

Section 5. Intensive Mental Health Outpatient Treatment. Amends MA statute (256B.0625, new subdivision). Defines intensive outpatient mental health services as a concentrated, structured treatment and rehab. service that combines components of already covered services into a coordinated package that will support several evidenced-based practices. Defines payment as 90% of rate paid for partial hospitalization.

Discussion: This adds a cost-effective level of care that is critical to intensive earlier intervention and aftercare—something between outpatient clinic services and inpatient hospital. Defines eligible providers as licensed or certified to provide all aspects of the services.

Section 6. Family Psycho-education. Amends MA statute Child Therapeutic Services and Supports (CTSS) (256B.0943, subd. 1) to cover family psycho-education services. Defines family psycho-education as a multi-modal outpatient and rehabilitative service for the benefit of the identified patient. Specifies eligible providers as certified to provide outpatient therapy and CTSS. Also clarifies that CTSS covers skills training provided to parents/caregivers without child present.

Discussion: Services help families understand, assist with treatment goals, and address problems posed by mental illness. Supports/strengthens family's role in treatment process for client's benefit.

Section 7. Family Psycho-Education. Adds family psycho-education as covered in Children's therapeutic services and supports.

Section 8. Diagnostic Assessment for Children's Therapeutic Services and Supports (CTSS). Amends the MA statute (256B.0943, new subd.) to specify that the reimbursement rate for diagnostic assessment use for this purpose should be paid at the same level as the nursing assessment used to authorize and plan home health and CADI waiver services.

Discussion: This provision increases the payment and the expectation for clinical leadership and individual treatment planning for services that are typically provided by unlicensed practitioners. This helps assure compliance with quality standards.

Section 9. Reimbursement Rate calculation. Amends MA to specify that reimbursement rates for mental health services will be calculated based on submitted charges from doctoral-level mental health professionals.

Discussion. This corrects a problem in the rate setting procedure in which submitted charges for each service <u>from all providers</u> are used to calculate the median charge. The full rate is then set as the median, minus a 24.6% discount. An additional discount is subtracted for masters-level professionals. The proposal would calculate the initial rate using charges from doctoral level providers only and then apply the discounts. The current method results in a double discount.

Section 10. Mental Health Centers and Clinics—Critical Access Providers. This would increase MA reimbursement rates for certain "critical access providers" who provide a disproportionate amount of uncompensated care and services under government programs.

Discussion: Similar reimbursement adjustments have been in place for hospitals, community health centers, and dentists. This strengthens key safety-net providers and draws Federal financial participation. A similar provision is in MHAG/Governor's mental health initiative bill (SF-3290).

Section 11. MinnesotaCare Limited Benefit for Adults without children. Amends MnCare Limited so that outpatient mental health would be covered the same as other MnCare programs.

Discussion. Strengthens the outpatient benefit, adding services by mental health professionals, partial hospitalization and day treatment, services often necessary for disease management or to avoid hospitalization.

Senator Wergin introduced–

S.F. No. 2511: Referred to the Committee on Health and Family Security.

1.1 A bill for an act
1.2 relating to human services; excluding aid and attendance benefits from the
1.3 MinnesotaCare definition of income for other household members; amending
1.4 Minnesota Statutes 2005 Supplement, section 256L.01, subdivision 5.

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

1.6 Section 1. Minnesota Statutes 2005 Supplement, section 256L.01, subdivision 5, is
1.7 amended to read:

1.8 Subd. 5. **Income.** (a) "Income" has the meaning given for earned and unearned
1.9 income for families and children in the medical assistance program, according to the
1.10 state's aid to families with dependent children plan in effect as of July 16, 1996. The
1.11 definition does not include medical assistance income methodologies and deeming
1.12 requirements. The earned income of full-time and part-time students under age 19 is
1.13 not counted as income. Public assistance payments and supplemental security income
1.14 are not excluded income.

1.15 (b) For purposes of this subdivision, and unless otherwise specified in this section,
1.16 the commissioner shall use reasonable methods to calculate gross earned and unearned
1.17 income including, but not limited to, projecting income based on income received within
1.18 the past 30 days, the last 90 days, or the last 12 months.

1.19 (c) Aid and attendance benefits from the United States Department of Veterans
1.20 Affairs shall be counted as income only for the individual receiving the benefits and shall
1.21 be excluded as income for other household members.

EFFECTIVE DATE. This section is effective July 1, 2006.

1.1 Senator .... moves to amend S.F. No. 2511 as follows:

1.2 Page 1, line 20, before "be" insert "not" and delete everything after "income" and
1.3 insert a period

1.4 Page 1, delete line 21

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

Senate
State of Minnesota

S.F. No. 3322 - Establishing a Reverse Mortgage Incentive Program

Author: Senator Linda Berglin

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

Date: March 27, 2006

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

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

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

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

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

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

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

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

Section 7 (287.04) exempts reverse mortgages obtained under section 8 from the state mortgage registration tax.

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

Section 9 (462A.05, subdivision 43) repeats the language of section 2 in the MHFA statute.

Section 10 is an appropriations section.

DG:rdr

Senators Berglin, Sams, Lourey, LeClair and Frederickson introduced–

S.F. No. 3322: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; establishing a reverse mortgage incentive program; establishing eligibility standards, benefits, and other requirements; appropriating money; amending Minnesota Statutes 2004, sections 47.58, subdivision 8; 256.01, by adding a subdivision; 256.975, subdivision 7; 256B.0911, subdivision 3a; 256B.0913, by adding a subdivision; 462A.05, by adding subdivisions; Minnesota Statutes 2005 Supplement, sections 256B.0911, subdivision 1a; 287.04.

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

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

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

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

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

(3) an explanation of the lending process;

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

2.1 (5) an explanation of the provisions of sections 256B.0913, subdivision 17; 287.04,
2.2 paragraph (k); and 462A.05, subdivision 42; and
2.3 (6) an opportunity to ask questions of the counselor.

2.4 Sec. 2. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision
2.5 to read:
2.6 Subd. 23. **Reverse mortgage information and referral.** The commissioner, in
2.7 cooperation with the commissioner of the Minnesota Housing Finance Agency, shall:
2.8 (1) establish an information and referral system to inform eligible persons regarding
2.9 the availability of reverse mortgages and state incentives available to persons who take
2.10 out certain reverse mortgages. The information and referral system shall be established
2.11 involving the Senior LinkAge Line, county and tribal agencies, community housing
2.12 agencies and organizations, reverse mortgage counselors and lenders, senior and elder
2.13 community organizations, and other relevant entities; and
2.14 (2) coordinate necessary training for Senior LinkAge Line employees, mortgage
2.15 counselors, and lenders regarding the provisions of sections 256B.0913, subdivision 17;
2.16 287.04, paragraph (k); and 462A.05, subdivision 42.

