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# **2013 MDH Legislative Budget Fact Sheets**

**Minnesota Department of Health**

**January 2013**



# Clean Water Fund - Assistance for Well Sealing Activities

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	250	250	0	0
Revenues	0	0	0	0
Net Fiscal Impact	250	250	0	0

## Summary

This proposal seeks to help protect public health and the environment by continuing support to help Minnesotans seal estimated 500,000 unused, unsealed wells and borings. Well sealing can be very expensive for a private well owner to undertake, which is an obstacle to ensuring that wells are sealed properly. These funds will provide a 50 percent cost share.

## Background

Unused wells, sometimes called “abandoned” wells, can pose a serious threat to groundwater quality by allowing contaminants to travel deep into the ground, bypassing the natural protection usually provided by layers of clay, silt, and other geologic materials. Although Minnesota leads the nation in sealing unused wells, sealing more than 250,000 wells in the past 25 years, an estimated 500,000 unused wells remain unsealed.

Minnesota law requires an unused well or boring be properly sealed by a state-licensed well contractor. Sealing costs can range from \$500 to seal a small, simple well, to tens of thousands of dollars to seal large-diameter, deep wells. Costs also increase for

wells that require significant work to clean out, remove pumping equipment, and perforate well casings to ensure a thorough sealing.

A total of \$500,000 was allocated from the Clean Water Fund for well sealing in fiscal years 2011-2012. The funds are being used to seal an estimated 225 private wells and 30 public water supply wells.

## Proposal

This proposal is to provide funds to help Minnesotans seal unused wells and borings. The funds will be used to provide a 50 percent cost share for sealing public and private wells and borings. Two administrative mechanisms will be employed:

1. Owners of public wells (including cities and other local governments, and persons who own wells serving mobile home parks, apartment buildings, condominium associations, motels, restaurants, etc.) will apply directly to MDH for cost-share grants.
2. Owners of private wells will apply to cooperating local governments, often Soil and Water Conservation Districts, which will receive grants from the Board of Water

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and Soil Resources (BWSR). MDH will pass funds to BWSR for their grant program.

MDH and BWSR both have established grant programs to serve the populations described.

In all cases, formal criteria will be used to rank candidate wells and borings according to the degree of risk they pose for groundwater contamination and public health. Criteria will include whether the well/boring is in a Wellhead Protection Area, interconnects aquifers, is in an area of known groundwater contamination, and contains human caused contaminants. Cost sharing will be limited to 50 percent of total sealing costs.

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# Clean Water Fund - Lake Superior Beach Monitoring

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	105	105	0	0
Revenues	0	0	0	0
Net Fiscal Impact	105	105	0	0

## Summary

This proposal requests \$105,000 per year from the Clean Water Fund in Fiscal Years 2014-15 to support the Lake Superior Beach Monitoring and Notification Program, which seeks to reduce beach users' exposure to and risk from disease-causing microorganisms in water.

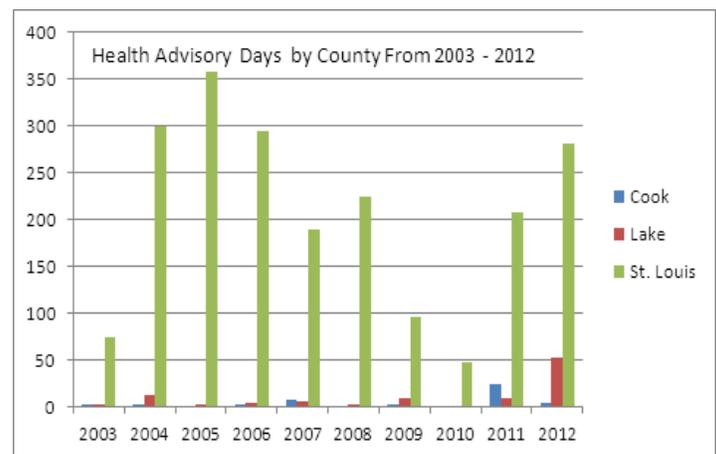
## Background

Minnesota's Lake Superior shoreline is lined with 80 beaches and visited by thousands of people each year. A significant portion of this coastline's recreational waters are subject to contamination from sources such as urban runoff, overflows from wastewater collection and treatment facilities, discharge from boats, human waste, animal feeding operations, pet waste and wildlife waste. The resulting contaminated water is a potential cause of gastrointestinal illness and other diseases.

The Beach Program is based in the Minnesota Department of Health's (MDH) Northeast District Office in Duluth. The program monitors 40 heavily used Lake Superior public beaches for *E. coli* bacteria levels from May to September every year.

Beaches that have higher use are monitored twice a week and beaches that are used less frequently are monitored once a week. MDH posts a health advisory when there are high bacterial levels that may cause disease in people using the beach. To notify the public of advisories, MDH posts signs at the beach. Additionally, MDH notifies community partners of elevated *E. coli* levels by email, and updates the program hotline (218-725-7724) and website ([www.MNBeaches.org](http://www.MNBeaches.org)).

The following chart shows the number of days an advisory was posted at beaches from 2003 to 2012.



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A Beach Team made up of representatives from various agencies along the North Shore advise the Beach Program. Agencies include the University of Minnesota Natural Resource Research Institute, the Minnesota Pollution Control Agency, Minnesota Sea Grant, Cook County Soil and Water Conservation District, county health departments, the Western Lake Superior Sanitary District and others.

### **Proposal**

This proposal would support the following four major activities:

- Water quality monitoring.
- Public notification of beaches that have elevated bacterial counts.
- Data analysis and management.
- Reporting beach assessment data to the public and MDH.

### **Rationale**

Currently, staff monitors the beaches using funding (\$209,000) from the federal Environmental Protection Agency (EPA) provided under the federal BEACH Act, a subsection of the Clean Water Act. This funding has been eliminated from the proposed EPA budget for the upcoming federal fiscal year. Without state funding, the program will not have the resources to monitor the beaches along Lake Superior or to notify the public of potentially harmful bacterial levels.

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# Clean Water Fund - Private Well Protection

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	325	325	0	0
Revenues	0	0	0	0
Net Fiscal Impact	325	325	0	0

## Summary

This proposal seeks to ensure safe drinking water by funding a study of private well water quality. Current data on private well water quality are limited because testing depends on an owner's initiative and vigilance, in contrast to highly monitored public water supplies. The study will help identify factors affecting water quality, and will support outreach to owners and contractors.

## Background

Private wells are required to be sampled for nitrate, arsenic and bacteria at the time of construction. Results from this sampling indicates approximately 11 percent exceed the arsenic drinking water standard and just under one percent exceed the nitrate drinking water standards. The water from new wells is required to test negative for bacteria before being used.

## Proposal

The private well study will use existing private well monitoring networks and data, supplemented by targeted sampling, to characterize the occurrence and magnitude of contaminants in private wells.

Activities will include:

- Follow-up testing of water from private wells to evaluate changes in nitrate and arsenic concentrations over time.
- Testing selected private wells for radium and manganese to determine distribution and potential health risk of these contaminants.
- Evaluation of existing and new well data and geology to determine geological and well construction influences on contaminant occurrences.

Based on the evaluation, information and guidance will be developed. For well contractors, guidance will be developed for well placement and construction standards to minimize risks. For well owners, outreach efforts will be developed to increase the ability to identify and address potential issues. This will include water testing recommendations, well maintenance and treatment for specific water quality issues.

