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Senate
State of Minnesota

S.F. No. 3208 - Postadoption Search Services Training

Author: Senator Ann H. Rest

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

Date: March 28, 2006

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

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

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

Paragraph (d) requires the social service agencies to provide the information listed in this paragraph to the commissioner of human services.

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

JW:mvm

Senators Rest, Lourey, Wergin and Kiscaden introduced–

S.F. No. 3208: Referred to the Committee on Health and Family Security.

A bill for an act

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

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

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

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

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

(c) All private agency staff providing adoption services, including postadoption search services, shall complete at least eight hours of postadoption search services training as a component of preservice training.

(d) All social service agencies shall provide the commissioner of human services with the following data on postadoption search services every June 30 and December 31:

(1) the number of search requests received and the number of search requests that are processed;

(2) the percentage of requests resulting in successful location of the other party;

(3) the percentage of requests resulting in successful completion of the commissioner's designated form for family medical and social history;

(4) the time from request for search to completion of search;

(5) the number and type of efforts used to complete the search; and

(6) the fee charged for each search conducted. The commissioner shall compile the data annually and submit a report to the house and senate committees with jurisdiction over adoption no later than January 30 of each year.

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

259.87 RULES.

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

Senator ..... moves to amend S.F. No. 3208 as follows:

Page 1, line 17, delete "eight" and insert "six" and after "training" insert a period

Page 1, delete lines 18 to 25

Page 2, delete lines 1 to 5

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S.F. No. 3265 - Methamphetamine Coordinator

Author: Senator Julie A. Rosen

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

Date: March 27, 2006

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

Subdivision 2 specifies the duties of the methamphetamine coordinator.

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

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

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

JW:mvm

Senators Rosen, Lourey and Koch introduced–

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

A bill for an act

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

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

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

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

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

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

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

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

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

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

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

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

(8) fielding methamphetamine-related calls;

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

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

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

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

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

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

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

Sec. 2. **APPROPRIATION.**

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

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S.F. No. 2751 - MinnesotaCare – Spenddown Option

Author: Senator Tarryl Clark

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

Date: March 24, 2006

S.F. No. 2751 creates a spenddown in MinnesotaCare for certain individuals with life-threatening ongoing medical conditions.

Section 1 (256L.07, subdivision 1) exempts parents who are eligible under Minnesota Statutes, section 256L.07, subdivision 7, from the eligibility limit of this subdivision.

Section 2 (256L.07, subdivision 7) states that an individual who has excess income is eligible for MinnesotaCare if that individual has medical expenses for a life-threatening, ongoing medical condition that are more than the amount of the individual's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard for the eligibility category that applies to the individual. Medical expenses may be deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. If the enrollee does not pay the spenddown amount on or before the last business day of the month, the enrollee is ineligible for this option for the following month. This section also defines "life-threatening, on going medical condition" to mean any condition that is considered a presumptive condition for purposes of automatic eligibility under the Minnesota Comprehensive Health Association.

KC:ph

Senators Clark, Solon, Koering, Rosen and Lourey introduced–

S.F. No. 2751: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; allowing persons with life-threatening medical conditions to spend down excess income under MinnesotaCare; amending Minnesota Statutes 2004, section 256L.07, by adding a subdivision; Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1.

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

Section 1. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and

shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Notwithstanding paragraphs (b) and (c), and subdivision 7, parents are not eligible for MinnesotaCare if gross household income exceeds $25,000 for the six-month period of eligibility.

Sec. 2. Minnesota Statutes 2004, section 256L.07, is amended by adding a subdivision to read:

Subd. 7. **Persons with life-threatening medical conditions; excess income.** Notwithstanding subdivision 1, paragraph (b), a person who has excess income is eligible for MinnesotaCare if the person has expenses for medical care for a life-threatening, ongoing medical condition that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard for the appropriate eligibility category specified in section 256L.04. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the last business day of

the month in order to be eligible for this option in the following month. For purposes of this subdivision, "life-threatening, ongoing medical condition" means a condition listed as a presumptive condition for purposes of containing coverage under the Minnesota Comprehensive Health Association.

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S.F. No. 3098 - Alternative Approval Process for New Hospital Construction (the A-3 Delete-Everything Amendment)

Author: Senator Linda Berglin

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

Date: March 27, 2006

S.F. No. 3098 establishes an alternative process for approving exceptions to the hospital construction moratorium in situations where more than one entity is interested in building a new hospital in the same service area.

Section 1 (144.551, subdivision 1) adds an exception to the hospital construction moratorium for any projects that are eventually approved under section 3.

Section 2 (144.552) modifies the requirement that an entity seeking a moratorium exception must submit a plan to the Minnesota Department of Health (MDH) for a public interest review. This section requires a plan submission from an organization seeking to obtain a new hospital license only in cases where the organization has been notified by MDH under section 3 that it is subject to the requirement for a public interest review. This section also requires MDH to conduct a public hearing as part of the review process.

Section 3 (144.553) establishes an alternative approval process for moratorium exceptions.

> **Subdivision 1** requires an organization seeking a new hospital license to submit a letter of intent to MDH, specifying the location and number of beds for the proposed hospital. MDH must publish a notice giving other interested organizations 30 days to notify MDH that they are also interested in obtaining a hospital license to serve the same area. If no other organizations express interest, MDH must notify the original entity that it is subject to a public interest review.

Subdivision 2 requires MDH to conduct a needs assessment on the proposed new hospital if one or more additional organizations responds to the original letter of intent. The commissioner must make a determination of need within 90 days, and each interested organization must provide to MDH sufficient information to allow MDH to make this determination. If MDH determines the new hospital is not needed, the agency must notify the applicants.

Subdivision 3 requires MDH, if it determines that a new hospital is needed, to do the following:

- select the applicant best able to provide services consistent with the review criteria established in this subdivision;
- determine market-specific criteria regarding access, quality, cost, and feasibility, and other criteria at the agency's discretion. In developing other criteria, MDH must consider the need for mental health services, the need for uncompensated care, and the need for coordination with other hospitals in order to avoid duplication and to provide specialized services in adequate volume to ensure high-quality care;
- define a service area for the proposed hospital. Parameters for establishing service areas are outlined in this subdivision;
- publish the criteria within 60 days of the determination of need and accept proposals from the applicants for an additional 60 days;
- select the most qualified applicant following (1) a hearing conducted by the agency or a designee, such as an administrative law judge; (2) a public hearing; and (3) consideration of input from legislators and local elected officials.
- submit the recommended proposal, during the time frame outlined, to a regular session of the Legislature.