2.17 Sec. 3. Minnesota Statutes 2004, section 256.975, subdivision 7, is amended to read:
2.18 Subd. 7. **Consumer information and assistance; Senior LinkAge.** (a) The
2.19 Minnesota Board on Aging shall operate a statewide information and assistance service
2.20 to aid older Minnesotans and their families in making informed choices about long-term
2.21 care options and health care benefits. Language services to persons with limited English
2.22 language skills may be made available. The service, known as Senior LinkAge Line, must
2.23 be available during business hours through a statewide toll-free number and must also
2.24 be available through the Internet.
2.25 (b) The service must assist older adults, caregivers, and providers in accessing
2.26 information about choices in long-term care services that are purchased through private
2.27 providers or available through public options. The service must:
2.28 (1) develop a comprehensive database that includes detailed listings in both
2.29 consumer- and provider-oriented formats;
2.30 (2) make the database accessible on the Internet and through other telecommunication
2.31 and media-related tools;
2.32 (3) link callers to interactive long-term care screening tools and make these tools
2.33 available through the Internet by integrating the tools with the database;

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

(5) conduct an outreach campaign to assist older adults and their caregivers in
3.4 finding information on the Internet and through other means of communication;
3.5 (6) implement a messaging system for overflow callers and respond to these callers
3.6 by the next business day;
3.7 (7) link callers with county human services and other providers to receive more
3.8 in-depth assistance and consultation related to long-term care options; ~~and~~
3.9 (8) <u>provide information and assistance to inform older adults about reverse</u>
3.10 <u>mortgages, including the provisions of sections 47.58; 256B.0913, subdivision 17; 287.04,</u>
3.11 <u>paragraph (k); and 462A.05, subdivision 42; and</u>
3.12 <u>(9)</u> link callers with quality profiles for nursing facilities and other providers
developed by the commissioner of health.
3.14 (c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness
3.15 of the statewide information and assistance, and submit this evaluation to the legislature
3.16 by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps
3.17 in service delivery, continuity in information between the service and identified linkages,
3.18 and potential use of private funding to enhance the service.

3.19 Sec. 4. Minnesota Statutes 2005 Supplement, section 256B.0911, subdivision 1a,
3.20 is amended to read:
3.21 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
3.22 (a) "Long-term care consultation services" means:
(1) providing information and education to the general public regarding availability
3.24 of the services authorized under this section;
3.25 (2) an intake process that provides access to the services described in this section;
3.26 (3) assessment of the health, psychological, and social needs of referred individuals;
3.27 (4) assistance in identifying services needed to maintain an individual in the least
3.28 restrictive environment;
3.29 (5) providing recommendations on cost-effective community services that are
3.30 available to the individual;
3.31 (6) development of an individual's community support plan<u>, which may include the</u>
3.32 <u>use of reverse mortgage payments to pay for services needed to maintain the individual in</u>
<u>the person's home</u>;
3.34 (7) providing information regarding eligibility for Minnesota health care programs;
3.35 (8) preadmission screening to determine the need for a nursing facility level of care;

4.1 (9) preliminary determination of Minnesota health care programs eligibility for
4.2 individuals who need a nursing facility level of care, with appropriate referrals for final
4.3 determination;
4.4 (10) providing recommendations for nursing facility placement when there are no
4.5 cost-effective community services available; and
4.6 (11) assistance to transition people back to community settings after facility
4.7 admission.
4.8 (b) "Minnesota health care programs" means the medical assistance program under
4.9 chapter 256B and the alternative care program under section 256B.0913.

4.10 Sec. 5. Minnesota Statutes 2004, section 256B.0911, subdivision 3a, is amended to
4.11 read:
4.12 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
4.13 services planning, or other assistance intended to support community-based living must be
4.14 visited by a long-term care consultation team within ten working days after the date on
4.15 which an assessment was requested or recommended. Assessments must be conducted
4.16 according to paragraphs (b) to (g).
4.17 (b) The county may utilize a team of either the social worker or public health nurse,
4.18 or both, to conduct the assessment in a face-to-face interview. The consultation team
4.19 members must confer regarding the most appropriate care for each individual screened or
4.20 assessed.
4.21 (c) The long-term care consultation team must assess the health and social needs of
4.22 the person, using an assessment form provided by the commissioner.
4.23 (d) The team must conduct the assessment in a face-to-face interview with the
4.24 person being assessed and the person's legal representative, if applicable.
4.25 (e) The team must provide the person, or the person's legal representative, with
4.26 written recommendations for facility- or community-based services. The team must
4.27 document that the most cost-effective alternatives available were offered to the individual.
4.28 For purposes of this requirement, "cost-effective alternatives" means community services
4.29 and living arrangements that cost the same as or less than nursing facility care.
4.30 (f) If the person chooses to use community-based services, the team must provide
4.31 the person or the person's legal representative with a written community support plan,
4.32 regardless of whether the individual is eligible for Minnesota health care programs.
4.33 The person may request assistance in developing a community support plan without
4.34 participating in a complete assessment. If the person chooses to obtain a reverse mortgage

5.1 as part of the community support plan, the plan must include a spending plan for the
5.2 reverse mortgage payments.
5.3 (g) The team must give the person receiving assessment or support planning, or
5.4 the person's legal representative, materials supplied by the commissioner containing
5.5 the following information:
5.6 (1) the purpose of preadmission screening and assessment;
5.7 (2) information about Minnesota health care programs and about reverse mortgages,
5.8 including the provisions of sections 47.58; 256B.0913, subdivision 17; 287.04, paragraph
5.9 (k); and 462A.05, subdivision 42;
5.10 (3) the person's freedom to accept or reject the recommendations of the team;
5.11 (4) the person's right to confidentiality under the Minnesota Government Data
5.12 Practices Act, chapter 13; and
5.13 (5) the person's right to appeal the decision regarding the need for nursing facility
5.14 level of care or the county's final decisions regarding public programs eligibility according
5.15 to section 256.045, subdivision 3.

5.16 Sec. 6. Minnesota Statutes 2004, section 256B.0913, is amended by adding a
5.17 subdivision to read:
5.18 Subd. 17. **Services for persons using reverse mortgages.** (a) Alternative care
5.19 services are available to a person who satisfies the following criteria:
5.20 (1) the person qualifies for the reverse mortgage incentive program under section
5.21 462A.05, subdivision 42, and has received the final payment on a qualifying reverse
5.22 mortgage, or the person satisfies the criteria in section 462A.05, subdivision 42, paragraph
5.23 (b), clauses (1) to (5), and has, for a period of at least 24 months or in an amount of at least
5.24 $15,000, expended substantially all of the payments from a reverse mortgage for services
5.25 and supports, including basic shelter needs, home maintenance, and modifications or
5.26 adaptations, necessary to allow the person to remain in the home as an alternative to a
5.27 nursing facility placement; and
5.28 (2) the person satisfies the eligibility criteria under this section, other than age,
5.29 income, and assets, and verifies that reverse mortgage expenditures were made according
5.30 to the spending plan established under section 256B.0911.
5.31 (b) In addition to the other services provided under this section, a person who
5.32 qualifies under this subdivision shall not be assessed a monthly participation fee under
5.33 subdivision 12 nor be subject to an estate claim under section 256B.15 for services
5.34 received under this section.

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

6.3 Sec. 7. Minnesota Statutes 2005 Supplement, section 287.04, is amended to read:

6.4 **287.04 EXEMPTIONS.**

6.5 The tax imposed by section 287.035 does not apply to:
6.6 (a) A decree of marriage dissolution or an instrument made pursuant to it.
6.7 (b) A mortgage given to correct a misdescription of the mortgaged property.
6.8 (c) A mortgage or other instrument that adds additional security for the same debt
6.9 for which mortgage registry tax has been paid.
6.10 (d) A contract for the conveyance of any interest in real property, including a
6.11 contract for deed.
6.12 (e) A mortgage secured by real property subject to the minerals production tax of
6.13 sections 298.24 to 298.28.
6.14 (f) The principal amount of a mortgage loan made under a low and moderate
6.15 income or other affordable housing program, if the mortgagee is a federal, state, or local
6.16 government agency.
6.17 (g) Mortgages granted by fraternal benefit societies subject to section 64B.24.
6.18 (h) A mortgage amendment or extension, as defined in section 287.01.
6.19 (i) An agricultural mortgage if the proceeds of the loan secured by the mortgage are
6.20 used to acquire or improve real property classified under section 273.13, subdivision 23,
6.21 paragraph (a), or (b), clause (1), (2), or (3).
6.22 (j) A mortgage on an armory building as set forth in section 193.147.
6.23 (k) A reverse mortgage that qualifies for the incentive program under section
6.24 462A.05, subdivision 42.