## Rationale

Protecting private well owners from contamination risk supports the MDH Vision and Mission goal to make physical environments safe and healthy. Private wells supply drinking water for 1.1 million Minnesotans - 20 percent of the state population.

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Although testing is required for nitrate and arsenic, the standards have regulatory authority only for public water supplies and not private wells. Follow up sampling or treatment is the responsibility of the well owner. Most wells are not sampled for any other contaminants and many older wells have never been sampled for any contaminants.

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# Clean Water Fund - Source Water Protection

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	1,615	1,615		
Revenues				
Net Fiscal Impact	1,615	1,615	0	0

## Summary

This proposal will assist local communities in development and implementation of source water protection plans, which reduce risks associated with land and water uses that may contaminate public drinking water.

## Background

Source water protection plans are used by communities that use groundwater for drinking water to reduce the risk that land and water uses may contaminate public drinking water. Source water protection is tailored to meet the contamination risks specific to each community by relying on a partnership between state and local government, land owners, and the public water supplier. The Minnesota Department of Health (MDH) has administrative rules that specify how a source water protection plan is developed for public water supply wells, in addition to the responsibilities of a public water supplier for implementing source water protection actions. However, public water suppliers often need technical assistance to develop and implement source water protection plans as well as to finance specific actions for reducing contamination risk to their water supply wells.

## Proposal

MDH provides technical assistance to public water suppliers relating to the development and implementation of source water protection plans. In 2008, MDH made a commitment to the Governor’s Office and to the Minnesota Legislature that it would accelerate the rate at which it brings the state’s 935 community water supply systems that use groundwater into the source water protection program using money from the Clean Water Fund. The goal is to complete plan development by the year 2020. MDH has established a grant program that provides financial resources to public water suppliers to implement contamination risk reduction measures to public water supply wells.

Clean Water Fund support for the 2014-2015 biennium will continue commitment to the year 2020 planning goal and to expand the financial assistance for contamination risk reduction. No new FTEs are anticipated.

## Rationale

Protecting public water supply wells from contamination risk supports the MDH Vision and Mission goal to make physical environments safe and healthy. The 935 community public water

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supply systems that use groundwater provide drinking water to approximately 2.9 million Minnesotans, all of whom benefit from efforts to safeguard their drinking water from contamination.

MDH has other state and federal funding to support the source water protection program but it is not sufficient to maintain the level of activity required to meet the year 2020 planning goal and it was never sufficient to create and support the source water protection grant program. The Clean Water Fund request provides the additional fiscal resources needed to accelerate the source water protection program.

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# Clean Water Fund - Upgrade County Well Index

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	390	390	0	0
Revenues	0	0	0	0
Net Fiscal Impact	390	390	0	0

## Summary

The Minnesota County Well Index (CWI) is the principal source of well location, construction and associated geologic information in the state. It is used by the general public, communities, businesses, realtors, consultants, well contractors, researchers and local, state and federal agencies for managing and protecting public health, groundwater and drinking water supplies in Minnesota. Funding for the CWI will update the index’s technology infrastructure, eliminate a backlog in entering well records, and further expand the index’s use.

## Background

The CWI contains more than 450,000 well records and is jointly managed by the Minnesota Department of Health (MDH) and the Minnesota Geological Survey. The information contained in the CWI provides a snapshot of the well, including geologic, and groundwater conditions, by providing details on well location, depth, construction, and water level. The CWI also facilitates locating and mapping wells onto aerial photos, and the development of groundwater models.

Clean Water Funding was provided for state fiscal years 2011-2012 to begin updating the CWI. The

CWI has a backlog of non-digitized paper records that need to be entered into the index. More than 15,000 of the approximately 70,000 historical well paper records have been entered in CWI.

Input from stakeholders, including well contractors, environmental consultants, state and local governments, helped identify enhancements to the CWI to help meet stakeholder needs. Funding is needed to continue implementation of the stakeholder updates and enhancements.

## Proposal

MDH requests Clean Water Fund assistance to continue to enhance, update and expand CWI by:

- Completing backlogged well records.
- Updating the online search system including searchable images of original well records.
- Developing an application for well contractors to submit and manage well information online.
- Developing an online system/mobile application for pinpointing and submitting well locations using standardized GPS/GIS.
- Creating web services to provide access to data for external users.

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### **Rationale**

This project will enhance the CWI's capacity to support groundwater protection and prevent threats to drinking water supplies. Updating the CWI is necessary to support long-term groundwater protection efforts and provide stakeholders with cost-effective access to well records statewide. CWI is an essential tool for citizens, well contractors, private engineering and environmental firms, realtors, local governments, and state agencies. An enhanced CWI will provide them with the ability to rapidly locate and map wells, evaluate local and regional geology and groundwater flow, and aid in monitoring and tracking trends in groundwater quantity and quality over time.

Specifically, investing in CWI protects public health by providing accessible information that supports:

- Evaluation of the short- and long-term availability and quality of drinking water.
- Planning for the placement and protection of future drinking water wells, both public and private.
- Investigation of groundwater contamination and identification of actions that will protect drinking water supplies.

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# Clean Water Fund - Water Contaminants of Emerging Concern

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Clean Water Fund				
Expenditures	1,170	1,170	0	0
Revenues	0	0	0	0
Net Fiscal Impact	1,170	1,170	0	0

## Summary

This proposal appropriates funding for the Contaminants of Emerging Concern (CEC) program to assess, evaluate and develop health-based guidance for new and potential drinking water contaminants.

## Background

Every year, studies conducted in Minnesota and across the country find unexpected contaminants in our lakes, rivers, and even drinking water. Often, these are chemicals about which little is known. The contaminants may or may not be “new,” but their presence in Minnesota’s water may be new or unexpected.

These contaminants are being found now because:

- There are better methods for finding substances at lower levels.
- Additional substances are being looked for.
- New substances are being used.
- Old substances are being used in new ways.

Most contaminants are from products that accidentally or intentionally end up in water through storm water runoff, because of how people use them, or disposal through septic systems and city sewers. These contaminants can include pesticides, pharmaceuticals, personal care products, flame retardants, and plasticizers.

The Minnesota Department of Health (MDH) Drinking Water Contaminants of Emerging Concern program investigates and communicates the exposure potential and health risk of contaminants of emerging concern in drinking water. The CEC program develops human health-based drinking water guidance values (how much of a substance is safe to drink). These guidance values are developed using available toxicity and exposure information. MDH scientists calculate guidance values that will protect people who drink from a water source for different time periods, whether briefly, occasionally, or daily for a lifetime.

MDH places a high priority on understanding whether children are more exposed and/or vulnerable to the health effects of contaminants. The calculations MDH uses are designed to protect the most vulnerable groups as well as the most exposed.

## Proposal

The work of CEC program staff includes identifying contaminants of emerging concern, selecting contaminants for in-depth research (screening), and completing evaluations that result in drinking water guidance and information about exposure. The program began in 2010 with an initial screening of 27 contaminants and guidance

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developed for 10 contaminants during the first two years. MDH anticipates continuing to screen 10 contaminants and to provide guidance for up to five contaminants annually. To date, staff has completed screening of 36 contaminants and review of 16 contaminants.

Staff evaluates new methods for assessing health risks from contaminant exposure, especially in cases where little is known about the contaminant. Recently, the program began to work more closely with the MDH Public Health Laboratory to better understand the analytical challenges posed by contaminants and ensure methods are available to test for contaminants in water. This work will expand in the Fiscal Year 2014-15 biennium.