Legislative acceptance of the proposal constitutes approval of a moratorium exception. Legislative rejection concludes the process but does not prohibit a new application. In the event of a legislative failure to act, upon the conclusion of the legislative session MDH must make the agency's recommendation the final approval of the project. The terms "legislative acceptance," "legislative rejection," and "legislative failure to act" are defined.

Subdivision 4 requires the parties to any stage of the process outlined in this section to pay an equal share of the agency's expenses.

DG:rdr

Senators Berglin, Lourey, Wergin, Koering and Johnson, D.E. introduced–

S.F. No. 3098: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; establishing a process to evaluate certain hospital construction proposals; amending Minnesota Statutes 2004, section 144.552; Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 144.

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

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

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

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(20) a project approved under section 144.553.

Sec. 2. Minnesota Statutes 2004, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) A hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license must submit a plan to the commissioner of health. The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding.

(c) The commissioner shall review the plan and, within 90 days, ~~but no more than six months if extenuating circumstances apply,~~ issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

(d) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house and senate committees having jurisdiction over health and human services policy and finance.

Sec. 3. **[144.553] ALTERNATIVE APPROVAL PROCESS FOR NEW HOSPITAL CONSTRUCTION.**

Subdivision 1. **Notice; request for proposals.** (a) Immediately upon the completion of a review under section 144.552 of a project involving the issuance of a hospital license, if the commissioner determines that the plan submitted under that section is in the public

interest, the commissioner shall publish in the State Register a notice of that finding and a request for applications from any other entities interested in constructing a hospital in response to that finding.

(b) The commissioner shall accept applications for 30 days from the date the notice is published. If no other applications are received, the commissioner shall notify the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance that no project has been approved under this section and that section 144.551 applies to the construction of a hospital in this instance.

(c) If one or more additional entities applies to construct a hospital in response to the commissioner's request for applications, the commissioner shall select the applicant determined under the process established in subdivision 2 to be best able to provide services consistent with the review criteria established in subdivision 2.

Subd. 2. **Process when multiple applicants seek approval.** (a) When multiple applicants seek approval to build a hospital, the commissioner shall:

(1) determine market-specific criteria that shall be used to evaluate all proposals. The criteria must include standards regarding:

(i) access to care;

(ii) quality of care;

(iii) cost of care; and

(iv) overall project feasibility;

(2) establish additional criteria at the commissioner's discretion. The criteria determined under this clause shall constitute the sole criteria under which the competing proposals shall be evaluated; and

(3) define a service area for the proposed hospital. In a community that includes an existing hospital, the service area shall consist of the zip codes in closest proximity to the existing hospital that make up 80 percent of that hospital's admissions. In a community that does not include an existing hospital, the service area shall consist of:

(i) in the 11-county metropolitan area, in St. Cloud, and in Duluth, the zip codes located within a 20-mile radius of the proposed new hospital location; and

(ii) in the remainder of the state, the zip codes within a 30-mile radius of the proposed new hospital location.

(b) The commissioner shall publish the criteria determined under paragraph (a), clause (1), in the State Register within 60 days of the deadline for applications under subdivision 1. Once published, the criteria shall not be modified with respect to the particular project and applicants to which they apply. The commissioner shall publish with the criteria guidelines for a proposal and submission review process.

(c) For 60 days after the publication under paragraph (b), the commissioner shall accept proposals to construct a hospital. The proposal must include a plan for the new hospital and evidence of compliance with the criteria specified under paragraph (a), clause (1). Once submitted, the proposal may not be revised except:

(1) to submit corrections of material facts; or

(2) in response to a request from the commissioner to provide clarification or further information.

(d) The commissioner shall determine within 90 days of the deadline for applications under paragraph (c), which applicant has demonstrated that it is best able to provide services consistent with the published criteria. The commissioner shall make this determination by order following a hearing according to this paragraph. The hearing shall not constitute or be considered to be a contested case hearing under chapter 14 and shall be conducted solely under the procedures specified in this paragraph. The hearing shall commence upon at least 30 days' notice to the applicants by the commissioner. The hearing may be conducted by the commissioner or by a person designated by the commissioner. The designee may be an administrative law judge. The purpose of the hearing shall be to receive evidence to assist the commissioner in determining which applicant has demonstrated that it best meets the published criteria.

The parties to the hearing shall consist only of those applicants who have submitted a completed application. Each applicant shall have the right to be represented by counsel, to present evidence deemed relevant by the commissioner, and to examine and cross-examine witnesses. Persons who are not parties to the proceeding but who wish to present comments or submit information may do so in the manner determined by the commissioner or the commissioner's designee. Any person who is not a party shall have no right to examine or cross-examine witnesses. The commissioner may participate as an active finder of fact in the hearing and may ask questions to elicit information or clarify answers or responses.

Notwithstanding section 16A.1283, applicants who are a party to the hearing shall pay the cost of the hearing, as determined by the commissioner. The cost of the hearing shall be divided equally among the applicants. Money received by the commissioner under this paragraph is appropriated to the commissioner for the purpose of administering this section.

(e) The commissioner shall issue an order selecting an application following the closing of the record of the hearing as determined by the hearing officer. The commissioner's order shall include a statement of the reasons the application best meets the published criteria. Prior to making a determination selecting an application, the

commissioner shall, through a process announced by the commissioner, accept comments from members of the public in the service area for the new hospital. The commissioner shall take this information into consideration in making the determination. The commissioner must also consider the input and preferences of legislators and local elected officials who represent the service area regarding the selection of the hospital provider.

(f) Any applicant aggrieved by the commissioner's order is entitled to judicial review by the Court of Appeals according to sections 14.63 to 14.69. Review by the Court of Appeals must be based on the administrative record and expedited.

(g) Following the determination under paragraph (d), the commissioner shall submit the matter to the legislature at its next regular session to be accepted or rejected. Legislative acceptance of the commissioner's recommendation constitutes approval of the proposal under section 144.551. Legislative rejection of the recommendation concludes the process but does not prohibit a new application under this section and section 144.552.

Subd. 3. **Result of legislative failure to act.** In the event that the legislature neither accepts nor rejects the recommendation made under subdivision 2, upon the conclusion of the legislative session, the commissioner may make the commissioner's recommendation the final approval of the project. The commissioner's decision to grant final approval to the commissioner's recommendation constitutes approval of the proposal under section 144.551.

Senator ..... moves to amend S.F. No. 3098 as follows:

Delete everything after the enacting clause and insert:

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

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

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

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

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

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

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

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

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

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

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be

eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

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

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

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

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

(20) a project approved under section 144.553.