6.25 Sec. 8. Minnesota Statutes 2004, section 462A.05, is amended by adding a subdivision
6.26 to read:
6.27 Subd. 42. **Reverse mortgage incentive program.** (a) The agency shall, within the
6.28 limits of appropriations made available for this purpose, establish, in cooperation with
6.29 the commissioner of human services, a program to encourage eligible persons to obtain
6.30 reverse mortgages to pay for eligible costs of maintaining the person in the home as an
6.31 alternative to a nursing facility placement.
6.32 (b) The incentive program shall be made available to a person who has been
6.33 determined by the commissioner of human services or the commissioner's designated
6.34 agent to meet all of the following criteria:

7.1 (1) is age 62 or older;

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

7.4 (3) is not a medical assistance recipient, is not eligible for medical assistance without

7.5 a spenddown or waiver obligation, is not ineligible for the medical assistance program due

7.6 to an asset transfer penalty, and does not have income greater than the maintenance needs

7.7 allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent

7.8 of the federal poverty guidelines effective July 1 in the year for which program eligibility

7.9 is established, who would be eligible for the elderly waiver with a waiver obligation;

7.10 (4) needs services that are not funded through other state or federal funding for

7.11 which the person qualifies;

7.12 (5) obtains a reverse mortgage loan under section 47.58 on a home with an estimated market value not to exceed $150,000. This limit shall be adjusted annually on April 1

7.14 by the percentage change for the previous calendar year in the housing component of the

7.15 United States Consumer Price Index - All Urban Consumers; and

7.16 (6) makes expenditures of reverse mortgage payments in accordance with a spending

7.17 plan established under section 256B.0911, subdivision 3a, in which payments, services,

7.18 and supports meet the following standards:

7.19 (i) substantially all of the payments received under the loan are used solely for

7.20 services and supports, including basic shelter needs, home maintenance, and modifications

7.21 or adaptations, necessary to allow the person to remain in the home as an alternative

7.22 to a nursing facility placement;

7.23 (ii) reimbursements for services, supplies, and equipment shall not exceed the

7.24 market rate; and

7.25 (iii) if the person's spouse qualifies under section 256B.0913, subdivisions 1 to 14,

7.26 the reverse mortgage payments may be used to pay client fees under that section.

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

7.28 (1) payment of the initial mortgage insurance premium for a reverse mortgage.

7.29 The maximum payment under this clause shall be limited to $1,500. This limit shall be

7.30 adjusted annually on April 1 by the percentage change for the previous calendar year in the

7.31 housing component of the United States Consumer Price Index - All Urban Consumers;

7.32 (2) with federal approval, payments to reduce service fee set-asides, through an

7.33 advance payment to the lender, an agreement to guarantee fee payments after 60 months if the set-aside is limited to 60 months, or through other mechanisms approved by the

7.35 commissioner; and

7.36 (3) other incentives approved by the commissioner.

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

8.5 Sec. 9. Minnesota Statutes 2004, section 462A.05, is amended by adding a subdivision
8.6 to read:
8.7 Subd. 43. **Reverse mortgage information and referral.** The commissioner, in
8.8 cooperation with the commissioner of human services, shall:
8.9 (1) establish an information and referral system to inform eligible persons regarding
8.10 the availability of reverse mortgages and state incentives available to persons who take
8.11 out certain reverse mortgages. The information and referral system shall be established
8.12 involving the Senior LinkAge Line, county and tribal agencies, community housing
8.13 agencies and organizations, reverse mortgage counselors and lenders, senior and elder
8.14 community organizations, and other relevant entities; and
8.15 (2) coordinate necessary training for Senior LinkAge Line employees, mortgage
8.16 counselors, and lenders regarding the provisions of sections 256B.0913, subdivision 17;
8.17 287.04, paragraph (k); and 462A.05, subdivision 42.

8.18 Sec. 10. **APPROPRIATION.**
8.19 The following amounts are appropriated from the general fund to the commissioner
8.20 of human services for the fiscal year beginning July 1, 2006:
8.21 (1) $....... for the purposes of section 2;
8.22 (2) $....... to be transferred to the commissioner of the Minnesota Housing Finance
8.23 Agency for the purposes of section 7; and
8.24 (3) $....... to be transferred to the commissioner of the Minnesota Housing Finance
8.25 Agency for the purposes of section 8.
8.26 Any money appropriated for these purposes that is not spent for the purposes indicated
8.27 does not cancel but shall be transferred to the medical assistance account.

Senator .... moves to amend S.F. No. 3322 as follows:

Page 5, line 1, before "as" insert "under section 47.58"

Page 5, delete lines 23 and 24 and insert "(b), clauses (1) to (5), and has otherwise obtained a reverse mortgage and payments from the reverse mortgage for a period of at least 24 months or in an amount of at least $15,000 are used for services"

Page 5, line 30, before the period, insert ", if one has been established"

Page 6, after line 2, insert:

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

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

Page 7, line 16, delete "makes " and insert "agrees to make"

Page 7, line 19, delete everything after "(i)" and insert "payments received under the loan for a period of at least 24 months or in an amount of at least $15,000 are used for"

Page 8, delete section 9

Page 8, line 21, after the semicolon, insert "and"

Page 8, line 23, delete "7; and" and insert "9."

Page 8, delete lines 24 and 25

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

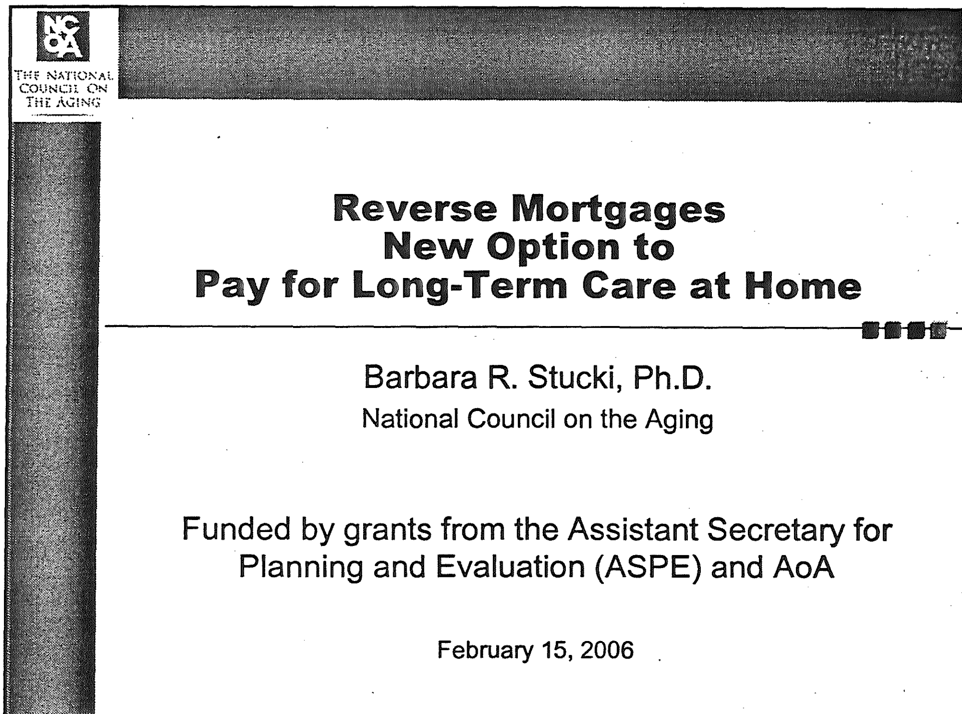
1.1 Senator .... moves to amend S.F. No. 3322 as follows:

