HOUSE RESEARCH

Bill Summary

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Overview

This bill contains various provisions related to health care policy. The bill contains provisions related to new born screening, safe patient handling, standard reference compendia, adverse health events, and long-term care.

Section

1 **Program creation; general provisions.** Amends § 43A.318, subd. 2. Permits public employees to buy into long-term insurance.

2 **Definitions.** Amends § 62Q.525, subd. 2. Modifies the definition of "standard reference compendia" used in law that requires health plans to cover prescription drugs for the treatment of cancer that have not been approved by the federal Food and Drug Administration for that purpose, if the drug is recognized for treatment of cancer in a standard reference compendia or an article in the medical literature. The modification to the definition deletes "United States Pharmacopeia Drug Information" from the list of compendia, and adds to the list the following:

- National Comprehensive Cancer Network's Drugs and Biologics Compendium
- Thomson Micromedex's DrugDex
- Elsevier Gold Standard's Clinical Pharmacology
- Other authoritative compendia as identified by the U.S. Department of Health and Human Services

3 **Root cause analysis; corrective action plan.** Amends § 144.7065, subd. 8. Requires facilities, in conducting the root cause analysis of an adverse health care event, to review the

impact of staffing levels on the event, if evidence shows staffing was a factor.

4 **Relation to other law; data classification.** Amends § 144.7065, subd. 10. States that a provider licensing board is not required to investigate the event when a licensed provider reports an adverse health care event.

5 **Suicide prevention plan.** Amends § 145.56, subd. 1. Modifies the current state suicide prevention plan by including that the plan should focus on awareness and prevention. (Current statutes specify prevention alone.) Adds Minnesota State colleges and Universities and the University of Minnesota to the list of entities with which the commissioner of health must collaborate in implementing the plan.

6 **Community-based programs.** Amends § 145.56, subd. 2. Current statute permits grants to community-based programs for suicide prevention and education for school staff, parents, and students in grades kindergarten through 12. Adds to this provision that grants may be provided for programs that provide prevention and education for students attending Minnesota colleges or universities.

7 **Certified doula.** Amends § 148.995, subd. 2. Modifies the definition of "certified doula" to include persons certified by the International Center for Traditional Childbearing.

8 **Doula services.** Amends § 148.995, subd. 4. Modifies the definition of "doula services." Clarifies that "doula services" means continuous emotional and physical support during labor and birth and intermittent support during prenatal and postpartum periods.

9 **Citation; Safe patient handling act.** Amends § 182.6551. Updates citation.

10 **Clinical settings that move patients.** Amends § 182.6552, by adding subdivision 5. Defines "clinical settings that move patients."

11 **Safe patient handling in clinical settings.** Adds § 182.6554.

Subd. 1. Safe patient handling plan required. (a) Requires that every clinical setting that moves patients in the state develop a written safe patient handling plan by July 1, 2010. Specifies that plans must seek to achieve, by January 1, 2012, the goal of safe patient handling by minimizing manual lifting of patients and utilizing patient handling equipment.

(b) Specifies specific considerations that the safe patient handling plans must address, including the following:

- assessment of risks;
- acquisition of an adequate supply of patient handling equipment;
- training of direct patient care workers;
- procedures to ensure physical modifications and construction projects are consistent with safe patient handling goals; and
- evaluations of the safe patient handling plan.

(c) Permits health care organizations with more than one covered clinic to establish a plan for each clinic or one plan for all of them.

Subd. 2. Facilities with existing programs. Deems certain clinical settings that move patients as in compliance with this section.

Subd. 3. Training materials. Requires the commissioner of labor and industry to make training materials on implementation of this section available to clinical settings that move patients.

Subd. 4. Enforcement. Specifies that this section is enforced by the commissioner of labor and industry under Minnesota Statutes, § 182.661. Provides that initial violations of this section shall not be assessed a penalty, and that subsequent violations of this section are subject to penalties provided in Minnesota Statutes, § 182.666.

Subd. 5. Restriction; civil liability. States that the safe patient handling plan is not a standard of care for purposes of civil liability. States that a court may not consider a breach of the plan as a breach of duty or breach of standard of care, or as negligence.

12 **Definitions.** Amends § 252.27, subd. 1a. Adds fetal alcohol syndrome to the definition of "related conditions" related to services for children with developmental disabilities.

13 **Recommendations.** Amends § 252.282, subd. 3. Removes obsolete language.

14 **Responsibilities of commissioner.** Amends § 252.282, subd. 5. Removes obsolete language.

15 **Court release.** Amends § 253B.095, subd. 1. Requires the court, in its order for a stayed commitment, to include a condition that the patient is prohibited from giving consent to participate in a psychiatric clinical drug trial while the court order is in effect.

However, if a stay of commitment is continued, the court may grant permission for the patient to participate in a specific clinical drug trial if the treating psychiatrist submits an affidavit that treatment options have been ineffective, and the patient may benefit from the trial. Prohibits the treating psychiatrist from being the researcher conducting the drug trial.

16 **Self-directed supports option plan requirements.** Amends § 256B.0657, subd. 5. Modifies the self-directed supports option to comply with federal regulations.

17 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Modifies the criteria used to determine eligibility for the alternative care program.