Sec. 2. Minnesota Statutes 2004, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license ~~must submit a plan to the commissioner of health~~ and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding.

(c) The commissioner shall review the plan and, within 90 days, but no more than six months if extenuating circumstances apply, issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

(d) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house and senate committees having jurisdiction over health and human services policy and finance.

Sec. 3. **[144.553] ALTERNATIVE APPROVAL PROCESS FOR NEW HOSPITAL CONSTRUCTION.**

Subdivision 1. **Letter of intent; publication; acceptance of additional proposals.** (a) An organization seeking to obtain a hospital license must submit a letter of intent to the commissioner, specifying the community in which the proposed hospital would be located and the number of beds proposed for the new hospital. When multiple letters of intent are received, the commissioner shall determine whether they constitute requests for separate projects or are competing proposals to serve the same or a similar service area.

(b) Upon receipt of a letter under paragraph (a), the commissioner shall publish a notice in the State Register that includes the information received from the organization under paragraph (a). The notice must state that another organization interested in seeking a hospital license to serve the same or a similar service area must notify the commissioner within 30 days.

(c) If no responses are received from additional organizations under paragraph (b), the commissioner shall notify the entity seeking a license that it is required to submit a plan under section 144.552 and shall notify the chairs of the house of representatives and

senate committees having jurisdiction over health and human services policy and finance that the project is subject to sections 144.551 and 144.552.

Subd. 2. **Needs assessment.** (a) If one or more responses are received by the commissioner under subdivision 1, paragraph (b), the commissioner shall complete within 90 days a needs assessment to determine if a new hospital is needed in the proposed service area.

(b) The organizations that have filed or responded to a letter of intent under subdivision 1 shall provide to the commissioner within 30 days of a request from the commissioner a statement justifying the need for a new hospital in the service area and sufficient information, as determined by the commissioner, to allow the commissioner to determine the need for a new hospital. The information may include, but is not limited to, a demographic analysis of the proposed service area, the number of proposed beds, the types of hospital services to be provided, and distances and travel times to existing hospitals currently providing services in the service area.

(c) The commissioner shall make a determination of need for the new hospital. If the commissioner determines that a new hospital in the service area is not justified, the commissioner shall notify the applicants in writing, stating the reasons for the decision.

Subd. 3. **Process when hospital need is determined.** (a) If the commissioner determines that a new hospital is needed in the proposed service area, the commissioner shall notify the applicants of that finding and shall select the applicant determined under the process established in this subdivision to be best able to provide services consistent with the review criteria established in this subdivision.

(b) The commissioner shall:

(1) determine market-specific criteria that shall be used to evaluate all proposals. The criteria must include standards regarding:

(i) access to care;

(ii) quality of care;

(iii) cost of care; and

(iv) overall project feasibility;

(2) establish additional criteria at the commissioner's discretion. In establishing the criteria, the commissioner shall consider the need for:

(i) mental health services in the service area, including both inpatient and outpatient services for adults, adolescents, and children;

(ii) a significant commitment to providing uncompensated care, including discounts for uninsured patients and coordination with other providers of care to low-income uninsured persons; and

(iii) coordination with other hospitals so that specialized services are not unnecessarily duplicated and are provided in sufficient volume to ensure the maintenance of high-quality care. The criteria determined under this paragraph shall constitute the sole criteria under which the competing proposals shall be evaluated; and

(3) define a service area for the proposed hospital. The service area shall consist of:

(i) in the 11-county metropolitan area, in St. Cloud, and in Duluth, the zip codes located within a 20-mile radius of the proposed new hospital location; and

(ii) in the remainder of the state, the zip codes within a 30-mile radius of the proposed new hospital location.

(c) The commissioner shall publish the criteria determined under paragraph (b) in the State Register within 60 days of the determination under subdivision 2. Once published, the criteria shall not be modified with respect to the particular project and applicants to which they apply. The commissioner shall publish with the criteria guidelines for a proposal and submission review process.

(d) For 60 days after the publication under paragraph (c), the commissioner shall accept proposals to construct a hospital from organizations that have submitted a letter of intent under subdivision 1, paragraph (a), or have notified the commissioner under subdivision 1, paragraph (b). The proposal must include a plan for the new hospital and evidence of compliance with the criteria specified under paragraph (b). Once submitted, the proposal may not be revised except:

(1) to submit corrections of material facts; or

(2) in response to a request from the commissioner to provide clarification or further information.

(e) The commissioner shall determine within 90 days of the deadline for applications under paragraph (d), which applicant has demonstrated that it is best able to provide services consistent with the published criteria. The commissioner shall make this determination by order following a hearing according to this paragraph. The hearing shall not constitute or be considered to be a contested case hearing under chapter 14 and shall be conducted solely under the procedures specified in this paragraph. The hearing shall commence upon at least 30 days' notice to the applicants by the commissioner. The hearing may be conducted by the commissioner or by a person designated by the commissioner. The designee may be an administrative law judge. The purpose of the hearing shall be to receive evidence to assist the commissioner in determining which applicant has demonstrated that it best meets the published criteria.

The parties to the hearing shall consist only of those applicants who have submitted a completed application. Each applicant shall have the right to be represented by

counsel, to present evidence deemed relevant by the commissioner, and to examine and cross-examine witnesses. Persons who are not parties to the proceeding but who wish to present comments or submit information may do so in the manner determined by the commissioner or the commissioner's designee. Any person who is not a party shall have no right to examine or cross-examine witnesses. The commissioner may participate as an active finder of fact in the hearing and may ask questions to elicit information or clarify answers or responses.

(f) Prior to making a determination selecting an application, the commissioner shall hold a public hearing in the proposed hospital service area to accept comments from members of the public. The commissioner shall take this information into consideration in making the determination. The commissioner must also consider the input and preferences of legislators and local elected officials who represent the service area regarding the selection of the hospital provider. The commissioner shall issue an order selecting an application following the closing of the record of the hearing as determined by the hearing officer. The commissioner's order shall include a statement of the reasons the selected application best meets the published criteria.

(g) Following the determination under paragraph (e), the commissioner shall recommend the selected proposal to the legislature on or before March 1 in an odd-numbered year and within 15 days of the first day of the regular session in an even-numbered year to be accepted or rejected. Legislative acceptance of the commissioner's recommendation constitutes approval of the proposal under section 144.551. Legislative rejection of the recommendation concludes the process but does not prohibit a new application under this section and section 144.552.