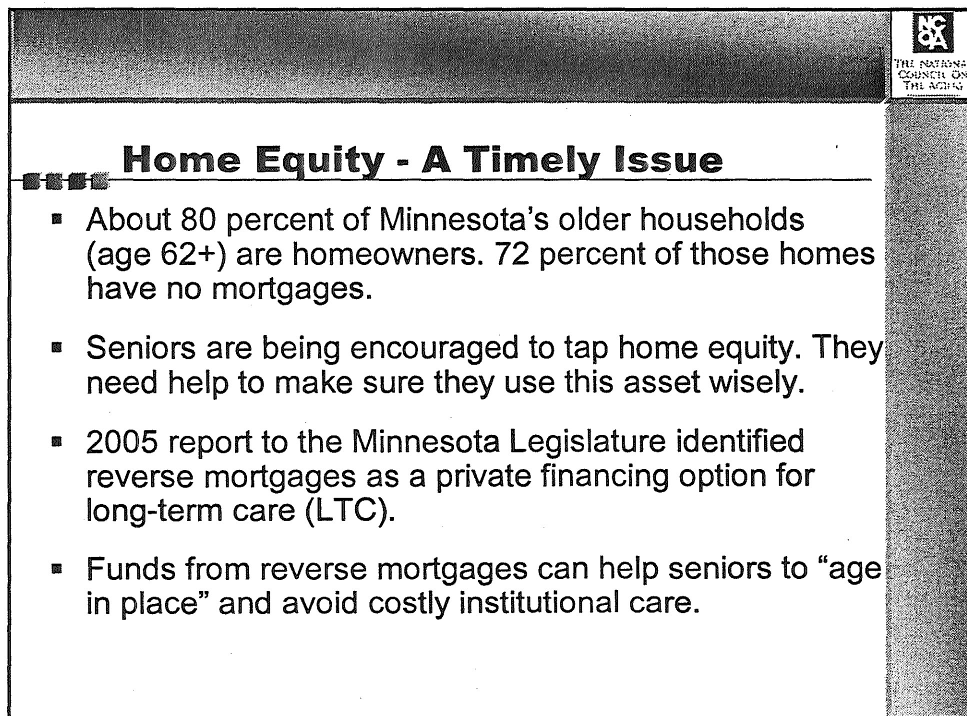
1.2 Page 6, delete section 7

1.3 Renumber the sections in sequence and correct the internal references

1.4 Amend the title accordingly

Senator Bergin





ASPE/AoA Reverse Mortgages for Long-Term Care Study

- 13 month study (Oct 2005 - Nov 2006). Funded by grants from ASPE and Administration on Aging.
- Goal – Work with selected states and communities to find ways to promote the appropriate use of reverse mortgages to help seniors pay for home and community services.
- Target population – Impaired older homeowners at risk of needing government assistance (Medicaid).
- Currently working with Minnesota, Washington State, and the city of Los Angeles.

What is a Reverse Mortgage?

Reverse Mortgages – The Basics

- A loan that allows homeowners age 62+ to convert home equity into cash while living at home for as long as they want.
- Can receive payments as a lump sum, line of credit, monthly payments (for up to life in the home).
- Funds can be used for any purpose. Payments are not taxed.
- Loan comes due when the (last) borrower moves out, dies, or sells the home.
- Borrowers continue to own the home. They are responsible for repairs, insurance, and taxes.

Types of Reverse Mortgages

- Home Equity Conversion Mortgage (HECM).
  - HUD program, insured by FHA.
  - Represents 90% of the market.
- Cash Account loans offered by Financial Freedom Senior Funding Corporation.
  - Designed for homes worth $600,00+.
  - Offer loans with no closing costs.
- Fannie Mae Home Keeper loan.

Consumer Protections

- Never owe more than the value of the house at the time of sale or repayment of the loan.
- Must receive counseling from a HUD-approved agency before they can take out a loan.
- Borrowers can cancel the loan for any reason within three business days after closing.

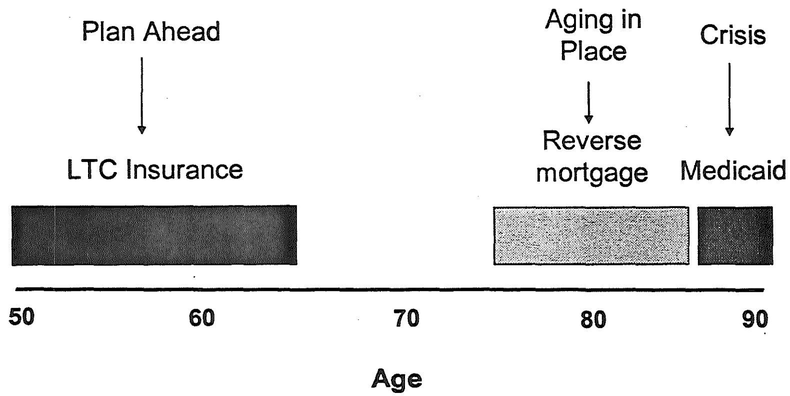
Loan Costs

- Origination fee.
- Mortgage insurance for HUD HECM loans.
- Other closing costs (title search, appraisal, etc).
- Repairs may be needed so the home meets FHA minimum requirements.

Using Reverse Mortgages to Pay for Help at Home

THE NATIONAL COUNCIL ON THE AGING

Reverse Mortgage – Fills a Gap



THE NATIONAL COUNCIL ON THE AGING

THE NATIONAL COUNCIL ON THE AGING

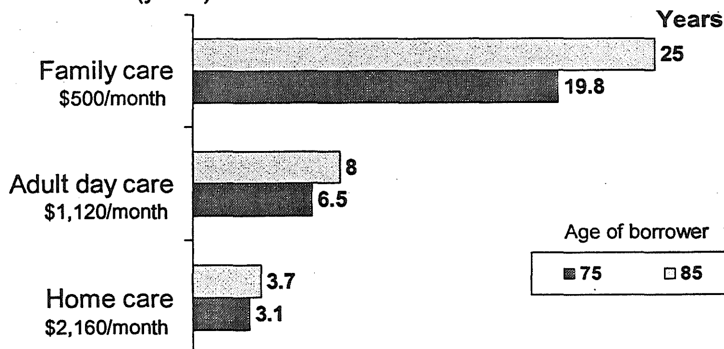
New strategy to build resilience

- Proactive - allows for earlier intervention to avoid problems.
- Pays for everyday expenses associated with aging in place. Loan can be used for any purpose.
- Enables borrowers to fill unmet needs and critical gaps in services.
- “Just in time” strategy to help seniors manage the monthly budget and reduce the impact of financial shocks.