MDH also develops research partnerships and works with technical contractors to carry out specialized research that supports the work of the program. MDH is working with experts to collect new data, assess new methods in risk assessment, and evaluate new models and tools to improve risk assessment for emerging concerns. Five research projects have been initiated under this program.

Additionally, MDH initiated an outreach and education grant program in 2012 with plans to provide approximately \$100,000 per grant cycle. Through this grant program, the public may become more aware of contaminants, the health effects of contaminants, the source of contaminants, how personal actions relate to exposure and release of contaminants, how people are exposed to contaminants, the combined effects of multiple exposures or multiple contaminants, and other concepts.

The first grant cycle resulted in innovative proposals that will begin in spring 2013. Proposed grant activities for this cycle include: a media campaign that includes newspaper inserts, billboards, and on-air public service announcements; development of culturally and linguistically appropriate materials for environmental education events; and increasing the

amount of pharmaceuticals and hazardous materials collected and properly disposed of through promotion and support of take-back and collection programs.

### **Rationale**

The work of the CEC program is vital to MDH and other state agency Clean Water Fund programs because it provides critical information needed to determine if a contaminant represents a human health risk. This information is used to set research priorities, prioritize cleanup actions, develop prevention strategies, and support sister agencies in developing guidance for other living things.

The work of the program is facilitated by collaborative relationships with the public, various local, state, and federal government agencies, academic organizations, non-profit groups, industry groups, and drinking water and wastewater professional organizations.

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# Core Public Health – Cancer Reporting System

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	350	350	350	350
Revenues	0	0	0	0
Net Fiscal Impact	350	350	350	350

## Summary

This proposal appropriates \$350,000 per year from the General Fund to develop a second-generation statewide cancer data collection system that will meet changing state and federal requirements, and provide more detailed cancer information at the local level.

## Background

The first generation statewide cancer data collection activity, the Minnesota Cancer Surveillance System (MCSS), began operation on January 1, 1988. The primary objectives of the MCSS are to:

- Monitor the occurrence of cancer in Minnesota and describe the risks of developing cancer.
- Inform health professionals and educate citizens regarding specific cancer risks.
- Address the public’s questions and concerns about cancer.
- Promote cancer control research including identification of new causes of cancer.
- Guide decisions about targeting cancer control resources. (Minnesota Statutes, sections 144.671 – 144.69)

The MCSS is a population-based public health surveillance activity. This means significant effort is made to identify all cancers that are newly diagnosed in all Minnesota residents. The MCSS takes hundreds of thousands of reports on cancer incidence and mortality and merges the information into detailed information for providers, policy-makers, the public and researchers. The quality of these data is very high. Once received, personally identifiable information is stored in a secure location.

Technology, state and federal administrative requirements, federal reporting guidelines, cultural opinions on science and government, public demand for detailed cancer data, and the role of the MCSS in public policy have changed considerably since the MCSS was implemented more than 25 years ago. As a result, Minnesota has needed for some time to redevelop its statewide data collection activity to continue meeting its legislative mandate. That need has now become critical. The 25-year-old data base design, the automated data flow structure, and the custom-created software programs have been stretched beyond their breaking points. This need is further amplified by the increasing societal pressure to provide more detailed information on

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cancer incidence to address the public's concern about cancer and environmental/industrial pollution. As a result, more detailed data, below the county level that is currently maintained by the MCSS, are now required.

### **Proposal**

The MCSS must be completely redesigned to meet the challenges presented by state and federal administrative requirements, needs of state cancer control programs, changes in medical care of cancer patients and how their records are maintained, and the public's demand for more detailed cancer information. The proposal is to conduct a six-year redesign and implementation project that will rigorously identify and bring to fruition the best method(s) to resolve these conflicting requirements.

Development of the proposed second generation statewide cancer data collection activity, the Minnesota Cancer Reporting System, will take six years and cost about \$350,000 per year. These funds will be used for a public health scientist to guide the design of the system, an options analysis, documentation of system requirements, and systems design and implementation.

A preliminary study concluded that the MCSS is a key MDH resource and needs to be updated if it is going to remain so. The funding and staff estimates required for this project are in addition to the current resources required to operate the MCSS. Continued operation of the MCSS is required to maintain the federal funding for this activity.

### **Rationale**

The new Minnesota Cancer Reporting System is needed to address the following problems with the MCSS:

- Reliance on one or two key staff.
- Outdated software and technology.
- Limited ability to implement efficient reporting and ascertainment protocols.
- Insufficient flexibility to adapt to ongoing changes in medical delivery systems and the needs of cancer control programs.
- Limited capacity to respond to the public's growing concern about community-level cancer rates.
- Cumbersome methodology for providing access to and integration of information available from electronic medical records and pathology reports.
- Inefficient methods to provide summary cancer data to the public.
- High operational costs, which are now about \$2.3 million a year (\$1.2 million state, \$1.1 million federal).

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# Core Public Health - Infectious Disease Laboratory Capacity

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	200	200	200	200
Revenues	0	0	0	0
Net Fiscal Impact	200	200	200	200

## Summary

This proposal seeks \$200,000 per year from the General Fund for the Minnesota Department of Health (MDH) Infectious Disease Laboratory (IDL) to maintain its capacity to perform core public health testing.

## Background

Infectious diseases are a significant public health concern and cause thousands and illnesses and deaths each year in Minnesota. To address these ongoing threats, as well as emerging infectious disease threats, the public health system needs to maintain laboratory capacity to enable rapid and accurate detection, and response to emerging health threats. For this purpose, MDH operates the state's Infectious Disease Laboratory.

In Fiscal Year 2012, the IDL performed 44,450 tests to monitor infectious disease trends and investigate infectious disease outbreaks. Many of the pathogens analyzed by the IDL are traditional pathogens of public health concern, including tuberculosis, syphilis and HIV. However, in addition to monitoring these well-known disease threats, the

IDL implements new test methods to detect emerging diseases and to investigate unexplained deaths and serious illness for which a pathogen has not been identified. For example, the IDL was the first laboratory in the state to detect the West Nile Virus.

The results of testing performed by the IDL are used in part by health care providers for individual patient treatment. The data are also used by MDH for purposes of disease monitoring, outbreak investigation, and evaluation of preventive strategies to protect the health of the public.

Funding for core infectious disease testing capacity has steadily decreased. Current funds no longer cover the growing cost of maintaining a highly sophisticated laboratory and performing testing. Laboratory equipment costs are soaring, and with them the cost of maintaining and repairing complex instrumentation.

## Proposal

The appropriation in this proposal will enable IDL to sustain core laboratory activities in the areas of

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foodborne disease, tuberculosis, rabies and sexually transmitted infections by providing general fund support for two existing FTEs, laboratory testing supplies, information technology (IT) support, and maintenance of equipment used for testing. Funds will also be used for improvements to the Laboratory Information Management System, which will promote electronic information exchange and decrease reporting time by one to two days.

### **Rationale**

This proposal will enable MDH to maintain a robust infectious disease lab that provides timely, accurate information about infectious disease threats and perform core public health testing.

MDH currently relies upon a shrinking supply of funding to support core testing activities at the IDL. The IDL is permitted to charge only a \$25 handling fee for each diagnostic specimen submitted for testing and receives the fee on only approximately 30 percent of diagnostic specimens it processes. The remainder is exempt from the fee.

Federal grant funding is typically targeted to specific activities and is not available to subsidize general capacity for diagnostic laboratory testing.