(h) In the event of legislative failure to act on the recommendation made under this subdivision, upon the conclusion of the legislative session the commissioner shall make the commissioner's recommendation the final approval of the project. The commissioner's decision to grant final approval to the commissioner's recommendation constitutes approval of the proposal under section 144.551.

(i) For purposes of this subdivision, "legislative acceptance" means the recommended project is approved by law; "legislative rejection" means the recommended project is rejected by law; and "legislative failure to act" means any other action or lack of action taken by the legislature.

Subd. 4. **Payment of commissioner's expenses.** Notwithstanding section 16A.1283, applicants who are a party at any stage of the administrative process established in this section shall pay the cost of that stage of the process, as determined by the commissioner. The cost of the needs assessment, criteria development, and hearing shall

be divided equally among the applicants. Money received by the commissioner under this subdivision is appropriated to the commissioner for the purpose of administering this section."

Amend the title accordingly

Senator ..... moves to amend S.F. No. 3098 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **REPEALER.**

Minnesota Statutes 2004, sections 144.551, subdivisions 2, 3, and 4; and 144.552, and Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1, are repealed."

Amend the title accordingly

Sen. Berglin

Minnesota Hospital Association

2006 MHA Moratorium Exemption Legislation

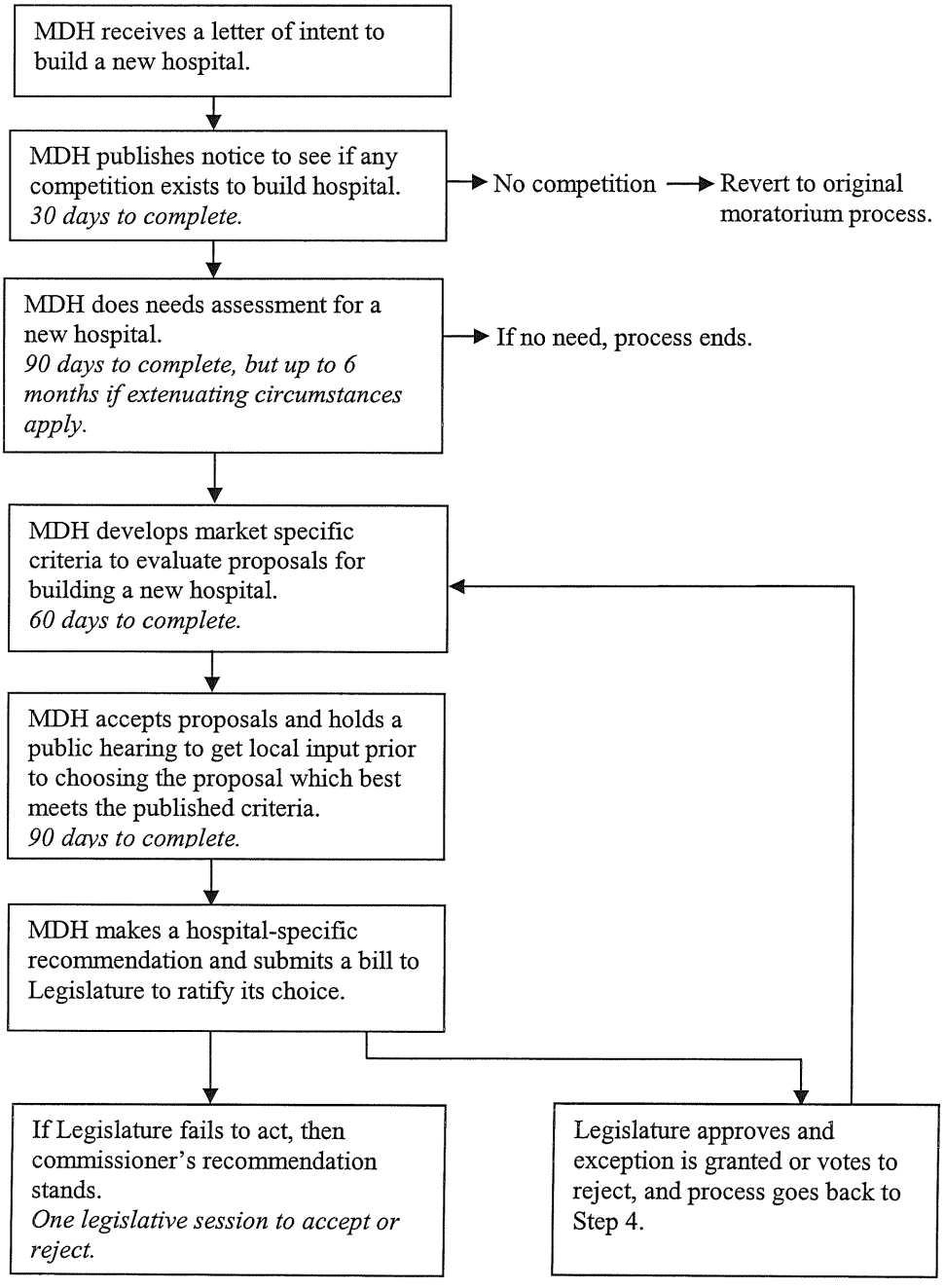
S.F. 3098: Berglin, Lourey, Wergin, Koering, Johnson D.E.
H.F. 3340: Bradley, Powell, Thiessen, Huntley, Abeler

Current law

1. Moratorium exceptions for adding beds (to an existing facility) remain as is with an addition of a public hearing required by MDH for needs assessment phase under current law.

Proposed new law addition

2. New hospital license exceptions:



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Testimony of James Hanko
President & CEO, North Country Health Services, Bemidji, Minn.
Before the Senate Health and Family Security Committee
On behalf of the Minnesota Hospital Association

Tuesday, March 28, 2006

Madame Chair and Members:

My name is James Hanko and I am the President and CEO of North Country Health Services in Bemidji, Minnesota.

In the fall of 2005, the Minnesota Hospital Association brought together a Task Force of its membership to discuss the current strengths and weaknesses of the hospital moratorium law, and to determine if any recommendations for improvement were needed and supported by the members.

The Task Force was comprised of 18 MHA members from across the state, representing both large and small, urban and rural hospitals. The intent of the task force was to create a solution that would consider and balance the needs for the diverse communities in Minnesota and the hospitals that serve them.

I had the opportunity to chair that Task Force, which met four times during November, December, January and February.

The Minnesota Hospital Association supports Senator Berglin's S.F. 3098, which represents the recommended statutory changes in the moratorium law that the MHA Board thought would improve upon the current process.

Briefly, I would like to highlight just a couple of the key conclusions of our Task Force.