THE NATIONAL COUNCIL ON THE AGING

Reverse mortgage funds could pay for home care for many years

Likely duration of funds based on monthly withdrawals from a HECM creditline (years)*



*Estimates based on HECM amount for a $122,790 home and an annual creditline growth of 5.36%. Source: NCOA analysis using the AARP reverse mortgage calculator

Reverse mortgages can help seniors to "age in place"

Reverse mortgages can increase the resilience of older homeowners:

- Support family caregiving.
  - Extra help to reduce the burden of care.
  - Provide income to unpaid caregivers.
- Pay for preventive measures.
- Keep the home livable.
  - Home repairs and maintenance.
  - Adaptive devices, home modifications.
- Support communities.
  - Strengthen ties of reciprocity that build social capital.
  - Reduce isolation.

THE NATIONAL COUNCIL ON THE AGING

Barriers and Options for Action

THE NATIONAL COUNCIL ON THE AGING

Key barriers limiting the use of reverse mortgages

- Myths and misperceptions about reverse mortgages.
- Closing costs for these loans.
- Worries about using money wisely, fraud and scams.
- Impaired elders may not be able to continue to live at home very long due to their chronic condition.
- Fear of impoverishment.

Options for Action

- Educate older homeowners and their families about using reverse mortgages for aging in place.
- Reduce upfront loan costs for borrowers who face financial challenges due to long-term care.
- Provide additional assistance and advice to help borrowers to stay at home as long as possible.

Barbara R. Stucki, Ph.D.
Project Manager, National Council on the Aging
Reverse Mortgages for Long-Term Care Project

Barb.stucki@ncoa.org
541-322-5610

Senator Berglin

MEMORANDUM

TO: Senator Linda Berglin

FROM: Barbara Stucki, NCOA

DATE: March 24, 2006

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 2. Potential impact of reducing closing costs and service fee set-aside

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

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

Senate
State of Minnesota

S.F. No. 3395 - Center for Health Care Purchasing Improvement

Author: Senator Sheila M. Kiscaden

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

Date: March 27, 2006

S.F. No. 3395 establishes the Center for Health Care Purchasing Improvement.

Section 1 (43A.312) Center for Health Care Purchasing Improvement

Subdivision 1 requires the Commissioner of Employee Relations to establish and administer the Center of Health Care Purchasing Improvement as an administrative unit in the Department of Employee Relations.

Subdivision 2 states that the purpose of the Center is to support the state in its efforts to be a more prudent and efficient purchaser of quality health care services.

Subdivision 3 authorizes the commissioner to appoint a director and up to three additional senior-level staff and other staff as needed. Authorizes the director, with the authorization of the Commissioner of Employee Relations and in consultation with the appropriate commissioners, to:

(1) initiate projects for the development of plan designs for state health purchasing;

(2) require reports or surveys to evaluate the performance of current health care purchasing strategies;

(3) conduct policy audits of state programs to measure conformity to state law or other purchasing initiatives or objectives;

(4) support the Administrative Uniformity Committee and other groups to advance agreement of health care administrative process streamlining;

(5) consult with the Health Economics Unit at the Department of Health regarding reports and assessment of the health care marketplace;

(6) consult with the Departments of Health and Commerce regarding health care regulatory issues and legislative initiatives;

(7) work with the Department of Human Services' staff and Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;

(8) assist Minnesota Comprehensive Health Association in health care purchasing strategies;

(9) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring strategies;

(10) recommend redeployment of staff among various state agencies to commissioners and the Governor to better organize purchasing efforts;

(11) consult with the Commissioner of Finance on: any fees to be assessed to agencies to support the activities of the Center and the calculation of fiscal impacts of health care purchasing strategies and initiatives;

(12) contact and participate with other relevant task forces, studies, and efforts;

(13) develop options or plans for building off existing examples or consensus on health care performance measures; and

(14) convene a group of health policy experts as advisors on health care market trends.

Subdivision 4 authorizes the commissioner, in consultation with the Commissioner of Finance, to assess appropriate fees or charges to state agencies for services and products received from the Center. Authorizes the Center to seek other external funding through grants or other opportunities and may administer grants and externally funded projects.

Subdivision 5 requires the commissioner to annually report to the Legislature and the Governor on the operations, activities, and impacts of the Center. Requires the report to be posted on the Department's Web site and made available to the public.

Section 2 appropriates $100,000 from the general fund to the Commissioner of Employee Relations.

KC:ph

Senator Kiscaden introduced–

S.F. No. 3395: Referred to the Committee on Health and Family Security.

A bill for an act

1.2 relating to state government; establishing the Center for Health Care Purchasing
1.3 Improvement; appropriating money; proposing coding for new law in Minnesota
1.4 Statutes, chapter 43A.

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

1.6 Section 1. **[43A.312] CENTER FOR HEALTH CARE PURCHASING**
1.7 **IMPROVEMENT.**

1.8 Subdivision 1. **Establishment; administration.** The commissioner shall establish
1.9 and administer the Center for Health Care Purchasing Improvement as an administrative
1.10 unit within the Department of Employee Relations.

1.11 Subd. 2. **Purpose.** The purpose of the Center for Health Care Purchasing
1.12 Improvement is to support the state in its efforts to be a more prudent and efficient
1.13 purchaser of quality health care services.

1.14 Subd. 3. **Staffing; duties; scope.** (a) The commissioner may appoint a director, and
1.15 up to three additional senior-level staff or co-directors, and other staff as needed who shall
1.16 be under the direction of the commissioner.

1.17 (b) With the authorization of the commissioner of the Department of Employee
1.18 Relations, and in consultation or interagency agreement with the appropriate
1.19 commissioners of state agencies, the director, or co-directors, may:

1.20 (1) initiate projects for development of plan designs for state health care purchasing;

1.21 (2) require reports or surveys to evaluate the performance of current health care
1.22 purchasing strategies;

1.23 (3) conduct policy audits of state programs to measure conformity to state statute or
1.24 other purchasing initiatives or objectives;

2.1 (4) support the Administrative Uniformity Committee under section 62J.50 and
2.2 other relevant groups or activities to advance agreement on health care administrative
2.3 process streamlining;
2.4 (5) consult with the Health Economics Unit of the Department of Health regarding
2.5 reports and assessments of the health care marketplace;
2.6 (6) consult with the departments of Health and Commerce regarding health care
2.7 regulatory issues and legislative initiatives;
2.8 (7) work with appropriate Department of Human Services staff and the Centers for
2.9 Medicare and Medicaid Services to address federal requirements and conformity issues
2.10 for health care purchasing;
2.11 (8) assist the Minnesota Comprehensive Health Association in health care
2.12 purchasing strategies;
2.13 (9) convene medical directors of agencies engaged in health care purchasing for
2.14 advice, collaboration, and exploring possible synergies;
2.15 (10) recommend redeployment of staff among various state agencies to
2.16 commissioners and the governor to better organize health care purchasing efforts;
2.17 (11) consult with the commissioner of finance regarding:
2.18 (i) any fees to be assessed to agencies to support the activities of the center; and
2.19 (ii) calculation of fiscal impacts, including net savings and return on investment, of
2.20 health care purchasing strategies and initiatives;
2.21 (12) contact and participate with other relevant health care task forces, study
2.22 activities, and similar efforts with regard to:
2.23 (i) promoting health information technology;
2.24 (ii) health care performance measurement and performance-based purchasing;
2.25 (iii) improving health outcomes for health care conditions of interest; and
2.26 (iv) identifying and overcoming barriers to more efficient, effective, quality health
2.27 care related to items (i) to (iii);
2.28 (13) develop options or plans for building off existing examples or consensus on
2.29 common health care performance measures relevant to ambulatory care, hospitals, and
2.30 health plans; and
2.31 (14) convene a group of health policy experts as advisors on health care market
2.32 trends.
2.33 Subd. 4. **Fees; funding.** The commissioner, in consultation with the commissioner
2.34 of finance, may assess appropriate fees or charges to state agencies for services and
2.35 products received from the center. The center may assist in seeking external funding

3.1 through appropriate grants or other funding opportunities, and may administer grants
3.2 and externally funded projects.