Therefore, because much of the testing performed by the IDL is either exempt from the handling fee, or is not funded by federal grants, the IDL relies on state funds to cover core public health testing.

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# Core Public Health - Lead Poisoning Prevention Program

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	100	100	100	100
Revenues	0	0	0	0
Net Fiscal Impact	100	100	100	100

## Summary

This proposal appropriates \$100,000 per year for surveillance efforts to respond to and prevent childhood lead poisoning.

## Background

Lead poisoning is one of the most common yet preventable pediatric health problems.

Recent literature documents that lead has no safe exposure. In 2011, 3,337 Minnesota children younger than 6 years old reported blood lead levels higher than federal guidelines (5 ug/dl).



The Minnesota Department of Health (MDH) lead surveillance program protects the public health by:

- Monitoring lead testing activities and tracking the occurrence of elevated blood lead cases in the state.

- Maintaining a high-quality database of information that can be used to effectively manage the risks associated with lead exposure.
- Providing the basis for strategies designed to reduce the occurrence of lead-related disease, conducted collaboratively with local, state and federal partners.

Local public health agencies rely on daily reports from MDH to respond to elevated lead cases in their jurisdictions and to ensure that lead hazards are thoroughly characterized and addressed. In addition, state lead data helped partners secure more than \$9 million in HUD funding in 2011.

More than 80 percent of all homes built before 1978 in the U.S. have lead based paint. Old homes with lead paint may be found in both urban and rural areas. Children less than 6 years old, and especially ages 1 to 3 years, are most vulnerable to lead's toxicity due to their growing bodies, nutritional needs, mouthing behavior and spending time on the floor. Minnesota has the unfortunate distinction of being the state where the most recent childhood lead poisoning fatality occurred in 2005.

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### Proposal

MDH had received funding from the Centers for Disease Control and Prevention (CDC) for lead poisoning prevention annually since 1994. However, the funding ended on September 1, 2012. The proposed state support is needed to maintain lead poisoning prevention efforts to:

- Meet statutory requirements for identifying and responding to children with elevated lead levels and providing education and other services.
- Continue medical case management for children with elevated blood-lead levels. (Currently there are over 1500 open cases).
- Meet requirements for sharing data with Medicaid, health plans, Environmental Public Health Tracking, and statewide HeadStart programs.
- Continue the Blood Lead Information System to support prevention, emergency response, and hazard reduction programs.

The proposed funding will support three primary focus areas:

1. Data collection.
2. Connection to services.
3. Primary prevention.

In addition to the appropriation in this proposal, MDH may look at other strategies to ensure a proper balance between resources for lead surveillance and other services to address elevated blood-lead levels in children.

### Rationale

Twenty years of progress towards eliminating childhood lead poisoning is jeopardized by federal budget cuts. State support is needed to maintain public health capacity to respond to and prevent lead poisoning.

Lead poisoning prevention is part of a larger Healthy Homes initiative in which MDH is engaged. A healthy home is dry, well ventilated, pest free, contaminant free, clean, safe and well maintained.

Coordination of mitigation efforts will reduce housing-based health threats, lower health care costs, coordinate state programs around health and housing, and build local capacity to better serve high-risk populations.



A statewide *Healthy Housing Strategic Plan* has been developed to guide implementation and priorities and an *Alliance for Healthy Homes and Communities* exists to coordinate diverse partners. Seven pilot projects have been conducted with local public health agencies to identify best practices.

Coordinating housing-based hazard mitigation and lead poisoning prevention will provide significant return on investment over the long term.

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# Core Public Health: Regional Support for Local Health Departments

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	350	350	350	350
Revenues	0	0	0	0
Net Fiscal Impact	350	350	350	350

## Summary

This proposal appropriates \$350,000 per year from the General Fund for regional MDH staff that support local health departments. MDH public health nurse consultants, preparedness coordinators and epidemiologists located in Bemidji, Duluth, Fergus Falls, St. Cloud, Marshall, Mankato and Rochester provide specialized expertise to local health departments in their assigned geographic region. They also link local health departments to other resources and expertise available from MDH and the Centers for Disease Control and Prevention.

## Background

Minnesota's public health system functions as a partnership between state and local governments. It was designed to ensure that the public's health and safety are protected statewide while providing local governments with the flexibility needed to identify and address local needs.

MDH and local health departments play complementary roles in protecting and improving health. The coordinated partnership between the

state and local levels of government in Minnesota is an efficient way to make the best use of public health resources.

- MDH provides specialized scientific, technical, and program expertise, and serves the entire state. It also provides data that local health departments need to carry out their work, and is responsible for overall public health policy development.
- Local health department strengths include deep connections within communities; and an understanding of local conditions, needs, and resources. The trained local public health workforce carries out public health activities so that all people in Minnesota have an opportunity to be healthy, regardless of where they live.

## Proposal

This proposal maintains 3.25 FTE MDH district office staff that would otherwise be eliminated due to recent federal funding reductions.

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### **Rationale**

MDH public health nurse consultants, epidemiologists and preparedness coordinators provide service and expertise which is not otherwise practical or cost-effective for an individual local health department to maintain. Those state employees live and work in the regions they serve, understand local context, and provide expertise that connects MDH with local health departments. The regional staff resources are highly valued by local health departments and essential to the effective functioning of Minnesota's interdependent state and local public health system.

The regional MDH expertise is needed now more than ever. The public health workforce is aging, with significant turnover within the local public health workforce and numerous retirements among local health department administrators and directors. At the same time, the complexity and range of public health issues that must be addressed has increased significantly.

In recent years, federal funds that have supported regional MDH staff have diminished. Ongoing state funding is critical to ensuring that MDH can maintain an adequate level of support for local public health departments.

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# Cost Recovery for Lab Testing

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	(147)	(147)	(147)	(147)
Revenues	(140)	(140)	(140)	(140)
Special Revenue Fund				
Expenditures	300	300	300	300
Revenues	300	300	300	300
Net Fiscal Impact	(7)	(7)	(7)	(7)

## Summary

This proposal requests changes to Minnesota Statutes, section 144.123, to allow the Commissioner of Health to enter into contracts to recover costs incurred for diagnostic analysis.

## Background

The Infectious Disease Laboratory (IDL) within the Public Health Laboratory at the Minnesota Department of Health (MDH) performs microbiological testing for a number of different purposes including:

- **Diagnostic testing.** This is laboratory testing that leads to or rules out diagnosis of disease for an individual patient.
- **Reference testing.** This testing includes identification of bacteria, viruses, fungi, or parasites that are sent to the IDL by other laboratories that were not able to identify the pathogen using the test methods available to them. The IDL has the capability to perform both standard reference methods as well as more highly advanced technology that allows the IDL to identify a broad range of pathogens that may represent a public health threat. This testing may also contribute to

diagnosis of disease for an individual patient.

- **Monitoring infectious disease threats.** The IDL analyzes bacterial, fungal, viral, and parasitic pathogens that are sent to the IDL as a requirement of the Minnesota Disease Reporting Rule (4605.7040). Results of this testing are essential to the work of the MDH Infectious Disease Epidemiology, Prevention, and Control (IDEPC) Division, which investigates and responds to disease outbreaks and cases of unusual or highly significant pathogens. In the event of an infectious disease outbreak, the IDL performs testing to provide data that is used by IDEPC to identify cases and to evaluate outbreak control measures.