18 **Services; service definitions; service standards.** Amends § 256B.0913, subd. 5a. Requires the lead agency to ensure that the benefit department recovery system in MMIS has the necessary information on any other health insurance or third-party insurance policy to which the client may have access.

19 **Client fees.** Amends § 256B.0913, subd. 12. Removes obsolete language.

20 **Spousal impoverishment policies.** Amends § 256B.0915, subd. 2. Clarifies that EW recipients with income at or below the special income standard, and who have a community spouse, are entitled to retain a maintenance needs allowance equivalent to the income

allowed for institutionalized persons.

21 **Property rate adjustments and construction projects.** Amends § 256B.431, subd. 10. Specifies the effective date of rate adjustments for nursing facilities that have completed a construction project not approved through the competitive moratorium exception process. If the request is made within 60 days of completion, the effective date is the first of the month following the completion date. If the request is made more than 60 days after completion, the adjustment is effective the first of the month following the request.

22 **Setting payment; monitoring use of therapy services.** Amends § 256B.433, subd. 1. Requires payment for ancillary materials and services provided to nursing facility residents to be made either to the vendor of ancillary services or to the nursing facility (outside of the facility's operating cost per diem). Strikes language allowing payment as part of the facility's operating cost per diem. Provides that "ancillary services" include MA covered transportation services.

23 **Administrative costs.** Amends § 256B.441, subd. 5. Includes in the definition of nursing home "administrative costs" all training, except as specified in § 256B.441, subd. 11.

24 **Direct care costs.** Amends § 256b.441, subd. 11. Modifies the definition of "direct care costs," by eliminating "staff education" and including: (1) employees conducting training in resident care topics; and (2) cost of materials used for resident care training, and resident care training courses outside of the facility attended by direct care staff.

25 **Contract provisions.** Amends § 256B.5011, subd. 2. Removes language requiring each intermediate care facility to establish and use a quality improvement plan.

26 **ICF/MR rate increases October 1, 2005, and October 1, 2006.** Amends § 256B.5012, subd. 6. Removes an obsolete reference.

27 **ICF/MR rate increases effective October 1, 2007, and October 1, 2008.** Amends § 256B.5012, subd. 7. Removes an obsolete reference.

28 **Variable rate adjustments.** Amends § 256B.5013, subd. 1. Changes the reporting requirement from quarterly to annually on the use of variable rate funds and the status of the individual on whose behalf the funds were approved.

29 **Commissioner's responsibilities.** Amends § 256B.5013, subd. 6. Modifies the commissioner's responsibilities related to variable rate adjustments.

30 **Reporting provider payment rates.** Amends § 256B.69, subd. 9b. The amendment to paragraph (a) requires the commissioner to also consult with health care providers, when developing guidelines for the reporting of provider reimbursement information. Also makes a conforming change.

A new paragraph (b) requires each managed care and county-based purchasing plan to provide to the commissioner:

(1) aggregate provider payment data, by subspecialty and primary care;

(2) evidence that increases in payments to the plan are passed on to providers, including information on the proportion of increases paid to providers, by subspecialty and primary

care; and

(3) information on the methodology used to establish provider reimbursement rates paid by the plan.

States that the data provided must allow the commissioner to conduct required analyses. Strikes language classifying data provided to the commissioner as nonpublic.

A new paragraph (c) requires the commissioner to analyze the data by procedure code, provider type, provider size, and geographic location, and to array provider rates across all plans by subspecialty and primary care category. Requires the commissioner to report this information annually to the legislature, beginning December 15, 2010. Requires the commissioner to make this information available on the agency's web site.

31 **911 Services to be provided.** Amends § 403.03. Amends the emergency communications statutes to permit the 911 system to make referrals to mental health crisis teams.

32 **Data management.** Amends § 626.557, subd. 12b. Simplifies data retention periods in the statewide data base and conforms to federal law.

33 **Health Department workgroup; hospital association committees.** Instructs the commissioner of health to consult with stakeholders to define staffing levels and develop questions to be included in the root cause analysis tool. Requires coordination between the Minnesota Nurses Association and the Minnesota Hospital Association in dealing with adverse health events and corrective action plans.

34 **Alzheimer's disease working group.**

Subd. 1. Establishment; members. Instructs the Minnesota Board on Aging to convene an Alzheimer's disease working group. Provides a nonexhaustive list of entities and individuals who should be considered for membership on the working group.

Subd. 2. Duties; recommendations. Requires the working group to examine the array of needs of individuals diagnosed with Alzheimer's disease, available services, and the capacity of the state and providers to meet these needs. Requires the working group to make recommendations on the following:

- Trends in the state's Alzheimer's population and the service needs
- Existing resources, services, and capacity
- Needed policies or responses

Subd. 3. Meetings. Provides that there must be at least four public meetings.

Subd. 4. Report. Requires the board to issue a report and recommendations to the governor and chairs and ranking minority members of legislative committees with jurisdiction over health care no later than January 15, 2011.

Subd. 5. Private funding. Permits the board to use funding provided by private foundations and other private funding sources to complete the duties of the working group.

Subd. 6. Sunset. Requires the working group to sunset upon delivery of the required report.

35 **Repealer.** Repeals § 256B.5013, subd. 2 (other payment rate adjustments), subd. 3 (relocation), and subd. 5 (required occupancy data).