Subd. 5. **Report.** The commissioner must report annually to the legislature and the
3.4 governor on the operations, activities, and impacts of the center. The report must be posted
3.5 on the Department of Employee Relations Web site and must be available to the public.

3.6 Sec. 2. **APPROPRIATION.**

3.7 $100,000 is appropriated in fiscal year 2007 from the general fund to the
3.8 commissioner of employee relations for the purposes in section 1.

1.1 Senator .... moves to amend S.F. No. 3395 as follows:

1.2 Delete everything after the enacting clause and insert:

"Section 1. [43A.312] CENTER FOR HEALTH CARE PURCHASING
1.4 IMPROVEMENT.

1.5 Subdivision 1. **Establishment; administration.** The commissioner shall establish
1.6 and administer the Center for Health Care Purchasing Improvement as an administrative
1.7 unit within the Department of Employee Relations. The Center for Health Care Purchasing
1.8 Improvement shall support the state in its efforts to be a more prudent and efficient
1.9 purchaser of quality health care services. The center shall aid the state in developing and
1.10 using more common strategies and approaches for health care performance measurement
1.11 and health care purchasing. The common strategies and approaches shall promote greater
1.12 transparency of health care costs and quality, and greater accountability for health
care results and improvement. The center shall also identify barriers to more efficient,
1.14 effective, quality health care and options for overcoming the barriers.

1.15 Subd. 2. **Staffing; duties; scope.** (a) The commissioner may appoint a director, and
1.16 up to three additional senior-level staff or codirectors, and other staff as needed who shall
1.17 be under the direction of the commissioner. The staff of the center shall be unclassified.
1.18 (b) With the authorization of the commissioner of the Department of Employee
1.19 Relations, and in consultation or interagency agreement with the appropriate
1.20 commissioners of state agencies, the director, or codirectors, may:
1.21 (1) initiate projects for development of plan designs for state health care purchasing;
1.22 (2) require reports or surveys to evaluate the performance of current health care
purchasing strategies;
1.24 (3) calculate fiscal impacts, including net savings and return on investment, of health
1.25 care purchasing strategies and initiatives;
1.26 (4) conduct policy audits of state programs to measure conformity to state statute or
1.27 other purchasing initiatives or objectives;
1.28 (5) support the Administrative Uniformity Committee under section 62J.50 and
1.29 other relevant groups or activities to advance agreement on health care administrative
1.30 process streamlining;
1.31 (6) consult with the Health Economics Unit of the Department of Health regarding
1.32 reports and assessments of the health care marketplace;
1.33 (7) consult with the departments of Health and Commerce regarding health care
regulatory issues and legislative initiatives;

2.1 (8) work with appropriate Department of Human Services staff and the Centers for
2.2 Medicare and Medicaid Services to address federal requirements and conformity issues
2.3 for health care purchasing;
2.4 (9) assist the Minnesota Comprehensive Health Association in health care
2.5 purchasing strategies;
2.6 (10) convene medical directors of agencies engaged in health care purchasing for
2.7 advice, collaboration, and exploring possible synergies;
2.8 (11) contact and participate with other relevant health care task forces, study
2.9 activities, and similar efforts with regard to health care performance measurement and
2.10 performance-based purchasing; and
2.11 (12) assist in seeking external funding through appropriate grants or other funding
2.12 opportunities and may administer grants and externally funded projects.
2.13 Subd. 3. **Report.** The commissioner must report annually to the legislature and the
2.14 governor on the operations, activities, and impacts of the center. The report must be
2.15 posted on the Department of Employee Relations Web site and must be available to the
2.16 public. The report shall include a description of the state's efforts to develop and use more
2.17 common strategies for health care performance measurement and health care purchasing.
2.18 The report shall also include an assessment of the impacts of these efforts, especially in
2.19 promoting greater transparency of health care costs and quality, and greater accountability
2.20 for health care results and improvement.
2.21 Sec. 2. **APPROPRIATION.**
2.22 $100,000 is appropriated in fiscal year 2007 from the general fund to the
2.23 commissioner of employee relations for the purposes in section 1."

Senate Counsel, Research,
and Fiscal Analysis

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

Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 2917 - Social Worker Exception

Author: Senator Becky Lourey

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

Date: March 27, 2006

S.F. No. 2917 provides for an exception to the social worker's licensure requirements by requiring the Board of Social Work to issue a license to an applicant who meets the following requirements:

(1) meets all the licensure requirements except for the examination;

(2) is currently licensed as a school social worker by the Board of Teaching; and

(3) has been engaged in the practice of social work in a school setting for the preceding 15 years.

This section expires August 1, 2006.

KC:ph

Senator Lourey introduced–

S.F. No. 2917: Referred to the Committee on Health and Family Security.

A bill for an act
relating to health occupations; requiring the issuance of a social worker license
1.3 under certain circumstances.

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

1.5 Section 1. **EXCEPTION TO SOCIAL WORK LICENSURE REQUIREMENTS.**

1.6 Notwithstanding the requirements of Minnesota Statutes, sections 148D.001 to
1.7 148D.290, the Board of Social Work shall issue a license to practice as a licensed social
1.8 worker under Minnesota Statutes, chapter 148D, to an applicant who:

1.9 (1) meets the requirements described in Minnesota Statutes, section 148D.055,
1.10 subdivision 2, paragraph (a), clauses (1), (3), (4), (5), and (6);

(2) is currently licensed as a school social worker by the Board of Teaching under
1.12 Minnesota Statutes, chapter 122A; and

1.13 (3) has been engaged in the practice of social work in an elementary, middle, or
1.14 secondary school, for the preceding 15 years.

1.15 The board must accept applications under this section until August 1, 2006.

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

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

Senate
State of Minnesota

S.F. No. 3522 - DHS Health Care Policy Bill (The A-1 Amendment)

Author: Senator Becky Lourey

Prepared by: David Giel, Senate Research (296-7178)
Katie Cavanor, Senate Counsel (651/296-3801)

Date: March 27, 2006

S.F. No. 3522 makes a number of policy changes in statutes governing health care policy.

Section 1 (256B.0625, subdivision 3f) modifies the language eliminating Medical Assistance (MA) coverage for circumcisions unless they are medically necessary to state that the prohibition on coverage applies to all circumcisions, not just to procedures involving newborns. This section also deletes an exception for procedures required because of well-established religious practice.

Section 2 (256B.0625, subdivision 17) allows payment for special transportation services, usually only available for transportation to MA-covered health care services, to also be made for transportation of MA recipients to receive pharmacy services, which are now covered by Medicare for persons dually eligible for MA and Medicare.

Section 3 (256B.15, subdivision 1c) requires a notice of potential claim filed under the MA claims statute to include only the last four digits of the recipient's Social Security number, not the complete number.

Section 4 (256B.69, subdivision 23) corrects a typographical error and corrects terminology.