Under Minnesota Statute, section 144.123 the MDH IDL is permitted to charge only a \$25 handling fee for each diagnostic specimen submitted for testing and not for the actual cost of testing. However, diagnostic submissions from certain facilities and specimens that are required by law to be submitted are exempt from the handling fee. IDL currently

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## **Cost Recovery for Lab Testing – Page 2**

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receives the fee on only approximately 30 percent of diagnostic specimens it processes.

submitters to bill third insurers should they choose to utilize the diagnostic services offered by the IDL.

In addition to the handling fee, the IDL also receives limited state general fund and federal grant monies. Federal grant funding is typically targeted to specific activities and is not available to subsidize general capacity for diagnostic laboratory testing.

### **Proposal**

The proposal involves a change in Minnesota Statute 144.123 to allow the Commissioner of Health to enter into contracts to enable MDH PHL to recover the full cost of diagnostic laboratory testing. The changes will discontinue the current \$25 handling fee and allow diagnostic laboratory tests to be charged at a level that fully recovers the cost of performing the test. The proposed language retains exemptions for specimens submitted under the disease reporting rule and any other exemptions deemed necessary by the Commissioner in order to protect public health.

### **Rationale**

The cost of maintaining a highly sophisticated laboratory (i.e., skilled scientists, instrument maintenance, IT support, cost of laboratory certification, and required proficiency testing) and performing the testing (instrument and laboratory supply costs) has increased over time. The current \$25 handling fee does not fully cover the cost of diagnostic testing performed by the IDL. Increasing the fee is not feasible because the cost of the various tests performed by the IDL varies widely depending on what is requested by the submitter. In addition, third party insurers typically do not reimburse submitters for the handling fee. Changing from a handling fee to a reimbursement model would enable the laboratory to recover the cost of diagnostic testing performed and would enable

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# Environmental Lab Accreditation Program

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	(290)	(290)	(290)	(275)
Revenues	(290)	(290)	(290)	(290)
Net Fiscal Impact	0	0	0	15

## Summary

This proposal seeks to authorize the Minnesota Department of Health (MDH) to contract with qualified and approved entities to assess environmental laboratories in the state as part of the Environmental Lab Accreditation Program (ELAP) overseen by MDH. Current national and international standards will be used to select assessors. This proposal will result in a reduction in fees for lab accreditation.

## Background

MDH currently operates an Environmental Lab Accreditation Program. The program ensures that a laboratory has the policies, procedures, equipment, and practices to produce reliable data in the analysis of environmental samples.

The accreditation process involves five main activities: application, proficiency testing, training, on-site laboratory assessments (inspections) and general program administration functions.

The laboratory assessment portion of the program involves an on-site assessment of the laboratory by a qualified laboratory assessor every two years. Laboratories are required to address any

deficiencies identified during the on-site assessment.

All of these components, along with any enforcement actions, must be monitored and documented, and comprise the administrative functions of the accreditation program.

## Proposal

The department proposes to establish partnerships with individuals and organizations willing to perform the assessment activities, with the department retaining an oversight role. The remaining activities, such as review of assessments, proficiency testing, monitoring of corrective actions, laboratory training, and all administrative functions will continue to be performed by the department.

Because independent assessors will perform the assessment tasks, the fees associated with this activity should be removed from the overall fee paid to the department. Instead, laboratories will pay the assessor body directly. The estimated reduction is 40 percent of the annual accreditation fees (i.e., base fee, test category fee and out-of-state

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administrative fee). Additional fees for other activities remain unchanged.

The department will establish a selection committee to recommend approval of qualified applicants. The selection committee will reflect a broad spectrum of interests, including municipalities and small businesses. The department will publish a list of approved assessors recommended by the selection committee and meeting the department's need for the expertise. Laboratories may choose any qualified assessor or group of assessors from the list.

### **Rationale**

Maintaining a viable environmental laboratory inspection program is critical to the citizens of this state and the MDH mission of ensuring the health of Minnesotans through protecting our environment. Federal agencies and other states already use a similar approach. In addition, professional organizations with members representing a wide range of laboratories and accreditation programs encourage the use of independent assessment bodies.

It is anticipated that cost-savings may be realized by laboratories of all sizes. Smaller laboratories may be able to negotiate costs lower than the amount saved from the existing fees because the fees charged by the department are normalized by category of tests rather than by the number of tests actually performed at each facility. Larger laboratories may also benefit as they will be able to select assessors from the list the laboratory already employs for assessments at their laboratory in compliance with regulations in other states, with client requirements or with federal programs. (One assessment may serve dual purposes.)

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# Health Care Facility Blueprint Review

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	0	0	0	0
Revenues	390	390	390	390
Net Fiscal Impact	(390)	(390)	(390)	(390)

## Summary

This proposal establishes a new fee for the current activity of reviewing construction plans, specifications, and related documents for health care facilities regulated by the Minnesota Department of Health (MDH) before construction is begun.

## Background

The Compliance Monitoring (CM) Division of the Minnesota Department of Health licenses health care facilities including: hospitals, nursing homes, boarding care homes, supervised living facilities, residential hospices, and freestanding outpatient surgical centers. CM certifies all of these health care facilities plus End Stage Renal Disease facilities on behalf of the federal Centers for Medicare and Medicaid Services (CMS). CMS pays for onsite inspections of completed construction projects for these health care facilities but does not pay for any pre-construction plan review activities.

These health care facilities serve a very vulnerable population of patients, residents, and clients. Many of these facilities treat and house patients 24 hours a day and seven days a week. Health care facility

physical plant standards are tailored for the provision of health services. Examples of areas covered are bedrooms, corridors, construction materials, toilet facilities, heating, cooling and ventilation, patient food preparation, plumbing, laundry and waste areas.

Long before an onsite inspection is conducted, CM's Engineering Services Section (ESS) provides a valuable service to health care facilities by reviewing plans and specifications for the new structure or changes. CM engineers review plans with architects, developers and providers in depth and answer questions along the way. The ESS reviews the plans to determine state licensing and federal certification compliance. The cost of this service is currently about \$390,000 per year. There are no fees being collected to cover the cost of this specific service. As a result, this activity is currently paid for out of the licensing fees so that all licensed facilities pay for this activity instead of only those seeking changes to their physical plant.

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### **Proposal**

This new fee would generate \$390,000/year, which would recoup the costs of providing the plan reviews. The fees range from \$30 to \$4,800 depending on the estimated construction project cost to the facility. The ESS conducts an average of 213 plan reviews every year. Every construction project is unique. Some projects are very large replacements of or additions to health care facilities, and some projects are very small remodeling changes. The proposed fees were designed to account for the small projects and are based on the cost of the construction project.

### **Rationale**

The cost of providing this unfunded activity is contributing to a growing deficit in the State Government Special Revenue Fund account for health care facilities. If this fee proposal is not implemented, MDH would have to reduce or cease the activity. Not doing construction plan reviews well in advance and assisting architects and developers during the process means that facilities might risk a serious physical plant issues which could jeopardize licensing/certification status and funding, or cost a considerable amount of money to repair or replace.

In establishing this fee, Minnesota joins numerous other states, including Indiana, Michigan, North Dakota, Washington and Wisconsin which already have fees for reviewing blueprints.

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# Home Health Care Licensing Reform

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Gov Special Revenue Fund				
Expenditures	1,857	2,415	2,395	2,395
Revenues	1,062	1,880	2,153	2,425
Net Fiscal Impact	795	535	242	(30)

## Summary

This proposal protects vulnerable adults and other consumers by ensuring home health care settings are safe, protected environments free from abuse and neglect. These changes:

- Ensure new home health providers meet state standards for safe, quality care.
- Increase inspection and enforcement efforts to match growth in the industry.
- Enhance and clarify state standards so that all home health care providers know what is expected of them.
- Streamline the licensing process so providers can focus on delivering quality care and the state can focus on enforcing standards.