- In most instances, the current moratorium law has worked well for the good of the public. It has ensured that there is a process to prevent the over-building of hospital capacity while at the same time allowing communities a mechanism to add hospital capacity as their health care needs grow.

- From 1984 until 2005, the moratorium law has been amended 19 times, allowing for some growth in the number of hospital beds in some communities. These exceptions have been granted with relatively little controversy, until this recent experience with the Maple Grove Hospital proposals.

(over)

- Our Task Force concluded that the process does *not* work well in situations when multiple organizations are competing for the siting of a new hospital in a community. In these situations, there are some shortcomings that should be fixed with the following changes:

    1. A more rigorous review process, one that includes clear, market-relevant criteria to be used to measure each competing proposal. This set, pre-defined process should also preclude multiple changes in the criteria or proposal submissions during the process.

    2. More involvement by the Minnesota Department of Health in an analytical and research role, which would conclude with a recommendation to the Legislature.

    3. Less involvement by the Legislature, while maintaining its oversight role in the moratorium process. These changes should make the process less political and give legislators more unbiased information regarding a moratorium exception proposal.

The task force recommendations that are included in this bill are as follows:

- The Minnesota Department of Health's (MDH) process to determine if there is a need for a new hospital should include community input from at least one public hearing.

- MDH should determine and publish specific criteria for judging the proposals.

- MDH should accept proposals according to a deadline and only allow changes in material facts only.

- MDH should evaluate the proposals according to the pre-determined criteria.

- MDH should be required to make a recommendation on which organization best meets the criteria.

- The full Legislature should retain the authority to approve MDH's recommendation. However, if no legislation is passed, the Commissioner's recommendation would stand.

- The process should have specific deadlines that ensure that a timely, efficient decision is made.

Thank you for the opportunity to share our comments regarding S.F. 3098. We believe this legislation preserves what has worked well with Minnesota's hospital moratorium law while making some needed improvements.

Senate Counsel, Research, and Fiscal Analysis

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State of Minnesota

S.F. No. 1640 - Reporting and Review of Provider Expenditures (Delete-Everything Amendment)

Author: Senator Sheila M. Kiscaden

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

Date: March 27, 2006

S.F. No. 1640 requires providers to report certain expenditures in excess of $1 million to the Commissioner of Health; establishes a process for third parties to request a public meeting and hearing on certain expenditures over $2 million; and authorizes the Commissioner to audit the referral patterns of certain providers.

Section 1 (62J.17) modifies the definition of major spending commitment to mean expenditures in excess of $1 million but equal to or less than $2 million.

Section 2 (62J.18) establishes reporting requirements, public meeting procedures, and hearing procedures for expenditures over $2 million.

Subdivision 1 states that this section applies to providers and those who would be a provider upon making an expenditure in excess of $2 million and exempts hospital construction moratorium projects.

Subdivision 2, paragraph (a), requires a provider intending to make a major spending commitment of $2 million for the acquisition of a unit of medical equipment or in excess of $2 million for a single capital project for the purpose of providing health care services must file a report with the Commissioner of Health at least 60 days before making the expenditure.

Paragraph (b), the Commissioner must maintain a database to track reported expenditures.

Paragraph (c), the Commissioner must maintain a list of persons interested in receiving notice of a report filed under this section and provide notice to all persons on the list and by

publication in the *State Register* within 15 days of receiving the report. The notice must include a copy of the report or a description of the proposed expenditure.

Subdivision 3 exempts from the public meeting and hearing any expenditure:

(1) to replace existing equipment with comparable equipment;

(2) made by a research and teaching institution for purposes of conducting medical education, medical research, or clinical trials;

(3) to repair, remodel, or replace existing buildings or fixtures if it does not involve substantial expansion of service capacity or the nature of health services provided;

(4) for building maintenance;

(5) for activities not directly related to the delivery of patient care services; and

(6) for computer equipment or data systems not directly related to the delivery of patient care.

The exemption also does not apply to mergers, acquisitions, and other changes in ownership or control that do not involve substantial expansion of service capacity or substantial change in the services provided.

Subdivision 4 permits a third party to request a public meeting on projects that exceed $2 million in capital cost within 30 days of the filing of the report. The meeting is to be an informational forum for the provider to answer inquiries and must be arranged and coordinated by the Commissioner on an expedited basis. The requesting party is responsible for all costs related to the meeting.

Subdivision 5 permits a third party to request within 30 days from the date of the public meeting that the expenditure be the subject of a hearing before the Commissioner. The hearing must be public and on an expedited basis and the party requesting the hearing must pay the Commissioner for the cost of the hearing. Money received by the Commissioner must be appropriated to the Commissioner for administering this section. The hearing must proceed on an expedited basis.

Subdivision 6 describes the criteria that the Commissioner must consider: need and access; quality of health; cost of health care alternatives available to the provider; and other considerations. Permits the Commissioner to adopt rules to establish additional criteria. The commissioner is required to make: findings of fact as to whether the expenditure is needed to ensure quality of health care. If the Commissioner determines that the expenditure is not needed, the Commissioner shall obtain an injunction prohibiting the provider from making the expenditure. The final decision of the Commissioner is entitled to judicial review and,

if reviewed, each party must pay their respective cost unless the appeal is not successful, then the party bringing the appeal must pay all cost.

Subdivision 7 authorizes the Commissioner to enforce this section according to Minnesota Statutes, section 144.99, subdivision 8. Compliance is a condition of medical assistance reimbursement and to provide services to state employees. The Commissioner may also assess fines in an amount up to triple the amount of the expenditure.

Subdivision 8 requires the Commissioner to conduct a retrospective review on expenditures in excess of $2 million if a public meeting is not requested.

KC:ph

Senators Kiscaden and Lourey introduced--

S.F. No. 1640: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying expenditure reporting requirements; establishing a separate reporting procedure for expenditures over $5,000,000; restricting certain medical referrals; appropriating money; amending Minnesota Statutes 2004, section 62J.17, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Section 1. Minnesota Statutes 2004, section 62J.17, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

(b) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending

commitment.

(e) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(f) "Major spending commitment" means an expenditure in excess of $1,000,000, but less than or equal to $5,000,000, for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(g) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(h) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

Sec. 2. [62J.18] [PROVIDER REPORTING IN EXCESS OF $5,000,000.]

Subdivision 1. [APPLICABILITY; DEFINITIONS.] (a) This section applies to providers and to persons who would become providers after making the expenditures described in subdivision 2.

(b) For purposes of this section, the terms used have the meanings given in section 62J.17, subdivision 2, except that "major spending commitment" means an expenditure in excess of $5,000,000.