Section 5 (256L.05, subdivision 2) requires MinnesotaCare applicants to verify eligibility for employer-subsidized health insurance on a form signed by the employer, rather than by simply providing employer contact information to the Department of Human Services (DHS) or to the county.

Section 6 (256L.15, subdivision 4) requires counties to pay a flat premium of $7.10 per month, rather than a sliding scale premium based on income, for adults without children formerly enrolled in General Assistance Medical Care but now enrolled in MinnesotaCare until their six-month renewal.

Section 7 (514.982, subdivision 1) requires MA lien notices to include only the last four digits of the recipient's Social Security number, not the complete number.

Section 8 deletes outdated language.

DG/KC:rdr

Senator Lourey introduced–

S.F. No. 3522: Referred to the Committee on Health and Family Security.

A bill for an act

1.2 relating to human services; changing health care provisions; modifying medical
1.3 assistance-related transportation costs, state agency claim provisions, alternative
1.4 services, commissioner's authorities, transitioned adults provisions, medical
1.5 assistance liens, commissioner's duties, and managed care contract provisions;
1.6 amending Minnesota Statutes 2004, sections 256B.15, subdivision 1c; 256B.692,
1.7 subdivision 6; 514.982, subdivision 1; Minnesota Statutes 2005 Supplement,
1.8 sections 256B.0625, subdivisions 3f, 17; 256B.69, subdivision 23; 256L.05,
1.9 subdivision 2; 256L.15, subdivision 4; Laws 2005, First Special Session chapter
1.10 4, article 8, section 84; repealing Minnesota Statutes 2004, section 256B.692,
1.11 subdivision 10.

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

1.13 Section 1. Minnesota Statutes 2005 Supplement, section 256B.0625, subdivision 3f,
1.14 is amended to read:

1.15 Subd. 3f. **Circumcision ~~for newborns~~.** ~~Newborn~~ Circumcision is not covered,
1.16 unless the procedure is medically necessary ~~or required because of a well-established~~
1.17 ~~religious practice~~.

1.18 Sec. 2. Minnesota Statutes 2005 Supplement, section 256B.0625, subdivision 17,
1.19 is amended to read:

1.20 Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs
1.21 incurred solely for obtaining emergency medical care or transportation costs incurred
1.22 by eligible persons in obtaining emergency or nonemergency medical care when paid
1.23 directly to an ambulance company, common carrier, or other recognized providers of
1.24 transportation services.<u> Effective January 1, 2006, transportation costs and services are</u>
1.25 <u>covered only if the health care service obtained through the transportation is a health care</u>
1.26 <u>service covered by this chapter except that transportation to obtain pharmacy services for</u>

2.1 an eligible person also covered by Medicare is covered, even if the pharmacy service
2.2 obtained through such transportation is fully or partially covered by Part D Medicare.
2.3 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,
2.4 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that
2.5 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial
2.6 transportation, or private automobile.

2.7 The commissioner may use an order by the recipient's attending physician to certify that
2.8 the recipient requires special transportation services. Special transportation includes
2.9 driver-assisted service to eligible individuals. Driver-assisted service includes passenger
2.10 pickup at and return to the individual's residence or place of business, assistance with
2.11 admittance of the individual to the medical facility, and assistance in passenger securement
2.12 or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers
2.13 must obtain written documentation from the health care service provider who is serving
2.14 the recipient being transported, identifying the time that the recipient arrived. Special
2.15 transportation providers may not bill for separate base rates for the continuation of a trip
2.16 beyond the original destination. Special transportation providers must take recipients to
2.17 the nearest appropriate health care provider, using the most direct route available. The
2.18 maximum medical assistance reimbursement rates for special transportation services are:
2.19 (1) $17 for the base rate and $1.35 per mile for services to eligible persons who
2.20 need a wheelchair-accessible van;
2.21 (2) $11.50 for the base rate and $1.30 per mile for services to eligible persons who
2.22 do not need a wheelchair-accessible van; and
2.23 (3) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for
2.24 services to eligible persons who need a stretcher-accessible vehicle.

2.25 Sec. 3. Minnesota Statutes 2004, section 256B.15, subdivision 1c, is amended to read:
2.26 Subd. 1c. **Notice of potential claim.** (a) A state agency with a claim or potential
2.27 claim under this section may file a notice of potential claim under this subdivision anytime
2.28 before or within one year after a medical assistance recipient dies. The claimant shall be
2.29 the state agency. A notice filed prior to the recipient's death shall not take effect and shall
2.30 not be effective as notice until the recipient dies. A notice filed after a recipient dies
2.31 shall be effective from the time of filing.
2.32 (b) The notice of claim shall be filed or recorded in the real estate records in the
2.33 office of the county recorder or registrar of titles for each county in which any part of
2.34 the property is located. The recorder shall accept the notice for recording or filing. The
2.35 registrar of titles shall accept the notice for filing if the recipient has a recorded interest in

the property. The registrar of titles shall not carry forward to a new certificate of title any notice filed more than one year from the date of the recipient's death.

(c) The notice must be dated, state the name of the claimant, the medical assistance recipient's name and the last four digits of the Social Security number if filed before their death and their date of death if filed after they die, the name and date of death of any predeceased spouse of the medical assistance recipient for whom a claim may exist, a statement that the claimant may have a claim arising under this section, generally identify the recipient's interest in the property, contain a legal description for the property and whether it is abstract or registered property, a statement of when the notice becomes effective and the effect of the notice, be signed by an authorized representative of the state agency, and may include such other contents as the state agency may deem appropriate.

Sec. 4. Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A,

4.1 if adopted, for the purpose of demonstrations under this subdivision, the commissioner
4.2 may contract with managed care organizations, including counties, to serve only elderly
4.3 persons eligible for medical assistance, elderly and disabled persons, or disabled persons
4.4 only. For persons with primary diagnoses of mental retardation or a related condition,
4.5 serious and persistent mental illness, or serious emotional disturbance, the commissioner
4.6 must ensure that the county authority has approved the demonstration and contracting
4.7 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
4.8 commissioner shall not implement any demonstration project under this subdivision for
4.9 persons with primary diagnoses of mental retardation or a related condition, serious and
4.10 persistent mental illness, or serious emotional disturbance, without approval of the county
4.11 board of the county in which the demonstration is being implemented.

4.12 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
4.13 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
4.14 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
4.15 under this section projects for persons with developmental disabilities. The commissioner
4.16 may capitate payments for ICF/MR services, waivered services for mental retardation or
4.17 related conditions, including case management services, day training and habilitation and
4.18 alternative active treatment services, and other services as approved by the state and by the
4.19 federal government. Case management and active treatment must be individualized and
4.20 developed in accordance with a person-centered plan. Costs under these projects may not
4.21 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
4.22 and until two years after the pilot project implementation date, subcontractor participation
4.23 in the long-term care developmental disability pilot is limited to a nonprofit long-term
4.24 care system providing ICF/MR services, home and community-based waiver services,
4.25 and in-home services to no more than 120 consumers with developmental disabilities in
4.26 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
4.27 prior to expansion of the developmental disability pilot project. This paragraph expires
4.28 two years after the implementation date of the pilot project.

4.29 (c) Before implementation of a demonstration project for disabled persons, the
4.30 commissioner must provide information to appropriate committees of the house of
4.31 representatives and senate and must involve representatives of affected disability groups
4.32 in the design of the demonstration projects.