## Background

Home care providers offer a broad range of services to people of all ages in clients' homes. Home care services can range from helping clients with bathing and meals to providing specialized health care by licensed professionals, and caring for clients with cognitive and/or memory deficits.

Minnesota's home health care industry has grown in the last 20 years due to an aging population that increasingly prefers home-based care. The

Minnesota Department of Health (MDH) licenses 1,545 home care providers, which is an increase of 209 percent since 1995 and 24 percent since 2007. Eight percent or 196 of home care providers are federally certified under the Centers for Medicare and Medicaid Services (CMS) and meet Medicare requirements in addition to state licensure.

Since 1987, MDH has licensed and regulated the home care industry to ensure safe, quality care.

MDH accomplishes this by:

- Reviewing license applications from providers.
- Conducting on-site inspections (surveys).
- Taking enforcement actions as appropriate to protect the public.
- Providing information to consumers about their rights.
- Providing information to providers about how to comply with home care laws.

Current funding supports only four inspectors, one investigator, two licensing/enforcement staff, and some supervisory and administrative support to regulate more than 1,500 providers, many of whom operate in numerous locations. In 2011, these 9.25 full-time equivalent staff conducted 185 inspections of 108 distinct providers and received 331

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complaints, 95 of which were substantiated. MDH has taken enforcement actions against licensed home care providers for a variety of violations that result in unsafe conditions for clients, including:

- Failure to treat wounds or to notify doctors and families of changes in health condition.
- Failure to administer medications as ordered or to maintain record of medications given.
- Failing to use proper infection control standards.

This proposal was developed at the direction of the 2007 and 2012 legislatures. The 2007 Legislature authorized MDH to conduct strategic planning with providers, consumers, advocates, and regulators to identify and address regulatory issues in home care. MDH created the Homecare Regulatory Framework Workgroup including representatives from the Ombudsman for Long Term Care, Care Providers of Minnesota, Aging Services of Minnesota, Minnesota Home Care Association, AARP, Eldercare Rights Alliance, Minnesota Nurse's Association, Hospice Association, Alzheimer's Association, Minnesota Board of Nursing, Minnesota Board on Aging, and the Minnesota Department of Human Services (DHS). This group met over two and a half years, reviewed existing regulations and provided recommendations for revising the state's home care licensing regulations. The recommendations are part of this proposal.

During the 2012 legislative session, the Health and Human Services Omnibus bill, Article 2, Section 12 directed the MDH to provide recommendations to the legislature by February 1, 2013, on the development of a comprehensive plan to increase inspection and oversight of licensed home care providers in Minnesota. The Governor's budget proposal reflects these recommendations.

### Proposal

- Supports staffing levels necessary to inspect each licensed provider once every three years and new providers within the first year of operation; to conduct license application reviews, complaint investigations, and enforcement actions in a timely fashion; and provide related administrative work (total of 31.80 full-time-equivalent staff).
- Streamlines four license types into two levels of licensure - Basic or Comprehensive - based on the level of services provided.
- Increases license application requirements to ensure applicants can provide home care service safely and have proper systems in place.
- Establishes a temporary one-year license for new providers during which an onsite inspection survey is conducted by MDH to ensure new providers are in compliance.
- Clarifies licensing requirements related to medication management and staff competency; reorganizes statutory provisions for easier readability; and provides a new website for providers and consumers.
- Establishes a transition period from the old licensure structure and requirements to the new structure and requirements.
- Creates an Advisory Council that includes client and provider membership to advise MDH on novel standards and provider practice issues.

### Rationale

Minnesotans rely on the state to ensure home care is safe for vulnerable adults and children. Based on recommendations from a workgroup of consumers and providers, this proposal helps state oversight keep pace with growth and change in Minnesota's home care industry.

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# Lead Abatement Enforcement Penalty

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	0	0	0	0

## Summary

This proposal amends the Health Enforcement Consolidation Act (HECA) to be consistent with the U.S. Environmental Protection Agency (EPA) for lead abatement compliance activities. This will allow Minnesota to retain authorization to enforce and implement rules under EPA’s lead regulations.

## Background

A minor change to the HECA, Minnesota Statutes, section 144.99, subdivision 4, will give the Minnesota Department of Health (MDH) the ability to issue a \$5,000 per violation per day penalty for specific lead regulated work activity violations. The proposed change will allow MDH to become a USEPA State Authorized lead program and to administer federal lead regulations at the state level. Without this authority the state will have a gap in protecting workers and the public from lead exposure and poisonings. MDH has been given similar enforcement penalty authority to meet USEPA regulatory requirements for its Drinking Water Protection program. Although MDH does not anticipate having to use this increased penalty authority, it is a requirement by USEPA to maintain existing authorization and obtain additional authorization status for the lead programs.

## Proposal

This proposal amends language in Minnesota Statutes, section 144.99, subdivision 4, of the Health Consolidation Enforcement Act to allow MDH authority to issue fines to be consistent with US EPA’s §745.327 (3) (ii) requirement. The proposed change emulates the department’s Drinking Water Protection program authority to meet USEPA enforcement requirements. The proposed change adds this subsection: (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead firm or person performing regulated lead work, an administrative penalty order imposing a penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

## Rationale

Losing the ability to manage federal lead standards at the state level would increase the risk of Minnesotans becoming lead poisoned. Maintaining status as an EPA-authorized program ensures the lead abatement program remains a Minnesota program and is not lost to USEPA in 2014. It will also allow MDH and local agencies to meet application requirements for state HUD funding of lead hazard reduction and healthy homes grants.

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# Modify Mortuary Science Regulations

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	50	50	50	50
Revenues	50	50	50	50
Net Fiscal Impact	0	0	0	0

## Summary

The proposal better tailors regulation of the funeral care industry in two ways. The first distinguishes alkaline hydrolysis (AH) facilities from crematories, and establishes a fee for licensing AH facilities. The second allows funeral home branch establishments to operate without an embalming and preparation room provided all preparation is done at a central licensed location.

## Background

The Minnesota Department of Health (MDH) licenses funeral homes and crematories. The rate of cremation as final disposition now exceeds 50 percent in Minnesota. Since 2003 alkaline hydrolysis facilities have been licensed under the statutory definition of a crematory. Minnesota has two licensed AH facilities: one at Mayo Clinic, and is used for final disposition in the anatomy bequest program, and one owned and operated at a private funeral home.

Concerns about the environment and other issues have expanded the interest in alternatives to cremation. As interest grows in this alternative to burial or cremation, it is necessary for the state to address the requirements that are unique for this process in order to ensure the safety of operators

and the public. A stakeholder workgroup including representatives from the Minnesota Funeral Directors Association, Mayo Clinic, the University of Minnesota Mortuary Science program, the University of Minnesota Veterinary School, the Metropolitan Council, individual funeral homes, and the public met to discuss the appropriate standards for AH.

## Proposal

MDH and the workgroup developed licensing requirements for AH facilities; those recommendations are contained in the proposal. It is unlikely AH licensing will provide a net change in fee revenues since the fee amounts for AH facilities will be the same as the fees for crematories. However, it will allow clarity in tracking the fees from AH rather than blending them with crematory fees. Separate licensing will also clarify in statute those requirements which are the same or similar to requirements of crematories, and those requirements which are different.