Subd. 2. [REPORTING REQUIREMENT.] (a) A provider that intends to make a major spending commitment in excess of $5,000,000 for the acquisition, by purchase or lease, of a unit of medical equipment or in excess of $5,000,000 for a single capital project for the purposes of providing health care services must file a report with the commissioner at least 60

days before committing to make the expenditure. The report must contain the information described in section 62J.17, subdivision 4a, paragraphs (b) and (c).

(b) The commissioner shall maintain a database to track expenditures reported under this subdivision.

(c) The commissioner shall maintain a list of all persons who have registered with the commissioner for the purpose of receiving notice by electronic mail of a report filed under this subdivision. The commissioner shall, within 15 days of receiving an expenditure report, provide notice of the report by electronic mail to all persons on the list and submit a summary of the report for publication in the State Register. The notice must include either the report or an easily understandable description of the proposed expenditure in the report. The publication in the State Register must include an easily understandable description of the proposed expenditure in the report and information on how to obtain a copy of the report. In addition, the commissioner shall make reasonable efforts to notify persons or classes of persons who may be significantly affected by the proposed expenditure in the report. The commissioner may recover the reasonable costs incurred in providing notice under this paragraph through costs paid by third parties involved in proceedings under this section.

(d) No provider may commit to making the expenditure until the procedures described in this section are completed.

Subd. 3. [PUBLIC MEETING.] (a) Within 30 days of the State Register publication under subdivision 2, a third party may request a public meeting on expenditures that exceed $5,000,000. The public meeting shall serve as an informational forum for the provider to answer inquiries of interested third parties.

(b) The commissioner shall arrange for and coordinate the meeting on an expedited basis. The party requesting the meeting shall pay the commissioner for the commissioner's cost of the meeting, as determined by the commissioner. Money received by the commissioner for reimbursement under this section is

appropriated to the commissioner for the purpose of administering this section.

Subd. 4. [PUBLIC MEETING EXCEPTIONS.] (a) Subdivisions 3, 5, and 6 do not apply to an expenditure:

(1) to replace existing equipment with comparable equipment used for direct patient care. Upgrades of equipment beyond the current model or comparable model are subject to subdivisions 3, 5, and 6;

(2) made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school or by a federal or foundation grant, or clinical trials;

(3) to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided;

(4) for building maintenance including heating, water, electricity, and other maintenance-related expenditures;

(5) for activities not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities; and

(6) for computer equipment or data systems not directly related to the delivery of patient care services, including computer equipment or data systems related to medical record automation.

(b) In addition to the exceptions listed in paragraph (a), subdivisions 3, 5, and 6 do not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Subd. 5. [HEARING.] (a) Within 30 days from the date of a public meeting under subdivision 3, a third party may request that the planned expenditure be subject to a hearing before an administrative law judge. The hearing and review of the planned

expenditure shall be according to the relevant provisions of the Administrative Procedure Act, except as otherwise provided in this subdivision.

(b) A hearing under this subdivision is a public proceeding.

(c) A party to the hearing must pay for the party's representation before the administrative law judge. The party requesting the hearing shall pay the costs assessed by the chief administrative law judge according to section 14.53. Money received for services rendered by the Office of Administrative Hearings under this subdivision shall be deposited in the state Office of Administrative Hearings account and appropriated according to section 14.54.

(d) A hearing requested under this subdivision must proceed on an expedited basis.

Subd. 6. [HEARING CRITERIA; DECISION; RULES.] (a) The administrative law judge shall consider the following criteria:

(1) need and access, including, but not limited to:

(i) the need of the population served or to be served by the proposed health services for those services;

(ii) the project's contribution to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly, as well as the extent to which medically underserved residents in the provider's service area are likely to have access to the proposed health service; and

(iii) the distance, convenience, cost of transportation, and accessibility to health services for those to be served by the proposed health services;

(2) quality of health care, including, but not limited to:

(i) the impact of the proposed service on the quality of health services available to those proposed to be served by the project; and

(ii) the impact of the proposed service on the quality of health services offered by other providers;

(3) cost of health care, including, but not limited to:

(i) the financial feasibility of the proposal;

(ii) probable impact of the proposal on the costs of and charges for health services provided by the person proposing the service;

(iii) probable impact of the proposal on the costs of and charges for health services provided by other providers;

(iv) probable impact of the proposal on reimbursement for the proposed services; and

(v) the relationship, including the organizational relationship, of the proposed health services to ancillary or support services;

(4) alternatives available to the provider, including, but not limited to:

(i) the availability of alternative, less costly, or more effective methods of providing the proposed health services;

(ii) the relationship of the proposed project to the long-range development plan, if any, of the person or entity providing or proposing the services; and

(iii) possible sharing or cooperative arrangements among existing facilities and providers; and

(5) other considerations, including, but not limited to:

(i) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the expenditures;

(ii) special needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the immediate geographic area in which the entities are located, which entities may include, but are not limited to, medical and other health professional schools, multidisciplinary clinics, and specialty centers;

(iii) the special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages; and

(iv) the impact of the proposed project on fostering competition between providers.

(b) The commissioner may adopt rules to establish additional hearing criteria.

(c) After applying the criteria under this subdivision, the administrative law judge shall make findings of fact as to whether the planned expenditure is needed to ensure quality health care. If the administrative law judge finds that the planned expenditure is not needed to ensure quality health care, the provider may not undertake the planned expenditure. The order of the administrative law judge constitutes the final decision in the case as applicable under section 14.62. A final decision in the case is entitled to judicial review under sections 14.63 to 14.69. In the event of an appeal, each party must pay the party's respective costs, except that the party bringing the appeal must pay all costs if the appeal is unsuccessful.

Subd. 7. [ENFORCEMENT.] The commissioner may enforce this section by denying or refusing to reissue the permit, license, registration, or certificate of a provider that does not comply with this section, according to section 144.99, subdivision 8. Compliance with this section is a condition of medical assistance reimbursement. The commissioner of employee relations shall not permit a provider that does not comply with this section to provide services to state employees. The commissioner may obtain an injunction prohibiting the provider from making the planned expenditure. In addition, the commissioner may assess fines against a provider that incurs an expenditure that is found by the commissioner as not needed to ensure quality health care according to this section in an amount up to triple the amount of the expenditure.

Subd. 8. [RETROSPECTIVE REVIEW.] Nothing in this section or section 62J.17 shall be construed to prohibit the commissioner from conducting a retrospective review of an expenditure in excess of $5,000,000 according to section 62J.17, subdivision 5a.

Sec. 3. [62J.24] [MEDICAL REFERRALS.]