4.33 (d) A nursing facility reimbursed under the alternative reimbursement methodology
4.34 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
4.35 provide services under paragraph (a). The commissioner shall amend the state plan and
4.36 seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state.

(g) Notwithstanding section ~~256B.0261~~ 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation ~~targeted case management~~ service coordination. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 5. Minnesota Statutes 2004, section 256B.692, subdivision 6, is amended to read:

Subd. 6. **Commissioner's authority.** The commissioner may:

(1) reject any preliminary or final proposal that substantially fails to meet the requirements of this section, or that the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state,

or would substantially impair an enrollee's choice of ~~care systems~~ managed care organizations when reasonable choice is possible, or would substantially impair the implementation and operation of the Minnesota senior health options demonstration project authorized under section 256B.69, subdivision 23; and

(2) assume operation of a county's purchasing of health care for enrollees in medical assistance and general assistance medical care in the event that the contract with the county is terminated.

Sec. 6. Minnesota Statutes 2005 Supplement, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

(b) In determining eligibility for MinnesotaCare, the commissioner shall require applicants and enrollees seeking renewal of eligibility to verify both earned and unearned income. The commissioner shall also require applicants and enrollees to ~~submit the names of their employers and a contact name with a telephone number for each employer for purposes of verifying~~ verify whether the applicant or enrollee, and any dependents, are eligible for employer-subsidized coverage, as defined in section 256L.07, subdivision 2. Verification of access to employer-subsidized coverage shall be provided on a Minnesota health care program form completed and signed by the employer, or other employer issued documentation. Data collected is nonpublic data as defined in section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 7. Minnesota Statutes 2005 Supplement, section 256L.15, subdivision 4, is amended to read:

Subd. 4. **Exception for transitioned adults.** The county ~~agencies~~ of financial responsibility shall pay ~~premiums~~ a premium of $7.10 for each month described in section 256L.05, subdivision 3, paragraph (e), for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, until six-month renewal. The county ~~agency~~

7.1 of financial responsibility has the option of continuing to pay premiums under subdivision
7.2 2, paragraph (a), for these enrollees past the first six-month renewal period.

7.3 **EFFECTIVE DATE.** This section is effective September 1, 2006.

7.4 Sec. 8. Minnesota Statutes 2004, section 514.982, subdivision 1, is amended to read:
7.5 Subdivision 1. **Contents.** A medical assistance lien notice must be dated and
7.6 must contain:
7.7 (1) the full name, last known address, and the last four digits of the Social Security
7.8 number of the medical assistance recipient;
7.9 (2) a statement that medical assistance payments have been made to or for the
7.10 benefit of the medical assistance recipient named in the notice, specifying the first date
7.11 of eligibility for benefits;
(3) a statement that all interests in real property owned by the persons named in the
7.13 notice may be subject to or affected by the rights of the agency to be reimbursed for
7.14 medical assistance benefits; and
7.15 (4) the legal description of the real property upon which the lien attaches, and
7.16 whether the property is registered property.

7.17 Sec. 9. Laws 2005, First Special Session chapter 4, article 8, section 84, is amended to
7.18 read:
7.19 Sec. 84. ~~SOLE-SOURCE OR~~ **SINGLE-PLAN MANAGED CARE**
7.20 **CONTRACT.**

7.22 Notwithstanding Minnesota Statutes, section 256B.692, subdivision 6, the
7.23 commissioner of human services shall ~~not reject~~ consider a county-based purchasing
7.24 health plan proposal that requires county-based purchasing on a ~~sole-source or~~ single-plan
7.25 basis if the implementation of the ~~sole-source or~~ single-plan purchasing proposal does
7.26 not limit an enrollee's provider choice or access to services. ~~The commissioner shall~~
7.27 ~~request federal approval, if necessary, to permit or maintain a sole-source or single-plan~~
7.28 ~~purchasing option even if choice is available in the area.~~
7.29

Sec. 10. **REPEALER.**
Minnesota Statutes 2004, section 256B.692, subdivision 10, is repealed.

256B.692 COUNTY-BASED PURCHASING.

Subd. 10. **Report to the legislature.** The commissioner shall submit a report to the legislature by February 1, 1998, on the preliminary proposals submitted on or before September 1, 1997.

1.1 Senator .... moves to amend S.F. No. 3522 as follows:

1.2 Page 5, delete section 5

1.3 Page 7, delete section 9

1.4 Renumber the sections in sequence and correct the internal references

1.5 Amend the title accordingly

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

Senate
State of Minnesota

S.F. No. 3355 - Community Health Clinics

Author: Senator Becky Lourey

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

Date: March 27, 2006

S.F. No. 3355 adds to the definition of "governmental unit" nonprofit community health clinics providing family planning services. The result of this addition would permit these clinics to participate in the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP).

KC:ph

Senators Lourey, Kiscaden, Dille, Foley and Higgins introduced–

S.F. No. 3355: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying the definition of governmental unit; amending
1.3 Minnesota Statutes 2004, section 145.925, by adding a subdivision.

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

1.5 Section 1. Minnesota Statutes 2004, section 145.925, is amended by adding a
1.6 subdivision to read:

1.7 Subd. 10. **Definition of governmental unit.** For purposes of section 471.59,
1.8 subdivision 1, nonprofit community health clinics providing family planning services as
1.9 defined in this section shall be included in the definition of "governmental unit."

Sen. Lowrey

StarTribune.com | MINNEAPOLIS - ST. PAUL, MINNESOTA
Last update: March 26, 2006 – 7:00 PM

Editorial: More support for family planning

State, lawmakers should restore and expand funding.

For every public dollar spent on family planning, government saves $3 in costs for prenatal and newborn care. That's a worthwhile investment, one that Minnesota had been increasing for nearly three decades.

Last year, however, the Legislature cut family-planning support in half, reducing the allocation by more than $3 million. That change, along with delays in accessing a new source of federal funding, threatens the survival of clinics that offer contraception and other services. The Pawlenty administration and the Legislature should make family planning a priority, simplify the system and keep crucial dollars flowing to clinics.

Under the previous two administrations, that commitment grew to $10 million per biennium through the Health Department. During that same period, federal funding flattened and failed to keep pace with rising costs. So in recognition of growing needs, the state applied for funding through Medicare and Medicaid. That was approved in 2004 and channeled through the Human Services Department. Yet the program is not yet officially established, so funds have not been distributed.

Planned Parenthood officials say implementation problems include inadequate computer systems, staffing and training; and a lack of confidentiality safeguards for teens.

At the end of the 2005 legislative session, a compromise deal to preserve MinnesotaCare health care funding resulted in the family planning cuts -- with the idea that those funds would be covered upon full use of the federal program. Trouble is, "full use" is not well-defined. And switching the program from health to human services along with folding in Medicaid/Medicare procedures has complicated and slowed down the transfers.

Recent federal action could make matters worse. Congress passed a budget reconciliation bill that allows states to charge co-pays and to opt out of some Medicaid-supported programs. If states use those options, services will be even further out of reach for poor families.

Combined, these changes make it harder to access birth control and other family planning services -- particularly for younger, lower-income and immigrant people. That's exactly the wrong direction to go. Only about 40 percent of Minnesota women and teens who need publicly supported contraceptive services receive them. That's an argument to expand, not diminish, access to programs.

Minnesota was on the path to progress in providing these important services. Now is no time to regress. State agencies should streamline and simplify

eligibility and get waiting federal funds to providers. And lawmakers should restore and increase state support for family planning.

©2006 Star Tribune. All rights reserved.