Additionally, MDH has determined some funeral home licensing requirements may be eased without harm to the public. Specifically, the requirement that a funeral home contain an embalming and

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preparatory room is removed provided all preparation is done at a central licensed location.

It is estimated elimination of the prep room requirement under certain circumstances may increase the total number of funeral home establishments by 12 per year. The fees for licensing funeral homes will remain the same, with or without a prep room.

### **Rationale**

Consumers and the public rely on the state to ensure there are adequate standards in place and corresponding state agency oversight of those standards. AH standards directly affect not only the consumers of those services, but also the workers at the facilities and the public living near the facility. AH is becoming more widely accepted, and it is important to have legislation that regulates this newer aspect of the funeral services industry. The proposal lessening the physical plant requirements of all branch funeral offices may allow consumers more choices of services around Minnesota.

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# Protecting Ground Water from Geothermal Heat Systems

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Government Special Rev				
Expenditures	152	149	149	149
Revenues	150	150	150	150
Net Fiscal Impact	2	(1)	(1)	(1)

## Summary

This proposal seeks to modify Minnesota Statutes, section 103I (Wells and Borings) by replacing the term “vertical heat exchanger” with “bored geothermal heat exchanger.” This change expands the definition of geothermal heating systems, which will help protect groundwater from potential contamination from all heat exchange systems using any boring/drilling methodology.

## Background

Current statute requires most wells and borings, including geothermal borings installed vertically in the ground (vertical heat exchangers), to be installed by state-licensed contractors and constructed to state standards. This regulation helps ensure the process is protective of groundwater and drinking water supplies.

In recent years, new directional or angle boring machines have been increasingly used to install geothermal borings in the ground at a variety of angles and depths. These borings are constructed similar to, and can be installed as deep as, vertical heat exchangers but because these are not vertical, they are not currently regulated. This means they may be constructed by unlicensed persons, may be constructed with inferior materials and methods,

may not be grouted, and may contain toxic heat transfer fluids such as ethylene glycol (common automobile antifreeze) or methanol (“wood alcohol”). There are also concerns with systems impacting neighbors. These situations can cause a risk to groundwater, which is the primary source of drinking water for 75 percent of Minnesotans.

## Rationale

MDH proposes to change the current statutory term, “vertical heat exchanger” to “bored geothermal heat exchanger.” Under this proposed change, any person installing a geothermal heat exchanger in a boring will be required to be licensed and bonded (as is currently required of vertical heat exchanger contractors) to install heat exchanger piping using approved materials and methods, to seal the borings with grout to prevent surface contamination from affecting groundwater and improve exchanger performance, and to use only approved low-toxicity heat transfer fluids, in the same way vertical heat exchangers are now constructed. This will ensure that the borings and the fluids used in them do not present a risk to human health and groundwater. Addressing all types of bored geothermal heat exchangers will ensure similar installations are regulated consistently.

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This proposed change does not apply to dug or trenched horizontal heat exchanger systems.

The fees that are currently charged for permitting vertical heat exchange borings would be extended to the bored geothermal heat exchangers. Fees would also be generated by the additional contractor licenses. The total additional revenue is estimated to be \$150,000, which would cover the additional costs necessary for inspection and administration of the additional contractors and borings.

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# Rent Savings

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	(100)	(100)	(100)	(100)
Revenues				
Net Fiscal Impact	(100)	(100)	(100)	(100)

## Summary

This proposal reflects projected rent savings from closing one of the Minnesota Department of Health’s three metro-area facilities. Savings come from consolidating some staff into existing leased space and relocating some department operations to smaller, low-cost space.

## Background

The Minnesota Department of Health (MDH) is in the process of closing its facility at Snelling Office Park (SOP) in St. Paul. MDH also occupies approximately 160,000 square feet of state-owned space in the Orville L. Freeman Building on the capitol campus and approximately 125,000 square feet of leased space in the privately owned Golden Rule Building in downtown St. Paul.

MDH first began leasing space at SOP in 1997 and by 2012 was leasing nearly 65,000 square feet of space at SOP to support three main functions:

- Office space for metro-area field teams in two MDH program areas;
- Operations space for department support services such as shipping/receiving, warehousing, and printing; and
- Conference center space for MDH programs and their partners

When the landlord declined to renew MDH’s lease beyond December 31, 2012, MDH began a process of relocating these functions to other metro-area locations. Metro-area field teams were co-located with their respective programs at the Freeman and Golden Rule Buildings. Support services are being relocated to new leased space near SOP and conference center reservations are currently being rescheduled for other public and private conference space while the department evaluates cost-effective options for meeting its conference room needs.

## Proposal

This proposal reduces the MDH general fund appropriation by \$200,000 per biennium to reflect rent savings from closing the Snelling Office Park location.

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# Statewide Health Improvement Program (SHIP)

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
Health Care Access Fund:				
Expenditures	20,000	20,000	20,000	20,000
Revenues	0	0	0	0
Net Fiscal Impact	20,000	20,000	20,000	20,000

## Summary

This proposal seeks to improve Minnesotans' health and reduce health care costs through a sustainable, long-term approach to reducing preventable chronic diseases. The proposal funds proven strategies that support healthier choices and behaviors through the Statewide Health Improvement Program (SHIP).

SHIP strategies focus on community-level efforts to improve people's health by reducing certain key risk factors that contribute to chronic diseases such as cancer, diabetes and heart disease. This funding from the Health Care Access Fund (HCAF) will allow SHIP to have a statewide reach and will help Minnesota accelerate progress toward the twin goals of improving health and reducing health care costs. Through broad public-private partnerships and with sustained SHIP funding, the goal is to increase Minnesota's proportion of healthy weight adults by 9 percent (from 38 to 47 percent), and to reduce young adult tobacco use by 9 percent (from 27.8 to 18.6 percent) by 2020.

## Background

Recent data show Minnesota now spends almost \$7,000 per capita each year on health care. Obesity and tobacco use are the leading drivers of rising health care costs in Minnesota. Minnesota spends \$2.9 billion in annual medical costs (2007) as a result of tobacco use, and \$2.8 billion in annual medical costs as a result of obesity (2006).

It is estimated that tobacco use, poor diet and physical inactivity may be responsible for as many as 800,000 deaths each year in the United States. Tobacco use is the single most preventable cause of disease, disability, and death. In Minnesota, 19 percent of adults smoke and nearly two-thirds of adults are overweight or obese. More than 25 percent of Minnesota youth use tobacco products.

The Centers for Disease Control and Prevention (CDC) report that as much as 70 percent of what influences a person's health status can be addressed through prevention. This means we can make great progress in preventing diseases and driving down health care costs by addressing the major risk factors of physical inactivity, poor nutrition, and tobacco use and exposure. Meanwhile, a 2012 report from the Trust for America's Health indicated Minnesota could achieve \$4.189 billion in health care cost savings by 2020 if the average Minnesotan's Body Mass Index (BMI) decreased by 5 percent (cumulative).

In state Fiscal Year (FY) 2010-11, the Minnesota legislature appropriated \$47 million to fund statewide implementation of proven SHIP strategies in all 53 Community Health Boards and nine of 11 tribal governments throughout Minnesota. In FY 2012-13, SHIP funding was reduced by 70 percent to \$15 million. With this funding reduction, only 18 SHIP grants were awarded to 25 Community Health Boards and one tribal government. To make a significant statewide impact on health care costs, restoration of SHIP funding is imperative.