(a) No individual physician or physician group engaged in a

solo or group practice, whether conducted for profit or not for profit and however organized, that is wholly owned and controlled by one or more of the physicians so associated, or, in the case of a not-for-profit organization, its only members are one or more of the physicians so associated, shall refer a patient for services to a health care entity that provides services through use of magnetic resonance imaging, positron emission tomography, linear accelerator equipment, or computerized axial tomography, if:

(1) the physician holds a direct or indirect ownership or investment interest in the entity;

(2) the physician's immediate family holds a direct or indirect ownership or investment interest in the entity; or

(3) the physician or member of the physician's immediate family has any direct or indirect arrangement involving compensation with the entity.

(b) For purposes of this section, the following definitions have the meanings given them:

(1) "control" means the ownership of at least 50 percent of the equity in an entity or the ability to appoint at least 50 percent of the members of the governing body of the entity;

(2) "health care entity" means an entity that provides health care-related testing, diagnosis, or treatment of individuals, but does not include a hospital, hospital affiliate, or a constituent of a hospital system;

(3) "hospital affiliate" means any entity that, directly or indirectly, is controlled by, controls, or is under common control with a hospital or a joint venture in which the hospital participates;

(4) "hospital system" means an organized group of health care providers in which at least one constituent is a not-for-profit hospital; and

(5) "investment interest" means an ownership or investment interest through equity, debt, leasehold interest, or other means, regardless of whether the interest is direct or indirect.

(c) The commissioner shall assess a fine against a person

who violates this section. The amount of the fine shall be not less than $25,000. Any continuing violation of this section is punishable by a fine of not less than $25,000 and not more than $100,000 per day of operation and by one or both of the following:

(1) referral of the physician to the Board of Medical Practice for appropriate disciplinary action; and

(2) revocation of the health care entity's license or registration.

(d) The attorney general may proceed on behalf of the state to enforce penalties that are due and payable under this section in any manner provided by law for the collection of debts and may bring other enforcement action, as described in section 144.991, subdivision 7.

Senator ..... moves to amend S.F. No. 1640 as follows:

Delete everything after the enacting clause and insert:

" Section. 1. Minnesota Statutes 2004, section 62J.17, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

(b) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.

(e) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(f) "Major spending commitment" means an expenditure in excess of $1,000,000 <u>but less than or equal to $2,000,000</u> for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(g) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(h) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

Sec. 2. **[62J.18] PROVIDER REPORTING IN EXCESS OF $2,000,000.**

Subdivision 1. **Applicability; definitions.** (a) For purposes of this section, the terms used have the meanings given in section 62J.17, subdivision 2, except that "major spending commitment" means an expenditure in excess of $2,000,000.

(b) This section applies to providers and to persons who would become providers after making the expenditures described in subdivision 2. This section does not apply to hospital construction projects subject to the hospital construction moratorium under section 144.551 or to the public interest review under section 144.552.

Subd. 2. **Reporting requirement.** (a) A provider that intends to make a major spending commitment in excess of $2,000,000 for an acquisition, by purchase or lease, of a unit of medical equipment or in excess of $2,000,000 for a single capital project for the purposes of providing health care services must file a report with the commissioner at least 60 days before committing to make the expenditure. The report must contain the information described in section 62J.17, subdivision 4a, paragraphs (b) and (c).

(b) The commissioner shall maintain a database to track expenditures reported under this subdivision.

(c) The commissioner shall maintain a list of all persons who have registered with the commissioner for the purpose of receiving notice by electronic mail of a report filed under this subdivision. The commissioner shall, within 15 days of receiving an expenditure report, provide notice of such report by electronic mail to all persons on its list, and by publication in the State Register. The notice must include either a copy of the report or an easily understandable description of the proposed expenditure in the report. The notice in the State Register must include a copy of the report, along with an easily understandable description of the proposed expenditure in the report. In addition, the commissioner shall make reasonable efforts to notify persons or classes of persons who may be significantly affected by the proposed expenditure in the report. The commissioner may recover the reasonable costs incurred in providing notice as required in this paragraph through costs paid by third parties involved in proceedings described in this section.

(d) No provider may commit to making the expenditure until the procedures described in this section are completed.

Subd. 3. **Exceptions.** (a) Subdivisions 4, 5, and 6 do not apply to an expenditure:

(1) to replace existing equipment with comparable equipment used for direct patient care. Upgrades of equipment beyond the current model or comparable model are subject to subdivisions 4, 5, and 6;

(2) made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school or by a federal or foundation grant, or clinical trials;

(3) to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of the service capacity or a substantial change in the nature of health care services provided;

(4) for building maintenance, including heating, water, electricity, and other maintenance-related expenditures;

(5) for activities not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities; or

(6) for computer equipment or data systems not directly related to the delivery of patient care services, including computer equipment or data systems related to medical record automation.

(b) In addition to the exceptions listed in paragraph (a), subdivisions 4, 5, and 6 do not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Subd. 4. **Public meeting.** (a) Within 30 days from the date the notice requirements of subdivision 2, paragraph (c), are satisfied, a third party may request a public meeting on expenditures that exceed $2,000,000. The public meeting shall serve as an informational forum for the provider to answer inquiries of interested third parties.

(b) The commissioner shall arrange for and coordinate the meeting on an expedited basis. The party requesting the meeting shall pay the commissioner for the commissioner's cost of the meeting, as determined by the commissioner. Money received by the commissioner for reimbursement under this section is appropriated to the commissioner for the purpose of administering this section.

Subd. 5. **Hearing.** (a) Within 30 days from the date of a public meeting under subdivision 4, a third party may request that the planned expenditure be subject to a hearing before the commissioner. The hearing and review of the planned expenditure shall be according to the relevant provisions of the Administrative Procedure Act, except as otherwise provided in this subdivision.

(b) A hearing under this subdivision shall be a public proceeding.

(c) A party to the hearing must pay for the party's representation before the commissioner. The party requesting the hearing must pay the commissioner for the commissioner's cost of the hearing, as determined by the commissioner. Costs of the hearing shall include, but not be limited to, the cost of the hearing and costs related to the commissioner's findings and order as provided in this section. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section. Payment of costs by the party shall not be contingent upon and shall not affect the commissioner's findings and order under this section.

(d) A hearing requested under this subdivision must proceed on an expedited basis.