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### Proposal

SHIP aims to create better health where Minnesotans live, work, learn and seek health care by partnering with communities, businesses, schools, and health care providers. SHIP funds will be awarded to backbone community organizations (local community health boards and tribal governments) that will be responsible for implementing proven strategies that lead to sustainable, population-based health improvement changes. In FY 2014-15, \$40 million from the HCAF will be invested in local communities to implement evidence-based, community-level, comprehensive strategies. These strategies make it easier for individuals to make healthy choices and have been shown in national research to be both effective and sustainable. By making these healthy choices easier, the initiatives will address the key risk factors of poor nutrition, physical inactivity and tobacco use and exposure. SHIP grantees will focus efforts on school, worksite, community, and health care settings.

While many communities currently served by SHIP grantees are well positioned to participate in the program moving forward, communities that did not receive SHIP funding because of the reduction of funding for FY 2011-12 are at differing stages of readiness. For this reason, MDH will use a tiered approach for implementing the next iteration of SHIP to: 1) re-establish local capacities, partnerships and skills in currently unfunded communities, and 2) provide the opportunity for existing partner communities to accelerate health improvement efforts addressing obesity, tobacco use and other risk behaviors.

Grantees will select their approaches from a Menu of SHIP Strategies, based on community needs and readiness. Working with local Community Leadership Teams, grantees will develop plans to implement policy, systems and environmental change strategies in their schools, communities, worksites and health care settings. Grantees will be required to actively evaluate their efforts through standardized evaluation tools and reports.

A state infrastructure for technical assistance, training and support for grantees is important for SHIP success. Evaluation is also an indispensable component of SHIP, demonstrating what is working and where improvement is needed. MDH will continue to provide a rigorous and science-based evaluation effort. This will measure the impact of the state's investment in evidence-based, community health improvement practices that work to prevent costly chronic diseases, such as heart disease, stroke, diabetes and cancer.

### Rationale

SHIP takes a unique approach to prevention of chronic disease and impact on health care costs — it moves upstream to curtail disease before it starts, thus preventing or delaying the need for costly medical treatments. It looks at sustainable changes that impact a community or school and not individual-based programs that disappear (along with behavior change) when the funding stops.

Because the problems of obesity and tobacco addiction have taken decades to get to the point of being the leading real causes of disease and death, the solutions are not easy or short-term. It will require sustained efforts over time to change community conditions to achieve better health.

As a national model and leader for health improvement, SHIP uses sustainable approaches that build upon the values of local control, proven strategies, strong partnerships and health care cost containment. Across Minnesota, communities have embraced the SHIP approach. They have proven their ability to mobilize for action through innovative approaches, new partnerships, and leveraging resources in their communities.

Funding that allows statewide implementation of the evidence-based, community-level, comprehensive SHIP strategies will result in better health, lower health care costs and improved quality of life in Minnesota.

### For more information:

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# Strengthen Newborn Screening Program

Fiscal Impact (\$000s)	FY 2014	FY 2015	FY 2016	FY 2017
State Gov Special Revenue Fund				
Expenditures	2,148	2,154	2,160	2,166
Revenues	2,300	2,450	2,460	2,504
Net Fiscal Impact	(152)	(296)	(300)	(338)

## Summary

This proposal improves health outcomes for newborns and reduces medical costs by strengthening Minnesota’s Newborn Screening Program. The changes include adding tests for severe immune system disorders and serious heart defects, expanding public education efforts, and adjusting fees to match costs.

## Background

Newborn Screening is a legally mandated initiative that screens babies at birth for serious, but treatable health conditions. Approximately 68,000 infants are born in Minnesota each year, nearly all of whom receive newborn screening.

The screening detects harmful or potentially fatal conditions in newborns to protect them from the serious problems that develop without early treatment. The conditions for which screening is performed may affect the infant’s metabolism, endocrine or immune systems, blood, breathing, or hearing and cannot be detected only through examination of the baby.

By working closely with physicians, hospitals, specialists, and parents, Minnesota’s Newborn Screening Program ensures all babies have access to

screening and that babies who have one of the conditions are linked quickly with care and treatment before symptoms develop.

The Minnesota Department of Health (MDH) has screened Minnesota newborns since 1965.

Approximately 180 children per year are found to have one of the 54 conditions on the screening panel. An additional 250 children each year are identified with hearing loss.

The Newborn Screening Program is fee based and is funded through the sale of cards used to collect the screening specimens. Hospitals and midwives purchase the cards, and the cost is included in the amount billed for the infant’s delivery and hospital stay and/or is reimbursed by insurance. The fee was last increased for screening purposes in 2007, from \$61 to \$101, primarily to support mandated hearing tests. In 2010 the fee was raised by five dollars to provide outreach to parents of children with hearing loss.

## Proposal

This proposal raises the newborn screening fee from \$106 to \$140 per specimen screened. The \$34 increase per specimen funds the following four activities:

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### **Severe Combined Immune Deficiency (SCID) and other T-Cell Lymphopenias Screening**

SCID, sometimes called “Bubble Boy” disease, refers to a group of conditions that result in a severe inability of the immune system to fight infection. If unrecognized and untreated, SCID often leads to serious chronic health problems or death. Survival beyond one to two years is rare without treatment.

Through newborn screening, babies with SCID can be diagnosed and treated before three months of age. Long-term survival for children treated before three months is greater than 95 percent. Without newborn screening, diagnosis is almost always delayed, increasing the risk of death and higher health care costs for treatment. Cost studies show that treatment for an infant with a late SCID diagnosis costs an average of \$2.2 million. Medical care for a child with an early SCID diagnosis is \$250,000. This proposal funds lab equipment, testing supplies, and staff to administer SCID screening.

### **Critical Congenital Heart Defects (CCHD) Screening**

Congenital heart defects are the most common and lethal of birth defects, accounting for nearly 30 percent of all infant deaths due to birth defects.

Critical Congenital Heart Defects (CCHDs) are heart defects that require surgery or intervention within the first year of life. Babies with a CCHD are at significant risk for death or disability if their condition is not diagnosed soon after birth. While some heart defects are found prenatally or at birth, not all are found before babies leave the hospital. By measuring blood oxygen levels, the screening detects critical heart conditions before visible

symptoms emerge. This proposal funds technology costs for CCHD reporting and follow-up.

### **Health Education**

The effectiveness of newborn screening depends on a strong partnership between the Newborn Screening Program and doctors and midwives who administer screening and on quick follow-up by parents whose children test positive for a condition. This proposal funds educational efforts to ensure parents and providers are aware of program changes and updated processes. It also supports enhanced education about newborn screening in the prenatal period and a broader health education initiative to increase parental, provider, and public awareness of newborn screening.

### **Fee Program Deficit**

A portion of the fee increase fixes a structural deficit in the Newborn Screening Program. By law, MDH must monitor fee accounts and recommend fee level changes to ensure that revenues approximate the costs to operate its programs. The current deficit emerged as program costs increased for equipment, technology, contracts, and supplies while revenues fell due to a steady decline in birth rates since 2007. Also, significant expenses to the program resulted from a number of recent lawsuits and a recent Minnesota Supreme Court ruling.

### **Rationale**

This proposal implements a recent U.S. Department of Health and Human Services recommendation that state newborn screening programs expand screening panels and improve educational and testing practices. Investing in new tests and enhanced education allows the program to further improve health outcomes for babies and reduce costs.

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