Subd. 6. **Hearing criteria; decision; rules.** (a) The commissioner shall consider the following criteria:

(1) need and access, including, but not limited to:

(i) the need of the population served or to be served by the proposed health services for those services;

(ii) the project's contribution to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly, as well as the extent to which medically underserved residents in the provider's service area are likely to have access to the proposed health service; and

(iii) the distance, convenience, cost of transportation, and accessibility to health services for those to be served by the proposed health services;

(2) quality of health care, including, but not limited to:

(i) the impact of the proposed service on the quality of health services available to those proposed to be served by the project; and

(ii) the impact of the proposed service on the quality of health services offered by other providers;

(3) cost of health care, including, but not limited to:

(i) the financial feasibility of the proposal;

(ii) probable impact of the proposal on the costs of and charges for providing health services by the person proposing the service;

(iii) probable impact of the proposal on the costs of and charges for health services provided by other providers;

(iv) probable impact of the proposal on reimbursement for the proposed services; and

(v) the relationship, including the organizational relationship, of the proposed health services to ancillary or support services;

(4) alternatives available to the provider, including, but not limited to:

(i) the availability of alternative, less costly, or more effective methods of providing the proposed health services;

(ii) the relationship of the proposed project to the long-range development plan, if any, of the person or entity providing or proposing the services; and

(iii) possible sharing or cooperative arrangements among existing facilities and providers; and

(5) other considerations, including, but not limited to:

(i) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the expenditures;

(ii) special needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the immediate geographic area in which the entities are located, which entities may include, but are not limited to, medical and other health professional schools, multidisciplinary clinics, and specialty centers;

(iii) the special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages; and

(iv) the impact of the proposed project on fostering competition between providers.

(b) The commissioner may adopt rules to establish additional hearing criteria.

(c) After applying the criteria under this subdivision, the commissioner shall make findings of fact as to whether the planned expenditure is in the public interest. If the commissioner finds that the planned expenditure is not in the public interest, the commissioner may obtain an injunction prohibiting the provider from making the planned expenditure. The order of the commissioner constitutes the final decision in the case as applicable under section 14.62. A final decision in the case is entitled to judicial review under the provisions of sections 14.63 to 14.69. If the decision is appealed, each party must pay the party's respective costs, except that the party bringing the appeal must pay all costs if the appeal is unsuccessful.

Subd. 7. **Enforcement.** The commissioner may enforce this section by denying or refusing to reissue the permit, license, registration, or certificate of a provider that does not comply with this section, according to section 144.99, subdivision 8. Compliance with this section is a condition of medical assistance reimbursement. The commissioner of employee relations shall not permit a provider that does not comply with this section to provide services to state employees. In addition, the commissioner may assess fines against a provider that incurs an expenditure that is found by the commissioner as not needed to ensure quality health care pursuant to the provisions of this section in an amount up to triple the amount of the expenditure.

Subd. 8. **Retrospective review.** If a public meeting is not requested under subdivision 4, the commissioner shall conduct a retrospective review in accordance with section 62J.17, subdivision 5a, and may subject the provider to prospective review and approval in accordance with section 62J.17, subdivision 6a.

Sec. 3. Minnesota Statutes 2004, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 62J.18;115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10),

(12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9509; 144.992; 326.37 to 326.45; 326.57 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator ..... moves to amend the delete-everything amendment (SCS1640A-1) to S.F. No. 1640 as follows:

Page 6, after line 30, insert:

"Sec. 3. Minnesota Statutes 2004, section 144.698, is amended by adding a subdivision to read:

Subd. 6. **Reporting on uncompensated care.** (a) A report on the services provided to benefit the community, as required under subdivision 1, clause (5), must report charity care in compliance with the following requirements:

(1) For a facility to report amounts as charity care adjustments, the facility must:

(i) generate and record a charge;

(ii) have a policy on the provision of charity care that contains specific eligibility criteria and is communicated or made available to patients;

(iii) have made a reasonable effort to identify a third-party payer, encourage the patient to enroll in public programs, and, to the extent possible, aid the patient in the enrollment process; and

(iv) ensure that the patient meets the charity care criteria of this subdivision.

(2) In determining whether to classify care as charity care, the facility must consider the following:

(i) charity care may include services that the provider is obligated to render independently of the ability to collect;

(ii) charity care may include care provided to patients who meet the facility's charity care guidelines and have partial coverage, but who are unable to pay the remainder of their medical bills, but this does not apply to that portion of the bill that has been determined to be the patient's responsibility after a partial charity care classification by the facility;

(iii) charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the facility's eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's reasonable efforts;

(iv) charity care may include care to individuals whose eligibility for charity care was determined through third-party services for information gathering purposes only;

(v) charity care does not include contractual allowances, which is the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;

(vi) charity care does not include bad debt;

(vii) charity care does not include what may be perceived as underpayments for operating public programs;

(viii) charity care does not include unreimbursed costs of basic or clinical research or professional education and training;

(ix) charity care does not include professional courtesy discounts;

(x) charity care does not include community service or outreach activities; and

(xi) charity care does not include services for patients against whom collection actions were taken that resulted in a financial obligation documented on a patient's credit report with credit bureaus.

(3) When reporting charity care adjustments, the facility must report total dollar amounts and the number of contacts between a patient and a health care provider during which a service is provided for the following categories:

(i) care to patients with family incomes at or below 275 percent of the federal poverty guideline;

(ii) care to patients with family incomes above 275 percent of the federal poverty guideline; and

(iii) care to patients when the facility, with reasonable effort, is unable to determine family incomes.

(b) For the report required under subdivision 1, clause (5), the facility must, in determining whether to classify care as a bad debt expense:

(1) presume that a patient is able and willing to pay until and unless the facility has reason to consider the care as a charity care case under its charity care policy and the facility classifies the care as a charity care case; and

(2) include as a bad debt expense any unpaid deductibles, coinsurance, co-payments, noncovered services, and other unpaid patient responsibilities.

EFFECTIVE DATE. This section is effective for facility fiscal years ending on or after December 31, 2006."

Page 7, after line 5, insert:

"Sec. 5. Minnesota Statutes 2005 Supplement, section 214.071, is amended to read:

214.071 HEALTH BOARDS; DIRECTORY OF LICENSEES.

Each ~~health~~ health-related licensing board ~~under chapters 147, 148, 148B, and 150A,~~ as defined in section 214.01, subdivision 2, shall establish a directory of licensees that includes biographical data for each licensee.

Sec. 6. **[214.121] PRICE DISCLOSURE REMINDER.**

Each health-related licensing board shall at least annually inform and remind its licensees of the price disclosure requirements of section 62J.052 or 151.214, as applicable, through the board's regular means of communicating with its licensees."

3.1 Renumber the sections in sequence and correct the internal references

3.2 Amend the title accordingly